“You get hardened to it”: Nurses experience of working with severe and frequent self-injury

Elizabeth Boyd

A thesis submitted in partial fulfilment of the requirements of the University of Lincoln for the degree of Doctorate in Clinical Psychology

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Abstract
This study explored the subjective experience of nurses working with female in-patients engaging in frequent and severe self-injury. Instances of self-injury within female secure inpatient hospitals include scratching of the skin, self-ligation and removal of body parts. Six nurses working at a high secure hospital in England were interviewed using interpretative phenomenological analysis methodology. From the data, two super-ordinate themes were established; ‘Experiencing of affect’ and ‘containing processes’. ‘Experiencing of affect’ involved the sub themes: ‘fear of patient death’, ‘state of perturbation’ and ‘culmination of stress’. The theme ‘containing processes’ involved sub-themes: ‘Habituation’ (toward the self-injury), ‘enjoyment of the job’, ‘establishing boundaries’ and ‘peer support’. It was hypothesised that these latter themes provided some containment for nurses’ distress or protection from the negative impacts of working with self-injury. These findings differ somewhat from existing literature on professionals working with self-injury. The theoretical and clinical implications of these findings for nursing practice when working with self-injury are considered.
Statement of Contribution

Dr Phyllis Annesley (Consultant Clinical Psychologist and Clinical Supervisor for this project) helped at project proposal stage, aided participant recruitment and offered insightful feedback and supervision during data analysis and write-up. Dr Roshan das Nair provided invaluable help and supervision throughout the research process particularly during data-analysis and write up. Both I and Dr Annesley would like to thank all six staff members for their participation in this study.
‘You get Hardened to it’: Nurses Experience of Working with Severe and Frequent Self-injury Within a Secure Hospital

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Abstract

In an English secure hospital nurses work with individuals engaging in severe and frequent self-injury. Using interpretative phenomenological analysis, this qualitative study explored the experience of this on six nurses. Two super-ordinate themes were found: ‘Experiencing of affect’ and ‘containing processes’. Whilst nurses experienced fear of patient deaths, a number of containing processes meant they coped effectively with the self-injurious behaviour much of the time. Previous literature on professionals working with self-injury has described the experience as stressful and distressing. Therefore these findings further inform how professionals might experience working with self-injury. The theoretical and clinical implications of these interpretations for nursing practice when working with self-injury are considered.

Key words: Forensic, hermeneutic phenomenology; interpretive methods; interpretative phenomenological analysis (IPA); mental health nursing; provider perspective and behaviour; psychology; self-harm.
Many professionals within the physical and mental health field encounter individuals who self-injure. Self-injury varies enormously in severity ranging from skin scratching to self-ligation to removal of body parts (Favazza, 1992). Self-harm is defined as those acts of “self-poisoning or self-injury, irrespective of the apparent purpose of the act” (NICE: National Institute for Clinical Excellence, 2004, p.7). This broad definition reflects the lack of consensus amongst researchers and clinicians about the characteristics and definitions of self-injury and whether or not self-injury includes suicidal behaviour. In practice and research distinguishing non-suicidal from suicidal self-injurious behaviours is a debated and complex issue. The high prevalence of suicidal ideation amongst those who self-injure, which ranges between 28-41% across studies, reiterates the difficulty in differentiating suicidal from non-suicidal self-injury (Gardner & Cowdrey, 1985; Jones, Congin, Stevenson, Straus, & Frei, 1979; Pattison & Kahan, 1983; Walsh & Rosen, 1988). In addition to this, it has been found that amongst those who have self-injured, in the following 12 months after self-injury, the suicide rate rises to 30 times that of the general population (Cooper et al., 2005). With the close prevalence and association between self-injury and suicide (NIMHE, 2005) and the prevalence of both within the population under study, this article uses the term self-injury for all self-injurious behaviours irrespective of the purpose, function or nature of the act (NICE, 2004).

Prevalence rates of self-injury vary across studies due to the lack of consensus over definitions (McAllister, Creedy, Moyle, & Farrugia, 2002). Studies estimate the prevalence of self-injury ranges between 5.8% and 77% in clinical populations (Langbehn & Pfohl, 1993; Zlotnick et al., 1996). However in clinical inpatient units, rates of self-injury can be influenced by extreme outliers who engage in self-injury as often as 100 times a year (Swinton, Hopkins & Swinton, 1998). The client population within inpatient settings can also influence rates of self-injury. Many individuals with a diagnosis of borderline personality disorder (BPD) self-injure (Andover, Pepper, Ryabchenko, Orrico, & Gibb, 2005; Klonsky, Oltean, & Turkheimer, 2005).
In clinical populations, the prevalence of self-injury amongst patients with BPD ranges between 60 and 90% (Black, Blum, Pfohl, & Hale, 2004; Gunderson & Ridolfi, 2001; Shearer, 1994). Therefore for professionals in clinical settings working with patients with BPD it is highly likely they will work with individuals engaging in self-injury more frequently and who pose a greater suicide risk than other populations.

[See extended paper: Epidemiology of self-injury].

It is commonly accepted that nursing is highly stressful hence the plethora of research on nursing stress and the Government’s drive to tackle work stress and burnout (Bersani & Heifetz, 1985; Burnard, Edwards, Fothergill, Hannigan, & Coyle, 2000; DoH: Department of Health, 2002a, 2002b; McVicar, 2003). Psychiatric nursing can present particular challenges because of the nature of the client group, patient violence displayed and the unreciprocated care giving staff offer (Schulz et al., 2009). Working with self-injury and suicidal behaviour is a nursing stressor highlighted within the literature (Burnard et al., 2000; Loughrey, Jackson, Molla & Wobbelton, 1997; Melchior, Bours, Schmitz & Wittich, 1997).

[See extended paper: Nursing stress]

In July 2008, The PsychINFO, PubMed, OVID, EMBASE, ASSIA, UNLOC, Web of Knowledge and Web of Science databases were all searched from inception dates to present day. Boolean searching and truncation was used with the Athens search platform for primary studies with the key terms in this area including ‘self-harm*/injur*/mutilat*/wound*’, ‘suicid*’ and ‘parasuicidal’ behaviour. The search results were then refined with terms ‘professional’, ‘stress*’, ‘staff’, ‘patient*’ and ‘nurs*’. Following inclusion and exclusion study criteria a total

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4 Start date of searches for databases: PubMed (1950’s); EMBASE (1980); Medline (1950); ASSIA (1987); PsychINFO (1806); Web of Science (Science of Citation Index, 1900; Social Sciences Index, 1956; Arts & Humanities Citation Index, 1975).

5 Inclusion and exclusion criteria were based on my subjective evaluation of the relevance of the studies to the topic under study. Broadly however studies were excluded if studies were literature reviews or where the focus was suicide intent behaviours, where self-injury was not distinctly identified e.g. challenging behaviours, the study sample was self-injurers themselves, attitudes or beliefs about self-injury; training and knowledge of staff in self-injury and evaluation of such interventions; assessment, management, treatment and treatment efficacy of self-injury; service provision. Studies accepted for the
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of 11 studies were found, published since 1994. Only one of these studies related to nurses experiences of self-injury in long-term inpatient wards.

[See extended paper: Database search]

The literature commonly cites anecdotally how challenging it is to deal with those who engage in repetitive self-injury (Allen, 1995; Arnold, 1995; Connors, 2000; Hopkins, 2002; Huband & Tantam, 2000; McAllister et al., 2002; NICE, 2004; Raphael, Clarke & Kumar, 2006; Tantam & Whittaker, 1992). McAllister et al., (2002) state that self-injury can “evoke strong emotions and negative attitudes in [emergency department] staff” (p. 579). Johnstone (1997) refers to mental health professionals commonly experiencing emotions of despair, helplessness and rage when working with self-injury. Such is this prevalent view of working with those who self-injure that theoretical literature e.g. Dialectical Behaviour Therapy and Cognitive Analytic Therapy includes specific guidance for staff to manage their own emotions when working with self-injury (Linehan, 1993; Ryle, 1997). The current literature review revealed a paucity of systematic investigations investigating the psychological impact of self-injury with psychiatric nurses. Research with professionals working with self-injury tends to focus on attitudes and perceptions towards self-injury or the patients and the consequences of such cognitions on nurse-patient relationship and nursing care (Huband & Tantam, 2000; Maurice & Trudel, 1982; McAllister et al., 2002; McCann, Clark, McConnachie & Harvey, 2007; Patterson, Whittington & Bogg, 2007; Ramon, Bancroft & Skrimshire, 1975).

[See extended paper: Critique of current literature in this area].

Literature suggests a number of factors might influence staffs’ experiences of working with those who self-injure such as attributions about patients or the behaviour (Arnold, 1995; Favazza, 1998; Mackay & Barrowclough, 2005; Rayner, Allen & Johnson, 2005), level of nurses training or experience (Friedman et al., 2006; Raphael et al., 2006), staff gender or nature

literature review were those studies focusing on the experience of professionals, carers, parents or staff involved working with those who self-injure.
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of the patient-professional relationship (Fish, 2000; Mackay & Barrowclough, 2005), and the
degree of exposure to self-injury (Hastings, Tombs, Monzani and Boulton, 2003). Whether or
not patients are perceived to meet the socio-cultural role of a ‘good patient’ can also influence
the experience for professionals working with patients (Kelly & May, 1982; Johnson & Webb,
1995; Koekkoek, van Meijel & Hutchemaekers, 2006). Patients with a BPD diagnosis are often
labelled ‘difficult patients’ because of the complexity of their condition and the challenges these
cause for nursing (Bland & Rossen, 2005; Koekkoek et al., 2006). Labelling patients as difficult
can affect the nurse-patient relationship and nurses’ experiences of working with these patients
(ibid). The literature portrays therefore that working with patients who self-injure can be a
highly idiosyncratic experience because of a multitude of social, cultural, patient and
professional factors.

[See extended paper: Factors influencing experience of working with self-injury; role of
psychiatric nursing; difficult patients; borderline personality disorder; countertransference].

The impact of working with self-injury has been explored with doctors and nurses
within Accident and Emergency (A & E) departments and Medical Admission Units using
qualitative designs e.g. grounded analysis, interpretative phenomenological analysis (IPA) and
thematic analysis (Anderson, Standen & Noon, 2003; Hadfield, Brown, Pembroke & Hayward,
2009; Holdsworth, Belshaw & Murray, 2001; Mackay & Barrowclough, 2005). These studies
find a number of consistent themes. Staff members in these departments tend to focus on the
medical aspects such as treatment of wounds rather than any psychological concerns the
individual might have (Anderson et al., 2003; Hadfield et al., 2009; Holdsworth et al., 2001).
Despite this focus on the physical aspects, those working with people who self-injure can have
negative emotional responses such as anger, helplessness and frustration provoked in them
(Hadfield et al., 2009; Holdsworth et al., 2001). These reactions can arise through role or
practice limitations or lack of specialist skills and knowledge to help the patients therapeutically
(Anderson et al., 2003; Hadfield et al., 2009; Holdsworth et al., 2001). Difficulty in identifying
with the patient’s distress and their self-injurious behaviour can also be a factor in staff’s

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emotional response (ibid). It should be considered that A & E professionals have only brief interactions with self-injurers whereas nurses within secure hospital settings experience different practice demands and are likely to experience longer term relationships with patients (Baker, Richards, & Campbell, 2005; Maden, Curle, Meux, Burrows & Gunn, 1995).

[See extended paper: Mental health professionals’ experiences of self-injury]

The only research pertaining to the experiences of psychiatric nurses working with self-injury was that by Wilstrand, Lindgren, Gilje & Olofsson (2007) in an acute medical setting in Sweden. Using content analysis of interviews, themes of ‘feeling burdened with frustration’, ‘feelings related to life-threatening nature of self-injury’ and ‘abandonment of co-workers’ were constructed. In addition, a theme of balancing professional boundaries was found which encapsulated nurses’ descriptions of wanting improvement in care provision, tolerating their personal feelings and the need to have confirmation and support from their co-workers. This study suggested nurses had difficulty coping with a variety of emotions when working with self-injurious patients. Furthermore, they had difficulty maintaining consistency across the staff team in patient management and care. Such organisational and professional difficulties as a source of frustration have been found in nurses’ experiences of suicidal patients within A & E departments (Anderson et al., 2003) and in other professional groups working with self-harm and suicidal behaviour (Anderson et al., 2003; Hopkins, 2002; Loughrey et al., 1997; McAllister et al., 2002; Raphael et al., 2006; Slaven & Kisley, 2002).

[See extended paper: Psychiatric nurses and self-injury]

There is a gap in the literature for quantitative or qualitative enquiry into psychiatric nurses’ experience of working with severe and frequent self-injury in long-term in-patient settings (Thompson, Powis & Carradice, 2008). Understanding staff reactions to individuals engaging in self-injury is important for the quality of the therapeutic relationship and therapeutic milieu (Connors, 2000; Markham & Trower, 2003; Morgan & Priest, 1991; NICE, 2004; NIMHE, 2005; Wilstrand et al., 2007). It is also important for understanding the needs of staff and to inform effective support systems for staff (NICE, 2004; Wilstrand et al., 2007).
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aim of this study was to explore psychiatric nurses experience of working with self-injury within a female inpatient psychiatric service, including how nurses made sense or coped with their experiences.

[See extended paper: Significance of understanding impact of self-injury on staff; Rationale]

Method

Research Design

Phenomenological research is a useful and recognised framework for capturing healthcare professionals’ work-related experiences and meanings thereof (Drew, 1993; Fade, 2004; Yardley, 1997). As embodied individuals, nurses’ experiences and understanding of their encounters with patients will be infused or shaped by their a priori experiences, assumptions and beliefs. Therefore in order to understand nurses in-depth lived experience working with self-injurious individuals, a qualitative methodology was needed that would also allow for an interpretation of their idiographic experience and meaning-making as viewed from the embodied, cognitive-affect and existential phenomenological perspectives (Smith, Flowers & Larkin, 2009). For these reasons, interpretative phenomenological analysis (IPA: Smith, Jarman & Osborn, 1999; Smith & Osborn, 2004) was undertaken for interpretation of nurses’ life-world or Lebenswelt (Smith & Osborn, 2003/2006).

Theoretically, IPA derives mainly from phenomenology, in particular that associated with Heidegger (1927/1962). It also draws on hermeneutics, idiography and social constructionism. The hermeneutic approach considers that meaning is hidden but can be accessed through reflection and interpretation of the participant’s experience by the researcher. In IPA the role of the researcher and their fore-conceptions for the interpretation is acknowledged. It is argued that it is unrealistic to assume that all fore-conceptions can be bracketed out from interpretation (Finlay, 2008; Luft, 1969). Therefore fore-conceptions are critically reflected upon by the researcher during the interpretative process (Munhall, 1994; Ricoeur, 1995).
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[See extended paper: Research design; Epistemological position; Methodology; Researcher; Bracketing; Research Diary).

**Setting**

Participants were recruited from a high secure hospital in England housing a unit for female patients comprising around 50 patients and approximately 220 staff. Patients are held under the Mental Health Act 1983 (as amended by the Mental Health Act 2007).

[See extended paper: Setting]

**Participants**

Previous studies using IPA to study experiences of working with self-injury (Thompson et al., 2008; Wilstrand et al., 2007) and sample sizes recommended for qualitative methodology and IPA (Smith et al., 2009) were considered for determining sample size. To meet the primary aim of obtaining rich idiographic descriptions, six participants were interviewed (five female; one male). Participants experience working on the unit ranged between 3 and 18 years.

[See extended paper: Procedure; Participant recruitment; Sample size; Participants]

**Procedure**

Interviews conducted by myself were 45 to 90 minutes in length. Each interview began with an initial question to orientate the participant and establish rapport: ‘Could you tell me about a particular incident of self-injury that you have experienced whilst working here?’ Follow on questions and prompts were used to facilitate the interview and clarify meanings and obtain rich details regarding their experiences.

[See extended section: Interviews; Semi-structured interviews]

**Ethical consideration**

All participants gave written consent to participate in the study. Interviews were audio-taped and transcribed with confidentiality and anonymity assured. Participants had the option of 15 minutes debrief time with myself following each interview and were advised on local staff support systems available to them. The local Research and Development department and the
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Nottingham Research Ethics Committee 1 gave their approval for the research on 5th January 2009. [See extended paper: Ethical considerations; Materials. See Appendix A]

**Analysis**

Analysis was undertaken within an IPA framework (Smith & Osborn, 2006). Following transcription of interview data, participants were assigned pseudonyms to protect anonymity. Analysis is described here in a number of stages although in reality this is not necessarily such a linear process. During immersion in the data, my linguistic, descriptive and interpretative comments and any identifiable themes were recorded besides the transcript. This process of analysis through abstraction continued until I could find no new themes from the data. To check for internal consistency and evidence for the themes, all transcript excerpts relevant to particular themes were copied to separate files [See Appendix B]. This also highlighted divergences and convergences within themes themselves. Themes were clustered using abstraction and reference to the research aim using bubble maps [See Appendix C] to identify relationships between themes such that super-ordinate themes were identified. All participants’ super-ordinate and subordinate themes [see Appendix D] were then grouped to form a master table of themes [See Appendix E] based on the most consistent and relevant themes across all participants. [See extended paper: Analysis]

**Quality assurance**

To ensure the research was scholarly rigorous, reliable and valid, principles of quality assurance appropriate for qualitative methodologies were considered (Elliott, Fischer & Rennie, 1999; Yardley, 2000). Sensitivity to context was ensured by a detailed critical review of the literature, an understanding of the theoretical underpinnings of IPA and my interpretation remaining grounded in the participants’ accounts of their experiences. In addition, the cultural and occupational context in which data was generated and interpreted was considered. Use of a research diary provided the otherwise hidden introspective and reflective account of my own orientation, assumptions and experiences as researcher therefore providing transparency (Elliott et al., 1999).
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[See extended paper: Quality assurance; Role of the research diary]

**Results**

Based on the data two super-ordinate themes were interpreted to reflect the experience of working with self-injury: ‘Experiencing of affect’ and ‘containing factors’ [See Appendix F for diagrammatic structure of results]. ‘Experiencing of affect’ entailed three sub-themes; ‘fear of patient death’, ‘state of perturbation’ and ‘culmination of stress’. The second super-ordinate theme entailed four sub-themes of ‘enjoyment of the job’, ‘habituation’, ‘establishing boundaries’ and ‘peer support’.

[See extended paper: Additional minor themes; Minor themes excluded]

**Experiencing of Affect**

This super-ordinate theme conveys the nature and impact of affect experienced by nurses when working with self-injury.

*Fear of patient death.* This was a predominant experience for participants whilst working on the unit. The fear is portrayed in Gaia’s recall of a particular incident:

> She stuck it back down again so you are still yelling through the door and at the time you don’t sort of think of it all, you are thinking ... we have got to get this out otherwise she is going to peg it and we were sort of screaming and yelling at her (Gaia).

Patient creativity in self-injury methodology meant nurses always had to be alert in order to prevent possibly life-threatening self-injury. It was the life saving techniques involved

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6 The names of participants used within the article are fictitious pseudonyms.

7 (...) is used where material has been removed or is unknown.
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and a perceived responsibility for preventing deaths however that left one participant feeling

“completely out of [her] depth”. Another described it as:

At the end of the day, it’s their life in your hands and when it’s somebody’s mortality at your finger-tips, that is what’s scary. (Alice)

Although none of the participants had experienced a patient death personally, they did describe occasions when they had saved a life. This reinforced to them the life-threatening nature of this level of self-injury. The fear of a patient dying was related to the possible repercussions for them as nurses. They feared their competency and professionalism being judged by others and their jobs being at risk:

That wariness of ‘have I done everything, am I doing everything that I could have been doing’, because if that patient had died they would have looked back and said ‘well she’d done this a few times previously why hadn’t this been done, why hadn’t that been done (Steff).

For nurses in this study concerns about a patient dying, their careers as well as concerns about their own safety due to the threat of violence from patients, resulted in a fearful experience at times.

State of perturbation. The second sub-theme defined as ‘anxiety, mental uneasiness’ (Soanes & Stevenson, 2005, p. 1315) demonstrates how particular episodes of self-injury or fear thereof impacted on them such that it permeated their thoughts both in work and at home. One participant described this as:

I was thinking about it at night when I was in bed. It was still there. Unfortunately my partner was on nights that night as well, which did not help and I just thought, the one night I could do with him being at home, not particularly to talk to him about it, just to,
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for somebody to be there and it was in my head for most of the night ... it is still something that I really do think about a lot (Jayne).

Participants described perturbation on occasions where they believed the self-injury was likely to occur. They described this experience as something intuitive:

You just know, there’s something in the back of your mind, when you work there all the time ... Weird feeling. It affects the back of your neck. There was just something not right (Alice).

This perturbation appeared connected with the instant adrenalin response during incidents that persisted some time after the incident. One participant described it as:

Yeah I think it’s [adrenalin] there for the rest of the shift and then if there is a lot of blood particularly. When anything happens the adrenalin just goes. It’s just automatic now, a normal response (Sophie).

*Culmination of stress.* Participants described crescendos of stress resulting from the impact of incidents occurring in quick succession, often resulting in them taking sick leave:

Sometimes it’s just like a build up of things. Like we had the death and we had the really nasty day that day like self-harming and I came in the next morning and found someone with a ligature around their neck and I just couldn’t deal with it then (Jayne).

The stress affected them physically and emotionally which then impacted on their ability to perform in the role with others:

My blood pressure was quite high and it concerned me ... Blood pressure has always been fine. And I knew I wasn’t right in myself because usually when I’m at work or out

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8 Square brackets within participant quotes ([ ]) are used for clarificatory information.
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of work I am all smiling and laughing that sort of thing and I didn’t want to talk to anyone (Steff).

This theme highlighted how demanding and stressful the role is and participants’ ability to cope on a daily basis with the self-injury. Participants managed to the point when incidents became so frequent they had little time to recoup. Stress was likely to occur on these occasions.

**Containing Processes**

The interviews were dominated by factors that provided participants with a sense of containment from the unfavourable experiences of working with self-injury.

*Enjoyment of the job.* Nurses described how much they loved the job and working at the unit. They enjoyed the busy and varied nature of the role. This enjoyment appeared compensatory for the difficulties they encountered. They also described the unique and challenging role and the prestige of working at a high profile unit:

> When people ask me what I do, I do say where I work as I do feel quite proud to be working here because not everybody can do it and not everybody can work in the women’s service ... we do work hard, it is more difficult work. But I wouldn’t change that (Steff).

The challenge of the job and the enjoyment of it provided a sense of satisfaction and self-worth:

> I need to be doing something that I love and am good at for me to process and be better in the outside world as well ... a better me because I am doing something that I want to do, something that I like doing (Jayne).

*Habituation.* The frequent exposure to, and predictability of, the self-injurious behaviours appeared to habituate nurses to the anxiety of the wounds themselves. The reduction of any anxiety or shock about the wounds or self-injury appeared facilitated by self-injury being...
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seen as the norm on the unit and the apparent conditioned systemic response to self-injurious behaviours:

The self-harming it is just part of it and you deal with it day in day out and you know, you don’t very often get through a week where you haven’t seen some kind of blood or wound or something or you know took a ligature off somebody (Jayne).

It appeared that this process occurred over time through repeated exposure:

Some patients come in with new behaviour that people haven’t experienced before and for a little while its awful but even that becomes normal behaviour because people start copying it and so it goes round and it just gets to be normal behaviours (Gaia).

As participants were so exposed to the self-injuring on a daily basis, they believed they had become hardened to it over time as though the impact no longer penetrated them or was able to impact on them:

The longer you’re here, the less it [self-injury] affects you really... I think you just get hardened to it. I think over the years it just gradually filters away (Tim).

**Maintaining boundaries.** Maintaining boundaries could be sub-divided into maintaining the boundaries with patients and with work. Participants conveyed a definite sense of not accepting responsibility themselves for patients self-injuring despite patients trying to lay blame upon them:

I don’t feel responsible at all because that’s her choice, her choice to do it. She’s got a long history of self-harm anyway... I’ve told her that I’m not going to accept hurting herself as an excuse, that my leaving is an excuse for doing that (Steff).
‘You get hardened to it’

Participants drew a line between themselves and the patients by defining the nature of their relationship with patients to avoid emotions getting in the way: ‘I never go over the line with them as such’ (Sophie). Their professionalism remained at the forefront:

No matter how much you enjoy working [with the patients], there is still that very distinct boundary between them and us because it is that working relationship so whilst you do have to maintain a really close working relationship with them, that’s it (Gaia).

Participants knew they had to work closely with patients but not so close that the relationship became less therapeutic and more personal. Therapeutic relationships were such that they knew and understood the patient well enough to be able to predict behaviours and hence occasions when self-injury was likely to occur. As one participant described:

It’s important to know them ... in this setting it is easier to maintain that relationship and get that therapeutic relationship and understand them better ... it helps me work with it better I think because I think I know what they are capable of more probably with the self-harm and everything else but more like you know how far they are going to go or what kind of behaviours trigger things (Jayne).

Social therapeutic time with patients was also a preventative or functional stratagem against self-injury:

I do stay quite close to them. I play scrabble with the girls ... the way I see it well I’m better doing that really than leave them on their own ya know (Tim).

Maintaining boundaries also related to a line being drawn between home and work. For the participants this helped fix anxieties or worries about work within the work setting and prevented seepage into their personal lives. One participant described:
‘You get hardened to it’

I don’t go home and worry, no I don’t take it home with me. I might have ten
minutes when I get home moaning and groaning and stuff but after that we’ve kind
of said … work is work and home is home (Gaia).

However participants acknowledged that this was not always easy:

Here I can’t be angry so I kind of bring it all up as soon as I get home. If the washing
isn’t done, I blow up (Jayne).

The nurses also drew on their professional role and responsibilities to maintain this
emotional distance:

It’s a patient, I’m here to look after them, I’m here to make sure when I walk off the
shift they are breathing (Sophie).

Maintaining that distinction between work and home was helped by the physical
boundary around the hospital itself. It appeared that nurses used the physical act of coming in
and out of the security gates to separate work and their life (and emotions) so that neither
penetrated the other:

What I personally feel about it that’s got nothing to do with it because when I come to
work I do my job and my personal feelings are left at the control room…what I think
about things, that’s just my thoughts, but when I’m at work I’m a nurse and then I just
have to do the job, well, try to anyway (Steff).

The establishment of boundaries with the work and the patients might suggest a defense
against the mental and emotional impact of the work on the self. These boundaries gave a sense
of containing a functionally close nurse-patient relationship rather than an emotionally close
one. Participants conveyed these boundaries as vital for them to perform in their role without
incuring work stress.

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Peer support. This was what nurses used to emotionally ventilate and validate their embodied experiences with self-injury alongside their use of formal support systems; supervision and debriefing. A sense of togetherness as a team in dealing with the impact of the work appeared important:

We have got quite a good team on the ward so you have formal supervision but you also have supervision a lot more than that, just more informal (Gaia).

Peer support took the form of talking at work and talking outside:

If something bad has happened, we tend to keep in touch with each other, text each other or ring each other, go out to meet for a drink, go out for the evening, just do different things. And that helps. That does help (Steff).

Participants indicated that debriefing felt restrictive (e.g. time and formality) compared to how they wished to recover from an incident. Hence their use of peer support. Participants also reported that due to staffing constraints, debriefing was not always available when they required it or was not enough because they had to go straight back onto the ward. One participant described it as:

Sometimes you can have that [debriefing] but because we are so short staffed at times it’s difficult. That day when I was involved in . . . really two serious incidents, we were debriefed in the morning, but in the afternoon because we had to go to the hospital, I wanted to go home. I was absolutely a wreck. I had to stay on a long day till half past nine, not just me but the rest of my colleagues and we had all been involved in both those incidents and it was absolutely awful (Alice).

Participants imagined a more useful form of debriefing:
‘You get hardened to it’

A debriefing thing where we could talk about it but not how they want to talk about it. ... but it would have to be in a more relaxed environment, taking us completely away from it ... them not saying you’ve got half an hour to talk about it ... somewhere we can sit down, go for a drink ... and then you can say what a fucking day. And then it just all comes out about how it all happened and thoughts and feelings rather than we have this amount of time, sit here you talk about it ... then to give you the reaffirmation that you have done your job as you should be doing (Sophie).

It appeared that peer support was highly valued when working with self-injury for reassurance, validation and ‘emotional ventilation’. Emotional ventilation is a term used here to encapsulate the process whereby participants verbally vented their frustration, concerns and feelings with one another. They appreciated that organisational systems were in place to support them and utilised these, but it also showed how the real support stemmed from their colleagues. This validated what they experienced and how they coped with the stressors.

Discussion

The variety of emotions indicated in the literature as experienced by mental health staff working with self-injury such as self-recrimination, guilt, rage, resentment and sympathy toward patients were not reported by participants in this study (Clarke & Whittaker, 1998; Feldman, 1988; McAllister et al., 2002; Wilstrand et al., 2007). Furthermore, this study did not find nurses overwhelmed with emotions as might be expected from existing literature (Loughrey et al., 1997; Perseius, Kåver, Ekdahl, Åsberg & Samuelsson, 2007; Wilstrand et al., 2007). These participants did not report that working with the self-injury was in itself problematic as has been indicated with psychiatric nurses working with self-injury elsewhere (see Wilstrand et al., 2007). The containing aspects of the participants’ experiences found here might account for these divergences from the literature. This study did find that nurses were fearful of life-threatening self-injury. This was supported by feeling perturbed by serious incidents when they occurred or the imminent sense thereof. These fears centred on the possible
repercussions for themselves such as being judged negligent. This contrasts with previous research where nurses have self-recriminated for actions they might or might not have taken leading up to a self-injurious incident (Perseius et al., 2007). The fear over the potential repercussions should a patient die has been found in other qualitative studies exploring impact of self-injury (Loughrey et al., 1997; Wilstrand et al., 2007) and working with patients with BPD (Perseius et al., 2007). Within the context of a high profile maximum secure hospital and the possible public and media scrutiny if untoward incidents occur, it is perhaps unsurprising that nurses are fearful of being blamed or judged culpable (Higgins, Hurst & Wistow, 1999; Leicestershire Health Authority, 1997; Prins, 1993; West Midlands Regional Health Authority, 1991). This may account for the differences between the impact participants report in this study and that of other nurses in other settings.

**Containing Processes**

Containing process encapsulates how certain factors ameliorated the distressing or stressful aspects of working with self-injury. I interpreted that the containing processes facilitated nurses’ emotional detachment from the self-injury but also the patients. It is also possible that the limited staffing resources, the frequency at which self-injury occurs on the unit and the demands of physically attending to the injuries means that nurses have less opportunity to emotionally engage with the patients. This was illuminated by one participant reporting that playing scrabble with patients was criticised by colleagues because it was not deemed a nursing priority. The socio-cultural perspective should also be considered in respect to the inherent tension nurses have in establishing relationships with mentally disordered offenders (MDOs) and maintaining dual roles as nurses but also enforcers/detainers (Caplan, 1993; Holmes & Federman, 2006). Nursing of MDOs within a humanistic philosophy can be morally and ethically challenging (Foucault, 2006; Mason, 2002; Mason & Chandley, 1990). Nurses are not immune to feeling dispassionate or negative about treating particular individuals (Kent-Wilkinson, 1996; Podrasky & Sexton, 2007). Besides nursing, nurses must enforce discipline which requires surveillance and control within clear power differentials. Nurses in this study...
'You get hardened to it'

outlined those clear boundaries of watching behaviours and observing patients rather than knowing them. Issues of control, personal safety and power are barriers to altruistic nursing relationships with MDOs (HMSO, 1992; Mason, 2002) and form a gap within the nurse-patient relationship. It is perhaps not surprising that in this context these participants did not experience being burdened by their emotions or that they had sufficient emotional distance to not experience distress from patient self-injury.

Nurses comparing themselves with other nurses in the hospital who disliked working at the female unit exemplified how participants gained self-respect for undertaking this unique and challenging role. As well as enjoying the busy and varied work participants appeared interested in their role and conveyed a confidence and sense of empowerment from the work challenges. Perceived personal reward as a factor in coping with work stressors has been encapsulated within the model of effort-reward imbalance (Siegrist, 1996). This model postulates that efforts or costs within a work role need to be equalised by the respective rewards to prevent stress. The importance of perceived rewards for reducing stress or burnout by staff working in challenging roles like psychiatric nursing is also endorsed within the literature (McVicar, 2003; Schulz et al., 2009).

Nurses’ discussion of how over time they became numb to the self-injury suggests a process of change over time. It is suggested that time and experience working with self-injury as well as the socio-cultural context of self-injury on the unit had resulted in them becoming desensitised to self-injury. Habituation to the self-injuries has relevance to literature of repeated exposure to extreme affect laden stimuli resulting in a reduction of physio-psychological reactions (Averill, Malmstrom, Koriat & Lazarus, 1972; Bradley, Lang & Cuthbert, 1993; Dijksterhuis & Smith, 2002; Klorman, 1974). However this presumes that when first working with the self-injuries, nurses experienced some anxiety. Participants’ descriptions of the routine and socialisation to managing self-injury on the unit appear reflective of a shared objective practical belief system almost dissociated from the patients and the patients’ distress.

Organisational culture is ‘the system of shared meanings, including language, patterns of
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behaviour, value systems, feelings, attitudes, interactions and group norms of its members’ (Harvey & Brown, 1996, p. 11). It is suggested that nurses’ descriptions of, and interest in, the physical injuries and the creativity of patients’ methods to self-injure is a reflection of nurses focusing on the physical as opposed to the emotional perspective. This allows them to detach or distance the self from the unbearable. Methods nurses or staff find to detach themselves from the psychological stresses of nursing is reported elsewhere such as the use of humour, ‘acting’ in the role, and focusing on the physical or technical (Carlen & Bengtsson, 2007; Hadfield et al., 2009; Hay & Oken, 1972; Wilstrand et al., 2007). The focus on the rudimentary aspects of their role was highlighted by one participant’s statement that if patients were ‘breathing at the end of the shift’ (Sophie) they had done their job. It is possible that this is an example of nurses’ distancing themselves from distress.

Nurses in this study were certain about the need for establishing boundaries with patients such that responsibility for the self-injurious behaviour remained with the patients. Previous literature has suggested that professionals can feel guilty or responsible when self-injury occurs (Fish, 2000) or that staff have difficulty maintaining such boundaries (Thompson et al., 2008; Wilstrand et al., 2007). These participants conveyed the sense that the boundaries with patient and their work were a strategy to lessen the emotional impact on them in this work. Theoretically nurses’ perception of locus of control for self-injurious behaviour remaining within the patient could also be seen as nurses projecting responsibility back to the patient by way of defence from anxiety (Rayner et al., 2005). Huband and Tantam (2000) argued that prolonged exposure to self-injury increases the likelihood of professionals doing the latter. This was deduced from findings that inpatient staff (who tend to experience more self-injury) were more likely to believe patients had control over their behaviour than day care or outpatient staff (Ibid). Therefore nurses establishing boundaries and rejecting responsibility for patients’ behaviours might be a result of defensive projection (Feldman, 1988). Irrespective of whether these boundaries are a rational, emotional or unconscious undertaking, the participants described these strategies as effective for avoiding the emotional impact of the work. Indeed
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Currid (2008) found that acute mental health unit nurses framed their experience of stress as when their home/work balance became disrupted. This suggests that these work/home boundaries found here are reflective to nursing in other contexts and not specific to working with self-injury.

It is postulated that to be therapeutically beneficial for the patients and psychologically beneficial for the nurses, there needs to be existential, emotional, physical and psychological commitment, known as intimacy, on the part of the nurse (Kadner, 1994; Mattisasson & Hemberg, 1998; Salvage, 1990; Webb & Hope, 1995; Williams, 2001a, 2001b). However others assert the need for clear conceptualisations for terms such as ‘closeness’ in nursing according to professional and personal perspectives (Peplau, 1988). This study indicates that the nurses’ actively ensured closeness with patients but only in a professional capacity.

The use of peer support amongst nurses as a containing factor is supported by Wilstrand et al’s (2007) study in which nurses’ spoke of discussing those emotions and thoughts hidden from patients with their peers. Nurses in this study reported that supervision was used and helpful. However, they also reported debriefing was often unhelpful for reasons that it was conducted inappropriately or was ill-timed. With participants stating that stress occurs at times when incidents occur in quick succession, it suggests that effective debriefing is highly important. Studies of debriefing effectiveness are not only scarce but problematic because of the heterogeneity across studies in the processes and nature of the debriefing practices (Dyregrov, 1997; Raphael, Meldrum & McFarlane, 1995). Nurses in this study indicated a number of ways in which they believed debriefing could be more supportive and helpful to ‘let off steam’. Such suggestions have been indicated previously for those working with self-injury (Fish, 2000). The participants here appeared to benefit most from the informal day-to-day support of their peers for their emotional ventilation although some described this as ‘moaning’.

[See extended paper: Discussion]
Conclusion

This article presents the first qualitative analysis of psychiatric nurses' experiences of working with severe and frequent self-injury in a secure hospital within the United Kingdom. Much of the existing literature is anecdotal regarding professionals' experiences of working with self-injury. This article has provided an in-depth understanding about the nursing experience when the behaviour is at its most severe and frequent. This study found whilst participants spoke of stress on occasions, they did not find working with self-injury as stressful or distressing on a daily basis. Nurses in this study believed frequent exposure to self-injury on a daily basis resulted in them habituating to the sometimes horrific injuries they encountered. This has not been found or acknowledged in previous research in this area. Nurses did convey a sense of fear because of the life threatening nature of some self-injurious behaviour. Nurses’ fear of the latter appears related to the concerns for patients themselves but also concern for the potential litigation as a result of a patient death. Establishing boundaries and utilising peer support appeared to protect the nurses from the emotional impact and involvement of working with self-injury and patient distress. A culmination of stress occurred when self-injurious incidents occurred in quick succession when nurses were unable to have adequate debriefing. With this being a high secure hospital and therefore quite a unique setting, the social and cultural influences upon nurses and therefore the nature of the therapeutic relationships maintained with patients is considered as a factor in why these nurses did not find working with self-injurious behaviour distressing per se. In particular these quite unique contextual factors are considered as instrumental in why staff undertook certain strategies to protect themselves. In addition, it might explain why it was that participants could habituate to the self-injury and derive pleasure from their role. However these were seen as effective for staff and could therefore inform other settings as to mechanisms or strategies that may be beneficial for staff when working with those who self-injure.
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**Researcher Reflection**

As a social constructionist and hence my beliefs surrounding the co-production of knowledge and meaning, IPA allowed me to acknowledge my a priori ideas about clinical work with self-injury but also captured the differing realities both through the research question and the methodology. As a research instrument, a brief summary of my reflexivity regarding my position and perspective in relation to this research and the participants needs to be outlined for credibility (Aldridge & Aldridge, 1996). From my past experiences within forensic and inpatient mental health settings I gained an embodied and psychosocial understanding of the difficulty maintaining dual roles of being a professional in a therapeutic capacity but also an enforcer/custodian. I also have the belief that because of this obstacle in my therapeutic relationships, I was able to distance myself such that I did not suffer adversely when those individuals harmed themselves or died. As researcher I need to ensure that I do not look for these assumptions to be fulfilled at the expense of them also being questioned or modified (Research diary, 10.05.09). [See Appendix G: Research diary]

For purposes of worthiness and credibility, a research diary excerpt has been selected as an example of the hermeneutic circle:

‘In thinking also about the double hermeneutic and coming from a questioning but empathic position, my initial interpretation is nurses appeared protected from what might otherwise be a very emotional experience. I have the image of a glass shield between nurses and patients that allows a panoptic emotionally impenetrable view of patients and their behaviour. The theme of containment has resonance within this clinical context with it being a secure hospital and patients being contained. Just as patients might self-regulate their emotions through self-injury, nurses also attempt to self-regulate their emotions using their own mechanisms. The need to avoid or manage the emotional aspect of working with self-injury appeared consistently across all the transcripts despite alternative interpretations being made. This interpretation indicated how my pre-research horizon of nurses absorbing and being burdened with emotions,
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based on the literature and my clinical experience, was challenged and altered throughout the research process’ (Research diary, 10/10/09).

[See extended paper: Critical reflection]

**Clinical Practice Implications**

The study highlights how important the use of boundaries, peer support and perceived rewards were for participants when working with those who self-injure. The participants in this study had an average of eight years experience in this service. Aside from training and education being provided to help nurses working with self-injury in this setting, staff should be encouraged in building their resilience to work stressors. Self-care, reflection, life balance, positive professional relationships being built through networks and mentoring and maintaining positivity through positive emotions, laughter and optimism are key strategies identified in Jackson, Firtko & Edenborough’s, (2007) review of the resiliency literature. All strategies that resonate with those which participants appear to be using in this study. Consultation with staff on how the service can best support staff in utilising these strategies is therefore recommended. Such strategies could also be encouraged through staff consultation, supervision and team training. A team training format would provide an opportunity for shared reflection and identification of staff’s strengths and abilities to cope with this environment and promotion of a shared sense of achievement and enjoyment in the role. Training around death of patients and procedural processes thereof might also alleviate fears associated with life-threatening self-injury.

This study has also stressed the vital role of staff support or debriefing on occasions when incidents are unusually frequent in a short period of time. Nurses wanted time away from the ward to be debriefed or for personal ‘time-out’ following incidents. However this was not often possible due to the need to ensure adequate staffing levels on the ward. Since data collection, a new post-incident diffusion and debriefing staff intervention system has been introduced. For minor and less serious incidents, staff are given immediate support on the ward known as diffusion therefore tackling the practical issue of ensuring adequate staff cover on the
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ward post-incidents. For the more serious incidents, a full psychological debriefing occurs. This new system should ameliorate some of the concerns identified by participants regarding the availability post-intervention staff support. Participants’ desire to ‘get away’ from the ward post-incident however is difficult to achieve and remains a practical dilemma for ward managers. The new support system is currently being evaluated within the service. Based on the findings regarding staff support needs, it is recommended that a more comfortable environment is provided for debriefing with refreshments available that facilitate staff to feel valued and nurtured at times of distress.

[See extended paper: implications for practice]

**Future research**

The aim of IPA is not to achieve representation in the sample with regard to population or probability. Future research could use this research as a guide to ascertain whether the themes found amongst these participants apply more generally within this setting but also other settings or populations in which self-injury occurs. Research could explore further the association between stress amongst professionals working with self-injury and factors such as habituation and therapeutic boundaries and the relevance of these themes as protective factors and exploring the impact of training or experience on this association. If an association were to be found, in-house questionnaires could be generated for future assessment and monitoring of the impact on staff working with those who self-injure. Exploring the lived experience of nurses in this setting reveals the complexity and subtlety of their experiences e.g. fear of patient deaths can relate to self-perceived personal incompetency or fear of others perceiving them as incompetent. Such specificity in nurses’ experiences needs to be considered in research employing questionnaire methodology and staff training.

There is an increasing need for meta-synthesis of qualitative studies to integrate and verify findings from isolated studies therefore improving understanding in particular areas (Sandelowski, Docherty & Emden, 1997). It is hoped that if further studies are conducted in this area in the future, this study will facilitate systematic reviews on working with self-injury in 0910, RES, Research Project, UoF: 4073829, UoFL: 07091309, Page 29 of 170
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and across different settings and contexts through techniques such as narrative inductive method or qualitative comparative analysis (Jones, 2004). With research suggesting the therapeutic benefit on patients in having close relationships with nurses (Huband & Tantam, 2000), this research highlights the difficulties nurses have in providing this without them feeling vulnerable to emotional burden. The findings of this study and the current research underway with staff at this high secure hospital on nurse-patient relationships with a cognitive analytic framework (forthcoming), would be complemented by further research with patients to explore their experience of the nurse-patient relationships and whether staff strategies demonstrated here are perceived as mutually beneficial by patients themselves.

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*Lodge Medium Secure Unit, Leicester*. Leicester: Author.


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work with young self-harming women showing borderline personality symptoms.  


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Extended Background

**Behaviours of self-injury.** Favazza’s (1992) classification of self-injury or self-mutilation falls into three categories. The first and most common type of self-injury is ‘superficial/moderate self-mutilation’. This type includes such acts as cutting, skin scratching, burning or interference with wound healing. The second category ‘stereotypic self-mutilation’ is characterised by the distinctive habitual and repetitive behaviours and is commonly seen amongst those with developmental disorder or learning disabilities. Such examples would include repetitive head banging. The third category; major self-mutilation’ such as self-enucleation, auto-castration or removal of body parts, is relatively rare (Favazza, 1992).

**Self-injury terminology.** There are many synonymous terms that exist for self-harm including ‘self-injury’, ‘deliberate self-harm’ (Mangnall & Yurkovich, 2008), ‘self-mutilation’ (Favazza, 1989; Nijman et al., 1999); ‘self-wounding’ (Huband & Tantam, 2000; Tantam & Whittaker, 1992), and ‘parasuicide’. This variety of terms has arisen over time from attempts to differentiate amongst self-harming behaviours. For example, it has been argued that self-harm behaviours where there is suicidal intent, differ structurally and functionally from acts which are a habitual coping mechanism for emotional regulation (Claes & Vanderereycken, 2007; Duffy, 2006; Klonsky, 2007; Suyemoto, 1998).

**Suicide and self-injury.** Individuals who have self-harmed may have difficulty identifying their motivation for the self-injury or be ambivalent about the intent behind it when asked retrospectively. Self-injurers may also deny the presence of any suicidal intent therefore avoiding mental health service involvement. Similarly, it is difficult to differentiate demographically between those who engage in self-harm and who have attempted suicide in the previous 12 months and those who self-harm without suicide attempts in community samples (Lloyd-Richardson, Perrine, Dierker & Kelley, 2007). This reflects the difficulty in differentiating those suicidal intent self-injuries and those non-suicidal. However, research has ascertained that individuals who engage in more moderate or severe forms of self-injury and who exhibit more varied and frequent forms of self-harm are more likely to report current suicidal ideation and previous suicide attempts (Lloyd-Richardson et al., 2007). This suggests
the association between suicidal behaviours and self-injury may be closer when self-injury is of greater severity.

The difficulty in differentiating self-harm according to the presence of suicidal intent is reinforced when the association between completed suicides and self-injurers is considered (Department of Health, 2002a; NHS Centre for Reviews and Dissemination, 1998). A four year follow-up study of 7968 self-harmers attending an A & E department found that the risk of suicide in people who have self-injured rises to 15 times that of the local population and 30 times that of the national population (Standardised Mortality Rate 15.4, 95% CI 11.8-19.9) (Cooper et al., 2005). In the same study, women were 23 times more likely to commit suicide following self-harm than women in the general population (SMR 23.2, 95% CI 14.5 to 35.1). Similarly men in this study were 13 times more likely to commit suicide than the men in the general population (SMR 12.9, 95% CI 9.2 to 17.8). This suggests that relative to the general population, women and men who self-injure are more at risk of suicide than men and women who do not engage in self-injury. Long term follow-up of outcomes following deliberate self-harm suggest suicide occurs at much higher rates than suicide in the general population (De Moore & Robertson, 1996; Ekeberg, Ellingsen & Jacobsen, 1994; Owens, Horrocks & House, 2002). However there is a higher rate of suicide amongst men than women (Cooper et al, 2005). Together these statistics suggest that prior to suicide, women are more likely to engage in self-injury than men but that males, when they self-harm, are more likely to commit suicide than females and that men are less likely to present to hospital previous to a suicide attempt. In respect of all completed suicides, over a quarter have a preceding episode of self-injury which further demonstrates the close association between suicide and self-injury (Owens & House, 1994).

Particular psychiatric diagnoses are also associated with a high risk of self-injury and suicide such as borderline personality disorder (BPD) (APA: American Psychiatric Association, 2000). Long-term follow-up studies have found that between 3% and 13% of patients with BPD commit suicide (McGlashan, 1986, Paris, 2002; Stone, 1993). Such evidence provides strong support for the association between self-injury and suicidal behaviour and the

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risks of the latter when dealing with those who self-injure. For this reason management and treatment of self-injury has become a prominent area of attention in relation to the Government’s strategy to improve mental health and to reduce suicide rates (DoH: Department of Health, 1999, 2002a; NICE, 2004). Therefore when working with self-injurers or those with BPD, the likelihood of managing suicidal intent and suicidal behaviours in addition to the self-injury is increased.

**Epidemiology of self-injury.** Incidences of self-injury often go unreported which means a true estimate is unobtainable. It is believed that statistics based on general hospital attendances only account for two thirds of actual incidences of self-injury (Kennedy & Kreitman, 1973). Estimates of self-injury within the general population range between 1 and 4% (Briere & Gill, 1998), which increases to 7% in student populations (Gollust, Eisenberg & Golberstein, 2007). Historically females have found to be two or three times more likely to engage in self-injury than men however more recent research indicates rates of male self-harm are now only slightly lower than that of women (Hawton & Fagg, 1992; Hawton, Fagg, Simkin, Bale & Bond, 1997; McLoone & Crombie, 1996). The mean age for women presenting with self-harm is 15-24 and for men 25-34 years (Charlton et al., 1992; Charlton, Kelly, Dunnell, Evans & Jenkins, 1993). However such statistics should be treated with caution as figures based on service attendances depend on when they present or become involved with health services as opposed to when the self-injurious behaviour began. Variation in the estimates will be due to definitions used for self-injury and whether or not suicidal intent behaviours are included within that. It is argued that such high associations between BPD and self-injury are as a result of self-injury being a diagnostic criterion for BPD as opposed to an association (Favazza, 1998).

**Nursing stress.** Stress amongst mental health professionals and nurses is frequently documented (Burnard et al., 2000; Loughrey et al., 1997; Melchoir et al., 1997). The subjective nature of stress, its severity or symptomatology and lack of consistency in conceptualisations of stress and burnout means measurement or classification of stress or a consensual understanding of the nature and common factors associated with stress is highly problematic.
A number of common methodological limitations in studies such as low or unrepresentative sample sizes, poor sample descriptions and a diverse number of unstandardised stress measurement instruments (Carson et al., 1996), make comparisons and conclusions difficult (Foxall, Zimmerman, Standley & Bene, 1990; McVicar, 2003). However meta-synthesis of studies of nursing stress offers some consistently found factors (McVicar, 2003). Nursing stressors include workload, leadership/management issues, professional conflict, dealing with families, the emotional burden of caring and violence exhibited towards them (Carson, Wood, White & Thomas, 1997; McVicar, 2003; Phillips, 1996). Within psychiatric settings, the close proximity to patients when they are in an aggressive or highly distressed mental state can be stressful because of the level of responsibility for managing the patients on these occasions, ensuring the safety of patients and the threat of violence towards nurses themselves (Lanza, 1983; Rooney, 2009). Working with patients and their distress can also be stressful however this will vary according to the nature of the nursing role and nurse-patient relationship, staff experience or training (Perseius et al., 2007). Melchoir et al., (1997) conducted a meta-analysis of published studies investigating variables associated with burnout amongst psychiatric nurses. Burnout can be defined as “a prolonged response to chronic emotional and interpersonal stressors on the job, and is defined by the three dimensions of exhaustion, depersonalisation/cynicism and inefficiency” (Maslach, Schaufeli, & Leiter, 2001, p397). Job satisfaction, staff support and involvement with the organisation was negatively associated with burnout such that these could be considered risk factors of burnout in psychiatric nurses.

However due to the idiosyncratic nature of burnout symptomatology (Kahill, 1988), there is huge variety in symptomatology which increases the likelihood of a definition of burnout being met even with only few symptoms such as anxiety and headaches (Beemsterboer & Baum, 1984). This makes comparisons of variables associated with burnout problematic. However, Melchoir et al.’s (1997) findings are not distinct from findings of studies of burnout in nursing with other populations (Blegen, 1993; Duquette, Sandhu, & Beaudet, 1994; Schaufeli, 1990). The studies used in Melchoir et al.’s (1997) meta-analysis were all published therefore introducing possible bias towards
only those studies with findings found to be significant. Sullivan (1993) however found a correlation between emotional exhaustion and the patient-care sub-scale of the purposefully-devised psychiatric nursing stress inventory, amongst nurses working in acute admission wards. The sub-scale of the psychiatric nursing stress inventory specifically captures the degree of contact with violent, high risk and behaviourally challenging patients. This might suggest working with patients who exhibit such behaviours increases the risk of nurse burnout however this was not a random sample of nurses working in acute admission wards. Furthermore, stress was measured by participants’ estimations of to what degree certain situations occurred in their work thereby failing to account for actual frequency or intensity of stressors. The psychiatric nursing stress inventory has not been validated and therefore its validity and reliability is also questioned. Therefore these conclusions associating emotional exhaustion with challenging behaviours on acute wards should be treated with caution.

Looking specifically at violence and psychiatric nursing stress, the literature is again inconclusive (Lanza, 1983). Lanza’s (1983) study found violence against nurses to be a particular stress factor however as a retrospective study it is questionable how much participants could accurately recall symptomatology retrospectively but also the influence of self-report bias without clinical stress measures to triangulate this data. Other findings have found assaults on nurses do not necessarily result in additional stress. Whittington and Wykes (1992) explored the impact of assault on staff in psychiatric hospitals and found that although the anxiety immediately after minor assaults (when not incurring physical injury) was high, it remained within normal limits according to the State-Trait Anxiety Inventory (Spielberger, Gorsuch, Lushene, Vagg & Jacobs, 1983) and levels of anxiety soon decreased following the incidents. Whittington and Wykes (1992) did however acknowledge such findings were only applicable to minor violent incidents and that there were outliers with a number of participants experiencing very high negative emotional reactions.

It has been suggested that factors related to management of aggressive or violent patients can also be a source of stress for nurses. Within psychiatric and/or in-patient settings patients can become so violent, distressed or
disturbed that they are placed under continuous observation because of concerns for their safety and that of others. Although a number of synonymous terms exist for this procedure ‘constant observation’ is an apt term for when patients are observed at close hand, sometimes behind a locked door of a seclusion room or in physically close proximity (Rooney, 2009). The practice and method of constant observation varies across settings according to the level of security, risk, local policies and procedures and nurse responsibilities. Guidelines by the Standing Nursing and Midwifery Advisory Committee (1999) define it as a nurse being within an arm’s length of a patient at all times (Bowers, Gournay, & Duffy, 2000). The distressed mental state and behaviour of patients undergoing constant observation can often be quite extreme. Patients being observed can sometimes see this as controlling and punishing and are often hostile to the observers as well as being highly emotive. Nurses can find the experience stressful not least for the risk of injury to self but also being in such close proximity to the patient and bearing the brunt of the patient’s distress and hostility (Busteed & Johnstone, 1983). Typically nurses carrying out this role are responsible for ensuring the ongoing safety of the patient and preserving life. Rooney (2009) explored nurses’ constant observation experiences using a phenomenological enquiry approach with six un/registered nurses within an acute psychiatric setting. Six themes were established. Nurses saw the importance of being in the moment with the patients and had a sense of pride in carrying out the role despite it being challenging. Nurses saw constant observation as a chance to engage with the patients in a therapeutic way. They acknowledged that with the competing role involved in observation and the power imbalance (safety, containment and care), it was difficult to always respect the patient’s rights and dignity or feelings. Furthermore it was acknowledged that the experience could be physically draining with the degree of alertness, knowing what to say to patients but also spending an hour in close proximity to someone highly disturbed or distressed. Nurses appreciated the support of their colleague during constant observation in case of eventualities which is indicative of the demands made upon nurses conducting the procedure. One theme was the nurse’s sense of responsibility over the situation and possible consequences if something serious or wrong were to happen.
Further research using stress measurement tools with staff conducting constant observations is needed to further validate these qualitative findings.

White-Kress (2003) postulated that when nurses’ reactions to self-injury are intense, the risks of burnout or vicarious trauma are increased. Such claims are unsubstantiated in research however. Burnard et al. (2000) found that amongst 301 community mental health nurses, ‘client-related factors’ such as self-harm were third in a rated list of 27 different sources of job stress. It is hypothesised that sources of patient-related stress for community mental health nurses would differ to psychiatric nursing stressors due to differing nursing practice demands, the increased severity of psychiatric patients’ challenging behaviours and increased levels of interaction and contact with patients on psychiatric wards. A lack of comparative research of job stressors amongst mental health professionals in differing roles means that it is not clear whether psychiatric nursing might be more stressful than nursing of other patient groups or nursing roles (Maslach & Jackson, 1982; Melchior et al., 1997; Savicki & Cooley, 1987; Sullivan, 1993).

In summary there appear to be a number of sources of stress amongst nurses and in particular psychiatric nurses. Relative to stress amongst other nursing populations or nursing of other groups, the evidence of particular stressors for psychiatric nurses is inconclusive. Studies are needed that compare nursing stress when working with different populations and in different settings to inform the literature. However the difficulty in differentiating and measuring particular client related stress factors such as self-injurious behaviours stressors independent of organisational or professional factors remains a problematic methodological issue.

**Database search of relevant studies.** Studies with the focus on staff attitudes, opinions or attributions towards the self-harm/injury/mutilation or management of self-injury were excluded as evidence in this area is comprehensively documented elsewhere and was not the focus of this research. Of the relevant papers found in the database search, one study related to nurses’ experiences of self-injury on a long-term inpatient ward. The remainder of studies found were of staff experiences from short-term medical admission or acute wards, A & E departments or community mental health
domains. Similarly articles where the focus was on the actions or experiences of self-injurers themselves or their treatment were excluded.

**Critique of current literature in this area.** Connors (2000) described fear, anger, helplessness and feelings of failure amongst mental health professionals dealing with individuals and their self-injurious behaviour. Similarly, it is reported that the emotional responses nurses have to self-injurious behaviour can affect the way they think about and behave with their client (Rayner et al., 2005). However these studies fail to adequately account for their methodology or sources used to obtain such information. The literature appears to be based on anecdotal clinical reports of staff working with self-injury and supplementary information obtained as a result of research or clinical investigations focused on other aspects of self-injury or nursing experiences. Allen (1995) reported the anxieties found amongst staff working with self-harmers, if not contained, could lead to ‘strong reactions’ therefore adversely affecting treatment outcomes. The aim of Allen’s (1995) study was to help nurses access published research data to inform their practice and develop clinical practice guidelines. This was conducted within a reflective research based practice model with a ward manager and four primary nurse team leaders from an acute ward setting. Reflecting on what had occurred in the discussion group Allen (1995) reported that nurses had reported difficulty in responding therapeutically to threats of suicidal behaviour. Staff stated they either over-responded (increased observation) or under reacted (ignored based on nurses assumptions it was unlikely to occur). Similarly, when they were less reactive and handed responsibility back to patients it led to fears around the threats being followed through and patients actually harming or killing themselves. Such anecdotal findings although informative, lack empiricism and systemisation.

**Factors that influence the experience of working with self-injury.** Studies indicate that the experiences professionals have of working with self-injury are constitutive of a huge number of complexly interlinked factors. For example a lack of knowledge or training about self-injury can affect how they view the patient and the behaviour and therefore their reactions to the behaviour (Friedman et al., 2006; Raphael et al., 2006). This is why training for
staff working with self-injury is highly recommended (Liebling, Chipchase & Velangi, 1995; NICE, 2004). Findings also suggest the nature of the patient-professional relationship or the professional role and even gender of the professional (Mackay & Barrowclough, 2005) may be an influencing factor. For example staff having worked longer in A & E departments appeared to be indicative of increased anger reactions amongst staff towards self-injurious patients (Friedman et al., 2006). Feelings of guilt and self-blame do not appear in studies with A & E staff where the interaction with individuals is only temporary and the role more concerned with physical treatment rather than day to day care of that individual. Guilt is however a frequent experience for professionals caring for self-injurious individuals on a long-term basis (Loughrey et al., 1997; Wilstrand et al., 2007). Despite staff being aware of individual choice and the difficulty in preventing the behaviour, thoughts of what should or could have been done to prevent the self-injury still occur. Fish (2000) conducted in-depth unstructured phenomenological interviews with nine direct care staff in a forensic secure unit for learning disabilities who worked with mostly female self-harmers. Staff tended to report experiencing thoughts and beliefs around self-recrimination e.g. thinking what actions they should and should not have done to prevent the self-injury, which appeared to trigger feelings of guilt and questioning of their abilities and competence. This suggests that where the patient-professional interaction is based more on long-term care of the individual, feelings experienced by the professional differ compared to when the interaction is brief and of a different function e.g. to risk assess and attend to wounds only. Similarly, where the role of the professional is more managerial and hence professional responsibility for the clients increased, evidence suggests that the experience is related more to concerns for professional repercussions of a person self-injuring (Fish, 2000).

The level or degree of exposure staff have of self-injurious incidents may also be a factor in impact of the behaviour. In a randomised control trial, Hastings et al., (2003) compared participants’ negative emotional responses to a videotape of an adult with learning disability engaging in self-injurious behaviour. Staff and students at the secure forensic unit were allocated randomly to four conditions varying on function of self-injury (attention-
maintained versus escape-maintained), and severity of self-injury (mild versus severe). Students (with no experience of challenging behaviours) had a more negative reaction on the Emotional Reactions to Challenging Behaviour Scale (Mitchell & Hastings, 1998) than did experienced ‘direct care staff’ at a secure forensic unit. Whilst this suggests a possible numbing effect occurs through experience and exposure to self-injury, it was also hypothesised this could be a reflection of staff having learnt to deny the emotional impact as a means of coping with challenging behaviours (Hastings et al., 2003). Despite its merit as an experimental study, it could be predicted that watching a video lessened the emotional impact on participants than had they been there interacting with the person self-injuring in reality, therefore this study’s ecological validity is questionable. Similarly with no debriefing of participants it was not certain whether participants had reacted to the therapist’s behaviour (of not responding to the self-injury) in the video rather than reacting to the self-injurer’s behaviour.

Repeated exposure to traumatic events and/or number of years working with traumatic events has been found a predictor of PTSD symptomatology amongst ambulance personnel suggesting working in highly traumatic situations for long periods can result in extreme stress within individuals (Jonsson, Segesten & Mattsson, 2003; Scott & Strandling, 1994).

The experience of working with self-injury can be affected by the attributions of the staff member toward the behaviour or patient (Arnold, 1995). Attributions regarding the patient’s level of controllability over their self-harm is found to be associated with emotional response amongst A & E staff (Mackay & Barrowclough, 2005). Similarly nurses’ attributions about the sick role of patients can also influence their experiences. When patients are perceived as inflicting illness or injury upon themselves rather than avoiding it, this can result in nurses attributing them as less deserving of help because they do not conform to the sick role (Rayner et al., 2005).

**Role of psychiatric nursing.** The nursing role is broadly one of caring for the ill and injured. Psychiatric nursing in particular involves the promotion of mental well-being and provision of holistic care and support for individuals experiencing mental ill-health. Caring is an abstract and indeterminate term and definitions vary according to the clinical nursing area (Ray, 1989).
of caring within psychiatric nursing could therefore be defined differently from the meaning of care on an intensive care unit. There is a lack of research into how care is defined within psychiatric hospitals. Chiovitti (2008) undertook a grounded theory approach to generate a substantive theory around nurse caring in an acute psychiatric setting. Chiovitti (2008) theorised caring within a basic social psychological process of ‘Protective Empowering’ in which nurses defined their role as protective because of the patients risk of harm to self and other, and also empowering because of the intent and support given to helping patients resume activities of daily life and healthy living. Six categories were elicited to encapsulate the contexts through which this protective empowerment occurred namely; keeping the patients safe, encouraging the patient’s health, authentic relating and interactive teaching. In order for them to carry out this caring role two antecedent and sustaining categories are needed which are respecting the patient and not taking the patient’s behaviour personally. The latter encapsulated the ability of nurses to reflect on their work and nursing relationships with patients, their self-care and ability to take alternative perspectives about situations they and the patients might find challenging. Not taking the behaviour personally was necessary to be able to sustain protective empowerment. However the ability to do so might be made more difficult when patients appear to reject or challenge support offered to them. Therefore the experience of caring for patients who receive and take on advice might differ from the experience of caring for those who reject support and advice who are sometimes labelled as ‘difficult’ patients.

The ‘difficult’ patient. With sometimes limited understanding of the function of self-injury, nurses may have difficulty in empathising with an individual’s behaviour that appears to be self-inflicted and therefore under the individual’s control (Favazza, 1998). Anderson et al’s (2003) study comments how working with those who self-harm can lead carers or clinicians to reflect on their own lives in an attempt to find empathy with the client. However this can be difficult with nurses or mental health professionals experiencing such behaviour as so far removed from anything they have ever experienced. This acts to put distance between the patient and the nurse (Anderson et al., 2003). Nursing of self-injurious patients can also be challenging in that patients who
self-injure tend not to follow societal norms or behaviours regarding patient help-seeking whereby nursing support is received and obeyed to resulting in treatment progress. Nurses see their role as being ‘preservers of life’ and feel frustrated and stressed in dealing with patients whom they perceive have little regard for the value of life and who appear to reject offers of help (Anderson et al., 2003). Winnicott (1949) went as far as describing carers feeling hate when it was perceived that support and care offered was being rejected. The frustration felt through self-harmers appearing to have little value for life may however be specific to suicidal behaviours in light of the supposed distinct functions of suicidal and non-suicidal behaviours (Claes & Vanderereycken, 2007).

Professionals may misunderstand that self-injury is more a coping or life preservation behaviour than a life ending one (Favazza, 1998). In working with difficult patients who reject societal norms of help seeking or adhering to advice offered, nurses may question their role, autonomy and competency (Fincham & Emery, 1998; Kelly & May, 1982). This can lead to feelings of helplessness because of a lack of solutions acceptable or meaningful to the client (Rayner et al., 2005). If patients are deemed as unappreciative or unreasonable regarding the care they receive, power struggles can also occur (Wright & Morgan, 1990).

The rejection of nursing support and perceived sabotage of treatment progress is not conducive to what would be termed ‘good’ patient behaviour (Johnson & Webb, 1995). Patients who do not fit into this category or whose behaviours are considered deviant or rule breaking are sometimes termed ‘difficult’ patients (Johnson & Webb, 1995; Kelly & May, 1982; Koekkoek et al., 2006). The term ‘difficult patient’ encompass a heterogeneous group of patients leading Koekkoek et al., (2006) to conduct a literature review of studies between 1979 and 2004. Koekkoek et al., (2006) found behaviours of difficult patients can be classified according to four dimensions: withdrawn and hard to reach (e.g. paranoid psychosis); demanding and claiming (e.g. self-destructive and BPD); attention seeking and manipulative (e.g. substance misuse) and aggressive and dangerous (antisocial personality disorder). Koekkoek et al., (2006) also hypothesised that difficult patients include three subgroups of namely the ‘unwilling care avoider’, ‘the demanding care claimer’ and ‘ambivalent care seeker’. The unwilling are those who dispute their illness and
who view mental health service input as an intrusion. Care seekers are those with a chronic mental illness who have difficulty sustaining consistent relationships with caregivers. Care claimers are those patients often seeking short-term assistance with housing, medication or declaration of incompetence. Ambivalent care seekers were seen as female, demanding, self-destructive and dependent. It could be argued that with the complex nature of self-injury, self-injurers could meet all these classifications of ‘difficult patients’. Those who self-injure within clinical populations can therefore be identified as difficult for a number of reasons. Firstly, for the chronicity of the problem or psychiatric disorder and therefore the difficulty in resolving the problem, secondly, dependency on care whereby patient behaviour or need for care is received as demanding, clinging and claiming. Dependency can be sub-divided again into good and bad patients by nurses in that although they can be dependent they can either be reasonable and appreciative or selfish and unable to appreciate the value of given care (Strandberg & Jansson (2003). Thirdly, difficult patients are found to be difficult because of certain characteristics e.g. BPD and fourthly, if patients lack reflective capabilities. Difficult patients have also been described as such because of the difficulties within the interpersonal relationships. Patients with borderline personality are often labelled difficult because of the behaviours exhibited, the chronicity and dependency on services (APA, 2004; Fiore, 2005). Difficult patients can evoke frustration and anger in nurses resulting in fight/flight responses (Podrasky & Sexton, 2007). If patients who self-injure are labelled as difficult patients, this may be a factor in the nursing experience of such patients.

**Borderline personality disorder.** Factors associated with the person who self-injures may alter the experience for professionals working with them. Repeated self-injury is a clinical indicator for BPD therefore although those that self-injure do not always have a diagnosis of BPD (Crowell, Beauchaine & Lenzenweger, 2008), co-morbidity is high (APA: American Psychiatric Association, 2000; van der Kolk, Perry & Herman, 1991; Zlotnick, Mattia & Zimmerman, 1999). The American Psychiatric Association defines BPD as a pervasive pattern of instability in four areas: affect regulation, impulse control, self-image and interpersonal relationships (APA; 2000). Other clinical indicators
for BPD include chronic suicidal tendencies, impulsive aggression and emotional dysregulation. Compared with other psychiatric disorders those with BPD are often perceived as more challenging and difficult to treat because of the multiplicity of severe and challenging clinical signs (Bland & Rossen, 2005; Cleary, Siegfried, & Walter, 2002; Hennessey & McReynolds, 2001; Jones & Cowman, 2007; Linehan, 1993) and require more mental health resources (Lieb, Zanarini, Schmahl, Linehan & Bohus, 2004). Cleary et al., (2002) conducted a survey of 229 mental health staffs’ experiences of working with clients with a diagnosis of BPD using a 23 item purposefully devised questionnaire. 85% of those reported at least monthly contact with such clients. 84% reported dealing with those clients to be moderate or very difficult.

It is unsurprising therefore that working with those who have BPD can be highly stressful. On-going supervision for the therapists of patients with BPD is needed as is ensuring adequate therapeutic boundaries being in place with such patients (Bland, Tudor & McNeil Whitehouse, 2007; Lieb et al., 2004). Similarly nursing staff face the challenge of providing a therapeutic environment but also managing the risks of patients harming themselves. A tentative balance is maintained between respecting the integrity and autonomy of the patients whilst exerting control to ensure their safety (Samuelson, 2000). Nurses also face the difficulty of extreme fluctuations in affect shown towards them ranging from dependency and clingy behaviour to extreme anger or verbal abuse when patients feel rejected. This can extend to physical aggression directed at nurses or themselves. Manipulation of nurses or splitting within staff is found when working with patients with BPD. Often staff dealing with such patients can experience countertransference with risks of them themselves acting out in response (Hennessey & McReynolds, 2001). Reactions to working with BPD can include anger, helplessness, frustration and irritability (Hennessey & McReynolds, 2001; Perseius et al., 2007) that require professionalism and patience as protection from the emotional outbursts, paranoid ideas and impulsive behaviours (Workgroup on Borderline Personality, 2002). Nurses’ perceptions and beliefs around the aggression and impulsivity of those with BPD result in fears of successful suicide attempts (Perseius et al., 2007) and efforts to maintain a social distance from patients (Markham, 2003).
Misperceptions of patients having control over their behaviour can lead to mislabelling of behaviours such as attention seeking. Negative misattributions about intent of the patient’s behaviours as well as more pessimistic outlook of treatment outcomes can also result in the experience of nursing such individuals as aversive (Markham & Trower, 2003). Often nursing staff of hospitalised patients with BPD feel inadequately prepared in caring for such patients because of a lack of clinical supervision, appropriate training or professional support (Bland & Rossen, 2005). Nurses must be sufficiently equipped in understanding the complex aetiology and functionality of the patient’s difficulties to prevent the negative nursing reactions and experiences just described. The close association between BPD and self-injury particularly in more acute or inpatient settings means that differentiating the nursing impacts or experience of either in isolation is difficult. Further research comparing staff reactions to self-injury in patients with and without a diagnosis of borderline personality disorder would better inform this issue.

**Countertransference.** Professional misattributions or misunderstanding of patients and their behaviours and hence their worthiness of treatment has clinical implications regarding treatment (Radley, 1994). Nurses can find it difficult to form therapeutic empathic relationships and engage with the self-injuring individual (Clarke, 2002). For this reason concepts of countertransference and transference are often considered to illuminate the interpersonal processes within the patient-nurse interpersonal dynamic and reflect what the experience might be for the professional treating those that self-injure. Countertransference is where the therapist/carer transfers feelings towards the client that are more about the therapist’s own difficulties or issues, than the clients (Jacobs, 2007). It can also be defined in a more holistic way as the ‘natural and expected emotional response elicited in the therapist in the context of his/her relationship with the patient’ (Ens, 1999, p.321).

Countertransference in professionals working with difficult patients can range from anger to disappointment and powerlessness however the specific nature of the countertransference will differ across individual client/therapist relationships due to their idiographic nature (Rayner et al., 2005). One way of relieving themselves of the uncomfortable emotions is for the mental health professional
to attribute the negative feelings onto the client and blame the client with the use of labels as ‘attention seeking’; ‘demanding’ or ‘manipulative’ (Tantam & Whittaker, 1992). Countertransference could include rejection of that person thereby reinforcing feelings of low self-esteem and negative self-beliefs in the self-injurer (Rayner et al., 2005). Analytically, it is not uncommon for multidisciplinary teams to become split over care of particular patients as a result of patient’s analytic splitting and projective identification (Burnham, 1966; Carser, 1979; Gabbard & Wilkinson, 2000). Such dynamics in therapeutic contexts can impede therapeutic relationships and decisions made regarding the individuals treatment such as right of choice and responsibility being taken over their self-injurious behaviour (Fish, 2000; White, McCormick, & Kelly, 2003). The care that the patient receives and the nature of the therapeutic relationship are crucially important for the self-worth, progress and treatment outcomes of a person who self-injures (Liebling et al., 1995; Pembroke, 1991). Therefore monitoring and managing staff and team reactions to self-injurious patients is important not just for the staff but patients as well.

**Mental health professionals’ experiences of self-injury.** Studies using questionnaire vignettes and predefined professional distress indices indicate that mental health staff reactions to self-injury include helplessness, irritation and frustration (Holdsworth et al., 2001; Mackay & Barrowclough, 2005). However inadequate sample sizes for statistical analysis (Holdsworth et al., 2001) and use of questionnaires or predefined lists raises methodological questions over the ability to capture the experience of professionals (Lincoln & Guba, 1999). Using such instruments without pilot studies suggest the researchers assumptions might be somewhat imposed on participants. Hadfield et al. (2009) however conducted interviews using an interpretative analysis methodology with five A & E doctors on their responses to treating those who self-harm. Incorporated within the theme of ‘treating the body’ participants spoke about their focus being with the physical treatment of the injury and the difficulty they had with the sense of urgency they experienced to therapeutically address the behaviour with those presenting to the department for the first time. Participants felt helpless in managing their emotional responses to the self-harm such as anger, helplessness and frustration and had concerns dealing...
with self-harm when associated with psychiatric presentations. Doctors felt that professional mental health support was lacking. Findings also suggested that doctors felt their role of helping people to feel better and resolve crises was challenged by this group. This resulted in them protecting themselves by trivialising the self-harm. Other protective features included avoidance of exploring in any depth the self-injury with the individual. Personal experiences of self-injury increased the sense of competency in managing patients. Themes of mirroring of societal and cultural responses were found which included keeping an emotional distance from the patient by remaining grounded in medical discourse and action but also perpetuating learned helplessness of self-injurers through treatment decisions made over and above the wishes of individuals who self-injure.

Psychiatric nurses and self-injury. Wilstrand et al. (2007) conducted narrative interviews with six Swedish psychiatric nurses and performed content analysis on the data (Graneheim & Lundman, 2004). Two themes of ‘being burdened with feelings’ and ‘maintenance of professional boundaries’ were found although these themes and their sub-themes were interlinked. The theme ‘being burdened with feelings’ comprised of three sub-themes; ‘fearing for the patient’s life threatening actions’; ‘feeling overwhelmed by frustration’ and ‘feeling abandoned by co-workers and management’. Emotional responses of fear, uncertainty and powerlessness at patients repeatedly harming themselves and the potential fatal aspects of this were evident. This fear leading to a constant state of high alert has been documented elsewhere in the literature (Loughrey et al., 1997). The second theme found of ‘balancing professional boundaries’ in Wilstrand et al’s study comprised of four sub-themes; ‘maintaining professional boundaries’; ‘managing personal feelings’, ‘feelings confirmed by co-workers’ and ‘imagining better ways of care’. The difficulties staff had in maintaining boundaries was reported despite attempts by the staff team to work in tandem on ‘the same script’ with particular clients. Team consistency in ways of working with patients was difficult because of differences across staff in their idiographic relationships with these clients or their reactions to patient’s self-injurious behaviour. As a result of these factors conflicts tended to arise in the approach staff wished to take with patients. Differences in how
staff engage and relate with patients who self-injure has been an issue such that support for staff to resolve professional conflicts is often advised (Grunebaum and Klerman, 1967; Loughrey et al., 1997). Staff conflicts in management of, and relationships with, self-injurious patients has also been found with patients with BPD and has been framed with a psychoanalytic perspective of psychological defence such as splitting or projective identification (Gabbard and Wilkinson, 2000). Maintaining boundaries was also described in a case study report by Loughrey et al’s (1997). They documented the impact on nurses when dealing with one particular self-injurious patient within a psychiatric inpatient service. Nurses in this case reported frustration in battling with the constant dilemma between caring and supervising clients but also ensuring respect towards client integrity and autonomy. Nurses’ difficulties in obtaining a balance between control and autonomy of patients because of the possible increase of self-injurious behaviours as a result of too much autonomy or too much control has been described elsewhere (Feldman, 1988).

The nurses in Wilstrand et al’s (2007) study also experienced difficulty balancing the need to respond and attend to the wounds but at the same time not rewarding the behaviour with attention. Nurses revealed that to cope with their own emotions they prevented their feelings being revealed to patients and instead ‘acted’ in the role, sometimes with the use of humour and irony. This was so they could conduct themselves professionally and effectively. It appeared from the data however that away from the patients nurses discussed their feelings and difficulties with co-workers and through supervision or debriefings. Nurses in Wilstrand et al’s (2007) study felt that the setting was ill equipped or unable to meet the needs of this client group, e.g. a lack of time for quality interaction between clients and nurses or that they themselves felt lacking in knowledge or understanding to adequately care for the patients. In summary, Wilstrand et al’s (2007) study revealed that the impact on nurses working with this client group centred on anxiety about the potential fatal nature of these acts and being able to maintain a therapeutic and professional distance from the clients. It also revealed frustrations about their own ability to deal with the behaviours and the clients and the resources available to them in which to provide the best treatment. However with the term self-harm used in this study it...
was unclear whether participants were referring to self-harm inclusive of suicidal intent. Quotes from participants suggested participants were referring to suicidal and non-suicidal self-injury however. This study provided an informative and valid insight into nurses' experiences of self-injury. Wilstrand et al. (2007) acknowledged that because this was a qualitative study the findings might not be generalised to other contexts or disciplines but that similar research elsewhere would be useful to support or question their findings. However no information was provided on the patient population in which the nurses worked making future comparisons with other studies difficult due to lack of awareness of the sorts of demands made upon nurses from patient behaviours. The researchers were all nurses experienced in the psychiatric care of those who self-injured and therefore familiar with the concepts and language used by the interviewees. However being familiar in nursing and the care of self-injury may have also influenced the interpretation of data. The authors do not acknowledge how their own experiences may or may not have been influential in their analysis. Similarly, with the interviews being in Swedish but interpreted in English, some misinterpretation of meanings and words from the interviews may have occurred. Wilstrand et al's (2007) study stated that theme consensus was reached by all three researchers although there was no discussion of richness of the data or consistency and reliability of the themes across all participants.

Significance of research

Given the ever increasing prevalence of self-injury (Kapur & Gask, 2006) and the high prevalence rates within clinical and psychiatric populations (Langbehn & Pfohl, 1993; Zlotnick, et al., 1996), research has tended to focus on the classification, nature and function of self-injury as well as development and evaluation of its treatment. As indicated above managing the impact of working with staff reactions is not only important for staff care but also that of the patients and treatment efficacy. Strong emotions evoked can result in reactions that affect the ability to engage in therapeutic relationships or provide therapeutic responses to self-injury (Anderson et al., 2003; Connors, 2000; Markham & Trower, 2003). Avoidance of the patients or avoidance of talking with the client about their self-injury were identified as a strategies staff utilised to relieve personal and organisational stress for mental health professionals in
Fish’s (2000) study of staff at a secure learning disability unit. It is these kinds of negative reactions that can adversely influence treatment outcome or care received (Allen, 1995; Mangnall & Yurkovich, 2008; Markham, 2003). A lack of training and accurate understanding of self-harm or injury are suggested to be factors that result in poor treatment provision (Arnold, 1995; Fish, 2000; Mangnall & Yurkovich, 2008; NICE, 2004). Patients also report feeling dissatisfied with the treatment and care that they receive because of factors such as the attitudes of staff towards them which can affect efficacy of treatment (Arnold, 1995; Barstow, 1995; McAllister et al., 2001; Pembroke, 1996; Pembroke, Smith, & the National Self-Harm Network, 1998; Smith, 2002; Warm, Murray & Fox, 2002). Research in this area has therefore sought to develop clinical practice with this client group and to understand more about this little known but increasing phenomenon (Allen, 1995). A better understanding of staff reactions when working with self-injury in specific populations and settings may inform means of staff support and care along with the establishment of protective mechanisms from any negative impact.

**Research rationale**

Within a high secure maximum security hospital, severity and frequency of self-injury is often extreme with as many as two to three incidences, on average, each day. Nursing staff are in direct and daily contact with those who deliberately harm themselves. Injuries in this setting can range from cutting and scratching to insertion of faeces or objects into already infected wounds or removal of body tissue and breaking bones and self-ligation. Previous research on the impact of self-injury amongst other professionals e.g. community mental health workers and A & E staff suggests the impact or experience of working with self-injury can be context specific as well as richly idiographic. Therefore to capture the nature of the impact on nurses in this particular setting where self-injury behaviours are extreme a qualitative phenomenological approach was taken. Use of quantitative methodologies in this instance would risk the assumptions or predictions of the researcher on the research findings a priori and failure in capturing an adequate account of participant’s experiences. This study is the second qualitative study exploring the experience of nurses dealing with severe and frequent self-injury. The first being Wilstrand et al’s (2007)
study. However it is the first to be conducted within a UK service and within a high secure setting. It should be noted that IPA approach is generally not amenable to comparison across studies because of the idiographic nature of this methodology. However findings may have utility and relevance to other clinical nursing settings or populations where self-injury occurs and where features of the study are similar. In addition, the study findings may further inform clinical nursing practice and literature.

Extended Method

Research Design

An overview of the epistemological and theoretical commitments of IPA will be outlined here. [Please refer to Appendix I for a diagrammatic overview of the research design process].

Epistemological positions

Critical realism. Critical realism proposes that reality or phenomena exist independently of how they might be understood or described by humans (Bhaskar (1975/1997). Sayer (2000) defined the real as what socially or naturally exists irrespective of whether we are aware of it or observe it. What is known is therefore seen as an outcome of action, following mechanisms acting within particular contexts across time and places that are influenced by social and historical processes (Robson, 2002). As a result, individuals differ in the meanings ascribed to their experiences because of their differing contextual realities. The aim of critical realism is to seek a common understanding of reality through triangulation thereby reducing chance of error (Bhaskar, 1998). There are two dimensions ascribed to knowledge within the critical realist perspective. The intransitive dimension refers to what is studied and the transitive dimensions refer to the theories and discourses about the intransitive (Bhaskar, 1975/1997). If applied to the context of this research, the reality of nurses’ experiences of self-injury is intransitive whereas the transitive would be the study of their experiences (Bhaskar, 1975/1997). Therefore for understanding nurses’ realities of working with self-injury, their realities must be conceptualized within the many mechanisms occurring at the time in the social world including the political, organizational, economic as well as psychological.
The political, social, and cultural mechanisms influencing someone’s experience is an important consideration within a critical realist approach. This is also recognized within IPA as is the influences on the researcher’s own theories of reality whilst making sense of the participant’s reality. In addition, IPA accords with the critical realist approach that what is observed or known is fallible and theories or knowledge are open to critique.

**Constructionism.** Despite there being a number of versions of constructionism (Burr, 1995), the key premise is that there is no objective description of events or objects, only our constructions of them, which can lead to an infinite number of possible alternative constructions (Burr, 1998 as cited in Parker, 1998). A constructionist viewpoint defines “all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty, 1998, pp.42). Constructionism posits that no interpretation of a reality is true or valid, only some that may be more or less useful for the purpose in which they are required. Although some ‘realist’ constructionists would argue that our interpretations can be a true account of the world (Nightingale & Cromby, 2002). Not to be confused with subjectivism whereby meaning is created, constructionism refers to how meaning is constructed from our engagement with the world and being embedded in that world. In another way, the construction of meaning comes only from the interdependence of subject and the world or ‘intentionality’. With this in mind, constructionism moves towards social constructionist viewpoint which posits that knowledge and phenomena are socially and linguistically derived specific to a historical and cultural context.

In addition knowledge and reality is viewed as sustained by social process (Burr, 1995).

**Phenomenology.** Spiegelberg (1976) defined phenomenology as “a philosophical movement whose primary objective is the direct investigation and description of phenomena as consciously experienced, without theories about their causal explanation and as free as possible from unexamined preconceptions and presuppositions,” (p. 3). The founder of phenomenology, Edmund Husserl (1859-1938) believed that the lived experience of the
individual provides access to understanding reality (Ashworth, 2003). For Husserl reality was not something outside of an individual’s experience, but that the experience itself and what is known by the individual, is the reality. Husserl also believed that through exploration of commonalities across people’s lived experience, some representation of the reality of that phenomenon under study might be found (Natanson, 1973). Phenomenological methodologies that draw on Husserl’s perspective are largely descriptive. Therefore where the research aims to establish a description of the individual’s experience without consideration to the meanings embedded in that experience pure descriptive methods would be chosen. In comparison, the post modern paradigm of interpretative phenomenology or hermeneutics, associated with Heidegger (1962), diverges from descriptive phenomenology in that it aims to draw out and interpret meaning in people’s experiences that might otherwise be beyond their consciousness (Spielgelberg, 1976; Streubert & Carpenter, 1999). Both the views of the researcher and that of the participant's integrate to form new understandings of that participant’s social reality (Outhwaite, 1985). In this sense, the perspective of the researcher and the questions asked of the data will determine the interpretation of meaning therefore resulting in ‘perspectival subjectivity’ (Kvale, 1996).

**Theoretical perspectives**

Hermeneutics is defined as “the theory of the operation of understanding in relation to the interpretation of text” (Ricoeur, 1978, pp.141). This perspective recognises that eliciting meaning of experience stems from understanding the social, historical and cultural context of the individual (Schwandt, 1999). Hermeneutics has been used in many disciplines including nursing where experiences related to health can be understood in the context in which they occur and with a focus on the meaning to the individual (Charalambous, Papadopoulos & Beadsmoore, 2008; Myers, 1995). The knowledge produced is therefore a result of dynamic interaction and interpretation of an individual’s own sense making of their experience from another perspective. Within research, Ricoeur (1991) postulated that interpretation of the participants’ experiences should not be an understanding of their intentions conveyed in the text but instead form an understanding of their experience and the meaning of it. The
understanding derived from the study should therefore describe modes of being in the world (Wiklund, Lindhol & Lindstrom, 2002). The meaning of experience found within hermeneutic interpretative phenomenology is seen as a fusion of sense-making of both the participant and the researcher, a concept known as co-constitutionality (Koch, 1995). Smith et al., (2009) suggest that IPA maintain a middle ground approach between two interpretative positions; hermeneutic of empathy and a hermeneutic of suspicion. The former would be the participants’ experiences reconstructed whereas the latter would be a reconstruction drawing on external theoretical perspectives providing such viewpoints appropriately draw out the meaning of the experience (ibid.). Therefore through the double hermeneutic of the researcher making sense of the participants making sense of their experience, there is potential for any number of interpretations on a particular subject which some have argued limits the explanatory power of the research itself (Berger & Luckmann, 1966). Similarly there is the possibility of error in interpretation. However such an argument seems bound in the empirical quest for objectifying knowledge of absolute truths generalisable to all and a discomfort with living with just partial explanations or possibilities of misunderstanding that are intrinsic part of the processes within hermeneutic phenomenology (Schwandt, 1999).

**Language.** The sense making process and actions of the participant in qualitative paradigms is seen as constructed through language and their interpretations within the social context. Language, both verbal and written, is therefore instrumental in qualitative methodologies due to its role in human communication, interpretation and understanding of people’s experiences and meaning making (Smith & Osborn, 2003/2006). Similarly, through language such as verbal or written text it is possible to understand differences in meanings people have about similar experiences. Different qualitative approaches use language in different ways and each hold different theoretical assumptions accounting for the variability across the methodological procedures and the role of language (id.). For example within a social cognition paradigm the differences in meanings of experiences that people have are seen to be reflected in their language and behaviour (Fiske & Taylor, 1991). Within phenomenology the role that language and social context plays in meaning
making is closely aligned with that of symbolic interactionism, a perspective of the philosopher Herbert Blumer (Blumer, 1969). The premise of symbolic interactionism is that people act towards things according to the meanings they construct of them and that these meanings or constructions arise from interactions with others and the social context (Blumer, 1969). This concurs with the rationale for exploring nurses’ experiences and their actions taken with patients.

**Methodology**

**Qualitative approaches.** The importance of subjective experience, idiographic meaning making and social relatedness are key propositions for the qualitative researcher (Ashworth, 2003/2006; Strauss & Corbin, 1998). Qualitative psychology broadly aims to explore, interpret and convey the rich subjective and idiosyncratic experience of individuals or groups of people that is largely inaccessible within quantitative approaches (Ashworth, 2003/2006; Smith, 2003/2006). Idiography is concerned with the particular and aims to establish specific knowledge about individuals themselves. In contrast, universal or nomothetic approaches are concerned with making generalisable and predictive claims about groups or populations. Both paradigms have an equal place in the seeking of knowledge with the idiographic often leading to the nomothetic (Smith and Eatough, 2006). Positivist or quantitative approaches view knowledge as an objective measurable reality and look for relationships between phenomena. Whereas Interpretative or qualitative approaches propose complex multiple realities that differ over time and situation specific to the individual (Denzin & Lincoln, 2005). Furthermore, rather than knowledge derived only from the senses as proposed by empiricist perspectives, interpretative approaches recognize tacit or intuitive knowledge that might not be expressed through language or that might not be directly observable. It has been questioned how subjectivity allows for objective elucidation of patterns of human behaviour and experience (Allen, 1985). Such critique fails to respect the theoretical and epistemological concerns around the production of knowledge embedded within qualitative methodologies. It also fails to account for the problems inherent in obtaining an objective, universal account of meaning experiences that are embedded within specific historical and social
contexts. Furthermore, hermeneutic perspectives would argue that knowledge can only be sought through discourse and interpretation of the meaning within language. Qualitative research intends to provide answers to questions about the nature of human experience and describe those processes and experiences rather than the quantitative approach of asking how many and how often (Jones, 2002). Data from both qualitative and quantitative methodologies can both be used for verifying or generating new theory or truths using particular systematic techniques and analyses (Glaser & Strauss, 1967). The methodological approach taken is largely determined by the research question, purpose and existing knowledge about the subject but also the philosophical assumptions and beliefs of the researcher.

Research with nurses or mental health professionals working with people who self-injure focuses mainly on individual attitudes and behaviour using methods (e.g. questionnaires), centered within a positivistic paradigm. Such research therefore fails to consider those mechanisms or contexts in which attitudes towards self-injury are formed e.g. the sense-making process of the individuals in relation to their own experiences. Data derived from quantitative methods may also reflect more of the theoretical understanding of the phenomenon or the researcher’s agenda than the experience of the participants themselves (Lincoln & Guba, 1999). Furthermore the influence of the powers, organizations and contextual systems in which nurses may be embedded in for how they make sense of their experience working with self-injury is largely ignored. Consideration of such factors allows for professionals working with self-injury in different settings being seen as constructors of meaning rather than passive recipients of an experience. It also informs how nurses working with self-injury might experience different realities hence the variations found within the literature of nurses’ experiences and reactions.

From a theoretical perspective, phenomenological research methodologies accord with a critical realist perspective in considering the varied experiences nurses might have when working with self-injury. Nursing or health care research often use phenomenological based interview methodologies to capture the differing realities either as patients or as professionals working with patients (Lopez & Willis, 2004; Schreiber, 1996). Interviews are so commonly
used that Silverman (1998) argued it gave a false sense of authenticity to what actually is purely anecdotal evidence. A phenomenological approach however is appropriate for gaining an understanding of the realties and possibly shared realities of psychiatric nurses’ experiences working with self-injury that remains currently overlooked within research and practice.

**Consideration of other methodologies.** For research that aims to capture individual experience a number of qualitative methodologies are available. The role of language or better still, how language is used as a resource for individuals' meaning making is the key focus within certain qualitative approaches such as discourse or conversation analysis. Discursive analysis involves the labour-intensive microanalysis of naturally occurring or existing text and talk. Such approaches would typically require real world investigations however ethical obligations mean that much discourse analysis research commonly utilizes semi-structured interview formats. Conversation analysis attempts to elucidate how the action of an interaction itself within a conversation led to an understanding of the other’s actions (Drew & Heritage, 1992) and again is a microanalysis of the hermeneutic in action. Methods include observation or recording of naturally occurring interactions (Heritage, 1984). Narrative psychology, influenced by humanistic psychology and social constructivism, aims to explore self construction through the concept of narrative such as stories and language (Crossley, 2002). It aims to establish order in meaning or intention through an organized interpretation of a sequence of events (Murray, 2003). With the influence of social constructionism, the role of the researcher and their story is contextualized within the research itself. Research participants are therefore required to provide an extended account of their lives and experiences within that which makes it an ideal approach for health psychology or trauma research arenas (Murray, 1997). It is argued however that human experience is not always analogous to narrative, or rather, stories are structured whereas lived experience are often not so linearly structured (Bell, 1990). Similarly a current weakness of narrative psychology stems from its infancy. Further definition and clarification of its principles, it is suggested, would reduce the tensions and confusions in current conceptualizations of this approach and bring greater conciseness and
methodological and theoretical clarity (Schiff, 2007 as cited in Bamberg, 2007, pp.27-36). Research questions using a narrative approach centre around the stories people hold based on their experiences and the actions taken as a result of those experiences. This research project did not aim to capture the narratives that participants held of their experiences with self-injury but rather the phenomenological experience in their everyday life. For this reason, IPA was considered more congruent with the aim of the research.

Grounded theory (GT: Glaser 1992; Glaser & Strauss, 1967) is a commonly used qualitative research methodology (Creswell, 1998). It aims to generate inductive theory and concepts grounded within the data using a systematic coding procedure of codes, concepts and categories that exemplify any patterns in the data. GT can be used to study diverse individual and interpersonal processes on a variety of topics. GT’s strengths include the use of systematic techniques that are representative of a positivistic stance whilst still incorporating an interpretative stance by attempting to capture the individual meaning, actions and intentions. Working at the micro-level and across the large sample size needed is not only time consuming but can also result in the meaning or context of what is being conveyed becoming lost within the data resulting in over-conceptualisation or data overload as well as data analysis confusion for the researcher (Glaser, 1992). Glaser and Strauss (1967) emphasized that for GT there should be no pre-conceived ideas or hypothesis prior to data collection and analysis. In reality, it is difficult to see how this can be truly obtainable with most researchers needing an agenda before instigating research or having a personal interest in the subject. GT does not acknowledge the role of the researcher’s interests or persuasions in undertaking the research or interpretation of the data as any findings are supposed to be solely grounded in the data (Thomas & James, 2006). Furthermore, Thomas and James (2006) questioned the ability for such open interpretation of data when procedurally such strict systematic coding processes are required. GT aims to use the relationships across participants’ experiences using theoretically based categories previously determined as relevant to the subject area (Glaser, 1992). However due to the lack of research in this subject area it is not yet known what these relationships might be. Therefore in this instance an explorative study
'You get hardened to it’

would be needed first to identify those possible themes relevant to nurses' experiences. These limitations and the lack of intention to generate theory in this explorative study therefore excluded the use of this methodology.

**Interpretative phenomenological analysis.** The existing literature, focus of this research, the research question and research strategy guided the method itself towards an interpretative phenomenological approach. Epistemological concerns around the ability to capture the participants' phenomenological experience or life-world purely as they see it without any influence from the researcher's or observer's own interpretations and assumptions (Gadamer, 1976, 1989; Heidegger (1927/1962) were considered valid concerns that further supported the use of an interpretative research methodology. IPA is epistemologically grounded within a framework of personal knowledge and subjectivity. The chief goal of IPA research is to explore, describe, and interpret the individual lived experience of others with the researcher attempting to make sense of the participants' meaning making. IPA does not claim to seek objectivity about an event or experience, or make any general or universal claims (id.). However IPA can be used as both an idiographic case study approach of shared themes of up to ten participants or as a theory building approach in which explanations of the data are used to form models or narrative (Smith et al., 1999). Underpinning IPA are three branches of philosophical thought; phenomenology, hermeneutics and idiography (Smith et al., 2009).

Within hermeneutic and symbolic interactionist approaches it is presumed that a dual process of interpretation occurs between researcher and participant and is as such a double hermeneutic (Ashworth, 2003/2006). To explain the double hermeneutic, Smith et al’s., (2009) description will be conveyed here “the researcher is making sense of the participant, who is making sense of x”. The IPA research process is therefore viewed as a dynamic process between the participants and the researcher in the construction of meaning and knowledge. The participant's life-world is captured with the influence and role of the researcher in the interpretation of the meanings and experiences of the participants also being acknowledged (Elliott, Fischer, & Rennie, 1999). Rather than adopt the perspective of one particular
phenomenological perspective, IPA takes a holistic approach by drawing on the intrapsychic (Husserl), embodiment (Merleau Potty), and existential (Heidegger and Sartre) viewpoints.

In wanting to study the impact of working with self-injury I needed to go beyond the descriptive or phenomenological to the interpretative by considering how my interpretation of participant’s experience might occur within a socio-cultural context. This allowed representation of a particular social reality but also the double hermeneutic. Whilst drawing on Husserlian based descriptive phenomenology for gaining individuals’ perceptions, IPA branches away from Husserlian techniques of reflexivity for bracketing out of any fore-conceptions (Natanson, 1973). This is because IPA believes in the overt role of the researcher as an analytical tool for the raising the awareness of what is unconscious in the participant through language and interpretation. In this respect, IPA concurs more strongly with hermeneutic traditions in which reflexivity can be used to acknowledge the researcher’s role in the interpretation (Smith, 2004). The researcher acknowledges their role in the interpretation through the concept and method of the hermeneutic circle. This relates to a dynamic non-linear way of thinking in which interpretation of the data moves back and forth at a series of levels between the part (e.g. single word) and the whole (e.g. the transcript) in an iterative fashion. Each new piece of interpretation further influences the researcher’s relationship with the data and hence later interpretation.

**The Researcher**

In IPA the researcher is seen as a research instrument and analysis is performed through an interpretative lens therefore it is important to clarify the position of the researcher with regard to the participants (Mauther & Doucet, 1998). Reflexivity occurred throughout data collection and analysis using a research diary. Ontologically, I have some affinity with social constructionism and social constructivism e.g. that the social world is derived through language and human interaction and that objectivity is impossible (Guba & Lincoln, 1985) which has concordance with phenomenology and particularly an interpretative qualitative approach. In a dynamic complex social world and in my clinical experiences, I am regularly faced with the complexity and variations of distress.
amongst individuals. I believe the proposition of similarity across human experience and meaning and hence categorization of that is difficult to establish although perhaps highly desired in the pursuit of evidence based practice. The meanings people have of their experiences are based on interactions with people and systems that is socially, culturally and historically embedded and therefore time and context dependent. Epistemologically, I believe that knowledge is produced contextually and therefore multiple realities exist which can only be understood through subjective interpretation of the actions and communications from the perspective of individuals. Therefore only by looking at a phenomenon from different angles can a more valid understanding of events be obtained. My clinical training and professional experiences to date have particularly influenced my opinions. In working within forensic and mental health settings and social phenomena such as criminal behaviour and mental illness I can see how historical, social and cultural contexts are important in the construction of what and how we might experience these phenomena.

I had conducted an extensive literature review of this area during the research proposal and design stage in order to establish the importance and possible significance of this research. These are commonly accepted essential requirements for the conduction of ethical research. This theoretical understanding and my professional or clinical experience of working with self-injurious individuals were seen as influential in the interpretation of the data. IPA allowed me to critically reflect on these fore-conceptions and my position in respect to the participants when trying to understand their lived experiences of working with self-injury.

Bracketing. In some qualitative methodologies, fore-conceptions, attitudes and beliefs of the researcher about the subject or research are identified and set aside to ensure the data is grounded in the experience of the participants. Otherwise known as bracketing (Drew, 1999) the researcher holds aside from the research and analysis those prior assumptions, values or personal knowledge about the subject to ensure the impact of the researcher is monitored and unbiased therefore ensuring transcendental subjectivity. Luft (1969) however believed the bracketing out of the researcher’s fore-conceptions is a problematic concept within qualitative research because we may not be
aware or conscious of all of all our fore-conceptions, and even if so, our ability to bracket everything out is largely impossible. It is also argued that bracketing is not useful in IPA because the researcher is co-interpreter of experiences and therefore the perspective of that researcher is vital data for understanding how meaning was produced (Koch, 1995; Munhall, 1994). It is more effective and reliable to identify and record fore-conceptions to ensure transparency in the research. For example, the hermeneutic analysis of the participants’ experiences and life world in this research was influenced by my clinical and psychological training and theoretical knowledge.

**Setting**

The research setting is a therapeutic service (Trauma and Self-Injury) for women with various mental health needs including Learning Disability, Personality Disorder and Mental Illness.

**Procedure**

**Participant recruitment.** Inclusion and exclusion criteria were chosen following consultation with the unit’s trauma and self-injury steering group. Both qualified and unqualified nurses were deemed eligible for inclusion due to them both having direct experience working with self-injury.

*Inclusion criteria:*

- Unqualified and qualified nurses employed by the Nottinghamshire NHS Trust.
- Nurses have worked within the NHS HSW for at least 12 months to ensure adequate experience of self-injury within the service.
- English speaking as researcher only speaks English.
- Employed in a role that involves direct face-to-face contact with those who self-injure.

*Exclusion criteria:*

- Those that do not provide informed consent for participation in the research.
Non-English speaking people due to researcher only speaking English and limited resources for using an interpreter. Use of interpreter may have introduced issues around confidentiality within interviews.

**Identification of participants.** Following ethical approval for the study, 212 potential participants were identified from the staff role database by the project’s clinical supervisor (Consultant Clinical Psychologist), at the research site. Homogenous sampling was used according to the inclusion and exclusion criteria. Purposeful selection of the sample allows informants to be identified for their knowledge and ability to provide information necessary to answer the research question (Crowley & Mitchell, 1994). The IPA approach favours that participants form a homogenous group with regard to the research question. The central requirement is that all participants are experts in the experience under study as opposed to key attributes (Hadfield, 2009; Smith, 2004). Males and females were considered as eligible criteria for the study as both were deemed to be living with the experience. Both male and female nurses work in the unit and perform the same role. Having a male perspective would not disrupt consistency in the interview data but would allow for any divergences in the data to be discussed if found within the data. To not look at gender particularly with regard to differences between genders in expression of emotion amongst those eligible would seem inappropriate based on the aim of this study.

The project invitation letter [See Appendix J] was sent out to all 212 staff members of the sample. The letter included a response slip for staff to request further information about the study and a consent form. All response slips received were then responded to with the information sheet and consent form [See Appendixes K and L] via the internal mail system. Their right to refuse to answer questions or terminate the interview was emphasised in the information sheet. The information sheet also had a response slip requesting the staff member’s name; length of time they had worked with those who self-injured; name of ward they worked on; and contact details. Potential participants returned this slip and the consent form via the internal mail system using a S.A.E. A period of three weeks was given for consent forms to be returned.
As consent forms were received back, participants were contacted to arrange a convenient time for interview. Participants were interviewed on a first come first served basis until six interviews had taken place. A review of the quality of the data was then made in order to ascertain whether further interviews were needed. Interview length balanced the possible burden on participants in talking about possibly sensitive topics with ensuring a sufficient amount of data could be collected for capturing participants’ experiences (Denzin & Lincoln, 2000; Onwuegbuzie, 2003). Decisions made by myself during interviews around these issues led to some interviews lasting longer than others. Staff members who had returned consent forms but who were not recruited were sent a letter informing them of such and thanking them for their interest in the study.

Sample size. With only one study (Wilstrand et al., 2007) specifically related to the study topic, it was not possible to conduct a qualitative meta-summary of studies in which to guide sample size decisions. Wilstrand et al’s (2007) study had six participants with one interview each. A review of studies using IPA indicates a range of one to 15 participants depending on a number of factors such as how many times participants are interviewed. Smith et al. (2009) recommend between four and ten interviews for a PhD study which could involve 10 participants interviewed once or five participants interviewed twice. Smith et al. (2009) also recommend that researchers inexperienced in IPA methodologies opt for fewer interviews such that the focus will be on the quality of the analysis and reduce the likelihood of the researcher becoming overwhelmed with large amounts of data. Recommendations within the literature for sample sizes in IPA, with homogenous samples or where the goals are to gain idiographic knowledge and meaning of participants’ experiences range between six and eight (Kuzel, 1992; Morse, 1994; Smith et al., 2009; Smith & Osborne, 2003/2006) although the rationale for these estimates is debated (Onwuegbuzie & Leech, 2007).

Smaller sample sizes within IPA are desired due to the large amount of data that can be generated from just one participant or interview. In IPA, greater importance is placed on the ability to conduct in-depth analysis of the meaning making or experiences of participants such that differences and similarities can
be found, as opposed to the number of participants (Onwuegbuzie & Leech, 2007; Smith & Eatough, 2006; Smith and Osborn, 2003/2006). Purposeful selection of the sample reduces the need for large sample sizes as the participants are chosen for their ‘expert’ knowledge or experience of a phenomenon. A few participants would therefore be expected to provide sufficient data for answering the research question. However this depends on the richness of the data which in itself is subjective (Morse, 2000). In positivistic science, estimation errors are reduced by large sample sizes. In qualitative designs the risk of not obtaining all the information needed to answer the question (discovery failure) is reduced by sample selection, procedure and analysis.

As a result of the theoretical considerations and the literature, six interviews were chosen at the outset as the optimum number of interviews for answering this research question. Included in this decision was the organizational constraints on the part of the participants (to come away from their duties), researcher time for the project itself (alongside NHS training placement obligations), the idiographic nature of the research question and length of interviews.

With some transcription of interviews having occurred before data collection had ended and the knowledge of what had arisen during data collection still in my mind, I was able to make a decision following the sixth interview that there was no need for extending the sample size and number of interviews in order to answer the research question. The richness, clarity, breadth and variation of what participants had described in their experiences of working with self-injury gathered from the six interviews was more than adequate in offering sufficient material to interpret and answer the research question.

Participants

All six participants were qualified nurses. All were White English in ethnicity. Their ages ranged from 28 to 58 years. All participants had frequent and direct experience of dealing with those who self-injured. The time participants had spent working with this population at high secure hospital ranged between 3 and 18 years (3, 4, 8, 9, 18 and 18 respectively).
Interviews

Individual face-to-face interviews rather than focus groups were chosen due to the sensitive nature of the topic and participants possibly feeling more comfortable in disclosing information where their identity could be protected. In-depth interviewing involves participants being asked to verbally talk about their experiences, beliefs and perceptions. In this study they were asked to discuss their experiences of working with self-injury using the opening statement and key questions contained within the semi-structured interview (SSI). No information was derived from any other sources other than the qualitative interview.

Interviews were conducted face-to-face with participants in a private room in the staff-only area of the hospital. Each interview consisted of an initial framing statement to open the interview and orientate the participant. Every participant was reminded of their right to withdraw at any point, that the interview was to be audio-taped and that all data would be anonymised with their identity only being known to myself. Each participant was given a participant pseudonym e.g. (Jayne). Only I knew the identity of participants assigned to particular pseudonyms. The participants were advised to avoid using names of staff or patients during the interview to respect the anonymity of any patient or staff member mentioned.

To facilitate a good interview, the interviews were conducted with warmth, curiosity and interest towards the participant and the subject. This enabled the participants to feel at ease during the interview and have trust in me. My knowledge about self-injury from my past work experience and clinical training meant I could deal with the content of the interviews confidently and discuss the participants’ experiences in a calm and inquisitive way. My professional clinical training was useful in ensuring active listening skills were utilised and that any probes were implicit and not directive. Similarly, time was given for participants to give their full answers to ensure nothing was missed or that I did not exert too much control over the interview process.

The interview process made a number of cognitive and communicative demands on me as researcher; the memory to return to points made previously in the interview, actively demonstrating a genuine interest towards the
participate and the subject; maintaining concurrent mental tracks of responding to the participant but also thinking about further questions, and attending to contradictions and questions arising in the data. In addition, I needed to monitor participant’s verbal and non-verbal behaviour and assess the emotional and cognitive impact of the interview on the participants, encourage the participant to speak about difficult areas and make mental notes for later analysis.

At the end of each interview my observations and reflections about the tone and feel of the interview itself and any remarkable non-verbal communication that occurred was recorded. How the participant presented during the interview such as the perceived congruence between language and non-verbal communication was noted in the reflective diary.

**Semi structured Interview**

A purposefully designed semi-structured interview (SSI) schedule was devised to act as a guide to the interviews if needed (See Appendix M). SSIs are interviews in which a number of key open-ended questions are used as guidance for the interview to allow the participants freedom in their responses. SSIs have been used within IPA research and in self-harm research using IPA methodology (Smith & Osborn, 2003/2006; Thompson et al., 2008).

The SSI was constructed according to IPA guidelines (Reid, Flowers & Larkin, 2005; Smith & Osborn, 2003/2006), and based on previous literature (Thompson et al., 2008). The SSI was reviewed prior to interviews by the trauma and self-injury steering group within the unit which comprises of psychiatrists, un/qualified nurses and clinical psychologists. The interview schedule has an initial framing statement to open the interview and orientate the participant. Use of relevant prompts facilitated a flexible two-way discussion between the participant and the researcher such that both could fully engage with the dialogue but which ensured the researcher could maintain an appropriate level of control within the interview with regard to the research aim (Smith & Osborn, 2003/2006).

The questions within the interview schedule were kept to a minimum for ease of recall and use within the interview (Patton, 1990). This also ensured the
interviews were structured by focusing on the themes but were flexible such that the participants’ perspectives or understanding of their experience could be discussed (Kvale, 1983). With the questions as memory cues I could be responsive and attentive to the participants in what they wished to talk about but ensure the research questions were being answered. Various prompts and probing questions were used to encourage the participants to think about what was being discussed in new ways thus generating new information or knowledge about the subject. In concordance with the IPA approach, I acted as an active participant in the creation of the knowledge and data rather than being an observer. To do so I needed to take both an empathic and questioning stance such that the participant’s perspective could be heard and understood but also enquiring about what was said, how it was said and perhaps why and when it was said (Smith & Osborn, 2003/2006).

In IPA it is important that the researcher does not control the interview or dictate what information is derived. The researcher’s prior knowledge of the topic can be a hindrance and a benefit. Prior knowledge or expectations can mean the interview is guided more efficiently towards the information being sought and not hindered by discussion of already known knowledge but on the other hand it can mean the participants’ perspectives and experiences may be overlooked. Through ethical and methodological stringency, these potential flaws were addressed.

Despite my intent prior to the interviews of adhering to the SSI, it quickly became apparent in the first interview that to do so I would find restrictive to the spontaneity and flow of the conversation. In particular I found that having the SSI encouraged me to follow it and the questions in a linear fashion rather than follow the direction and pace that participants dictated With this being my first experience of using a SSI in research using this methodology and epistemology, I took this as a learning experience and reflected upon this (see researcher reflection). To have a number of questions in mind in which to answer the research question I believe is useful however to have these in a structured format specifically laid out I believe to be a mismatch with the approach and would therefore reflect on the use of SSIs further in future research using this approach.
Materials

Audio equipment. An audio cassette recorder was made available by the research site to record interviews.

Ethical considerations

Participants were asked to confirm their consent to participate in the study at the start of the interviews. Participants were encouraged to ask any questions about anything related to the research or their participation throughout the research process. Confidentiality was guaranteed as only I could identify participants by cross-matching the participant pseudonym, date and time of the interview on the audiotapes with the data records. However, the nature of qualitative interviews and the use of extensive quotations can create a risk to confidentiality (Haverkamp, 2005). Therefore participants were informed that any information within quotations perceived likely to reveal their identity would either be altered or omitted from the findings. Ethical approval was obtained from the local NHS Research Ethics Committee, the University Ethics Committee and Local NHS Research and Development Department who authorised access to the research site.

Particular ethical issues in this study were care of the participants during the interviews in light of the discussion and description of experiences of working with self-injury. As well as debriefing, advice was given on accessing support from line managers and clinical psychologists within the service. None of the participants requested additional support information or debrief. Ethical issues arose with regard to maintaining anonymity of the participants. It was difficult for participants to remain completely anonymous due to permission from ward managers being needed for participants to leave the ward for interviews. This was addressed by ward managers being contacted by myself prior to the interviews to authorise staff’s participation and request that staff member’s confidentiality be respected. Also participants were reassured that none of what was discussed would be discussed with anyone other than the clinical supervisor who would only view anonymised data. It is expected that the findings will be presented to the unit following completion of the study and that the research will be submitted for publication. Participants were informed of this. Despite my past employment within the hospital at which the research took place.
place (in a different directorate) there were no ethical issues arising with dual relationships. Similarly no conflicts of interest arose during the research process.

Analysis

Two interviews were transcribed by an external professional (who signed a confidentiality agreement) and the remainder by me. I also conducted accuracy checks on those transcripts transcribed by the external professional. All analysis was started following the final interview. Although I might have been able to further explore themes arising from earlier interviews if I had started analysis before this, on balance I felt that by having ideas of themes arising at the time of individuals may have reduced the spontaneity of the interview for what participants wanted to talk about or felt important.

Some debate exists over whether participants should be given choice for the pseudonyms or whether they be assigned by the researcher. If the latter, it is also discussed as to how these pseudonyms are chosen. For this study it was decided and agreed by the participants that pseudonyms would be assigned by the researcher but that they would be in keeping with the participants’ ethnic and demographic backgrounds.

Stages of analysis.

Stage one: Transcription. All audio interview recordings were transcribed and each line of text numbered for later referencing during analysis.

Stage two: Initial immersion: The first transcript was read through at least seven times so that I could fully immerse myself in the data. Anything of interest during this reading process pertaining to the topic under study that could not be related specifically to a segment of text was noted in the research diary. These could be based on the sense I was gaining from what participants said, key phrases, language used, and any links, connections or associations recalled with the interview itself. This became a key source of information for the interpretation and generation of themes during the IPA process (Smith & Osborn, 2003/2006).

Stage three: Coding. The transcript was then copied individually to another document. These documents had three columns (See Appendix N). A further in-depth reading of the transcript derived further exploratory comments.
about the impact of self-injury. These could be linguistic, conceptual, interpretative or descriptive in nature. These were added to the exploratory comments column. Any categories of meaning or themes that became apparent as encapsulating nurses experiences of self-injury were identified in a third column of ‘themes’ adjoining the transcript and given tentative labels e.g. ‘powerlessness, through a process of abstraction. In addition any reference to factors that impacted on their experience was documented such as peer support. At times the themes were described as found in the data e.g. helplessness but at others I found it more appropriate to move to a higher level of abstraction based on conceptual or interpretative meaning. This often stemmed from questions that I had of the data as it was occurring. Where higher order interpretations were made, my thinking at this point and rationale for this interpretation was documented in the exploratory comments column such that my interpretative process was transparent. This provided evidence for the audit trail (Elliott et al., 1999). This continued until I could no longer identify any new themes.

This process did not imply data saturation in that no new themes or knowledge could be found regarding the subject researched as is often inferred within qualitative research. Data saturation is often reported as when no new themes can be found despite further data being collected and added to the analysis and that therefore a reliable and full understanding about the topic has been obtained (Strauss & Corbin, 1998). Guest, Bunce and Johnson (2006) conducted 60 interviews and found no new information occurred after the first 12 interviews. However, such an understanding of data saturation is often misconstrued. Reaching saturation depends on the breadth of the research question itself (Strauss & Corbin, 1998), the sensitivity of the topic e.g. with personal and sensitive topics more interviews may be needed because of participants reluctance to disclose information, and researcher skill and knowledge of the topic under study (Morse, 2000). The concept of saturation as meaning all data about the topic that could be found has been found is a positivist concept and therefore questionable within qualitative research e.g. it is likely that conducting further interviews with say, 20 more participants would indeed derive additional themes. The issue of saturation in phenomenology...
based qualitative methodologies is in itself questionable as the data set is treated as a whole and interpreted hermeneutically. The essence of obtaining meanings of participant's experiences is such that obtaining the full variety of possible experiences about a phenomenon is unlikely. From a constructionist point of view it is more likely that saturation is the point at which the researcher themselves is unable to derive a new themes from the data.

Stage four: Theme consistency. To check for consistency and reliability of themes arising from the text all segments of text relevant to particular themes were lifted from the transcripts and placed in a separate theme file [See Appendix B]. This resulted in a file of text segments for each theme. Having these theme files was a good indication of the internal consistency, frequency and specificity or broadness of that theme within the transcripts. Text segments remained identifiable according to participant and line number. This allowed me to further check for presence of themes across all participants as they were included and similarities and differences observed across participants. By having all text for one theme in one file this allowed me to begin reconsidering theme titles through a process of abstraction. It also allowed me to begin comparing theme files which resulted in tentative links being made between themes or assimilation of themes to be considered within super-ordinate themes.

Stage five: Connecting the themes and establishing super-ordinate themes. I looked to see how different themes were related, similar or might clarify one another. I made a bubble map of all the themes that were identified from stage three (See Appendix C). Using this format it was easy to play with the themes, and move them around to better identify patterns or links between themes. Themes were arranged according to perceived strength of association or importance of the theme in relation to the rest of the interview data. As themes were clustered and arranged on the map it allowed me to begin identifying super-ordinate themes according to what themes appeared to have common. Clustering was based on abstraction and by considering all the many different ideas and interpretations I had accumulated in my mind during the previous few stages within the reflective diary. At this stage I also asked questions about the data by reference to the research aim itself e.g. by looking
at the maps, I asked what it told me about the cognitive experience of the participants. Where necessary some themes were subdivided or co-joined according to how I felt the themes intertwined or were structured according to the research question. This required me also to reflect on the data arising in conjunction with my own biases and assumptions via consultation of my research diary. The outcome of this was a map reflecting the participant’s experience of working with self-injury and my understanding of their experience.

Stage six: Master table of themes and super-ordinate themes. Using the bubble maps I then constructed a master table of super-ordinate themes and themes with relevant key words and the location of the text segment in the transcript (Smith & Osborn, 2003/2006) [See Appendix D]. This allowed me to have an overview of the participant’s interview and the information contained within.

Stage seven: Stages two to six were performed on subsequent transcripts. Subsequent transcript analysis was a back and forth process of going back to earlier transcripts when new information arose to see whether it made sense of previous information in a different way.

Stage eight: Group master table of super-ordinate themes and themes. By comparing all participants’ bubble maps and tables of themes I was able to extract the most consistent and important themes to produce an overall master table of super-ordinate themes and themes (see Appendix E) which reflected the interpretative structure of the data. To check for validity and consistency, quotes from each participant relevant to themes were taken from the transcript with the identity code. Through this process of comparing and contrasting of themes across participants, some of the ideas or themes I had initially thought to be important or prominent were dropped from the master table of themes based on factors such as prevalence, illumination of other themes, or the richness and power to the data set. This also meant some themes were re-named or some text segments allocated to other themes. Based on the variation across all participants of themes arising it was decided that any themes present in 50% or less of the participants would not be included in the main results. This meant themes e.g. anger, frustration, hopelessness, interest in the macabre, perseverance, self-care, increased knowledge and confidence...
and bodily experiences were removed from the group master table of superordinate themes and themes. As well as the lack of consistency across participants, it was felt these themes failed to inform the overall narrative that had been formed of the participants as a whole or that the data within those themes lacked richness. My justifications for retaining and removing of themes was discussed with the academic and clinical tutor for the study who also reviewed my analysis of themes at stage three. A representation of the study’s theme structure was produced (see Appendix F).

**Quality assurance**

Problems occur when principles and concepts of reliability and validity for quantitative research are applied to qualitative research. This is because of the differential paradigms and their infrastructure. The appraisal and conduction of good quality qualitative research has been a topic of lengthy debate resulting in a number of guidelines or frameworks (Elliott et al., 1999; Kvale, 1983; Smith, 2003/2006; Stiles, 1993; Walsh & Downe, 2006). The variety of qualitative approaches, each with differing philosophical positions, further hinders a consensus being reached (Walsh & Downe, 2006). Smith (2006) states that whilst “validity and quality are important considerations….qualitative research must be judged by criteria which are appropriate to it” (p. 232). As recommended by Elliott et al. (1999), authors are responsible for “addressing how they meet the intentions of the guidelines for reporting qualitative research, or alternative standards” (p. 221). On this basis, Elliott et al’s (1999) publishability guidelines and Yardley’s (2000) criteria were considered when conducting this study. Both of these guidelines are applicable to qualitative research irrespective of theoretical orientation.

Yardley (2000) has three broad principles for assessing quality in qualitative research; sensitivity to context; commitment, rigour, transparency and coherence; impact and importance. It is acknowledged that these terms are in themselves value judgements (Aldridge & Aldridge, 1996). Sensitivity to context included consideration and discussion of my position to the research and the participants which provided a representation of the hermeneutic production of knowledge in keeping with IPA’s epistemological position.
Commitment is evidenced through the use of in-depth interviews and use of systematic procedures throughout the research and analysis process.

Rigour, transparency and coherence or descriptive validity (Maxwell, 1992) is evidenced in a number of ways. To encourage richness and detail in the data, I portrayed curiosity and a naivety about participants’ experiences by asking prompts and follow-up questioning. I asked questions about meanings of terms used by participants even when I was clear in what they were saying to ensure that I did not make assumptions about the participants perspective of its meaning. An audit trail of the research process is evidenced by all audio-tapes, transcripts, coding sheets, interview schedule and the research diary which reflects the trustworthiness of the research (Koch, 1994; Morrow, 2005; Smith, 1999; Yin, 1989). In addition the audit trail of the data analysis provides further transparency [see Appendix O]. Sufficient detail about the sample, methodology and procedure of the study is provided such that anyone reading the study has enough information in which to form a judgement about the quality and usefulness of the work along with the appropriateness of the methodology in which to answer the research question (Elliott et al., 1999; Fade, 2004). Direct quotations of participants were used to evidence the persuasiveness of the analysis and illustrate the interpretations from the data and therefore provide descriptive validity (Elliott et al., 1999). Interpretative validity was demonstrated by grounded interpretation of participants’ actions and words e.g. where participants laughed in the context of the interview and reflecting on that. Furthermore, interpretation of themes was discussed and demonstrated with evidence in a coherent way such that interpretations are clearly evident to the reader. Transparency was also demonstrated by participants being given the opportunity to review, as opposed to agree with, the interpretation of their accounts (Elliott et al., 1999). Agreement from the participants of the researcher’s interpretation (it is argued) provides credibility and transferability of the research and is a form of member checking (Lincoln & Guba, 1999; Sandelowski, 1986). However in IPA it is argued that seeking agreement from participants of the researcher’s interpretations is incongruent with the methodology and the epistemology. It is unlikely that such agreement would be found because of the different position and perspective that the researcher.
brings to the research. Over time and as a result of their participation in the study, participants’ accounts and meaning of their experiences may also change further increasing the possibility that they might disagree with the researcher’s interpretation of the experience. For such reasons member checking is not endorsed in IPA. Despite this it was hoped that if consulted about the interpretations, participants would feel understood and listened to and that the research experience had therefore been an enriching one for them. Participants in this study declined to be further consulted on the results of the analysis which may be an indication of rapport and trust in myself as researcher based on my conduct and engagement with them during the research process. Although they declined they were given details of how they could contact me at any point should they wish to inquire about the analysis. This I was mindful throughout analysis and write up which ensured I remained in accordance with my ethical and methodological obligations for the results to remain grounded in the participants’ experience. It could be considered that in my awareness of participants approaching me regarding my analysis and interpretations, it might have affected the interpretative process itself e.g. that I actively altered my interpretations. Upon reflection of this I deemed that participants requesting access held no difference in my mind than did the awareness that I would be publishing the study and orally presenting the results to the research site. On both accounts therefore, uppermost in my mind was the need to conduct myself ethically and honestly and to remain true to the methodology even if this meant my interpretations might not be well received by the participants, reader or audience. If considering the double hermeneutic tradition it is understandable that as a researcher my interpretations might not be agreed by others because of the idiographic nature of the analysis and interpretation. The data analysis section, with the aid of summary tables and diagrams, provide a coherent account of the themes and super-ordinate themes which then come together to form an underlying structure of the impact of self-injury (Elliott et al., 1999). The value of any scientific method is how well it answers the questions asked of it in the first place (Elliott et al., 1999). Similarly, the value and significance of the research itself as well the methodology is a moral obligation for researchers (Hewitt, 2007). Justifications for this research involve the need to attend to the
paucity of systematic research around psychiatric nurses’ experiences of self-injury. In addition, it is hoped that the participants, research site and the literature in this area will benefit from the findings of this study and that these findings will have both clinical (e.g. staff training and support) and theoretical implications (e.g. providing data for later qualitative meta-synthesis in this subject area).

The need for interpretative consensus in IPA methodology is minimised because this would conflict with the notion of multiple realities and hermeneutic interpretation (Gadamer, 1989; Golafshani, 2003). However, copies of the original interview transcripts were reviewed by an independent researcher (a consultant clinical psychologist who had experience of working with those who self-injure) to provide the researcher with opportunity for clinical supervision and discussion of interpretation arising. Furthermore this along, with the research diary, provided some opportunity for researcher reflection and dialogue on the categories, themes and super-ordinate themes found from the data. The independent researcher had not seen the data previously, or been involved in the interviews or researcher’s interpretation and coding of the data. Disparities in interpretation between the researcher and independent researcher were discussed. Where there were disparities, the sources for each interpretation were discussed with regard to how excerpts from the transcript justified those meanings. Then based on these discussions, the interpretation best justified by the text was chosen (as would be expected within IPA methodology), rather than a consensus on one interpretation being reached (Smith & Osborn, 2003/2006).

**Role of the research diary.**

In phenomenological and hermeneutic research, the researcher’s experience during the conduction and analysis of the study is important data (Drew 1989; Koch, 1995; Munhall, 1994). Smith (1999) states “a reflexive journal promotes an internal dialogue for analysing and understanding important issues in the research project” (p. 360). Use of the diary provided the reasoning and reflections around my interpretations that can be absent in IPA research (Brocki & Wearden, 2006).
The reflective diary was a tool by which I made reflections and notes throughout the research process. It allowed me to monitor and consider the influence of pre-existing theoretical, contextual or personal preconceptions (fore-conceptions) on how the data was gathered and my interpretation of the meaning of participants' experiences (Brocki & Wearden, 2006; Dzurec, 1989; Smith, 1999). Included within the diary were my questions around the methodological process and difficulties found during conduction of the research.

**Extended Results**

**Additional theme material**

**Fear of patient death.** Participants' fear was also related to the risk of being attacked by patients during a self-injurious episode if they attempted to intervene. With the use of constant supervision when patients were at risk to themselves or others, one participant described his experience when sat outside the seclusion room:

I mean you can’t possibly go in because that’s often what they want you to do. [talking as if the patient] We’ll get you in here and then I can beat the crap out of you or hopefully ya know. So you’re also sat thinking about that, if we are going in, whose it going to be, whose turn is it? And it's quite possibly me because I'm the one who's been sat there whilst she’s self-harming (Tim).

Participants therefore had to manage their fear that without them intervening a patient would die, but in order to do that they had to manage their fears of being assaulted as well. Following an incident in which a patient's life had been saved one participant acknowledged the fear of the potential repercussions:

And that scared me a bit. After all these incidents I thought I could lose my job or this patient could die’ (Steff).

**State of perturbation.** Participants were able to recall everything they felt at times as though their sensory experience was heightened during particular incidents:
‘You get hardened to it’

It was everything, I’m just there, I’m there, I can see it. I can, I can hear them, and the smells there. Yeah. I suppose the smell ain’t there but it’s in your head ain’t it’ (Sophie).

For some this adrenalin helped them cope with managing self-injury incidents or risks they faced:

I was scared but your adrenalin takes over and you just do what you’ve got to do (Steff).

**Culmination of stress.** Another participant described:

You just plod on thinking it it’ll probably get better. But it never did. Then the bad day. And I thought I can’t do this anymore. But I did, I went back. But it didn’t affect me till six weeks later (Alice).

Participants also described how stress accumulated and affected them:

We had a patient on the ward who was being really difficult and the way it was being managed I found it was really hard and it’s the only time I have ever done it but I had time off sick with stress, just because every day I woke up I was crying before I went to work. I said this is ridiculous I cannot do this anymore, but because you don’t want to let people down you carry on going don’t you, until the point which just you just can’t do it anymore and I had four weeks off and when I went back because the way everything had been managed had changed, it was completely different. There just is almost only so much stress anybody can take. Just enough’s enough’ (Gaia).

**Habituation.**

You almost get numb I suppose numb is a good word you deal with it, you manage it, you sort it all out, but you sort of don’t absorb it (Gaia).

The culture of dealing with self-injury within the unit became a buffer to what they experienced within themselves as Gaia described:
Because you are talking to people who work here about the self-harm it almost becomes the norm and that almost protects you (Gaia).

**Maintaining boundaries.** The knowing of patients only to the point that they understood the person and their behaviour gave a sense that they could predict or anticipate the self-injuries therefore alleviating some anxiety. Nurses appeared comforted by having the sense that they knew what patients could be capable of:

I feel so out of my depth on there. There’s a lot of new patients on there since I were there, with a lot of different behaviours. When you don’t know that patient, it’s quite daunting. At least you know your own patients because you’re with them all the time, you know what they are going to do, you know their behaviours, you know when they’re off it, because you’re with them all the time (Alice).

**Peer support.** Another participant described how she saw supervision and debriefing in comparison to peer support:

It [supervision] does help yeah but it is not always formal supervision that I do it in, sometimes I talk informally to people….we said it was nice for us to sit here in the office doing the notes just talking about it rather than the actual debrief, I think that was more beneficial to me anyway (Jayne).

Peer support was so important that peers negative judgements was felt acutely, as one participant described:

The thing that does stick in my mind mostly is your colleagues, is their criticism you know. How you handled it or didn’t handle it or what you could have done that sort of thing (Tim).

Not one person asked me how I was, even though I had been over there supporting the staff through a nasty incident. But not one person asked me how I was (Steff).

Another participant described it as:
‘You get hardened to it’

Going back to years ago there was a lot more support, there was a lot more camaraderie than what there is nowadays.... I think sometimes the staff feel very isolated you know (Alice).

**Minor themes excluded.**

The data contained a number of themes that were dropped from the final table of themes due to a lack of consistency or sufficient data richness across all participants. These were feelings including anger and frustration. Frustration was described regarding obstacles that hindered their helping capabilities such as staffing resources and organisational procedures as one participant described:

Legally you can’t go in straight away. So if you have somebody, bleeding to death, you have to wait. Nobody should have to do that (Alice).

Participants described anger towards the patients for their dismissal of the seriousness of the self-injury at the time:

Her laughing it down saying it wasn’t anything. That it didn’t mean anything (Alice)

And anger towards the lack of acknowledgement or recognition for what nurses were doing:

You’re not particularly looking for pats on the back but what you are looking for is recognition that it is a very demanding job (Sophie).

Similarly within the super-ordinate theme of containing process, two participants spoke about how the job had led to personal development and self-confidence:

I feel like I’m good at it (laughter) it sounds really bad but that’s what I like about it and I think I am good at it....I feel I have grown and become more confident since I’ve been here (Jayne).
Within the super-ordinate theme of protection of the self, two sub-themes were considered; perseverance and self-care. Perseverance centred on aspects of the job that participants used to maintain their motivation and satisfaction in the job such as modifying expectations of patient change or progress but also their knowledge and skills:

I think that is one of the, not a hard thing but that's one of the things you come to accept, that with job satisfaction, you have to look for the little things because if you look at the big things all the time you just never get satisfied (Gaia).

Three participants spoke of the need for self-care outside of work such as going to the gym to relieve anger, eating properly and rewarding themselves with pleasurable activities with the family:

We always at home think well we work hard and we always have something to look forward to every month (Steff).

**Extended Discussion**

**Experiencing of affect**

This study indicated nurses experienced on occasion a variety of emotions when working with self-injurious patients. Such emotions e.g. hopelessness and anger, were however not featured as themes due to their inconsistently across the whole study sample. Previous research has indicated the stressful impact on nurses working with self-injury in community settings (Burnard et al., 2000; Loughrey et al., 1997; Melchoir et al., 1997). Nurses within this study described occasions in the past where they experienced stress in the role resulting in sick leave. Nurses appeared to see this stress as a result of incidents occurring very close together. Despite working with patients for longer and more intensively than would be expected in community settings it appeared that nurses were able to adequately buffer against the negative impact upon themselves for much of the time. It may be that the strategies and processes nurses found to contain their experiences have a part to play in this buffering. This study indicates that the experience of working with self-injury...
may not necessarily be as previously thought if personal, professional and environmental factors that provide support to staff, are in place.

**Containing factors**

**Enjoyment of the job.** The participants highlighted the challenging role of working in the unit. They appeared to gain a sense of achievement and satisfaction based on this. Similarly the social support from their peers could also be considered a rewarding aspect of the role. This sense of reward in performing the role appeared to provide some compensation for their efforts and tolerating the role’s negative aspects. The theoretical effort-reward imbalance model (ERI: Siegrist, 1996) focuses on the reciprocity of exchange in occupational effort and reward and the outcomes of this with regard to psychomedical work-related stress and burnout. This model has been used and validated in studies across various occupational settings (Siegrist, 1996; van Vegchel, de Jonge, Meijer, & Hamers, 2001; Weyers, Peter, Boggild, Jeppesen & Siegrist, 2006), although application of it in health care settings is scarce (Schulz et al., 2009). The main premise is where there is an imbalance between extrinsic effort and reward in the job, stress or burnout arise. Using the Maslach Burnout Inventory (MBI: Maslach, Jackson & Leiter, 1996) and the Effort-Reward Imbalance questionnaire (Siegrist & Peter, 1996), Schulz et al. (2009) found that when comparing medical ward nurses and psychiatric hospital nurses for the associations between the MBI and the ERI, medical nurses had higher ERI (effort, reward and over-commitment) scores and that these scores were predictive of emotional exhaustion on the MBI. This model and the supporting evidence provide some insight into how rewards in the job might compensate for the challenges or detrimental aspects of the nursing role in this study.

Since the 1980’s there has also been a shift from valuing a clinical/professional, detached or distant nurse-patient relationships towards a more intimate approach for ensuring positive treatment gains for the patient (Kadner, 1994; Salvage, 1990; Webb & Hope, 1995; Williams, 2001a, 2001b). This shift also arose over concerns around the impact on nurses maintaining a psychosocially and emotionally distant relationship with patients. An interview and observational qualitative study of nursing practice found managerial
attempts to protect nurses from becoming too involved with patients and
dependently, becoming distressed e.g. frequently moving patients or nurses to
prevent close relationships developing, was actually creating anxiety and
as being joint disclosure and reciprocity. Savage (1995) further implied nurses
need to care for and care about the patients and therefore have emotional,
physical and psychological involvement and commitment to the patients. Indeed
intimacy in the nurse-patient relationship is found to be valued by nurses and
patients alike according to some studies (Ersser, 1991, 1998; Wharton &
Pearson, 1988).

However a review of studies suggests conceptualisation of these terms
of closeness and intimacy is problematic (Timmerman, 1991; Williams, 2001a).
Within a social constructionist perspective it is unlikely that such terms will carry
concordant meanings across the differing medical, social and cultural contexts
of nursing practice and across individuals (Williams, 2001a). Indeed, Savage
(1995) found nurses perceived closeness as indicative of personal rather than
professional relationships. Such perceptions seem discordant with theoretical
conceptualisations of closeness or intimacy within the literature. Based on her
nursing experience and clinical observations. Peplau (1988) inductively
theorised the psychosocial dimensions of nursing. She supported the use of
emotional detachment and distancing in the nursing approach. Peplau (1988)
described a ‘professional closeness’ between nurse and patient as being close
enough to appreciate the patient’s perspective of their situation (e.g. empathy)
but not closeness to the person. Qualitative studies have indicated that personal
involvement is defined according to the level and nature of that involvement with
patients. Too much involvement or intimacy can lead to a detrimental impact on
nurses, patients, nurse-patient relationships as well as staff teams (May, 1991;
Morse, 1991; Ramos, 1992; Smith, 1992). Similarly Reed (1992) queried
whether promoting close relationships without sufficient support mechanisms in
place could increase nurses’ vulnerability. Closer inspection of Savage’s (1995)
study finds that while close relationships were not considered stressful by
nurses, they were perhaps linked with perception of failure. This indicates close
relationships are not always perceived as beneficial to nurses despite what may
'You get hardened to it'

be recommended within the literature as beneficial to patients. The nature of nurse-patient relationships are highly complex and agreed conceptualisations of them remain problematic and confusing.

The participants' habituation towards self-injury (with the exception of life threatening behaviours), use of peer support and the strict boundaries they put in place, is perceived as a system that they used to maintain an emotional distance and hence emotional involvement in their work. Participants lack of reported stress or anxiety related to patients' self-injuries specifically is seen as supportive of this. This cognitive and emotional distancing through use of boundaries and containment from habituation are perceived as serving participants well in the nursing relationships rather them less. This appears contradictory with the theoretical literature of nursing practice (Salvage, 1990) around close relationships with patients. Nurses in this study appeared to indicate more of a professional closeness ('I watch their behaviours only') and an avoidance of a personal closeness ('I establish a firm line'). The socio-cultural context of nursing practice may be relevant in light of the findings here. Intimacy within a nurse-patient perspective is difficult and problematic within the context of a market-led health service (Salvage, 1990; Williams, 2001a). Similarly within a secure mental health service such as this, nurses’ self-disclosures of a personal or confiding nature are not endorsed. However this might imply nurses are professionally hindered in developing close relationships rather than actively avoiding it for personal and emotional reasons.

Previous studies with community nurses working with self-injury found them to be in want of theoretical and practical knowledge to help them work more effectively with self-injurious patients (Thompson et al., 2008). This was not supported in the findings of this study. Nurses in this study appeared to have a proficient awareness and understanding of the function of self-injury but also how people who self-injure can relate with staff (e.g. patients use of manipulation). This was indicated in the interviews as to why nurses established and maintained such clear boundaries between themselves and the patients to avoid being drawn into any difficult interpersonal dynamics. Nurses here conveyed a good level of confidence and competence in working with self-injury. Only one nurse in this sample reported that she felt the life-saving
demands of the job role were beyond her capabilities and training expertise. The findings of this study suggested nurses were not being drawn into the reciprocating countertransference responses to patients that can be found when working with populations such as this e.g. the rescuer role or the punitive, punishing roles (Kerr, 1999; Rayner et al., 2005).

**Implications for clinical practice**

This research has suggested that whilst debriefing is used and appreciated, participants were dissatisfied in its application or timing. Participants also felt that due to staffing constraints not all staff involved in incidents had access to debriefing. Despite there being guidelines for debriefing process, staff appeared to want debriefing conducted with less formality and in comfortable settings away from the wards. There was a desire for acknowledgement of how staff wished to be debriefed rather than structure being imposed upon them. Debriefs coordinated by peers who are not perceived by the staff group as outsiders was also highlighted in the interviews. This is highlighted in the literature also (Dyregrov, 1997).

Nurses had particular fears around the life threatening actions of patients although none had been involved directly in an incident in which a patient died. Their fears may be heightened by a lack of knowledge or experience about what happens following a suicide or death through self-injury. Nurses should be encouraged in this area of psychiatric nursing to reflect upon their work with suicide or death of patients and development of skills in managing suicidal patients specifically if not already done so to help alleviate some of their anxieties.

Nurses in this study acknowledged the potential for complacency as a result of habituation and hence the risks to patient safety and care. Nurses should be supported such that a habituation or use of therapeutic boundaries does not impede a reflective therapeutic or empathic approach being taken with patients. Clinical supervision and support of nurses in this role should therefore encourage a reflective component. Clinical supervision of nurses working with self-injury may find it useful to consider the themes highlighted in this study.

**Critical reflection**

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"You get hardened to it"

For methodological, ethical and scientific critique of this study, guidelines for qualitative research were considered (Haverkamp, 2005; Russell & Gregory, 2003). Methodologically, use of IPA allowed for in-depth exploration of the lived experience of nurses working with self-injury within a secure hospital setting. Furthermore, the experience was that participants themselves, through reflection during the interviews, discovered new understandings about their experience e.g. Tim realised new connections between his experience and criticism from his peers. The occurrence of misconceptions of working with self-injury was also endorsed by the participants in this study who stated that their work with those who self-injured was often misperceived and misjudged by those within the rest of the hospital in which this unit was based.

Use of a semi-structured interview is a common data collection instrument within qualitative research (Burnard, 2005) and allowed for greater exploration of the participant’s lived experience that might otherwise be missed through use of more structured tools e.g. questionnaires. Participants reported that the opportunity to talk and reflect upon their experiences through the interview experience was a valuable one compared to if they had been sent a pre-determined questionnaire. This was supported by participant’s comments that it occasionally felt that concern for staff support or staff’s perspectives were overlooked. With the exploratory nature of this research it was felt that use of questionnaires might also impinge the researcher’s own assumptions and agenda upon the participant’s experience of self-injury. Research finds that qualitative research participant’s find talking about their emotive experiences therapeutic and can be beneficial in allowing them to feel heard and valued (Kvale, 1996; Lowes & Gill, 2006).

As a researcher external to the unit, the research taking place at their place of work and the power differential, it should be considered that participants may have experienced some difficulty disclosing personal information. This is particularly the case in light of participants reporting difficulty in talking during debriefs to ‘outsiders’ and how they utilise peer support with those who have shared similar experiences. Similarly, despite the efforts to instil participants with the sense of being co-researchers in the IPA process, the impact of the asymmetrical power relationship between myself as researcher
and the participant may have meant nurses had some difficulty opening up about their experiences. I may have been perceived as an expert or to be judging their breadth of knowledge or assessing the quality of care shown towards the patients (Haverkamp, 2005). The interviews were not a wholly reciprocal communication as I introduced the topic, guided the interview and determined the situation (Kvale, 1996). This was considered prior to the interviews resulting in me clearly expressing my naivety with regard to their role and experience working with self-injury thereby hoping to empower participants as informed experts in this research (Colbourne & Sque, 2005). Participant’s perceptions of the researcher’s professional background have been found influential in the process and outcomes of qualitative interviews (Richards & Emslie, 2000). However Richards and Emslie’s (2000) evidence to support these conclusions that professional background was a factor in their research is methodologically weak (Hewitt, 2007). Such role-boundaries may however have been reduced by my own personal disclosures about my opinions or past experiences with suicide and my casual attire. It is possible that my declaration of being a trainee clinical psychologist or from a university may have made participants hesitant about revealing any perceived vulnerabilities of lack of coping. In contrast, it is also considered that as a perceived ‘outsider’, participants may have also felt more comfortable talking about issues and concerns that was more critical of the unit or patients. Some less socially desirable comments made by the participants about patients, the organisation or their experience of self-injury would suggest that my role as an outsider was not a pertinent obstacle to data provided. Both perspectives however had the capacity for influencing the quality and content of data produced.

Qualitative research in contrast to quantitative methodologies aims to capture subjective experiences and patterns thereof across individuals or time. They do not require large sample sizes or representative samples that may serve as a basis for hypotheses (Patton, 1990). The findings here are specific to the context, sample and time in which the research was undertaken as well as my role as an instrument in the analysis of the data. The specificity of these findings should be considered as a result of a combination of factors such as nurse training and experience, organisational culture, supervision and forensic
context. For example at the time this research took place, staff contracts were being culled which may have led to anxiety within the unit about jobs as well as influence on nurses perceptions of management support and being valued as employees. This may have affected participant’s sense of reward in their role. Again, with the participants talking about the rewards and enjoyment of the role this is not seen as having affected the data. It should also be remembered that the generation of data, analysis and interpretation is a result of a socially constructed exchange between the participant and the researcher, further reiterating the idiographic nature of this research.

Despite this, contextual details provided about the sample and research setting allow for consideration of the study’s findings to clinical practice and existing theory. Details about the setting of the study, the participants and the process are also provided for transparency and possible replication and to allow the reader to consider the relevance of the findings to other contexts. However changes in the researcher, the research aim or question would be likely to derive new relationships with the participants and therefore new interpretation (Finlay, 2002). However this does not reduce the validity or reliability of the research as transparency of the meaning making process and the reflection of the realities conveyed by participants is provided throughout analysis (Annells, 1996).

In hindsight, this research would have benefited from an initial pilot study. This would have enabled me to familiarise myself with the methodology, style of interview and analysis. A pilot interview would have allowed me to test out my questioning style and particular questions as to the quality and richness of data they produced with these participants. Furthermore, data analysis of a pilot interview would have helped me identify my overuse of closed questions, interruption of the participant or failure to adequately probe participants for their experiences. It would have also allowed me to gain feedback from the participant on my performance and what they found helpful or not helpful in my style and questions. This would have further developed my interviewer skills. Secondy, based on hindsight I believe that at the research design stage, allowing for the possibility of a second interview with participants would have enabled me to gain further information and possibly enrich the quality of the
data obtained. Following an initial interview I would then be able to reflect upon the interview itself and return to participants to clarify previous information or seek further detail. A second interview may also have encouraged more personal disclosures with the participants with there being greater familiarity and rapport with the researcher. As it was because this had not been explained to participants at the outset when obtaining their consent for participation in the research, it was believed to be unethical to request further interviews. In addition a second interview would have got round the issue of participant’s talking at length about areas not pertinent to the research aim. With the participants having had little opportunity to talk about their experiences they had a lot they wished to talk about and I had some difficulty in guiding the interview towards relevant material without potentially shutting down the participants or risking the loss of seemingly irrelevant information that might actually become quite relevant. Again a second interview might have rectified this issue somewhat. However it could be argued that this conflict arises as a result of an unskilled researcher.

In concordance with IPA with me as researcher, the influences I brought to this research, the data collection and analysis was reflected upon. Consideration of my fore-conceptions was not just a methodological imperative but also an ethical one. Being critically reflective of my assumptions and motivations for the research meant I kept my analysis and interpretation of the data grounded within the experience of the participants as opposed to those more in keeping with my own experiences or beliefs around working with self-injury. This would have been unethical selection or interpretation of the data (Guillemiin & Gillam, 2004). Furthermore, my fore-conceptions, influenced by the literature were that participants’ experiences would lean towards trauma and distress. Insight of these underlying assumptions I had at the research design stage occurred later on in the research process when data began to contradict my assumptions. This again highlighted to me how subtle the subjectivity of knowledge construction can be and the role of the researcher in being mindful of this.

Analysis indicated that my involvement with the participant moved between my dual roles as clinician and researcher. My clinical experience with
‘You get hardened to it’

establishing rapport and encouraging dialogue with clients is evidenced throughout the interviews in how I portrayed occasional naivety in what participants were talking about and how I provided some personal disclosures of my own experiences. This reciprocal exchange of information I believe helped build rapport and facilitate the collection of data and is endorsed in interpretative and critical paradigms. My clinical experience and psychological knowledge are evidenced in the clustering and conceptualising of themes as well as theoretical considerations given to interpretation of participants’ experiences such as issues of countertransference. In addition, my clinical and therapeutic skills were reflected in the interview process in how I understood the meaning of the experience for the participants within a psychological framework and my tendency to summarise or paraphrase what the participants were saying. These influences just described demonstrate the amount of subjectivity in interpretative phenomenological research and the meaning-making of participant’s experiences. Despite identifying my fore-conceptions at the outset of this research many new insights as to how my beliefs and perspectives were influencing the research arose during the research process itself, which indicates the importance of the use of hermeneutic method within interpretative research.

Extended paper word count: 21,496
Total submission word count: 29,158
References


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diagnosis and functional differentiation. Comprehensive Psychiatry, 48, 137-144.


De Moore, G., & Robertson, A. R. (1996). Suicide in the 18 years after


Ens, I. C. (1999). The lived experience of countertransference in
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qualitative research. *Journal of College Student Development, 43, 461-473.*


Morse, J., (2000). Determining sample size. *Qualitative Health Research, 10*, 1, 3-5.


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Richards, H., & Emslie, C. (2000). The “doctor” or the “girl from the university”? Considering the influence of professional roles on qualitative interviewing. *Family Practice, 17*(1), 71-75.


You get hardened to it


"You get hardened to it"


‘You get hardened to it’


‘You get hardened to it’


‘You get hardened to it’

Appendix A: Ethical approval Letters

National Research Ethics Service
Nottingham Research Ethics Committee 1
1 Standard Court
Park Row
Nottingham
NG1 6GN
Telephone: 01158839425
Facsimile: 01159123300

16 December 2008

Miss Elizabeth Boyd
Trainee Clinical Psychologist
Lincolnshire Partnership NHS Foundation Trust
University of Lincoln
Health, Life and Social Sciences
Court 11, Satellite Building 8,
Brayford Pool, Lincoln
LN6 7TS

Dear Miss Boyd,

Full title of study: A qualitative study of the psychological impact on nurses working with severe and frequent self-injury within a secure hospital.

REC reference number: 08/H0403/150

The Research Ethics Committee reviewed the above application at the meeting held on 09 December 2008. Thank you for attending to discuss the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

The Committee agreed that all sites in this study should be exempt from site-specific assessment (SSA). There is no need to submit the Site-Specific Information Form to any Research Ethics Committee. The favourable opinion for the study applies to all sites involved in the research.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

- Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

- Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the
National Patient Safety Agency and Research Ethics Committees in England

‘You get hardened to it’

1. **Information Sheet:**
   - the title should be ‘participant information sheet’ instead of ‘patient information sheet’.
   - Disclaimer paragraph: the Committee felt this paragraph was a bit ambiguous and should be simplified. In addition, the time frame of crime should be defined.
   - under: “what about if I want to make a complaint” – “National Research Ethics Committee” should be changed to ‘Nottingham 1 Research Ethics Committee’.

2. **Consent Form:**
   - point 6 should be removed.

3. **Invitation letter:**
   - the sentence: “and I very much look forward to your help with this research” should be removed.

The Committee requested a copy of the amended documents for information only, to be filed.

**Approved documents**

The documents reviewed and approved at the meeting were:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>AB/140956/1</td>
<td>03 November 2008</td>
</tr>
<tr>
<td>Protocol</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>18 November 2008</td>
</tr>
<tr>
<td>Investigator CV</td>
<td>1</td>
<td>20 October 2008</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Investigator CV</td>
<td></td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Letter of invitation to participant</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Letter from Sponsor</td>
<td></td>
<td>07 October 2008</td>
</tr>
<tr>
<td>Evidence of Insurance</td>
<td></td>
<td>13 August 2008</td>
</tr>
<tr>
<td>Peer Review</td>
<td></td>
<td>07 November 2008</td>
</tr>
<tr>
<td>Peer Review</td>
<td></td>
<td>03 November 2008</td>
</tr>
<tr>
<td>Honorary Contact Request Form</td>
<td>1</td>
<td>18 November 2008</td>
</tr>
<tr>
<td>Interview Schedules/Topic Guides</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
<tr>
<td>Summary/Synopsis : Flowchart</td>
<td>1</td>
<td>24 October 2008</td>
</tr>
</tbody>
</table>

**Membership of the Committee**

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.
"You get hardened to it"

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.nhs.uk.

08/H0403/150 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mr Robert Johnson / Miss Rinat Jibli
Vice Chair / Co-ordinator

Email: rinat.jibli@nottapct.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comment

"After ethical review – guidance for researchers"

Copy to:

Dr Mark Gresswell
University of Lincoln,
Health, Life and Social Sciences, Court 11,
Satellite Building 8,
Brayford Pool,
Lincoln, LN6 7TS

R&D office for NHS care organisation at lead site - NHCT

0910, RES, Research Project, UofN: 4073829, UofL: 07091309, Page 124 of 170
Dear Miss Boyd,

Full title of study: A qualitative study of the psychological impact on nurses working with severe and frequent self-injury within a secure hospital.

REC reference: 08/H0403/150

Protocol number: 1

Thank you for your email of 05 January 2009. I can confirm the REC has received the documents listed below as evidence of compliance with the approval conditions detailed in our letter dated 16 December 2008. Please note these documents are for information only and have not been reviewed by the committee.

Documents received

The documents received were as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Letter of invitation to participant</td>
<td>2</td>
<td>05 January 2009</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>2</td>
<td>05 January 2009</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>2</td>
<td>05 January 2009</td>
</tr>
</tbody>
</table>

Please quote this number on all correspondence

08/H0403/150

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‘You get hardened to it’

Yours sincerely

Miss Rinat Jibli
Committee Co-ordinator

E-mail: rinat.jibli@nottspct.nhs.uk

Copy to:

Dr Mark Gresswell
University of Lincoln,
Health, Life and Social Sciences, Court 11,
Satellite Building 8,
Brayford Pool,
Lincoln, LN6 7TS

R&D office for NHS care organisation at lead site – Nottinghamshire Healthcare NHS Trust
'You get hardened to it'

Nottinghamshire Healthcare NHS Trust

E-mail: jayne.simpson@nottshc.nhs.uk

Research Management and Governance
B21, B Floor
Gateway Building
University of Nottingham
Innovation Park
Triumph Road
Nottingham NG7 2TU
Tel: 0115 8231295

Trust research study ref: FOR/26/03/09
(please quote in all correspondence)

26th March 09

Miss Elizabeth Boyd
Trainee Clinical Psychologist
Lincolnshire Partnership NHS Foundation Trust
University of Lincoln
Health, Life and Social Sciences
Court 11, Satellite Building 8,
Brayford Pool, Lincoln
LN6 7TS

Dear Miss Boyd

I am writing to confirm that the following study is authorised to take place within our Trust:

| Title: A qualitative study of the psychological impact on nurses working with severe and frequent self-injury within a secure hospital |
| Directorate(s): Rampton Hospital - Womens services |
| Start Date: 26th March '09 | End Date: 1st September '09 |
| Outline: To explore psychological impact on nurses working within the high secure womens service who work with those engaging in severe and frequent self injury. Qualitative interviews using a purposive sample of about 6 subjects will be carried out. |

We wish you well with your work. In accordance with the Research Governance framework, The Trust RMG Department follows up such work to assess its impact and influence on practice and policy. You will receive a brief progress report form to complete six months after the start of your study which will provide you with the opportunity to let us know of any problems you may be having. We will also ask you for some information at the end of your study.
"You get hardened to it"

Please keep this letter with you during the course of your research to confirm that you have Directorate and RMG Dept. approval, to gain access to the areas where your research is taking place. If you or others have concerns they can contact the RMG department on 0115 9934543 or mobile 07747 030196 or by email to jayne.simpson@nottshc.nhs.uk.

Yours sincerely

Jayne Simpson MSc
On behalf of Prof Chris Evans and Trust RMG Department

RMG Approval Letter\r\n\r\n0910, RES, Research Project, UofN: 4073829, UofL: 07091309, Page 128 of 170
Evidence of insurance

13 August 2008

Subject: To Whom It May Concern

Dear Sirs

EVIDENCE OF INSURANCE – University of Lincoln and Subsidiary Companies

We are writing to confirm that we act as Insurance Brokers to the above client and that we have arranged liability insurance on their behalf as detailed below:

PROFESSIONAL INDEMNITY INSURANCE

INSURER: RSA
POLICY NUMBER: To be confirmed
PERIOD OF INSURANCE: 01 August 2008 – 31 July 2009
LIMIT OF LIABILITY: GBP5,000,000
DEDUCTIBLES: GBP7,500

Subject to the policy terms, conditions, limitations, exclusions and cancellation provisions.
Appendix B: Sample of analysis: Stage four – theme content

Habituation

<table>
<thead>
<tr>
<th>Text segment</th>
<th>Participant</th>
<th>Code (line number)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We do get quite extreme self harm compared to some of the other wards it is not as much but I think you just get used to it.</td>
<td>Gaia</td>
<td>42</td>
</tr>
<tr>
<td>Not a lot of self harm makes me squeamish</td>
<td>Gaia</td>
<td>219</td>
</tr>
<tr>
<td>After you have seen a lot you sort of have to protect yourself don’t you? otherwise it just becomes ridiculous and that’s why I think a lot of it just goes over the top now</td>
<td>Gaia</td>
<td>36</td>
</tr>
<tr>
<td>I think only that you become quite blasé about it you know like the smaller things like the cutting and stuff it just becomes normal</td>
<td>Jayne</td>
<td>469</td>
</tr>
<tr>
<td>The longer you’re here, the less it affects you really</td>
<td>Tim</td>
<td>84</td>
</tr>
<tr>
<td>I think you get pretty hardened to what you see.</td>
<td>Tim</td>
<td>180</td>
</tr>
<tr>
<td>I think you just get hardened to it. I think over the years it’s just gradually filters away.</td>
<td>Tim</td>
<td>197</td>
</tr>
<tr>
<td>You get hardened to it.</td>
<td>Steff</td>
<td>271</td>
</tr>
<tr>
<td>No, now if I saw snot (laughter) and vomit. I don’t really like them. I cope with them but I don’t really like them. Anything else I’m usually alright.</td>
<td>Steff</td>
<td>291</td>
</tr>
<tr>
<td>R: Has that always been the case? You’ve not become more squeamish</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. I can remember when I was in school I didn’t know what I wanted to do and then somebody mentioned to me general nursing. I said ‘no, can’t do that too much blood and guts’.</td>
<td></td>
<td>294</td>
</tr>
<tr>
<td>But blood doesn’t bother me.</td>
<td>Sophie</td>
<td>361</td>
</tr>
</tbody>
</table>
Appendix C - Sample of analysis: Stage five - clustering using a bubble map

Enjoy the job
- Job satisfaction
- Small changes provide motivation
  - Days go faster
  - Become more confident
  - Become easy going
  - Become more

SELF AS PERSON

Busy and varied
- Interest in the macabre

Helplessness

Risk of assault

Lack of control

Hopelessness & resignation

Negative

Balance environment and safety
- Tiring
- When frequent and severe - difficult to not absorb it
- Patient's don't want help or engage with us

Training helps you - can control aspects - mopping up

Containing

P: Training helps you - can control aspects - mopping up

A game

Peer support

Supervision
- Numb to it
- Self-injury becomes the norm, normalisation -
- Habituation - doesn't impact on you

Emotional ventilation releases

STRESS

Therapeutic boundaries
- Set goals
- Hope that they change
- Perseverance

Protective factors
- Self care/Work life boundary -
- Modified expectations of patient progress
- Proactive

Sick leave when stress builds and reaches threshold

STRESS

Concern for consequences of SI: death

Supervision not available when need it

Lack of control

Concern for consequences of SI: death

Stress, adrenalin, not eating, thinking about work at home, low mood

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Appendix D: Sample of analysis: Stage six - participant table of themes.

**Table of super-ordinate themes and themes (Gaia)**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Line</th>
<th>Key words</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enjoyment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enjoy the work</td>
<td>178</td>
<td>enjoy working</td>
</tr>
<tr>
<td></td>
<td>257</td>
<td>buzz, being busy and different stuff happening</td>
</tr>
<tr>
<td></td>
<td>313</td>
<td>change, Fantastic</td>
</tr>
<tr>
<td>Personable patients</td>
<td>160</td>
<td>patients want relationship with you</td>
</tr>
<tr>
<td>Interest in the macabre</td>
<td>197</td>
<td>like the gory bits,</td>
</tr>
<tr>
<td></td>
<td>202</td>
<td>interested in that</td>
</tr>
<tr>
<td>Healing and helping</td>
<td>203</td>
<td>like aftermath, manage, deal and sort it</td>
</tr>
<tr>
<td></td>
<td>326</td>
<td>look for the little things</td>
</tr>
<tr>
<td>Belief in patient change</td>
<td>324</td>
<td>just going to take time</td>
</tr>
<tr>
<td></td>
<td>313</td>
<td>change, fantastic, motivation</td>
</tr>
<tr>
<td></td>
<td>323</td>
<td>she is much further on than three years ago</td>
</tr>
<tr>
<td></td>
<td>320</td>
<td>reflect people back</td>
</tr>
<tr>
<td></td>
<td>327</td>
<td>be satisfied with the little things</td>
</tr>
<tr>
<td><strong>Working in an extraordinary environment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Working with the extreme</td>
<td>171</td>
<td>looking at the extreme</td>
</tr>
<tr>
<td>Surreal</td>
<td>246</td>
<td>almost surreal sometimes</td>
</tr>
<tr>
<td><strong>Feelings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anger</td>
<td>546</td>
<td>manipulation, rile me</td>
</tr>
<tr>
<td>Feeling of helplessness</td>
<td>24</td>
<td>nothing you can do</td>
</tr>
<tr>
<td>Feeling of frustration</td>
<td>92</td>
<td>struggle to think of other stuff to do to help</td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>patients not willing to</td>
</tr>
</tbody>
</table>

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| **Hopelessness** | 128 | engage trying to create home environment |
|                 | 377 | assaults on staff |
| **Maintaining hope** | 378 | can’t see a way out |
|                 | 393 | nothing’s changed |
| **Need to protect yourself** | 416 | resigning yourself that this is how it’s going to be |
| **Lack of control** | 116 | hope ultimately they will switch |
| **Bodily experiences** | 36 | protect yourself |
| **Relief** | 203 | not being in control |
| **Fear** | 231 | queasy and nauseating |
| **Tiredness** | 241 | oh thank god for that |
| **Stress threshold reached** | 244 | she is going to peg it |
|                 | 252 | more of a rush |
| **Adapting** | 271 | knackered |
| **One step ahead** | 280 | time off sick, stress, |
|                 | 281 | crying |
|                 | 286 | enough is enough |
| **Creative working** | 337 | thinking about work at home |
| **Perseverance** | 302 | thinking about work at home |
| **Empowering others** | 304 | have a goal |

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"You get hardened to it

#### Habitation
get used to it 37  goes over the top
normalised 46  becomes the norm
numbness 54  get numb, don’t absorb it

#### Protecting yourself
Look after the self 294  have to look after yourself
Establishing therapeutic boundaries 179  very distinct boundary
Work-home split 181  don’t take it home
Peer support 186  informal supervision
488  have at least 6/7 people i talk to
282  don’t want to let people Down.
440  if moan too much, bring morale down

Supervision 406  people don’t actively seek it out
412  doesn’t impact on what you do

<table>
<thead>
<tr>
<th>272</th>
<th>wine</th>
</tr>
</thead>
<tbody>
<tr>
<td>342</td>
<td>gym, diet, me time</td>
</tr>
</tbody>
</table>

Have a moan 272  had a moan or 7
493  10 minutes moan, they don’t then build up, manage them when they are little things

#### Impact on self
Confidence 254  realise can handle more than thought
Assertive 455  stand up for what I want.

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Appendix E: Sample of analysis: Stage eight - Master table of themes for group

Group master table of themes

Super-ordinate theme: Experiencing of affect

**Fear (about patient death)**

Gaia: have to get this out otherwise she will peg it 243

Jayne: It was like (swore) hell you just nearly died on us, it was major 34

Steff: After all these incidents I thought, I could lose my job or this patient could die. 22

Sophie: just don’t just don’t go. You’ve got to stay, you can’t go 28

Alice: it’s their life in your hands and when you’ve got somebody’s mortality at your finger tips. That is what’s scary. 313

**State of perturbation**

Jayne: I was thinking about it at night when I was in bed. it was still there. 86

Tim: so you’re also sat thinking about that, if we are going in, whose it going to be whose turn is it. And it's quite possibly me because I'm the one who is sat there whilst she’s self-harming. 233

Steff: because i’ve been thinking a lot about it, 4

Sophie: It was everything, I’m just there, I’m there, I can see it. I can, I can hear them. and the smells there. Yeah. I suppose the smell ain’t there but it’s in your head ain’t it. There is something unsettling in it and you know something is not quite right but you can’t quite put your finger on it 91

Alice: Weird feeling. It affects the back of your neck. There was just something not right. 195

**Culmination of stress**

Gaia: I had time off sick with stress, just because every day I woke up I was crying before I went to work. 280

0910, RES, Research Project, UofN: 4073829, UofL: 07091309, Page 135 of 170
Jayne: sometimes it’s just like a build up of things. like we had the death and we had the really nasty day that day like self-harming and I came in the next morning and found someone with a ligature around their neck and I just couldn’t deal with it then.

Steff: And I knew I wasn’t right in myself because usually when I am at work or out of work I am all smiling and laughing that sort of thing and I didn’t want to talk to anyone.

Alice: You just plod on thinking it it’ll probably get better. But it never did. then the bad day. And I thought I can’t do this anymore. But I did, I went back. But it didn’t affect me till six weeks later.

**Containing processes**

*Enjoyment of the job*

Gaia: I sort of like the buzz of being busy all day and sort of being active all day and different stuff happening.

Jayne: That I need to be doing something that I love and am good at for me to process and be better in the outside world as well. ....a better me because I am doing something that I want to do, something that I like doing.

Tim: one of the things that I like about it is that every day is different. (laughter) yeah, so you just wonder in what way is today going to be different.

Steff: I do feel quite proud to be working here because not everybody can do it and not everybody can work in the women’s service.

Alice: Sometimes when you deal with things, you think I am privileged to work here because you do meet some interesting people.

**Habituation**

Gaia: I think a lot of it just goes over the top now self harm it almost becomes the norm and that almost protects you. You almost get numb I suppose numb is a good word you deal with it, you manage it, you sort it all out, but you sort of don’t absorb it.....
Jayne: you become quite blasé about it you know like the smaller things like the cutting and stuff it just becomes normal.

Tim: I think you just get hardened to it. I think over the years it just gradually filters away.

Steff: You get hardened to it.

Sophie: It’s just like yeah alright then. What can we do next, what’s for tea. People say how do you cope, and you just say you just get on with it. you don’t think.

**Maintaining boundaries (with patients)**

Gaia: there is still that very distinct boundary between them and us because it is that working relationship so whilst you do have to maintain a really close working relationship with them that’s it.

Jayne: it’s nobody’s fault but her own that she did it and it was her choice ....It’s their behaviour isn’t it. It helps me work with it easier I think. Because I think I know what they are capable of more. probably with the self harm and everything else but more like you know how far they are going to go or what kind of behaviours trigger things.

Tim: I do, I stay quite close to them........ the way I see it well I’m better doing that really than leave them on their own ya know?

Steff: No, I don’t feel responsible at all because that’s her choice, her choice to do it.

Sophie: I think it’s more knowing the behaviour more than them. I don’t know......I suppose for me it’s the behaviour I know more than actually them. I know the index offence and their history.

Alice: When you don’t know that patient, it’s quite daunting. At least you know your own patients because you’re with them all the time, you know what they are going to do, you know their behaviours, you know when they’re off it because you’re with them all the time.

**Maintaining boundaries (with work)**

Gaia: no I don’t take it home with me.... work is work and home
is home.

Steff: before I try to leave everything at the control room when I go home
What I think about things, that's just my thoughts, but when I'm at work, I'm a nurse and then I just have to do the job.

Sophie: I say well it's a patient, I'm here to look after them, I'm here to make sure when I walk off the shift they are breathing.

Peer support
Gaia: but we have got quite a good team on the ward so you have formal supervision but you also have supervision a lot more than that, just more informal.

Jayne: It does help yeah but it is not always formal supervision that I do it in sometimes I talk informally to people.
We said it was nice for us to sit here in the office doing the notes just talking about it rather than the actual debrief, I think that was more beneficial to me anyway.

Tim: the thing that does stick in my mind mostly is your colleagues, is their criticism you know. How you handled it or didn't handle it or what you could have done that sort of thing.
I don't think it does make much of a difference to me but um but I have my wife at home.

Steff: We do tend to have, if something bad has happened, we tend to keep in touch with each other, text each other or ring each other, Go out to meet for a drink, go out for the evening, just do different things. and that helps. that does help.
Not one person asked me how I was, even though I had been over there supporting the staff through a nasty incident. But not one person asked me how I was.

Sophie: it was with us for the rest of the day and we kept saying are you ok, yeah we're ok and it was a matter of dusting yourself down and starting all over again.

Alice: Going back to years ago there was a lot more support, there was a lot more camaraderie than what there is nowadays. Erm I think sometimes the staff feel very isolated you know.
Appendix F - Diagrammatic overview of super-ordinate and subordinate themes

Experiencing of affect

State of perturbation
- Sensations; Intuition; Troubled

Fear
- Relief

Stress

Containing processes

Pleasurable aspects of the job
- Interest in the macabre
- Awareness that this is Rampton – extreme behaviour
- Nursing aspect – dealing with injuries

Habituation
- Get used to it
- Numb to it
- Normalised – include intellectualisation/acceptance

Establishing Boundaries
- With patients
- With work (work life split)
- Rejection of personal responsibility
- Include boundary to the point of knowing them well enough

Peer support

*You get hardened to it
Appendix G: Research diary format and excerpts

Research stage: Research proposal

Reflection: My motivation and background for undertaking this research study. The priority for this doctoral thesis is to study something within my area of interest (self-injury). With my clinical experience and theoretical understanding of self-injurious behaviour I am already aware of the plethora of literature and research around the behaviour itself, its aetiology, function and classification. Furthermore I already have intentions for post-doctoral research validating a self-injury assessment tool I have constructed that is beyond the time span available for my doctoral thesis. Based on my knowledge of the literature I know there is a paucity of research on the experience of working with individuals who self-injure. I also note the frequent references in the literature that working with self-injurious individuals can be a distressing and emotional burden. My knowledge of the severity and frequency at which self-injury occurs at a local high secure hospital (which I can obtain access to) makes this a worthy area to explore the validity of the references cited within the literature. Is this indeed the case and if so, how do nurses cope with it on a daily basis? What strategies, if any do they employ?

Research stage: Data collection

Reflection: Previous professional experience in forensic settings and secure hospitals means that I bring to this research an assumed embodied and psycho-social understanding of what it is like to be in the role of a professional in such settings. In particular this leads me to wonder whether this study might
'You get hardened to it
also reveal the difficult balance between role of 'caring helper' and 'enforcer' that I had experienced. In addition I enter this research with assumptions that maintaining these dual roles infringes relationships with the patient or client resulting in ambivalence, cynicism and a close but unequal relationship forms because of the over-arching power differential. The sadness of this is that the nature of these contextualised relationships was what helped me carry on and deal with experiences such as prisoner suicide and client self-injury. As researcher I need to ensure that I do not look for these assumptions to be fulfilled at the expense of them also being questioned or modified.

**Research stage: Interview**

**Reflection:** Following the interview today I find myself questioning the data coming out and its relevance to my research aim. Is this capturing the experience on nurses of working with self-injury if they are talking so much about the kinds of injuries and the variety of methods patients employ to harm themselves. Thinking less about what they are saying but how they are saying it leads me to think instead about the meaning behind what participants stated. What purpose lies behind participant’s talking about the creativity of patients to self-injure? It could be that they find the personal impact difficult to talk about with me. Thinking however about how they conversed during the interview, the non-verbal communication and how I felt during the interview it seems that participant’s exclude the emotional aspects of patient’s distress. The focus on the physical aspects of managing the incidents supports what they are saying verbally that they attend to the behaviours rather than the patients and that they do not get emotionally close to the patients. I am surprised by this which informs
me of my prior assumptions of the research, e.g. that participants would express clearly the difficulty managing their emotions. This does not seem the case with the interviews to date, particularly today’s interviews.
Appendix H: Qualitative Health Research manuscript submission guidelines.

This is an amended copy of the journal guidelines for the purposes of this submission. Please refer to the web link for full manuscript submission guidelines: http://www.sagepub.com/journalsProdManSub.nav?prodId=Journal200926

WRITING TO PUBLISH IN QHR

Proper formatting will speed the peer-review process for your manuscript, and will facilitate a smoother production process if it should be selected for publication. Refer to the guidelines below, and to the Publication Manual of the American Psychological Association, [APA] 5th edition.

Improper formatting could result in burdensome revisions, lengthy delays in the review and production processes, and the possible rejection of your manuscript.

AVOID

• Writing in the third person, passive voice
• Inclusion of irrelevant data
• Anthropomorphisms
• Very long or “wordy” sentences
• Inconsistent writing style (especially with two or more authors)
• Tables listing participants and their demographic characteristics
• Back-to-back parentheses [incorrect: (xxx)(yyy) / correct: (xxx; yyy)]

WORD CHOICES

It is always best to use the most precise language possible to convey important data, concepts, and findings. Because QHR is an international journal published in U.S. English, there is the added need to avoid commonly-used English terms that might be misinterpreted by or confusing to readers whose first language is not English.

<table>
<thead>
<tr>
<th>Word</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>feel</td>
<td>It is appropriate to use this word when referring to a physical sense or state of mind; do not use it when your intent is “think” or “believe.”</td>
</tr>
<tr>
<td>further</td>
<td>This word is appropriately used when referring to distance. When writing of something in addition to that already stated—particularly at the beginning of a sentence—it is more appropriate to use “furthermore,” “moreover, “in addition,” or “additionally.”</td>
</tr>
<tr>
<td>may</td>
<td>It is a common mistake to use this word in place of “might.” “May” implies permission, “might” implies possibility, and “can” implies ability.</td>
</tr>
</tbody>
</table>
Be careful not to use this word when the intended meaning is “more than.”

“Since” is the appropriate word to use when referring to the passage of time; avoid using it when the intended meaning is “because.”

Use “U.S.” only as an adjective; for all other purposes, spell out “United States.”

Use “while” when referring to concurrent events. Do not use it when your intent is “whereas,” “although,” or “even though.”

<table>
<thead>
<tr>
<th>Instead of this . . .</th>
<th>Use this . . .</th>
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</thead>
<tbody>
<tr>
<td>as regards</td>
<td>with regard to; regarding</td>
</tr>
<tr>
<td>due to</td>
<td>because of</td>
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<tr>
<td>firstly; secondly</td>
<td>first; second</td>
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<td>towards</td>
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</table>

PUNCTUATION AND CAPITALIZATION

• If you use an acronym, the full spelling of the words must precede the first usage (even if you think everyone knows what it stands for), followed by the acronym in parentheses; e.g., World Health Organization (WHO). Thereafter you may use the acronym alone: WHO. Avoid the overuse of multiple acronyms.

• Capitalize proper names; do not capitalize words unnecessarily, such as titles and ranks; e.g., director, professor, doctor, chairperson.

• Title case is properly created by capitalizing (a) the first letter of the first word, (b) the first letter of the first word following a colon or “em” dash, (c) all important words, and (d) all words containing four or more letters.

• Use no spaces before, and only a single space after periods (.), commas (,), colons (:), semicolons (;), question marks (?), and quotation marks (“”). Use no spaces after opening quotation marks.

• Check your manuscript for double periods (..) and extra spaces between words.

• Refer to the APA Publication Manual for an excellent explanation of the proper use of hyphens and dashes; do not depend on Word’s “Spell Checker” function for decisions on hyphenation.

“REVIEW” YOUR MANUSCRIPT
One common reason for “revise” decisions is that authors are sometimes so immersed in their data and findings that they lose track of (a) whether the information presented contributes new knowledge, (b) whether the appropriate method and design have been used, (c) whether ethical standards have been met, (d) whether the information is presented in a complete, concise, and logical manner, with attention to writing style, and (e) what the reader needs/wants to know (remember that our readers have expertise in diverse areas, and therefore many will not be familiar with concepts and terminology common to your research area).

Before submission, we recommend an informal peer review of your article using these criteria:

Review Criteria

- **Importance of submission**: What are the manuscript’s strengths? Is it significant? Does it contain new and unique information?
- **Theoretical evaluation**: Is the manuscript logical? Is the theory parsimonious? Complete? Useful?
- **Methodological assessment**: Inductive approach? Appropriate method and design? Is the sample appropriate and adequate? Are data saturated? Theoretical analysis? Linked with theory and/or praxis?
- **Adherence to ethical standards**?
- **Manuscript style and format**: Evaluate writing style, organization, clarity, grammar, appropriate citations, and so forth. Is the manuscript unnecessarily long?

**PRIOR TO SUBMISSION**

- Proofread your manuscript aloud; doing so will help you identify awkward phrasing, run-on sentences, incomplete sentences, improper punctuation, missing text, and much more. (We recommend proofreading from a paper copy rather than a computer screen.)
- Have your manuscript professionally edited. This is especially important if English is not your first language. Remember to inform your editor of the need to use U.S. English spelling, and provide him or her with a copy of these Guidelines.

**PREPARING YOUR MANUSCRIPT**

**GENERAL STYLE**

In general, QHR adheres to the guidelines contained in the Publication Manual of the American Psychological Association [“APA”], 5th edition (ISBN 1-55798-791-2), with regard to manuscript preparation and formatting. [Elsewhere in these guidelines this
book is referred to as the APA Publication Manual, or just APA.] Additional help may be found online at http://www.apa.org/, or search the Internet for “APA format.”

Many universities and private organizations have Web sites devoted to APA style. Be aware, however, that whenever guidelines found on those sites, or in the APA Publication Manual, conflict with the guidelines included here, you must follow the **QHR guidelines.**

**KEEP IN MIND . . .**

- Qualitative Health Research is a peer-reviewed journal. Only complete, finished manuscripts should be submitted for consideration; do not send query letters or e-mail messages.

- It is preferred that you write both the abstract and the text of your manuscript in the first person, active voice; however, this is not a requirement. If you choose to write otherwise, ensure that the abstract and manuscript “match” in voice.

- We do not publish stand-alone abstracts, quantitative studies, manuscript outlines, pilot studies, manuscripts-in-progress, letters of inquiry, or literature reviews. Research articles must be pertinent to health.

**CONFIDENTIALITY AND PROTECTION OF PARTICIPANT IDENTITY**

QHR is committed to protecting the identity and confidentiality of research study participants. With the exception of participant action research (PAR), no information that could potentially allow identification of a participant—or even a specific study site—should be included in a submitted manuscript or, subsequently, included in a published article.

Each study participant referred to in the manuscript should be assigned a pseudonym. Study sites, such as hospitals, clinics, or other organizations, should not be named, but instead should be described; for example: “Study participants were recruited from the coronary care unit of a large metropolitan hospital on the eastern seaboard of the United States.” Authors who include participant names and/or photos must submit written permission from the participants to do so.

Manuscripts submitted to Qualitative Health Research are “blind” reviewed. Do not include author information, author references, or acknowledgements in the main manuscript document.

**ELEMENTS OF A MANUSCRIPT**

The following elements are **required** for each manuscript, and should be compiled in the following order:

1. Title page [submitted as a separate document]
’You get hardened to it

2. Abstract [p. 1]
3. Keywords [p. 1]
4. Main body of the manuscript ([main document”; beginning on p. 2]
5. References

The following elements may be included in your submission (they are optional):
A. Notes/footnotes/endnotes [place after the main body of the text, before the reference list]
B. Tables [place at the very end of the document]
C. Figures [submit in a separate document]
D. Appendices are published only in certain circumstances, at the editor’s discretion [place after the reference list and before any tables]

ORDER OF ELEMENTS
Compile the elements of your main manuscript document in the following order. Each element (except notes) should begin on a new page:
A. Abstract and keywords -required
B. Main manuscript text -required
C. Notes/footnotes (if any)
D. References -required
E. Appendices (if any)
F. Tables (if any)

DOCUMENT SETUP (See also Sample Manuscript).

**Document file type:** Submit only documents created in Microsoft Word, and only with the regular file extension of “.doc”; Word documents with “.docx” extensions, PDF files, or other types of documents cannot be accepted for consideration.

**Do not add any special coding or formatting to your documents that is not described within these guidelines.** Paper size: Letter, 8.5” x 11”. Margins: 1” on all sides

* * * * * * * * * * * *

**Ellipses/Ellipsis Points:** Almost every manuscript contains ellipses. They are used to indicate missing words in quotations, and are to be created in a very specific manner. Do not use the “Insert Symbol” function in Word to enter ellipses. The proper way to create ellipsis points is as follows: space/dot/space/dot/space/dot/space ( . . . ); that is, 3 dots, preceded, divided, and followed by spaces, like . . . this. If it is necessary to indicate missing words between sentences (instead of in mid-sentence), place a period (full stop) at the end of the first sentence, then format the ellipsis points as noted, and begin the next sentence (with a capital letter) immediately after the last space. Do not place ellipses within parentheses or brackets ( . . . ); the exception to this is in conversation analysis, when appropriate.
Font Size: 11 point font, including font used for titles, regular text, section headings, and quotations; however, fonts between 8 and 10 points in size should be used in tables and figures.

Font Style, Main Manuscript: Use Times New Roman font. Italics should be used only (a) as appropriate in the reference list (see APA), or (b) to introduce new or non-English words, or new concepts (2 to 3 words), and then only when the new word or concept is first introduced in the manuscript; subsequent use of the same word(s) should be in regular Roman font. QHR does not use italics for emphasis, and does not use underlining for any purpose other than conversation analysis (conversation analysis does not refer to regular participant quotations). Bolded font may be used for section headings, as appropriate according to these guidelines, and (sparingly) in tables and figures.

Font Style and Formatting of Conversation Analysis: [Note that this instruction does not pertain to normal quotations or block quotations.] Courier font should be used for sections containing conversation analysis (if any). Retain the conversation analysis sections in the desired location among the regular manuscript text, and do not set them as figures, in a box, or as excerpts. Use the following steps to apply (required) special formatting to the conversation text only:

• Set your font at 10 points, Courier style.
• Set your margins (only for the sections with this special text) at 1” on the left, and 4.55” on the right, so the available print area is 2.95” wide, flush left. (Do not attempt to achieve this with tabs and hard returns; use Word’s formatting features in Page Setup.)
• The line number, participant pseudonym (or other speaker identification), and transcribed text will need to fit across the 2.95” of printable line space. This is to ensure that the text will fit within the column format of the printed journal.
• Manipulate your text within this space until you have achieved the desired alignment for all lines.
• If your article is accepted, be sure to examine the publication proofs of the conversation analysis sections very carefully to confirm that the text is set and aligned correctly.

Font Style, Figures: For printing clarity and ease of reading, “sans serif” fonts are strongly recommended for figures; some common examples include Arial (this is the preferred style), Calibri, Franklin Gothic Book, Tahoma, and Verdana.

It is recommended that only one font style be used in each figure, with possible variations introduced through bolding, italicizing, capitalizing, or underlining—all of which should be used sparingly. It is further recommended that all figures within a single manuscript be prepared with the same font style.

• Line Spacing: Everything, in all elements of the manuscript, from the title page through the references, must be (exactly) double-spaced. The only exception is text within a figure. To set double spacing, go to Format > Paragraph > Line spacing > Double. Do not create double spacing with hard returns (by striking the “enter” key twice).
You get hardened to it

- **Text Justification**: All text should be left-justified; do not use full justification for any portion of your manuscript. The text at the right margin should be uneven.

- **Paragraphs**: Indent the first line of every new paragraph by .5” (½ inch; do not use two, .25” indentations). Do not insert additional line spaces between paragraphs, or between paragraphs and headings; the exceptions are (a) an extra line space (hard return) between the abstract and the keywords, and (b) after (not before) each excerpt/block quotation, numbered or bulleted list, or section of conversation analysis. Use a blank line between block quotes/excerpts if you have placed two or more in a row. Do not add any special formatting, such as increased line space before and after paragraphs, or before and after headings.

**Headings**: Do not follow APA guidelines for headings. QHR uses 4 distinct levels of headings (H = level), including:

H1: Centered, Bold, Uppercase and Lowercase Text in Title Case

H2: Flush Left, Bold, Uppercase and Lowercase Text in Title Case

H3: Indented (.5”), Italicized, Uppercase and Lowercase Text in Title Case

H4: Indented (.5”), italicized, lowercase text in sentence case and ending with a period. At this level, the paragraph text begins immediately after the heading, instead of on the next line.

Use at least two heading levels:

For manuscripts with 2 heading levels, use H1 and H2
For manuscripts with 3 heading levels, use H1, H2, and H4
For manuscripts with 4 heading levels, use H1, H2, H3, and H4

**Quotations**: Quotations of 40 or more words should be set as separate paragraphs, with the entire quotation indented .5” from the left margin (this is also referred to as a “block quote”). Do not change the right-hand margin. Some quotations of fewer than 40 words may also be set separately for uniformity of appearance. All other quotations should be contained within regular paragraphs, along with regular text.

**Quotation Marks**: In general, use double quotation marks (e.g., “Xxx.”) to set off quotations appearing within regular paragraphs, and to set off words being used with “special” meaning (or unusual spelling to convey special meanings within the text; e.g., “busy-ness”). In regular paragraphs, use single quotation marks to set off a quote within a quote (e.g., “Xxx, ‘Yyy,’ xxxx.”).

Do not use any quotation marks for block quotes unless there is a separate quote contained within the larger quote. In such a case, use double quotation marks (e.g., Xxxxxx, “Yyyy,” xxxx.) only for the separate quote within the larger quote.
**Spelling:** The spelling of English words varies among the many English-speaking countries of the world. QHR is published in U.S. English. Use Word’s spell check feature to ensure that you have used U.S. English spellings throughout your manuscript. Exceptions to this include (a) direct quotes from written, published material, and (b) as appropriate for titles in the reference list.

**Manuscript Length:** There is no predetermined page or word limit. Provided they are “tight” and concise, without unnecessary repetition and/or irrelevant data, manuscripts should be as long as they need to be. The editor may require a reduction in length if the manuscript contains superfluous material that does not add anything useful to the topic being discussed. Limits might be imposed on the number/size/length of tables, figures, reference lists, and appendices.

**PREPARATION OF REQUIRED MANUSCRIPT ELEMENTS**

A maximum of three (3) types of documents should be submitted: (1) title page; (2) main manuscript; and (3) figures (if any). Despite what the online system (Manuscript Central) programming might allow, do not submit such elements as abstracts, references, and tables as separate documents.

Refer to the Sample Manuscript for additional information.

1. **Title Page** [submitted as a separate document]

   The title page should include the following, in this order:

   a. Text for a running header (abbreviated title of your article) of no more than 40 characters + spaces in length. Place the running head on the title page only, and do not include it in the main manuscript document [set flush left]. Do not actually format the text as a header.

   b. Any author’s/authors’ notes or acknowledgements (optional), limited to two or three sentences, maximum. [set flush left]

   c. The article title. Capitalize all important words, and all words with four or more letters. [set centered; see the heading on this page for an example of title case]

   d. The name (not just initials) of each author, without credentials, in order, together with the affiliation of each author, including the institution/agency/organization (but not including department or division information); city where the institution/agency/organization is located; the state or province (if any); and country. Example: Janice M. Morse, University of Utah, Salt Lake City, Utah, USA [set centered; all state, province, and country names (except USA) must be spelled out]

   e. Complete contact information for all authors, including the proper form of address (i.e., Dr., Professor, Mr., Ms., Miss, Mrs., etc.), name, credentials, affiliation, mailing...
address (including the country name), primary e-mail address, secondary e-mail address (if any), telephone number, and fax number (if any) [set flush left]

A 1-sentence biographical statement about each author. Use the following example for formatting your statement(s), and be sure to include name, credentials, university or other institution (you may include department or division information here), city, state/province (if any), and country:

Janice M. Morse, PhD, FAAN, is a professor and presidential endowed chair at the University of Utah College of Nursing in Salt Lake City, Utah, USA.

The title page may actually be longer than one page. To retain author anonymity during peer review, it is submitted as a separate document. Title page information should not be included in the main manuscript document.

Manuscript title: A title should convey, as clearly and succinctly as possible, the main idea of a manuscript. It should be clear in meaning even when standing alone. Avoid unnecessary words, such as “A Qualitative Study of,” “A Doctoral Student’s Investigation of,” or “An Ethnographic Study.” A good title is generally 10 to 12 words (or fewer) in length. Avoid titles with a colon or a quotation unless it/they is necessary to convey an important concept or a particular meaning about the article. Do not (a) type your title in ALL CAPITAL letters, or (b) place a period (.) at the end of your title.

2. Abstract

The abstract should be placed on page 1 of the main manuscript document. It should be a single paragraph, no more than 150 words in length, and briefly describe your article. Briefly state the purpose of your research, the main findings, and your primary conclusions. Whether written in the first person, active voice, or otherwise, the abstract should “match” the voice in the manuscript. Do not (a) indent the first line of the abstract, (b) include in-text citations, (c) show the word count, or (d) include the manuscript title.

3. Keywords (See QHR Keyword List)

This is a brief list of words related to the topic(s) of your article that readers could search on to find the article (if published). Include all desired keywords selected only from the QHR keyword list. You may request that new keywords be added to the list, but the words should be general in nature, and not specific to a narrow topic. New keywords will be added at the editor’s discretion. Keywords should follow on the same page as the abstract; leave a blank, double-spaced line between the abstract and the keywords.

4. Main Manuscript Text
The main text of the manuscript begins on page 2, the page following the abstract and keywords. We prefer articles written in the first person, active voice, but will consider articles written in the third person provided the voice of the abstract and manuscript match (see Abstract, above). Use U.S. English translations of non-English quotations. Do not include the manuscript title in the main document. Authors are required to attend to copyright regulations.

The main text of the manuscript should be broken into appropriate sections by the use of section headings. Sections should flow in a logical sequence, and include, at a minimum, Method(s), Results, and Discussion (these are level-1 headings); other level-1 headings and subheadings may be used at the author's discretion. The author may choose to use different names for the three main sections, but the basic content should be that which would appropriately fall under the headings of Methods, Results, and Discussion. QHR does not use any headings (such as “Introduction” or “Background”) at the beginning of articles.

There are very specific guidelines for the use and formatting of in-text citations; refer to the APA Publication Manual, 5th edition, for details (the specific edition is very important). Every in-text citation should have a corresponding reference in the reference list, and vice versa.

5. References

The reference list (also known as a bibliography) should include complete references for the sources used in the preparation of your manuscript and cited in the text. Every citation should have a corresponding reference, and every reference should be cited in the text. You must cite and reference pertinent articles published in QHR in the 12 to 14 months immediately preceding submission of your manuscript.

The list should begin on a separate page following the last page of manuscript text (or the notes, if applicable). Each type of reference (journal article, book, chapter in edited book, newspaper, online reference, and so forth) must be formatted in accordance with the precise guidelines contained in APA. Elements such as spelling, punctuation, spacing, capitalization, and the use of italics or Roman (regular) font are as important as the content of the reference. (Note that if an author has two or more initials, there should be a space between the initials; incorrect = X.Y.Z.; correct = X. Y. Z.)

References should be listed in hanging paragraph format, in alphabetical order by the last name of the first author. The hanging paragraphs should be created by using Word’s Format > Paragraph feature, and not by using tabs. Be sure to use italics, rather than underlining, for titles. Non-English titles should be translated into U.S. English, with the English translation following immediately after the original title, in [brackets]. Proper formatting of the reference list is the responsibility of the author.
Avoid the use of unnecessary references and over-long reference lists. Extensive bibliographies will not be published; articles will include only the “essential” or key references. If the author wishes to offer a secondary reference list (for example, references used in meta-analysis), it should be so stated in the Author’s Note, and made available to readers by contacting the author directly; do not include it in the manuscript document, but it may be submitted separately for purposes of review.
Appendix I - Diagrammatic overview of research design

Paradigm
Phenomenological; Hermeneutic; Interpretative

Methodology
Interpretative Phenomenological Analysis
- Research journal started
- Proposal
- Ethical approval gained
- Study participant identification
- Study invitation letters sent out
- Participant information sheets sent out
- Participant consent forms sent out
- Study participants recruited from those returning consent

Data collection
- Identification of researcher fore-conceptions
- Interviews
- Research journal continued

Data analysis
- Transcription of audio data
- Immersion in the data
- Coding of themes (descriptive, interpretative and linguistic)
- Abstraction and clarification of themes
- Clustering of themes and development of superordinate themes
- Master table of themes with relevant data excerpts

Results
- Presentation of superordinate and sub ordinate themes

Write up
- Integration and critique of findings within the nursing and self-injury literature
- Discussion
- Researcher reflection
Appendix J - Participant invitation letter

Nottinghamshire Healthcare NHS Trust

Positive about mental health and learning disability

Research Title: Working with severe and frequent self-injury
Researcher: Elizabeth Boyd

Dear staff member

This is to invite you to take part in a research study, as part of a doctoral in Clinical Psychology thesis with the University of Lincoln, about your experiences as a nurse working with patients who self-injure severely and frequently. As you work with patients directly, within the NHS High Secure Women’s service at Rampton, you meet eligibility for taking part in this study. Participants in this study will be interviewed for 30 to 45 minutes about the positive and negative impact working in this difficult area has on them. It is important in this research that the experiences of nurses are captured as perceived and felt by the nurses themselves. Any information you provide in the interview used in the research, will remain anonymous. It is hoped that more can be understood about nurses’ experiences when working with self-injury which may inform further research, support and training for staff.

If you would like to know more about this study, please see the information sheet attached. Should you wish to take part upon reading this additional information, please complete and return the information sheet’s response slip, along with the consent form, to me c/o Dr XXX using the envelopes provided.

Thank you for taking the time to read this letter.
Yours sincerely

Elizabeth Boyd
Chief Investigator – Working with severe and frequent self-injury
Appendix K - Participant information sheet

Positive about mental health and learning disability

Participant Information Sheet
Research Title: Working with severe and frequent self-injury.
Researcher: Elizabeth Boyd

Hello, I would like to invite you to take part in a research study. Before deciding on whether you would like to take part, you need to understand why the research is being done and what it will involve. Please take some time to read the following information carefully. Talk with others about the study if you wish. Part 1 tells you about why this research is being done and what will happen. If you feel you would like to take part in the study, Part 2 gives you further information that you will need to know. If there is anything you are not clear about or you have any questions, please use the response slip below to ask your question. I will respond to all questions as your participation is important and valued.

Part 1

What this study is about

This study aims to explore the impact on psychiatric nurses of working with individual’s who engage in severe and frequent self-injury. It has been reported that working with self-injure can be a negative, as well as positive, experience for a number of reasons. Self-injury means those acts where individuals harm themselves on purpose. Types of self-injury include scratching, cutting or burning of parts of the body to insertion of objects into the body and removal or castration of body parts. By exploring the impact of self-injury on staff, it is hoped that more can be learnt about the care of staff who deal with self-injury on a regular basis.

What you will need to do

To find out about the impact on nurses of self-injury, staff will be interviewed about their experiences for up to 45 minutes. The interview is quite open ended to allow for participants to talk freely about their experiences of working with self-injury and any effects this may have had on them. Following the interview, fifteen minutes is allocated for you to unwind before returning to work. Therefore participation in this research will take no more than an hour.

If you would like to take part in the study after reading this information, you will need to complete the consent form (attached) and return this to the researcher. You have more than 24 hours to do this. Only a certain number of interviews can be conducted, therefore interviews will take place on a first come first served basis until the necessary number of interviews have taken place. Upon receipt of the consent forms, the researcher will contact you to either arrange a suitable time for the interview between yourself and the researcher, or thank you for your interest but inform you that all interviews have already taken place.

Why you are being invited to take part

To understand the impact working with self-injury has on staff, we first need to gather people’s understanding and perceptions of their experiences when working with those who self-injure. In the NHSHSW, many staff work with self-injury on a frequent basis, some of which can be severe forms of self-injury. As a psychiatric nurse, employed at the NHSHSW, you meet eligibility for taking part in this study. There are a lot of professionals who work with self-injury.
injury in a number of settings however only a few number experience the severity and frequency of self-injury that occurs within the service. As a result it is deemed important that your viewpoint and experiences be captured for this research.

**Your experiences of working with self-injury**

The interview is all about your experiences of working with those who self-injure. This may be something you might not have thoughts about before or may have difficulty with or find distressing. If you find this topic distressing or you have difficulty thinking about at this time, it is advised that you do not take part in this study. If you are unhappy with how you are treated during the study or any undue distress you may feel as a result these will be addressed promptly. I will follow ethical and legal guidelines and all information about you will be handled in confidence. Further information is provided on this in part 2. If you agree to participate in the study but later change your mind, you can withdraw from the study at any time. Your participation in this study is entirely voluntary and whether you participate or not, your employment at the service will not be affected. Following the interview, time is allocated to talk about anything you wish as a result of taking part in the research. It could be that the interview results in you thinking differently about your work with those who self-injure differently, and that you therefore want to share this with colleagues, the trauma and self-injury steering group or your line manager. This is entirely acceptable and you are encouraged to approach them should you wish to do so. If this study sounds interesting to you and you think you would like to take part, please read on.

**Part 2**

**Will what I talk about be known to others?**

The interview will be recorded using a dictaphone so that what is said can be transcribed (typed up) by the researcher. Only the researcher will have access to the tapes or the transcribed information. Any information you provide will not be identifiable to you as all quotes or information used for the research will be anonymised. As soon as you become a participant in this research, you are given a unique identification code (known only to the researcher). This code will be used by the researcher for analysis only and so that participant names are not used during or following the interviews. The interview tapes will be kept securely and safely within the research site for the duration of the study (nine months). The data will then be kept securely for seven years by the University of Lincoln before being destroyed. Only the researcher will have access to these.

**Do I have to take part?**

No, your involvement in this study is up to you and if you do not wish to be involved, you do not need to do anything more. If you do not respond to the response slip below, I will assume that you do not wish to take part.

**What if I want to withdraw?**

Should you feel you wish to withdraw at any point in the study, you are free to do so and can contact me on the contact details listed below. If you were to withdraw following completion of the interview and the data having being entered for analysis, it will not be possible to withdraw the data you have provided.

**What about if I want to make a complaint?**
All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect the rights, dignity, safety and wellbeing of all participants. This study has been reviewed and accepted by the Nottingham Research Ethics Committee. If you are unhappy with how you are treated as a participant at any point in the study, you have the right to contact the researcher through the contact details listed below in the first instance. If you would rather not speak to the researcher about your complaint but would prefer to speak to someone else regarding the research you can complain through the NHS Complaints procedure. Details for this can be provided by any member of staff. It is not certain the study will help you directly however the information you provide will help understand the experience of staff in working with self-injury which can then be used to conduct further research into, or investigations into training or support for staff.

**What happens with the results of the study?**

The results of the study will be made available from December 2010 upon request to the chief investigator. You can make this request via the email address below. The results may be published however there will be nothing to identify you or the information you provide in the interview. The study will also be examined by the University of Lincoln for the purposes of the clinical training qualification. Again there will be nothing that could identify you or the information you provide.

**Thank you**

Thank you for taking the time to read this information sheet. Should you wish to participate in this study, please complete the consent form attached, with your signature, and return it sealed, via the internal mail. When I receive the consent form I will contact you using the means you indicate on the response slip, to arrange a date for interview.

**Disclaimer**

In accordance with ethical procedure I am obliged to inform you that as chief investigator, I am duty bound to inform the authorities should I, in the course of the research, receive details about criminal activity currently being undertaken or planned. However, please be aware that you will not be asked about any criminal related activity at any point in the research process.

Contact details: elizabeth.boyd@students.lincoln.ac.uk

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**Response slip**

**Name.** ........................................................................................................................................

**Years/months worked in the NHS High Secure Health Service for Women.**....................

**Ward:** ........................................................................................................................................

Please find attached my informed written consent to take part in the study. I am happy to be contacted to arrange a date and time of interview. Please contact me on
............................................................................................................................................email/phone)
Appendix L - Consent form

PARTICIPANT CONSENT FORM
Research Title: Working with severe and frequent self-injury
Researcher: Elizabeth Boyd

1. I confirm that I have read and understood the information sheet (version.1.) for the above study. I have had the opportunity to consider the information and feel able to make a decision about whether I participate or not, based on the information provided.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that the study may be published upon completion but that any information I provide will be made anonymous for this.

4. I understand that the information I provide will be known only to the researcher throughout the study for the purposes of the study.

5. I understand that should my information indicate a risk of immediate harm to self or other, the researcher will be permitted to inform clinical management to inform them of this risk for support to be given in that instance.

6. I understand that the interviews will be audio-taped for transcription purposes only

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

_________________ ________________ _________________
Name of Participant     Date                     Signature

_________________ ______________ ___________________
Name of Person          Date                      Signature
Appendix M – Semi-structured interview schedule

Research Title: Working with severe and frequent self-injury
Researcher: Elizabeth Boyd

Interview Schedule

Greeting and opening of interview

Confirm participant is happy to proceed

Remind participants to try and avoid giving any patient details or names during the interview.

Remind participants of anonymity of interview data.

Inform participant that interview will last for up to 45 minutes with 15 minutes at the end for debrief.

*You get hardened to it

Ok so this interview is all about your personal experiences to date of working with patients who can engage in severe and frequent self-injury. I would like to hear as much of your experiences as possible and allow for you to talk about things that you wish to talk about.*

Time for participants to ask any questions

Interview

I suppose we should start by thinking about the kinds of experiences you have had working with those who self-injure. Can you think of an incident of self-injury past or recent that you have experienced whilst working here and describe it me?

Can you describe in your own words what happens to you in a situation like that?

How do you think working with self-injury affects you?*

Interview end – Thank participant for their participation

Debrief time (15 minutes allocated)

For occasions in the interview where discussion about the topic being researched may need to be facilitated further, the following supplementary questions may be asked.

• Emotional effects
Can you tell me about how incidences like this affect you emotionally? (Prompt with a definition if necessary).

- **Effect on behaviour**
  
  What impact do you think working with self injury has on how you behave?

  *Prompt: at work, at home and in everyday life*

- **Coping strategies**
  
  On a day to day basis how do you deal with the effects that you describe?

  What strategies do you think helps you cope with what you experience as a result of working with self-injury?

  Is there anything you do either in your professional or personal life that you feel helps you in any way cope when working with those who self injure or following an incident of self-injury?

  *Prompt: mental or physical strategies*
Appendix N: Sample of analysis: Stage three - Coding

<table>
<thead>
<tr>
<th></th>
<th>Jayne</th>
<th>Poor recall of details</th>
<th>Troubled – think about it at home</th>
<th>Troubled – Need for company</th>
<th>Think about it a lot even now</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jayne</td>
<td>I don’t know, it’s kind of, I can’t remember this was after room access so it was like probably around 2 or 3ish time. I don’t know I was thinking about it at night when I was in bed. It was still there. Unfortunately my partner was on nights that night as well, which did not help and I just thought the one night I could do with him being at home, not particularly to talk to him about it just to, for somebody to be there and it was in my head for most of the night ya know before I was asleep. And it still, it still, it didn’t upset me, well it does upset me but it still ya know that’s probably why I picked it as it is still something that I really do think about a lot. It is something that comes up a lot.</td>
<td>Thinking about the incident in bed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Do you remember it being quite like when you say it was going around your head was it more of a visual thing?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jayne</td>
<td>It was the blood, it was the blood more than anything, the amount of it in the room it was like clots and stuff like that. I can remember it exactly as it was, because obviously like the room was taped off as well because obviously if anything had happened to her it would have needed to be looked at and everything so it was kind of it was readily there for you to look at, again, which I think I probably did like just looked at the room and ‘thought flipping heck’ there is lot going on in this room type thing, very visual, so I think it was more the visual I think.</td>
<td>Very detailed visual memory</td>
<td>Thinking about all the blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Do you think that that’s the after effects? some people say that they can smell stuff or they can visualise stuff or they can hear stuff and it’s like they hear the banging and different people have different things</td>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>
when can recall stuff.

| Jayne | Not smell I think maybe the noise and the amount of people. It felt like there were hundreds of people in the small room. The room that was probably about this size not much bigger than this so it was like a lot of people with you know like emergency packs and things like that and then I can remember like I went downstairs and did this form out and I went back up and there were still lots of people in there and it was like people holding the saline solution bag do you know what I mean, like the bag and the ambulance crew were there then so there were even more people there then. | Sounds and noise remembered | Noisy and lots of people A lot of people in small room |

| R | And there is no time for you to process things then. Like bring yourself round from something like that you know like you still having to carry on despite all what is going on. |  |

| Jayne | Yes we carried on the shift. We sat in the office and filled out the IR1 and we did talk about it and we were debriefed but we were debriefed by people outside, if you know what I mean not our group. It wasn’t our staff group, it was people that worked in our environment but it didn’t, wasn’t there all the time so it was difficult. I found it difficult to be debriefed with people like that. I find it easier to debrief with people who were actually there and go through it like that... and we talked about that, we said it was nice for us to sit here in the office doing the notes just talking about it rather than the actual debrief, I think that was more beneficial to me anyway. | Talked about it with peer staff who were there Outsiders can’t understand their experience Peer discussions/debriefing is more appreciated and beneficial Formal debriefs are not helpful | Formal debriefing – difficult Peer support beneficial |

| R | So without that bit that could have been a very different experience I suppose. |  |

| Jayne | Yes I think it would have been. The next day it just turned to anger really | was it concern before if it turned | Anger at patient |
towards her because she just thought it was something like really funny and it was like ‘f****** hell you weren’t there’ I mean she just wasn’t responding properly you could see her life going out of her eyes and it was like ‘wow you don’t realise just how close you were to it’ and you’re just sat there quite blasé about it. I felt quite angry with her (laughter), quite angry with her and a lot of people were because of what she said

<table>
<thead>
<tr>
<th>R</th>
<th>I think that is quite a common reaction in terms of the anger in this population I mean with deliberate self harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jayne</td>
<td>Especially to that extent I have seen people cutting and stuff and to be honest my opinion of self harm is it’s, you know, I feel that if they need to cut then they should be able to, well to a certain extent because cutting is a way of releasing their emotions and everything. It’s this kind of thing like blood-letting that I don’t agree with at all but it is harder to understand. I think it is more of a suicide thing than self harm, that’s how I feel about it, it’s more of a ‘I don’t want to be here’ type of thing.</td>
</tr>
</tbody>
</table>

| to anger?       | Cognitively understanding of rationale of self-injury for patient- |
| Anger from embarrassment that they cared | Blood letting is not self-harm it more suicidal-incomprehensible |
| Patients need to empathise or appreciate what staff went through? | What is the importance of agreeing with or understanding the act of self-harm? |

| relaxed response to seriousness of self-injury | Intellectualisation If they need to self-injure they should can’t accept or understand life threatening actions/suicidal |
Appendix O: Audit trail of themes

<table>
<thead>
<tr>
<th>Quote</th>
<th>Description</th>
<th>Theme</th>
<th>Super-ordinate theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes it’s just like a build up of things. like we had the death and we had the really nasty day that day like self-harming and I came in the next morning and found someone with a ligature around their neck and I just couldn’t deal with it then (Jayne, 395)</td>
<td>Number of incidents close together build up of stress. Need to deal with incidents Thinking about the incident in bed</td>
<td>Stress</td>
<td></td>
</tr>
<tr>
<td>I was thinking about it at night when I was in bed. it was still there And it still, it still, it didn’t upset me, well it does upset me but it still ya know that’s probably why I picked it as it is still something that I really do think about a lot. It is something that comes up a lot. (Jayne; 86).</td>
<td>It’s scary now because we are responsible for someone’s mortality</td>
<td>Perturbation</td>
<td>Experiencing of affect</td>
</tr>
<tr>
<td>it’s their life in your hands and when you’ve got somebody’s mortality at your finger tips. That is what’s scary (Alice; 313)</td>
<td></td>
<td>Fear of death</td>
<td></td>
</tr>
<tr>
<td>one of the things that I like about it is that every day is different. (laughter). yeah, so you just wonder in what way is today going to be different (Tim, 140)</td>
<td>Like that everyday is different</td>
<td>Enjoyment of the job</td>
<td>Containing</td>
</tr>
<tr>
<td>I think a lot of it just goes over the top now self harm it almost becomes the norm and that almost protects you. You almost get numb I suppose numb is a good word you deal with it, you manage it, you sort it all out, but you sort of don’t absorb it (Gaia, 37)</td>
<td>Becomes the norm, which protects you, don’t absorb</td>
<td></td>
<td></td>
</tr>
<tr>
<td>there is still that very distinct boundary between them and us because it is that working relationship so whilst you do have to maintain a really close working relationship with them that’s it (Gaia, 179)</td>
<td>Boundary made between close working relationship and another relationship</td>
<td>Establishing boundaries</td>
<td>Containing processes</td>
</tr>
<tr>
<td>We do tend to have, if something bad has happened, we tend to keep in touch with each other, text each other or ring each other, Go out to meet for a drink, go out for the evening, just do different things. And that helps. That does help (Steff, 304)</td>
<td>We keep in contact with each other when incidents happen which helps</td>
<td>Peer support</td>
<td></td>
</tr>
</tbody>
</table>