

Murphy, C., Keogh, B. & Doyle, L. (2019) 'There is no progression in prevention' – The experiences of mental health nurses working with repeated self-harm. *International Journal of Mental Health Nursing*, <https://doi-org.elib.tcd.ie/10.1111/inm.12626>

Abstract

Caring for people who self-harm is an everyday experience for mental health nurses and an important part of their role. How mental health nurses respond to and support those who self-harm can have a significant impact on the outcomes for service users and their intentions to seek help in the future. Repeated self-harm can be a particularly challenging phenomenon as it is often misunderstood and can have a negative impact on the therapeutic relationship. This qualitative descriptive study aims to explore how mental health nurses understand and work with repeated self-harm. Nine nurses working in a range of mental health settings within one service participated in semi-structured interviews which were analysed thematically. Findings are presented in two themes exploring participants' perceptions and understanding of repeated self-harm, and the process of learning to work with repeated self-harm; and are reported in accordance with the consolidated criteria for reporting qualitative research guidelines (COREQ). Participants reported that nursing practice relating to repeated self-harm remains largely focused on maintenance of safety and prevention of self-harm despite the identification that this often does not work. It was accepted that there is sometimes a lack of understanding about the function of self-harm however participants reported understanding increased following specific education about self-harm. Participants also identified the potential for more empowering and recovery-orientated responses, including the utilisation of harm reduction approaches, to the care of those who repeatedly self-harm.

Key words: self-harm, repeated self-harm, mental health nurses, harm reduction.

Introduction and background

Self-harm, defined here as self-injury or self-poisoning irrespective of suicidal intent (Kapur *et al.* 2013) is recognised internationally as a significant public health problem. Community studies have identified that self-harm is particularly high amongst young people (Doyle *et al.* 2015a) and presentations to the Emergency Department (ED) for treatment of self-harm peak in this cohort (Griffin *et al.* 2018). Self-harm is known to be the strongest risk factor for subsequent completed suicide and studies show that 1 out of every 25 patients who present to the ED with self-harm will die by suicide in the 10 years following their initial presentation (Carroll *et al.* 2014). Furthermore, repeated self-harm, which is a common phenomenon, has been associated with poorer long term outcomes and an even greater risk of suicide (Zahl & Hawton 2004). This highlights the potential and importance of appropriate therapeutic responses in the early period following an incident of self-harm.

Following presentation to the ED, people who have engaged in serious self-harm are often admitted to mental health services for further assessment and treatment. Consequently, mental health nurses frequently work with patients who self-harm and are usually the first point of contact when presenting to the mental health services. A national study of incident reports of self-harm within mental health wards in the UK reports that self-harm in inpatient settings involves a wide range of different behaviours (James *et al.* 2012). This study identified that 65% of self-harm incidents took place within the acute services with most self-harm episodes occurring in private areas and were hidden from staff completely or only disclosed after the event. The majority of these self-harm episodes reviewed did not put the life of the patient at risk (James *et al.* 2012).

The literature is replete with findings suggesting that healthcare professionals' responses to those who self-harm are often negative and that a lack of understanding about self-harm contributes to these negative attitudes (O'Donovan & Gijbels 2006; Patterson *et al.* 2007; Wilstrand *et al.* 2007, Commons & Lewis, 2008; Thompson *et al.* 2008; Dickinson *et al.* 2009;

Gibb *et al.* 2010, Dickinson & Hurley 2011, Saunders *et al.* 2012; Kool *et al.* 2014; Tofthagen *et al.* 2014; Karman *et al.* 2015, Rayner & Warne 2016; O'Connor & Glover 2017). While there is less research available from the perspective of service users, existing studies identify poor treatment experiences and report that the care received from some mental health professionals is sub-standard due to unhelpful attitudes displayed (Pembroke 2006; Lindgren *et al.* 2018). While it is clear from the literature that self-harm induces negative attitudes, it has been identified that those who *repeatedly* self-harm experience even greater intolerance and negative attitudes (Gibb *et al.* 2010; Saunders *et al.* 2012). Furthermore, there is limited research about how mental health nurses work with repeated self-harm and in particular their responses to repeated self-harm and interventions used. Evidently there is a requirement to explore the issue of repeated self-harm in more depth; consequently the aim of this study is to explore how mental health nurses understand and work with repeated self-harm.

Methods

Design

A qualitative descriptive design was utilised for this study which is a particularly useful design to employ when exploring phenomenon about which little is known and when there is a requirement to describe key aspects of informants' experiences (Kim *et al.* 2017). This design is an appropriate method to address important clinical issues where the focus is not on increasing theoretical or conceptual understanding, but rather contributing to understanding and quality improvement in the practice setting (Chafe, 2017) by generating data that describes the "who, what, and where of events or experiences" (Kim *et al.* 2017, p23).

Sample and procedure

The sampling site was an acute mental health service in Dublin, Ireland which includes nurses working in in-patient units, community settings and as specialist mental health nurses in the Emergency Department. A purposeful sampling strategy was employed which sought registered mental health nurses who had experience of working with patients who engaged in repeated self-harm. Posters advertising the study were displayed in the common room of each unit and staff were invited to contact the researchers for further information. A total of 9 nurses came forward to participate in the study and all were included. Ethical approval was granted by the Research Ethics Committee of the Faculty of Health Sciences, Trinity College Dublin. All participants provided written informed consent and the voluntary nature of participation was made explicit as was the right to request a transcript of their interview, however no participant required this.

Data Collection

Data were collected through the use of semi-structured interviews which are a common method of data collection in descriptive studies (Kim *et al.* 2017). They were favoured because of their capacity to allow some structure and uniformity across interviews while still facilitating flexibility and probing of responses (Ellis 2013). An interview guide was developed which was informed largely by the aim of the study (Table 1) and asked questions about participants' experiences of working with those who repeatedly self-harm. The interviews were conducted by one of the researchers (CM) and took place in a designated private room within participants' working environment where they were audio-recorded and ranged in length from thirty to forty minutes.

Insert Table 1 here

Analysis

Data were analysed using a thematic analysis approach employing the 6-step framework of Braun and Clarke (2006) which enabled a deeper understanding of the data through the

development of themes and sub-themes. Data analysis began with the transcription of interviews which were then read several times to become familiar with the data. Following this, initial codes were generated which organised data into meaningful groups, codes were then collapsed to form an initial group of potential themes. The development of initial codes and themes was undertaken by one researcher (CM) who then presented these codes and themes to another researcher (LD) for validation. At this stage, Braun and Clarke (2006) identify how coding can be either theory-driven – approaching data with specific questions in mind to code around, or data-driven where the themes depend on the data produced. The analysis process for this study used both forms of analysis. The overall themes for the study were developed with the aim of the study in mind – to explore how mental health nurses understand and work with repeated self-harm. However, sub-themes within each theme were developed in a data driven process. The analysis led to the development of two over-arching themes and associated sub-themes (Table 1). Findings are presented within these themes and sub-themes with reference to some *verbatim* participant quotes to provide evidence of the findings in line with recommendations from Braun and Clarke (2006). Findings are reported in accordance with COREQ guidelines (Tong *et al.* 2007).

Insert Table 2 here.

Results

Eight participants were female and one was male. There was variation in years of experience as a mental health nurse ranging from 4 to 19 years. All participants had a minimum of degree level education, while 4 had a higher diploma and 2 had a MSc. degree. Participants worked in a range of mental health settings (Table 2).

Insert Table 3 here.

Mental health nurses' perceptions and understanding of those who repeatedly self-harm

This theme reports how participants' perceive and understand repeated self-harm and identifies that while self-harm is sometimes viewed as a risk-laden behaviour, there is also a level of understanding about the distress that repeated self-harm represents.

Perceptions of self-harm: a risky and attention-seeking behaviour?

Most participants discussed the concept of risk when reporting their perceptions of self-harm. Those who repeatedly self-harmed were considered to be 'a very risky group' (P1) and participants described being on 'high alert' (P4) in the provision of care to a person who self-harmed due to them being so 'unpredictable' (P2). Many participants compared the difference in caring for people who self-harmed and caring for people with a mental illness:

"With someone who frequently self-harms, the trust isn't there, they demand so much time and observation. Whereas someone who is psychotic, well you can let them off without having to stress too much about them." (P9).

Participants' mistrust of people who self-harmed was evident in how they described a hyper-vigilance around them:

"You can't take your eyes off them, I've had patients sneak knives, thumbtacks, needles. Anything they can get their hands on." (P5).

It was evident a judgement was made by some participants regarding how deserving a service user was of care and this was influenced by whether the nurse believed that the self-harm was 'their fault':

"I see some people who are very unwell and it is not their fault whereas those who self-harm without being unwell, it was their choice to do that or they did it for a specific gain." (P8).

Some participants believed people who self-harmed did so to get attention or to influence their care or surroundings:

“I was really busy with other things and she asked me for a chat, seemed fine and had been all day, I said ‘give me ten minutes’. Next thing I know the alarms are going off and she had cut herself really deep. She did it because I couldn’t give her the attention she needed right away.” (P9).

A distinction was also made between those who self-harmed privately and those who did so publicly with some participants believing that a hidden self-harm act was more serious than a public one:

“When someone does it out of sight you think, ok they must be feeling quite low, but it’s quite difficult when someone does it point blank in front of everyone, it’s more of an attention thing.” (P2).

Towards a better understanding of self-harm

Despite the sometimes negative perceptions about repeated self-harm there were also many descriptions of incidents where nurses sought to better understand and respond to it. It was reported that experiential learning was important to increase understanding of self-harm:

“Very little prepares you for self-harm, there is no textbook, you need to experience it then you will learn to understand it.” (P3).

It was recognised that negative attitudes about self-harm are not beneficial for either nurses or patients and a number of participants reported the importance of understanding the cause of self-harm and the distress associated with it.

“Self-harm are the tears and you need to find out what makes someone cry, then you come up with a plan together.” (P8).

In particular, the experience of trauma was recognised as one factor associated with self-harm with one participant noting that those who self-harm have experienced *'awful events in their life and naturally they are going to struggle to cope'* (P8). The importance of recognising their distress and understanding their response was also identified:

"I try to see their inner child, what distress brought about this problem they are having. Then I would work towards validating their response to this experience and make sure they know it is a legitimate one." (P6).

When nurses understood self-harm as a response to a traumatic event, they reported that service users had a *'sense of relief'* (P6) and *'felt better understood'* (P7). Participants indicated that once a person who self-harmed felt that support, they engaged in *'less self-harm'* and considered *'alternative methods'* (P8) to deal with complicated feelings. Some participants reported how this understanding of self-harm as a response to trauma came about specifically from attending education programmes specific to self-harm.

Learning to work with repeated self-harm

This theme reports how participants currently work with those who engage in repeated self-harm with the focus largely on the maintenance of safety and prevention of self-harm, and reports participants' perceptions of the move towards more sustainable and recovery-orientated interventions. This theme finishes with a focus on education and training which was identified by all participants as important to equip mental health nurses to work in a more relational and person-centred manner.

Maintaining safety and preventing self-harm

A predominant approach to caring for people who self-harm was maintenance of patient safety and prevention of self-harm. Several participants reported these approaches as prioritised nursing interventions for this client group with one participant stating they would be *'number*

I on the person's care plan' (P3). Participants revealed episodes of self-harm were stopped by control methods, such as removal of potentially dangerous objects, close monitoring, physical restraint or seclusion:

"We would try minimise the amount of dangerous or potentially dangerous objects around the person." (P4).

"Nursing one-to-one observations is a very common intervention here." (P5).

"If you see them self-harm, you have to try and stop them, that is what we do to try to maintain their safety. And then it ends up in either restraint or seclusion." (P2).

Medication was also reported as an intervention used in the care of somebody who was self-harming:

"It is not ideal but a number one go to is medication, we would initiate it if they were really distressed, about to self-harm or maybe just had a self-harming incident." (P9).

Almost all participants expressed dissatisfaction and feeling uncomfortable with resorting to these methods but do so because *'it is all we have'* (P2). One participant proposed they had little alternative strategies in their service to optimise patient safety and found this difficult:

"We know these things are not ideal but we are limited, it's not easy." (P9).

A strong desire to learn and use different interventions when caring for this client group was evident. Many participants expressed their unease with the extent they go to prevent self-harm from occurring, recognising that prevention is often not an effective strategy:

"We have had cases of people who are self-harming for 20 years, we are not going to stop them, all we are doing is stopping them in this facility so the minute they go out, they will do the same thing, then they come back in. There is no progression in prevention." (P2).

This expression of contention regarding the methods of control and prevention being used was consistent throughout interviews with participants believing it was not ‘*therapeutic*’ (P4) or a ‘*long-term solution*’ (P3). It was evident that participants believed these types of practices restrict the ability to understand why a person is self-harming in the first instance and may result in poor quality care in addition to impinging on their rights as a person:

“If this is someone’s way to manage their pain then you have to wonder if we are taking away their right to do this and ultimately making them more distressed.” (P3).

Empowering Approaches to Working with Self-Harm

In contrast to the prevention-orientated interventions identified, some participants, particularly those who had completed a training programme specific to self-harm discussed the use of less controlling and more recovery-focused and empowering interventions towards patients who self-harm. One participant explained:

“My role now is more about educating people about self-harming, about developing appropriate coping strategies and about ensuring people are responsible for their own actions and not taking that responsibility off someone.”(P1).

The usefulness of providing education to people who self-harm was emphasised with one participant stating:

“I teach people skills and in allowing that process to happen they then go home and take that responsibility to change.” (P6).

The importance of self-harm as a coping mechanism and the difficulties with suddenly stopping it was clearly understood by some participants:

“I wouldn’t immediately discourage someone to stop self-harming if it is their sole coping mechanism as that can be dangerous, unless of course it’s lethal and could possibly end their life.” (P7).

Participants highlighted the importance of working collaboratively and involving the person in decision-making around their care plan which can mean utilising harm reduction techniques if this is what is required:

“It is about finding out what works best for them, is there a healthier way you could deal with distress? If it [self-harm] is the only way they can deal with it you have to encourage them to do it safely, use clean implements or if they cut too deep seek medical attention.” (P8).

Provision of specialised education and training

Some participants described finding it difficult to understand why a person self-harmed and expressed an eagerness to ‘*learn and find out why*’ (P4) highlighting the need for specialised education. It was recognised that there was a lack of specific education about self-harm within undergraduate nurse training:

“You qualify and obviously, you’ve received a certain amount of education and that’s fine, but it’s so wide and varied and I think with additional education your ability to critically think is far greater.” (P1).

Some participants described feeling like they had little to offer people who self-harm and expressed a desire to change that feeling:

“I think it’s a total disservice to the patients.” (P4).

“I want to know more, I continually want to update my skills and knowledge, how best I can help them.” (P7).

Many conveyed an awareness of harm reduction interventions used in other countries when caring for people who self-harm but reported having no access to methods in their workplace:

“We have nothing...when you look at England and all the research they have, they are helping them and showing them how to do it safely and in our service we don't do any of that.” (P2).

The frustration of this specialist education deficit was evident in many participant narratives. Some participants had undertaken postgraduate studies that included self-harm modules. They spoke of the positive effect this education had on their perceptions and experiences when working with people who self-harm. One participant described her prior views of working with this client group, stating:

“It took me a long time to unfreeze to them, I was frozen and it took me a long time to thaw out but I'm so glad I did.” (P6).

However, the difficulty of putting their knowledge into practice was pointed out, believing it to be a struggle when colleagues were *‘not singing off the same hymn sheet’* (P9), and this was particularly pertinent in relation to the use of harm reduction strategies which were seen as somewhat contentious. Capturing the essential need for further education, one participant stated:

“With that extra bit of education, you would feel more comfortable in your role and you would have more confidence working with them [people who self-harm], but also educating colleagues about it.” (P1).

Evidence of how understanding about self-harm can be influenced by specialist education was succinctly reported by some participants:

“I used to think the old famous that’s just PD [personality disorder] behaviour, I had that mentality of classifying self-harm as not a sign of distress but a sign of attention-seeking which was absolutely hugely unhelpful, but that changed after my Masters’” [degree]. (P1).

Discussion

The findings from this study suggest that mental health nurses often define people who repeatedly self-harm as unpredictable and risky. Working with risk is accepted by mental health nurses as a core component of their role (Downes *et al.* 2016), however participants in this study reported a hyper vigilance around self-harm which often resulted in risk averse and controlling practices including seclusion and one-to-one observation. Current clinical management of self-harm focuses largely on stopping the person engaging in acts of self-harm (Sullivan 2017). The finding that mental health nurses’ approach to people who self-harm is predominantly focused on prevention and control methods is therefore unsurprising and is in keeping with other studies (O’Donovan & Gijbels 2006; Shaw & Shaw 2007; Taylor *et al.* 2009; Dickinson *et al.* 2009; McHale & Fenton 2010; Tofthagen *et al.* 2014; O’Connor & Glover 2017). Participants reported resorting to controlling and preventative as they perceived their main obligation as maintenance of patient safety. However, they also acknowledged that at times these measures of control were inappropriate, futile and impinged on a person’s rights, and expressed exasperation at the lack of therapeutic alternatives available to them. This reflects findings in other studies which report that mental health professionals often engaged in preventative and controlling methods to stop self-harm despite being aware of the unsustainability of these interventions (O’Donovan & Gijbels, 2006; Wilstrand *et al.* 2007; Tofthagen *et al.* 2014; O’Connor & Glover 2017).

In addition to these interventions not working in a sustainable manner, participants also reported that they had an adverse impact on their therapeutic relationship with patients. The

use of controlling and preventative methods undoubtedly effects a mental health nurse's opportunity to build and sustain a therapeutic alliance with a client who self-harms (Edwards & Hewitt 2011; O'Connor & Glover 2017) and it is suggested that the concept of prevention of self-harm may be in contrast to the needs of the service-user at a given point in time (Thomas & Haslam 2017). Accordingly, if the only approach to people who self-harm is focused on not doing it at all, then many clients will find that unsupportive and may withdraw from accessing services (Pengelly *et al.* 2008; Thomas & Haslam, 2017; Lindgren *et al.* 2018). Studies focusing on service users' views also report how their care in the mental health services is largely characterised by surveillance with no form of therapeutic input and this controlling care can increase their desire to self-harm again (Taylor *et al.* 2015; Morrissey *et al.* 2018).

It has been identified that there is limited evidence of recovery-orientated practices in relation to risk amongst mental health nurses practising in Ireland (Higgins *et al.* 2016). Within this study however a number of participants, notably those with further education and working within a specialist role, described their use of more recovery focused, empowering techniques when caring for people who self-harm. These participants recognised that interventions focusing merely on stopping self-harm can be unsuccessful and even lead to increasing the very risks sought to be reduced, a view supported in the literature (Inckle 2011; Thomas & Haslam 2017; Sullivan 2017). Participants recognised that there was 'no progression in prevention' and discussed the need to look to alternative ways of supporting people who engage in repeated self-harm.

Harm reduction is an approach to care which recognises the limitations of a prevention-based approach to self-harm, accepting that someone may need to self-harm at a certain point in time and focuses on supporting the person to reduce the risk and damage associated with it (Inckle 2011). The approach is based on the contention that preventing self-harm is not always possible and that suddenly stopping self-harm can be unhelpful and even dangerous for the

person who may escalate to more serious methods of self-harm if their preferred method has been removed (Inckle 2011; Sullivan 2017). One of the most common functions of self-harm is to cope with distress (Doyle *et al.* 2017), therefore removing this coping mechanism suddenly and without the provision of an alternative can be viewed as non-therapeutic and even unethical (Inckle 2011; Sullivan 2017). Guidance from the UK's National Institute for Health and Care Excellence (NICE) recognises harm reduction as a treatment approach in cases where stopping self-harm in the short-term is unrealistic (NICE 2011), and is argued to lead to a reduction when compared with more traditional ways of managing self-harm in the clinical environment (Sullivan 2017).

There is no established model of harm reduction in self-harm (James *et al.* 2017) and interventions are wide-ranging and can differ between clinical settings. Much attention is given to the contentious issue of the provision of clean instruments with which to harm oneself; however other more commonly utilised methods of harm reduction include employing alternatives to cutting and education on 'safe' ways to self-harm and appropriate self-aftercare (Pickard & Pearce, 2017; Sullivan 2017; Doyle *et al.* 2015b). However, crucially within this approach is the need for the person to engage in psychological therapy to explore the function and meaning of their self-harm to sustain longer term change and the development of alternative coping strategies (Edwards & Hewitt 2011; Sullivan 2017). Furthermore, a harm reduction approach also presents the opportunity to offer information and education to those who self-harm which participants in this study reported doing.

Participants in this study spoke about the importance of empowerment and encouraging service users to take responsibility for their self-harm. The concepts of empowerment, control and autonomy are central to recovery-orientated mental healthcare and in the context of self-harm, a harm reduction rather than prevention approach can be seen to increase these (James *et al.* 2017; Edwards & Hewitt 2011; Inckle 2011). The participants who

did report implementing a harm reduction approach reported it was an effective strategy that promoted clients to take responsibility for their actions and increased understanding of their reasons for self-harm. These participants stated they would not discourage someone from their self-harm if it was their only coping mechanism at that time, and instead set more realistic goals, in collaboration with the patient, to reduce the number of episodes and/or the gravity of injuries. These findings are in keeping with the results of the study by James *et al.* (2017) who discovered that mental health practitioners who had implemented a harm reduction approach reported a positive outcome including a reduction in episodes and severity of self-harm along with an apparent increase in empowerment of patients.

Harm reduction is not however universally accepted as an approach to the management of self-harm and this may explain why contradictions exist in this study in the way nurses work with repeated self-harm. One of the biggest problems identified are potential legal and ethical issues around allowing harm to occur in a clinical setting and the possible contravention of a professional duty of care (Edwards & Hewitt 2011; Sullivan 2017; Dickinson *et al.* 2009; James *et al.* 2017). In addition, it has also been reported that mental health nurses may not feel skilled, comfortable or empowered to discuss harm reduction techniques with patients (Pengelly *et al.* 2008). Furthermore, the emotional response to supervising self-harm and the psychological burden of working with the risk potentially associated with facilitated self-harm may be very difficult for health professionals to reconcile with (James *et al.* 2017; Pickard and Pearce 2017).

These arguments against the use of harm reduction are valid and are important to consider when considering the use of this approach in practice. However, it is important to note that harm reduction is not advocated as a routine measure and is not an approach that will be appropriate for all those who self-harm (NICE 2011; Sullivan 2018). It does not constitute a blanket permission to self-harm with staff allowing significant harm to occur (Sullivan 2017) and it is likely that the relevant inpatient population for whom harm reduction could be a

therapeutic option is relatively small (Pickard & Pearce 2017) and confined to those who repeatedly self-harm. Evidently, for this practice to be fostered by mental health nurses there is a requirement that they understand the functions of self-harm for the individual and the underlying distress associated with this act (Doyle *et al.* 2017; Thomas & Haslam 2017). Additionally, policies and guidelines in the clinical area need to adapt and greater collaboration is required from management and multi-disciplinary team members as it has been identified that the use of harm reduction is difficult in the absence of clear clinical and legal guidance (James *et al.* 2017).

A recent meta-synthesis of activities that facilitate personal recovery for those who continue to self-harm demonstrated the importance of key concepts such as empowerment, meaning and connectedness rather than a reductionist focus on reducing self-harm and the symptoms associated with it (Deering & Williams 2018). This does require a re-orientation of educational provision for mental health nurses who are key stakeholders in the provision of care to those who engage in repeated self-harm. Participants in this study reported that education about self-harm was somewhat ad-hoc and largely reliant on their own drive to access post-graduate mental health education which had a particular focus on self-harm. These findings suggest that recently qualified staff do not feel adequately prepared in caring for people who self-harm on a therapeutic level and are reliant on following the cultural procedures of their working environment, which mostly rely on control and prevention methods. Those participants who reported having engaged in specific education about self-harm had a better understanding about it and were more prepared to work in a recovery-orientated way. A systematic review of attitudes and knowledge of clinical staff regarding those who self-harm found that greater education was associated with more positive attitudes (Saunders *et al.* 2012). While an improvement in attitudes towards self-harm is to be welcomed, there is a need to ensure that this change goes further to incorporate nursing practices. Promisingly, findings by

Karman *et al.* (2015) identify that in addition to improving attitudes about self-harm, educational programmes can result in a decrease in the use of restrictive interventions and an increase in more patient-centred, recovery-orientated mental health nursing interventions. If quality care and positive outcomes for people who self-harm is to be achieved, mental health nurses need to be knowledgeable and confident in their approach and skills in working with this patient group. Evidently, more education specific to self-harm needs to be offered to mental health nurses in both undergraduate and postgraduate training.

Limitations

The sample size in this study was relatively small and confined to one mental health service, albeit encompassing a range of different settings. Consequently, the results may not be generalizable to mental health nurses in different services.

Conclusions

Mental health nurses work frequently with those who repeatedly self-harm. Reports from both service users and mental health nurses suggest that within these interactions are significant opportunities for improvement in how repeated self-harm is understood and responded to. This paper identifies how many aspects of the response to self-harm continues to be rooted in the paradigm of prevention and control, however it also provides evidence of mental health nurses' awareness of the futility of this approach and of a greater understanding of what leads a person in distress to repeatedly self-harm. Working in a more relational and recovery-orientated way with someone who repeatedly self-harms may lead to better outcomes for both service users and mental health professionals.

Relevance for clinical practice

Findings from this study highlight a number of key points with relevance for clinical practice. Firstly, there is evidence that responses to self-harm remain centred on prevention and control.

While this is borne from a desire to keep the person safe, it was evident from participants that it may have the opposite effect. Secondly, mental health nurses who utilised more relational and recovery-orientated approaches reported how this had a beneficial effect for both patients and nurses. Finally, it was evident that nurses who engaged in specialist education about self-harm utilised positive recovery-orientated responses suggesting that further education about self-harm may be associated with better outcomes for all.

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Table 1: Interview guide

Topic to be covered
Experiences of working with repeated self-harm
Perception of role when caring for people who engage in repeated self-harm
Understanding of repeated self-harm
Responses and interventions when working with repeated self-harm
Concerns about working with repeated self-harm
Preparedness to work with repeated self-harm

Table 2: Study Themes

	Theme	Sub-themes
Theme 1	MHNs perceptions and understanding of those who repeatedly self-harm	<p><i>Perceptions of self-harm: a risky and attention-seeking behaviour?</i></p> <p><i>Towards a better understanding of self-harm</i></p>
Theme 2	Learning to work with repeated self-harm	<p><i>Maintaining safety and preventing self-harm</i></p> <p><i>Empowering Approaches to Working with Self-Harm</i></p> <p><i>Provision of specialised education and training</i></p>

Table 3: Participant role and setting

Participant	Role and setting
1	Clinical Nurse Specialist (CNS): Liaison Mental Health Nurse, Accident & Emergency (A&E) Department
2	Staff Nurse: Female Psychiatric Intensive Care Unit
3	Staff Nurse: Community Day Hospital
4	Staff Nurse: Female Psychiatric Intensive Care Unit
5	Staff Nurse: Acute Inpatient Unit
6	CNS: Community Mental Health Nurse
7	CNS: Self-Harm Nurse, A&E Department
8	CNS: Community Mental Health Nurse
9	Staff Nurse: Acute Inpatient Unit