

Nurses' attitudes towards clients who self-harm

Author

McAllister, M, Creedy, D, Moyle, W, Farrugia, C

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TITLE: NURSES' ATTITUDES TOWARDS CLIENTS WHO SELF HARM

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Authors: Margaret McAllister, Ed D, RN

Senior Lecturer, School of Nursing, Griffith University

Debra Creedy, Ph D, RN

Professor of Nursing & Health

Centre for Practice Innovation in Nursing & Midwifery

Griffith University

Wendy Moyle, Ph D, RN

Senior Lecturer

Centre for Practice Innovation in Nursing & Midwifery

Griffith University

Charles Farrugia, B BehSc, B Psych

Psychologist, School of Psychology

Griffith University

Contact: Dr Margaret McAllister,

School of Nursing, Griffith University

Kessels Road, Nathan, Brisbane.

Queensland, Australia, 4111

Email: M.McAllister@mailbox.gu.edu.au

Tel: 61 + 07 + 3875 6460

Fax: 61 + 07 + 3875 7984

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NURSES' ATTITUDES TOWARDS CLIENTS WHO SELF HARM

ABSTRACT

Background. Deliberate self-harm is frequently encountered by emergency department (ED) nurses. However, clients are often dissatisfied with the care provided and clinicians feel ambivalent, helpless or frustrated when working with clients who self-harm.

Aim. The aim of the study was to develop and test a scale (Attitudes Towards Deliberate Self-Harm Questionnaire) to identify relevant dimensions of ED nurses' attitudes to clients who present with self-injury.

Method. Items on ADSHQ were drawn from a literature review and focus group discussions with ED nurses. The tool was piloted with 20 ED nurses not working in the target agencies. A survey of nurses working within 23 major public and 14 major private Emergency Departments in Queensland, Australia (n = 1008) was then undertaken.

Results. 352 questionnaires were returned (35% response). Analysis revealed four factors that reflected nurses' attitudes toward these clients. The factors related to nurses' perceived confidence in their assessment and referral skills; ability to deal effectively with clients, empathic approach; and ability to cope effectively with legal and hospital regulations that guide practice. There was a generally negative attitude towards clients who self harm.

Correlations were found between years of ED experience and total score on the ADSHQ, and years of ED experience and an empathic approach towards clients who deliberately self-harm.

Conclusion. There is a need for continuing professional development activities to address negative attitudes and provide practical strategies to inform practice and clinical protocols.

Keywords: nurses' attitudes, deliberate self-harm, emergency department

INTRODUCTION

Deliberate self-harm (DSH) is frequently encountered in emergency departments (ED) but is a hidden health problem worldwide. Approximately 4% of the population self-harms and it is one of the leading five causes of acute medical admission for women and men (Wilhelm et al. 2000). This study defines DSH as any intentional damage to one's own body, without a conscious intent to die. This definition excludes issues of suicidality, self-harm as a response to psychotic experiences, or as a repetitive act characteristic of some developmental disorders or brain injury. Nurses are most consistently and intensely involved in the care of people who present to ED because of self-harm. Nurses provide triage, First Aid, advanced interventions, psychosocial support, safety, and coordinate discharge or referral services.

Emergency Department nurses are often busy and confronted with competing issues and concerns in an emotionally charged environment. Cases are assessed and prioritised according to life threat, yet people who come to ED for assistance because of DSH may not be perceived as a 'good and deserving' patient (Sbaih 1993). Staff may make the person wait, express obvious expressions of frustration, anger, fear, helplessness, fail to empathise and fail to maintain safety and respect within the Emergency Department (Childs et al. 1994, Johnstone 1997).

According to consumer and professional literature, public attitudes to DSH remain negative (Pembroke 1991, Pembroke et al. 1998, Vivekananda 2000). Consequently, self-harm is often a secret, shame-inducing practice. The persistent myth that self-harm is an attention-seeking mechanism is inaccurate. Whilst clearly self-harm can communicate to others the pain that is inside, or that the individual needs help and is in crisis, self-harm is also commonly completed in private. Even family, friends and therapists may be unaware of episodes of self-

harm. In a study by van der Kolk et al. (1991), only 18% of therapists knew that their clients were self-injuring. Further, only those acts that cannot be treated by the individual at home using their own attempts at First Aid, tend to be seen by health professionals in ED or medical centres (MHF 1997, Pembroke et al. 1998). Any statistics gathered in health services are likely to seriously underestimate the actual incidence of deliberate self-harm.

Consumer experiences

The experiences of consumers have been investigated in a number of studies. Arnold's (1994) survey of women who self-harm found 69% were dissatisfied with emergency services and 96% were dissatisfied with psychiatric services. A study by Barstow (1995) and supported by others (Pembroke et al. 1998, McAllister et al. 2001) explored the personal experience of self-harm and found that when clients are transferred to the ED they are often ignored, have to wait, and experience judgmental comments and painful treatment.

Disturbingly, even though ED is an important access point for clients who may not otherwise seek professional care, clients sometimes do not stay for treatment, are lost to follow up and discharged without referral (Dennis et al. 1990, Ryan et al. 1998).

Hemmings (1999) interviewed five consumers of emergency services who reported ambivalence about the care they received and who felt as if staff were judging and punishing them. Hemmings suggested that how individuals are treated in an emergency setting is likely to influence profoundly whether they accept follow-up care. Thus if the service provided in emergency settings is inadequate it may become yet another trauma from which the person must struggle to survive.

Emergency department staff attitudes

Caring for people who present to ED because of deliberate self-harm often evokes strong emotions and negative attitudes in staff. According to Johnstone (1997), the bizarre and distressing acts of what appears on the surface to be masochism often elicit strong reactions in staff including, despair, helplessness, rage and even revenge. As a result, staff may tend to distance themselves from such clients rationalising that the person is manipulative, attention seeking or cannot be helped (Vivekananda 2000).

Relatively few studies on staff attitudes have used standardised measures to investigate the underlying dimensions of such attitudes. Furthermore, the findings of research studies that investigated attitudes of different professional or specialist groups have been inconsistent. Whilst one might expect that mental health professionals would have more empathy towards people who self-harm, none of the literature reviewed confirmed this assumption. For example, Anderson (1997) found no evidence of differences in attitudes between a sample of community mental health (n=33) and ED nurses (n=33). Responses to statements based on the Suicide Opinion Questionnaire (Domino et al. 1982) revealed generally positive attitudes by both groups. Suokas and Lonnqvist (1989), however, compared ED staff (n= 64) attitudes to self-harming clients with Intensive Care Staff (n=73) and found ED staff to be more negative towards these clients than the intensive care staff. McLaughlin (1995) investigated nursing staff attitudes through a survey that required respondents (n = 95) to describe what they understood by the term 'counselling' and then to prioritise a client's need for intervention using four hypothetical scenarios. Nurses' attitudes to clients who present with suicidal behaviour (mostly by overdosing) were found to be generally positive, with experienced nurses being more positive.

Sidley and Renton (1996) reported similar positive attitudes from a twenty-statement survey relating to clients who deliberately overdose. The survey was completed by 107 nurses (37% response rate) and while the majority of respondents (89%) endorsed the equal rights of these clients to be no less a priority for care, around half (55%) viewed self-harming behaviour as attention seeking and disliked working with this client group. While the response rate of 37% is adequate, the authors noted concern about the representativeness of the sample, and did not comment on the development, validity or reliability of the scale.

Relatively few empirical studies specifically investigated staff attitudes to self-harm. An exception is the study by Huband and Tantam (2000) with 213 clinical staff in the United Kingdom (55% response rate). A factor analysis of the scale identified a five-factor solution that accounted for 45% of the total variance, with loadings which ranged from 0.4 to 0.78. Of the key factors, the perception of control was dominant. Many staff (75%) reported that self-harm was difficult to manage and 65% felt it would be difficult to build a relationship with clients.

Studies have consistently reported that ED nurses experience a high degree of ambivalence, frustration and distress about self-harming clients (Alston & Robinson 1992, Palmer 1993, Hemmings 1999). While self-harm clients may evoke negative attitudes such as anxiety, anger and an absence of empathy, Boyes (1994) argued that staff reports frustration at their inability to 'cure' the patient. Although these attitudes may be unconscious, clients may sense rejection through the nurse's demeanour and manner. These findings are particularly important because a response of rejection or hostility may prompt further suicidal behaviour (Hemmings 1999). Emergency work is often carried out without cues of context: clinicians do not know the person or their world and they usually do not know what happens to the

client afterwards. This lack of context, according to Deiter and Pearlman (1998) can feel like an assault on identity, leading providers to question why they do this work or to question their effectiveness.

Further research on staff attitudes to clients who self-harm is required. There are few empirical studies of staff attitudes that have used reliable and valid measures specifically targeting self-harm. Of the studies reviewed, only one (Huband & Tantam 2000) reported on tool development, steps taken to enhance content validity, and reliability. The majority of work has been conducted in the United Kingdom and United States of America.

THE STUDY

Aims

To develop and test a valid and reliable scale to identify relevant components of nurses' attitudes to clients who present with self-injury, and the perceived effectiveness of the nurse's role in the Australian context.

Method

Questionnaire development

The development of the questionnaire occurred in three phases. First, an extensive review of the literature was undertaken to identify major issues related to nurses' attitudes, perceived role and quality of care in relation to self-harm. Second, a focus group interview was conducted with ten postgraduate students enrolled in a Master of Emergency Nursing program. Participants explored how nurses working in emergency departments respond to clients who present with self-harm; what physical, psychological and social interventions are provided, and their perceived effectiveness. This process assisted the development of the

survey tool items. Finally, the tool was piloted in one agency (n = 20), adjusted and redrafted to ensure face and content validity.

The Attitudes Towards Deliberate Self- Harm Questionnaire (ADSHQ) consists of 33 items on a four point Likert scale, ranging from 1 = strongly disagree to 4 = strongly agree. In order to reduce response bias one third of items were phrased in the negative direction. In addition to the attitude scale, respondents were also requested to provide socio-demographic information on their age, education level, years of nursing experience, extent of personal and professional experience with people who self-harm and any specific training in relation to self-harm.

Sample

Nurses working within 23 major public and 14 major private emergency departments in Queensland, Australia were surveyed. Large hospitals that typically employed approximately 40 nurses in the Emergency Department and smaller agencies that employ approximately 20 nurses were randomly selected for survey.

Ethical issues

Ethical clearance was provided by the University Human Research Ethics Committee, but in many instances, ethical clearance and permission to access emergency nurses was also required from each agency. This process took almost six months.

Data collection

Once agency approval was received the research team telephoned a designated contact person in each agency seeking their assistance in distributing questionnaires and encouraging completion. Information sheets and survey forms were delivered to each agency contact person for distribution to potential participants, along with stamped self-addressed envelopes. Participants were instructed to complete the questionnaire with no help from outside sources.

In order to improve response rates, the contact person was given a follow-up telephone call a week after the questionnaire was mailed. The study was conducted from January until December 2000.

Data analysis

The Statistical Package for the Social Sciences (SPSS), version 10 for Windows (SPSS, 2000) was used for all data analysis. Prior to analysis, SPSS DESCRIPTIVES and SPSS FREQUENCIES were used to examine the data for missing values, and fit between the variables' distributions and the assumptions of multivariate analysis. The relationships between categorical variables were examined using chi-square analyses, between continuous variables using Pearson product moment correlation test and between categorical and continuous variables using one-way analysis of variance. The psychometric properties of the ADHQ were assessed using Cronbach's alpha for reliability. An orthogonal (varimax) rotation was performed through SPSS FACTOR on the 33 items of the ADHQ. Factor and total scores on the ADHQ were calculated.

RESULTS

A total of 352 (35.42%) completed questionnaires were returned. Some respondents failed to provide all demographic details and were listed as 'missing' on the database. With regard to education level achieved, 75% (n = 260) of respondents had completed either a 3-year or higher tertiary degree. A further 16% (n = 55) indicated they had completed at least a year 12 level of education.

On average, respondents had 17 years nursing experience (mean = 17.3 years, range 1 –47 years, sd = 20 years). The average length of experience in the Emergency Department was nearly eight years (mean = 7.9, range 1 – 35 years, sd = 10 years). The nursing experience in

the hospital setting was a little over two times higher than that of experience in the accident and emergency setting.

Respondents were asked to indicate whether they had either personal or professional experience with people who engage in DSH, and whether they had any special training in dealing with people who self-harm. The majority of respondents (90.1%, $n = 317$) had no formal training in managing clients who deliberately self-harm, yet 96.3% ($n = 339$) of respondents indicated professional experience with people who deliberately self-harm. Moreover, just over one third (36.1%) of respondents indicated personal experience with people who deliberately self-harm.

Attitudes to deliberate self-harm questionnaire

All responses to items on the ADSHQ were summed. Negatively worded items, such as, “dealing with self harm patients is a waste of time” were reversed scored, that is, responses marked 1, 2, 3, or 4, are scored as 4, 3, 2, and 1 respectively. The total score on the ADSHQ was calculated as the sum of the ratings for the 33 items (possible score range =33-132). The mean total score for this sample was 65.16 ($sd = 4.38$, range = 46-87) indicating a generally negative attitude towards clients who deliberately self harm. A factor analysis was conducted on responses to the Attitudes to Deliberate Self-Harm Questionnaire (Tabachnick & Fidell 1989). Due to missing data in the returned questionnaires, a number of respondents were screened out leaving a total sample of 256 cases. A check of the component correlation matrix, produced through an oblique rotation, indicated that factor correlations were low and therefore an orthogonal (varimax) rotation was more appropriate to identify item loadings. Sampling adequacy ($KMO = .711$) and factorability of the correlation matrices (Bartlett’s test of sphericity $\chi^2 (528) = 2082.04$, $p < .001$) were both adequate. With an $\alpha = .001$ cut-off

level, nine of the 256 participants produced scores that identified them as univariate outliers and were therefore deleted from the principal components extraction, leaving a total of 249 cases in the analysis.

Four factors were extracted which accounted for approximately 36 percent of the total variance. With a cut of 0.40 for inclusion of a variable in interpretation of a factor, five of the 33 variables did not load on any factor. A further two items had non-simple solutions, and were deleted from the final solution. Means, standard deviations and ranges for the sum of items for the total scale and extracted factors are shown in Table 1. Loadings of variables on factors, percents of variance and eigenvalues for each factor are shown in Table 2. Loadings under 0.40 (approximately 18% of variance) are replaced by blanks. Loadings on each factor range from 0.406 to 0.766, with the majority around 0.60.

Insert Table 1 about here

Items measuring perceived confidence in assessment and referral of self-harm clients (Factor 1) accounted for 12.99% of the total variance. Nine variables loaded onto this dimension and relate to how well respondents believe they are able to assess self-harm and provide appropriate referral based on knowledge of referral services. Higher scores on this dimension (score range = 4-36) indicate a perceived ability to assess self-harm clients and provide appropriate referrals. Factor 2, comprising six items, accounted for 10.64% of the total variance, included items that reflected how well respondents believe they deal with self-harm clients. Higher scores on this dimension (score range = 4-24) indicate a perceived increased ability to deal with self-harm clients. The five items on Factor 3 related to empathy towards

self-harm clients. Higher scores on this dimension (score range = 4-20) indicated an empathic attitude. This dimension accounted for 6.97% of the total variance. Factor 4 accounted for 6.03% of the total variance. This dimension included six items (score range = 4-24) that reflected the nurses' perceived ability to cope effectively with legal requirements and hospital procedures that guide practice with self-harm clients.

Insert Table 2 about here

Reliability of the total scale and the four factors using Cronbach's alpha was relatively low ($\alpha = 0.4237$) and suggests that the scale captures four uncorrelated dimensions of attitudes towards deliberate self-harm. The scale reliability of each dimension was much higher (Dimension 1 $\alpha = 0.7129$; Dimension 2, $\alpha = 0.7381$; Dimension 3, $\alpha = 0.6747$; and Dimension 4, $\alpha = 0.5706$).

Further analysis was conducted to identify any associations between respondent characteristics and attitudes to clients who deliberately self-harm. These areas included years of nursing experience, ED experience, personal experience with someone who deliberately self-harms, and type of health service.

Using Pearson's correlation coefficient there were no significant correlations found between years of nursing experience and ADASHQ total score or factors. Significant correlations ($r = -.154$, $p < .05$) were found between years of ED experience and ADASHQ total score, and years of ED experience and an empathic approach towards DHS clients ($r = -.178$, $p < .01$).

There were no statistically significant correlations found between personal experience and total score or factors.

The influence of type of health service on staff attitudes to clients who deliberately self-harm were assessed by first placing services in large and non-large categories. A one way ANOVA identified two significant differences with staff in large hospitals scoring significantly lower on Factor 1 (lower perceived ability to assess and refer DSH clients) ($F(1,241) = 4.039, p < .05$), and staff in large hospitals scoring significantly lower on Factor 3 (less empathy towards DSH clients) ($F(1,241) = 4.436, p < .05$).

DISCUSSION

Results demonstrate that attitudes towards clients who deliberately self-harm are complex and multi-dimensional. The ADSHQ identified four dimensions that help to explain variations in nurses' attitudes towards self-harm. These dimensions are: perceived confidence in assessment and referral; ability to deal effectively with clients, empathic approach; and ability to cope effectively with legal and hospital regulations that guide practice. Nurses scoring higher on the four dimensions of ADSHQ are more likely to feel positive toward people who self-harm and the care they provide. Consequently, one might propose that where these dimensions are present, clients would similarly feel more positive towards the health care experience.

The four dimensions extracted on the ADSHQ accounted for approximately 36 percent of the total sample variance. This would constitute a medium effect (Cohen 1988) in the prediction of attitudes. Results from the factor analysis revealed that if staff perceive themselves as skilled to address the needs of clients who deliberately self-harm, they are more likely to feel

worthwhile working with such clients and less likely to demonstrate negative attitudes. This is particularly relevant when we consider the work of Malone (1996) who concluded that ED clinicians tend to feel they are doing nothing for such clients except treating symptoms.

While the scale achieved a degree of accuracy and consistency in measuring attitudes towards self-harm, further research using a larger sample is warranted.

Nurses' characteristics and attitudes to deliberate self-harm

No significant associations were found between attitudes and respondent characteristics of years of nursing experience, ED experience, or experience with someone who deliberately self-harms. However, staff in large hospitals indicated a lower perceived ability to assess and refer DSH clients, and had more negative attitudes towards them than those working in small settings. These findings further support the need to provide nurses, especially those working in large hospitals, with practical knowledge in relation to assessment, therapeutic responses, referral sources and practice regulations in relation to deliberate self-harm. Further research is indicated to explore more thoroughly the differences in care provided in large and small emergency services.

Personal experience and formal training

Queensland Emergency Departments perceived a lack of specialised education and training. Although nurses are frequently required to respond to clients presenting because of deliberate self-harm, most have no formal training or specialised preparation for this care.

Without focused skills training and deeper understanding of the complexity of self-harm and therapeutic responses of emergency clinicians, nurses are likely to provide inadequate emergency care for clients. Melville and House (1999) found that this inadequate care

comprises incomplete documentation of client needs including mental state, reasons for self-harm, suicidality and therapeutic responses provided. The effect on clients is likely to be further dissatisfaction with care, reluctance to use emergency services again, and avoidance of all health services (Dennis et al. 1990, Ryan et al. 1998). Consequently, morbidity and mortality rates related to untreated self-harm are likely to increase.

Incomplete assessment has three times the risk of repetition of self-harm (Crawford & Wessely 1998). Risk of repetition can also mean risk of suicide is increased. People who self-harm are 18 times more likely than the general population eventually to commit suicide (Ryan et al. 1997). Hickey et al. (2001) found that up to 58% of presenting clients are not assessed accurately and that non-assessed clients may be at greater risk of further self-harm and completed suicide than those who are assessed. Hospital services need to be organised such that self-harm clients managed in ED receive an assessment of psychosocial problems and risk.

It is imperative that nurses are skilled to perform and record a thorough risk assessment and emergency response to clients who self-harm. Even short educational sessions can make a difference. Crawford et al. (1998) found that even after a one hour teaching session, staff were more likely to assess accurately.

Perceived effectiveness of the nursing role

The ADShQ also assessed nurses' perceived confidence in providing care to clients who deliberately self-harm. Interestingly, there was no correlation between perceived confidence and age, years of experience in nursing, or specific ED experience. Respondents were more likely to agree that they felt helpless in dealing with the problems of clients who deliberately

self-harm. This is similar to the findings of Hemmings (1999) who found a high degree of ambivalence, frustration and distress about self-harming clients. Deiter and Pearlman (1998) argued more strongly that helplessness in staff is actually traumatising for them.

Clinicians who are traumatised may have difficulty regulating emotions, become more sensitive to violence, become numb, feel less self worth, or have difficulty keeping a connection with others. Deiter and Pearlman (1998) recommend that clinicians working with self-harm clients require education, supervision and training from professionals with expertise in psychological trauma. Again, our study confirms the need to provide emergency staff with access to tertiary education and in-service education to enhance their intervention and therapeutic skills. The content and process of educational programs could address deficits identified by Melville and House (1999) in relation to psychosocial assessments, mental state, reasons for self-harming, and testing for the presence or absence of suicidal thoughts. Deiter and Pearlman (1998) recommend that clinicians try to gain a meaningful balance in their personal and professional lives. In relation to the present study, we recommend that curricula include information and guided skills practice to: develop confidence, not just in assessment but in referral to follow up services; build empathy; and increase familiarity with the legal and institutional regulations, which can be used to safeguard clinician and client.

Future research

This study has provided a useful snapshot of perceptions held by ED nurses in Queensland, Australia, who provide care to the population of people who self harm. The study forms the basis for future research efforts aimed at determining the ways in which these perceptions influence clinicians' responses to patients and the care provided. Further research is needed to validate the various dimensions of the ADSHQ with a large sample, across time and across

different nursing groups. Dimensions of the questionnaire may also be useful as baseline measures in an intervention study to assess the effectiveness of an education program targeting attitudinal change. There is clearly a need to identify factors that influence nursing practice and are modifiable with appropriate intervention. Future research in this area could investigate the extent to which nurses are traumatised by distressing client behavior. Action based research could implement and evaluate restorative changes to the workplace in order to build professional efficacy and perceived helpfulness. Furthermore, a systematic evaluation of institutional policies and procedures could be undertaken to ensure that such procedures enhance rather than hinder care.

Study limitations

The limitations of the study were that the response rate (35.42%) was moderate and, importantly, the relationship between attitudes and actual nursing care was not examined in this study. Moreover, perceptions of nursing care may vary with those of service users, managers and multi-disciplinary team members.

CONCLUSION

This questionnaire exploring attitudes to deliberate self-harm identified four dimensions that help to explain variations in Queensland emergency nurses' attitudes. Nurses scoring higher on the four dimensions are more likely to feel positive toward people who self-harm and the care they provide. Consequently, one might propose that where these dimensions are present, clients would similarly feel more positive towards the health care experience. There is a need for continuing professional development activities to address negative attitudes and provide practical strategies to inform practice and clinical protocols.

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Table 1 Means, Standard Deviations, and Range for Total Scale and Extracted Factors

ADSHQ	Mean	SD	Range
Total Scale (sum of item scores)	65.16	4.38	46-87
Factor 1: Perceived confidence in assessment and referral of DSH clients	25.76	2.68	17-32
Factor 2: Dealing effectively with DSH clients	14.37	2.80	6-23
Factor 3: Empathic approach	11.02	2.39	5-19
Factor 4: Ability to cope effectively with legal and hospital regulations that guide practice	14.02	2.41	7-22

Table 2 Orthogonally Rotated Factor Loadings of the Attitudes To Deliberate Self-Harm Questionnaire Items

ADSHQ Item	F 1	F 2	F 3	F 4	Item mean	sd
30. Clients who deliberately self harm are in desperate need of help	.633				3.22	.58
28. Providing deliberate self harm clients information about community support groups is a good idea	.618				3.32	.55
19. Ongoing education and training would be useful in helping me deal appropriately with deliberate self harm clients	.586				3.35	.59
12. Knowledge of referral sources is important when dealing with deliberate self harm clients	.583				3.55	.51
20. Risk assessment is an important skill for me to have	.575				3.35	.56
29. Self harm clients are victims of some other social problems	.558				3.00	.54
24. Referral of DSH clients to external consultant services for further assessment or treatment is an effective course of action	.429				3.05	.65
17. Clients who deliberately self harm have been hurt and damaged in the past	.424				2.91	.66
23. I have the appropriate knowledge in counselling skills to help deliberate self harm clients		.766			2.08	.69
26. I have the appropriate knowledge in communication skills to help deliberate self harm clients		.717			2.45	.69
15. I deal effectively with deliberate self harm clients		.684			2.64	.65
5. I often feel helpless in dealing with the problems of DSH clients		-.595			2.83	.75
1. Overall, I am satisfied with the control I have in dealing with deliberate self harm clients in my unit		.564			2.67	.79
8. I feel useful when working with deliberate self harm clients		.430			2.36	.68
21. Clients who deliberately self harm are just attention seekers			.660		2.10	.69
11. Self harm clients just clog up the system			.649		2.07	.77
2. There is really no way I can help solve some of the problems the deliberate self harm patient has			.614		2.64	.81
25. Self harm clients are just using ineffective coping mechanisms			.562		2.45	.68
14. Dealing with self harm clients is a waste of the health care professional's time			.457		1.75	.66
16. The hospital system impedes my ability to work effectively with deliberate self harm clients				.647	2.28	.60
6. Sometimes I feel used by the hospital system				.586	2.36	.85
31. The legal system impedes my ability to work effectively with deliberate self harm clients				.558	2.11	.56
9. The way the hospital system works encourages repetition of deliberate self harm behaviour				.537	2.45	.79
22. Sometimes, when all other actions have failed, I feel the need to go to extremes when dealing with deliberate self harm clients				.448	2.17	.67
32. I feel that clients who self-harm are treated less seriously by the medical staff than clients with medical problems				.406	2.64	.74
Eigenvalue	4.288	3.511	2.242	1.990		
Percentage of total variance accounted for	12.99	10.64	6.79%	6.03		