Review

Staff attitudes, beliefs and responses towards self-harm: a systematised literature review

Pat Akinola; RMN. Gillian Rayner, Community Health and Midwifery, University of Central Lancashire, Preston, UK, Correspondence to: Gillian Rayner (GRayner@uclan.ac.uk)

Received: 28 January 2020; Revised: 10 June 2020

Abstract

Introduction/Aims Self-harm is a growing issue and remain a complex phenomenon in contemporary society. Understanding this behaviour may present challenges to staff providing care and support to patients who self-harm. There is an absence of a detailed review on staff attitudes, beliefs and responses towards self-harm; therefore the aim of this review was to explore and critically appraise research on how staff attitudes impact on care provision.

Methods Electronic databases were searched and relevant literature were critically analysed to gather evidence to address this review.

Results This review identified lack of training, staff support and limited resources as contributory factors to negative attitudes and hostility towards self-harm patients.

Conclusions Reasons for self-harm may be misconstrued, resulting to unhelpful responses and clients being ascribed stigmatising labels. Understanding factors that contribute to these unhelpful responses, allows for the development of core strategies that enhances effective care.

Key words

Beliefs, Education, Responses, Staff attitudes, Self-harm, Training

Introduction

Self-harm occurs across a wide spectrum of the population and continues to gain attention in contemporary society (Sandy, 2013). The National Institute for Health and Clinical Excellence (2011) defined self-harm as any act of self-poisoning or self-injury, carried out by an individual irrespective of their motivation. The most common form of self-harm as identified across studies involves cutting (Nock, 2010); however, starving, burning, hitting, breaking of bones, scratching and interfering with wound healing have also been identified to be other forms of self-harm (Wood and Craigen, 2011).

Self-harm has become prevalent and is a growing concern in the United Kingdom as well as other countries across the globe (James et al, 2012; Hay et al, 2015). Countries such as Canada and Australia have identified self-harming behaviour as a critical mental health issue and a major public health concern, especially among young adults (McAllister et al, 2008; Lewis et al, 2015) from the study on the Child and Adolescent Self-Harm in Europe (CASE Study), carried out in six European countries, namely Belgium, England, Ireland, Hungary, Norway, Netherlands and Australia, reported prevalence rates of self-harm of 13.5% for females and 4.3% for males, indicating more prevalence in females than in males (Madge et al, 2008). The Royal College of Psychiatrists (2010) found that the incidence of self-harm has been on the increase over the past 20 years and self-harm has been identified to be one of the top five causes of acute hospital admissions in the United Kingdom (Allen, 2007; Rees et al, 2015). According to Rees et al (2014), the UK has one of the highest rates of self-harm incidents in Europe, at 400 per 100 000 of the population (Rees et al, 2014; 2015).

Self-harm may be viewed in a negative way by staff as a 'manipulative' and an 'attention-seeking' behaviour (Rayner et al, 2005; Sandy, 2013). This has been reported to result in health professionals engaging in a variety of prejudicial attitudes and stigmatising behaviours, which impact on treatment processes and outcomes for individuals who self-harm (Mitten et al, 2016). Rayner et al (2005) stated that negative responses from staff may have been exacerbated by a lack of knowledge. The patients may be given a diagnosis of 'borderline personality disorder (Rayner et al, 2005). McHale and Felton (2010) noticed in their literature review that there continues to be negative attitudes displayed towards people who self-harm, and patients have reported dissatisfaction regarding staff attitudes and the care they received.

Since it is a commonly held view by staff that people who self-harm are diagnosed with a personality disorder **[**Rayner et al, 2005**],** it is worth considering what the term personality disorder means and if patients do have the diagnosis. Personality disorders are defined as enduring patterns of behaviour and inner experience that causes significant distress and disrupts social and occupational functioning (Davison et al, 2004). Personality disorder types were included in the Diagnostic Statistical Manual V (American Psychiatric Association, 2013); however, the DSM V personality disorder constructs are far too complex (Verheul, 2012) and there is no empirical justification for the number of criteria needed to make a personality disorder diagnosis as studies show that patients who fall one criterion below threshold are no longer considered to have a diagnosis (Skodol et al, 2011) It is therefore crucial for staff to understand patients behaviour and provide the needed care rather than label them as 'PDs'.

Other stigmatising labels commonly used by staff include referring to patients as 'cutter' or 'self-injurer' (Rayner et al, 2005). Such labelling, as suggested by Dickinson and Hurley (2012), means casting judgement on the clients, including a display of lack of positive regard, which can prevent clients who self-harm from seeking help. If staff continue to stigmatise clients who self-harm, they are unlikely to be able to engage and sustain positive therapeutic relationships with them (Rayner et al, 2005).

Rationale for review

Given the pervasiveness of self-harming behaviour and unhelpful responses from staff providing care, interest in achieving better outcomes for patients has grown, with research carried out to examine the reasons for self-harm (Wood and Craigen, 2011; Sandy, 2013; Doyle et al, 2015; Lewis et al, 2015), staff attitudes towards it and the effectiveness of professional interventions (Hadfield et al, 2009; McHale and Felton, 2010; Cleaver et al, 2014; Karman et al, 2015). However, there is an absence of a detailed review on staff attitudes, beliefs, responses and the effect these have on care provision.

Studies on the subject of self-harm and intervention programmes are diverse (Cooke and James, 2009; Egan et al, 2012; Kool et al, 2014). There have been few reviews that systematically summarised and organised the literature on staff knowledge and interventions for working with people who self-harm (Saunders et al, 2012). Rees et al (2015) provided a systematic review on the perceptions of paramedic and emergency care workers of those who self-harm. Cleaver et al (2014) published a scoping review of attitudes of emergency care staff towards young people who self-harm. Research has been carried out on the impact of educational interventions on staff attitudes and improvement in knowledge (Conlon and O'Tuathail, 2012; Saunders et al, 2012; Muehlenkamp et al, 2013; Wheatley and Austin-Payne, 2009); however, negative attitudes are still widely held by staff towards patients who self-harm. This is indicative of gaps in staff knowledge and suggests lack of specific training on core competencies and skills required to provide care effectively. This study therefore provides a critical review and appraisal of the literature on staff attitudes towards self-harm and suggests recommendations for effective interventions by identifying essential components that need to be incorporated in training curricula. When applied, these key components will enable staff in the health and social care sector to deliver care effectively to those who self-harm.

Methods

The MEDLINE, PsycINFO and CINAHL databases were searched for relevant articles on self-harm, selected search words and terms such as 'self-harm', 'self-mutilation', 'staff attitudes', 'staff beliefs', 'staff responses', 'staff perceptions', 'nurses attitudes' and 'healthcare professionals attitudes' as well as using the Boolean operators, 'AND' and 'OR'. Further searches were carried out on the Cochrane Library Database. The wildcard symbol (?) was used in substituting one or more letters in the search term (Schmidt and Brown, 2015) and truncation mark (*), was also applied to the search for variations in keywords (Gerrish and Lathlean, 2015). Using a methodological approach, papers obtained were reviewed thematically (Beck and Polit, 2013; Gerrish and Lathlean, 2015). The Critical Appraisal Skills Programme Tool (2013) was used to appraise the quality, authenticity and credibility of findings from the literature selected, analysing their strengths and weaknesses.

Inclusion and exclusion criteria

Although 46 research papers were retrieved for the literature review, a final selection of 19 primary research papers met the inclusion criteria These consisted of publications from 2002–2015.

The search matrix detailed primary research papers on staff attitudes towards patients in a variety of settings. These included doctors and nurses in emergency department units, nurses in acute mental health and secure inpatient units, CAMHS, paramedics and school nurses. (Appendix 1).

Articles that were excluded consist of unpublished researches, articles and journals published before 2002, ensuring that the review is based on the contemporary nursing research field. Studies reporting prevalence of self-harm before 2002 were excluded. Studies focusing on pharmacological interventions for patients who self-harm were also excluded as evidence regarding the effectiveness of such interventions are inconclusive.

Results

Lack of knowledge

Dickinson and Hurley (2012) explored the antipathy of nursing staff who work within secure units, and further confirmed that patients who self-harm were labelled 'personality disordered individuals' or 'PDs', 'attention seekers', 'manipulators' and 'difficult patients'.

Further beliefs held by staff include viewing clients as 'unresponsive' to care (Dickinson and Hurley, 2012) when self-injury is repeated. With this belief, time spent with clients has been considered a waste of time by staff, with further belief that efforts put in to provide care will not yield positive results (Dickinson and Hurley, 2012). If staff consider clients to be 'unresponsive' or 'untreatable', then they are likely to disengage and work with other clients who they deem will get better. Rayner and Warne (2015) found that these feelings and responses by staff not only prevented patients from getting further care but also prevented the formation of a trusting therapeutic relationship with staff.

Although staff may have been reported to display some negative attitudes, if they work within secure or forensic settings, the clients may present with more challenging self-harming behaviours that staff may find difficult to cope with. This has been identified as a contributory factor to stress and burnout, and is linked to increased negative reactions and hostility from staff, impacting on how care is delivered (Dickinson and Wright, 2008; Egan et al, 2012). Thus staff may be shocked or traumatised by the extent of the damage that the client has done to themselves. Therefore, it is important that both staff and clients' reactions and experiences are taken into consideration when understanding the interpersonal process of self-harm (Rayner and Warne, 2015).

Self-harm, labelling and stigma

Stigmatising behaviours from staff, such as ascribing labels to clients who self-harm**,** can result in negative outcomes that precipitates shame, fear, hopelessness, distrust, low self-esteem, social isolation and can prevent individuals from seeking help, treatment and identifying pathways to recovery (Stuart et al, 2012). These negative outcomes, either alone or in combination, impact on the behaviour of individuals who self-harm. In effect, these stigmatising labels, such as 'attention seekers' and 'manipulators' (Sandy, 2013), once internalised, are then applied to the self, resulting in reduced self-esteem and self-efficacy (Mitten et al, 2016). Rayner and Warne (2015) also revealed that based on previous negative experiences of seeking help, patients expected rejection and confirmation that they were worthless, which leads to increased anger, guilt and shame and the individual becomes 'trapped in a maintenance cycle of shame and self-injury'. It can be argued therefore that this cycle of shame reinforces self-injurious behaviour and contributes to secrecy following self-injury.

Attitudes towards self-harm and professionals' perspectives

Nurses in acute mental health and secure inpatient units

O'Donovan and Gijbels (2006) revealed that nurses viewed working with individuals who self-harm as challenging and frustrating especially when the client repeatedly self-harmed**.** Moreover, they reported not having enough time to build therapeutic relationships with the clients because of the busy nature of working in the acute setting (O'Donovan and Gijbels, 2006)

Dickinson and Hurley (2012) used a self-report questionnaire, the Self-Harm Antipathy Scale, to measure the attitudes of nurses and nursing assistants within mental health secure units revealed that staff demonstrated significant higher levels of emotional antipathy towards clients they cared for compared to nurses whose primary nursing registration was in mental health. However, this study identified that education had a positive impact on nurses who displayed lower levels of antipathy. The word 'antipathy' is the opposite of empathy, which underpins the basis on which therapeutic relationship with a client is built (Dickinson and Hurley, 2012). According to Patterson et al (2007a) antipathy is viewed as 'a relatively stable negative individual attitude towards people who self-harm'. With such attitude, the person who has self-harmed is viewed as a member of a stereotyped group by staff with negative emotional associations, thereby prompting a hostile and rejecting behaviour (Patterson et al, 2007). Dickinson and Hurley (2012) suggested that nurses need to re-evaluate their core nursing skills of showing empathy, being non-judgmental and displaying a positive regard to enable them to develop therapeutic communication and aim to build a therapeutic alliance with clients. Furthermore, there is need for both nurses and nursing assistants to have access to educational programmes about self-harm to enable them to care for clients appropriately and therapeutically. As identified in McAllister et al (2002), training in self-harm and relevant educational programmes for nurses from various fields of nursing would, therefore, be an area that will need to be further researched.

Beliefs held by staff regarding clients who self-harm has been linked to attributions they make. Wheatley and Austin-Payne (2009) posited that the attributions we make about ourselves and others, produces specific types of emotional responses based on Weiner's (1986) attributional theory

depending on internal and external situations, stability and controllability. This theory suggests that the higher stability and controllability a patient has, the more possibility that help will be withheld, whereas help will be offered if needs are attributed to uncontrollable factors (Wheatley and Austin-Payne, 2009). The study suggested that views on self-harm are linked to the 'propensity to help and that emotional responses can be a mediating factor' (Wheatley and Austin-Payne, 2009). Sympathy and pity is felt, leading to help being provided if the client is deemed unable to control the precipitants to self-harm. For example, data analysis examining the associations between the attributional variables and emotional responses from staff in the Wheatley and Austin-Payne (2009) study indicated that there were significant associations between control and sympathy and between control and pity. Significant positive correlations were also found between internality and pity and internality and helping, further indicating that self-harm was perceived more as a result of external factors in association with higher pity and helping scores.

Staff in the study by Wheatley and Austin-Payne (2009) who reported negative attitudes working with clients who self-harm also reported being more worried about providing care for this client group. For example, unqualified nursing staff reported more negativity and being more worried about working with clients who self-harm than qualified staff. Wheatley and Austin-Payne (2009) identified gaps in staff knowledge, prompting the need for training, ongoing staff development and supervision, to give staff a comprehensive knowledge of causes, functions and prevalence of self-harm and to enable staff to feel more positive and provide care therapeutically.

McCarthy and Gijbels (2010) used descriptive and correlational design to understand staff attitudes towards self-harm. They looked at age, sex, academic achievement and length of working experience in an emergency department unit, and found that nurses held positive attitudes towards individuals presenting to accident and emergency for treatment. They identified that participants who had received training in self-harm and also had a higher educational degree had a statistically significant increased ability to effectively care for people who self-harm. Similar findings were confirmed by Patterson et al (2007a) who developed a psychometric instrument, the Self-Harm Antipathy Scale, to measure nurses' attitudes towards self-harm. Respondents in the study consisted of those attending an 'Approach to self-harm' course and other courses not related to self-harm. Mental health nurses made up the majority of participants in this study; however, some general nurses and social workers were also included (Patterson et al, 2007a).

Findings from Patterson et al (2007a) revealed that participants with previous knowledge of self-harm reported significantly lower antipathy, which was confirmed by comparisons made in the study between nurses trained in the adult nursing field scoring high on antipathy, while those with training in the mental health field had lower antipathy score. According to Patterson et al (2007a), results on factor analysis on competence appraisal, care futility, client intent manipulation, acceptance and understanding and rights and responsibilities indicated that the adult nursing group in the study scored higher on these factors compared with the mental health nurse group. Furthermore, they found that antipathy scores recorded on competence appraisal, care futility and rights and responsibilities were significantly higher with the adult nursing group who had no previous study of self-harm. As such, while nurses with mental health training may be motivated and display a more tolerant attitude resulting from previous knowledge of self-harm, staff with adult nursing training may lack confidence and display a mixture of feelings, which include 'incompetence, powerlessness, empathy and moral judgement' when caring for clients who self-harm. Education and training was therefore identified as important in helping staff who lack awareness to understand the needs and distress experienced by clients who self-harm (Patterson et al, 2007 a, b).

Additionally, experience working with the clients may be influenced by years of experience, education, age, personal characteristics and situational factors (Arbon, 2004; Mackay and Barrowclough, 2005; Patterson et al, 2007 a, b). Staff must be aware that their beliefs, attitudes and perceptions can have a profound effect on clients who self-harm. The effects of social judgement, staff attitudes and the impact it has on the quality of care and treatment provided to clients must be included in the training curricula to promote a greater understanding of the needs and distress experienced by clients who self-harm (Conlon and O'Tuathail, 2012).

Although overall positive attitudes were reported, education and training in self-harm was highlighted as beneficial to staff. Conlon and O'Tuathail (2012) further suggested that education and training will enhance staff understanding and improve responses to clients' problems and needs.

Child and adolescent mental health service nurses'perspectives

Hay et al (2015) focused on the views and opinions of child and adolescent mental health services (CAMHS) professionals. They found that contrary to the negative and hostile attitude displayed by nursing staff to individuals who self-harm, CAMHS professionals displayed positive attitudes towards young people accessing their services. Findings from this research revealed that although the medical model of care was dominant in CAMHS, the CAMHS approach allowed for a variety of interventions to be carried out (Hay et al, 2015). The study highlighted concerns about the inability of professionals outside specialist mental health services to adequately manage self-harm, coupled with negative attitudes and the perception that resources were wasted due to the 'deliberate' nature of self-harm. The study further highlighted the need for continuous training with reflective practice to address negative attitudes and also emphasised the importance of networking and good communication between multidisciplinary teams.

Accident and emergency staff perspectives

McAllister et al (2002) carried out a cross-sectional study in Australia across accident and emergency departments, hospitals and other smaller agencies using the Attitudes Towards Deliberate Self-Harm Questionnaire to identify components of nurses' attitudes towards clients who self-harm. The results confirmed that there was a general negative attitude towards self-harm, especially among nursing staff working in larger hospitals. The majority of respondents in this study reported having no formal training on self-harm and felt helpless in dealing with clients who present with self-harm.

Conlon and O'Tuathail (2012), measured emergency department nurses' attitudes towards self-harm using the Self-Harm Antipathy Scale. The findings revealed that although positive attitudes were displayed towards clients who self-harm, slightly negative antipathy scores were recorded and staff revealed that they lacked experience in mental health knowledge and skills. Respondents also reported feeling frustrated with patients who repeatedly self-harmed and returned to hospital. The nurses also reported that they lacked the required training to effectively care for patients and had doubts about the level of support in place for them (Conlon and O'Tuathail, 2012). Therefore, training on how to conceptualise repeat presentations of

patients who self-harm would be beneficial to staff. This study found a range of contextual factors associated with working with clients who self-harm, including empathy, futility, moral judgement and powerlessness (Conlon and O'Tuathail, 2012). Linked to these are staff perceptions of clients and reasons for self-harming, clients' behaviour towards staff, medical assessments and management of the patient, which may in turn impact on how care is provided.

Research conducted by Hadfield et al (2009) investigated accident and emergency doctors' responses to individuals who self-injure, revealed that doctors focused on treating the body, silenced their own responses and mirrored social and cultural responses to self-harm, feeling helpless and frustrated when treating clients who repeatedly self-harmed. Doctors reported a lack of support from other mental health professionals as their efforts to help were deemed as hopeless because of repeated self-harming behaviour by clients (Hadfield et al, 2009). As a result, feelings of distress, helplessness and powerlessness experienced by doctors were intensified. These findings are consistent with findings from research conducted by Rayner et al (2005, Patterson et al (2007) and Conlon and O'Tuathail (2012) on staff attitudes towards self-harm; therefore, it was deemed important to be able to conceptualise the returning episodes of self-harm as different rather than seeing the client as untreatable. These findings support Hadfield et al (2009) study, which stated that 'many of the accident and emergency doctors expressed feeling helpless, frustrated, and in despair during consultations with people who repeatedly self-harm'. With such responses, the severity of emotional distress being experienced by the patient may not be understood. A mixture of coping with difficult emotions and thoughts as experienced by the staff exists alongside difficulties engaging with the clients because of busy work settings.

Further findings from Hadfield et al (2009) revealed that the accident and emergency doctors felt that other services had the expertise to deal with emotional aspects of self-harm in that, they focused more on treatment of the body. The doctors reported not being skilled in dealing with emotions as this was not the aim of the medical model. This study identified training to be important for accident and emergency doctors, to address their responses to emotional distress that contributes to an individuals' self-injurious behaviour; therefore, the staff response to the clients' emotional distress was important. As with findings from Hadfield et al (2009), participants in O'Donovan and Gijbels' (2006) study felt that the person-centred care they were supposed to provide to clients who self-harm was hindered by the 'dominance of the medical model of care'.

School nurses' perspectives

Cooke and James (2009) explored school nurses' experiences of working with young people who self-harm. They found that participants trivialised self-harm by focusing more on its physical manifestations rather than understanding its functions. School nurses reported feelings of frustration, lack of time, resources and feeling of futility, expressing the need for training that focuses both on theoretical and practical knowledge to ensure care is provided holistically (Cooke and James, 2009).

Discussion

Individuals who self-harm may perceive it as a form of self-help and a self-regulating behaviour that allows them to manage powerful feelings (Sandy, 2013; Berger et al, 2014; Lewis et al, 2015). Staff may consider this differently and have been reported to conceptualise self-harm as a form of 'irrational and pathological behaviour arising from lack of control and as something that must be stopped' (Harris, 2000, Lindgren et al, 2004 cited in Bosman and Meijel, 2008:183. Indeed, Pao (1969) described the possible anxiety experienced by staff following self-injury as 'castration anxiety,' which results to the staff feeling 'impotent' and helpless. This may occur as a result of the cumulative effect of clients' self-injurious behaviours on staff (Pearlman and Saakvitne, 1995) and creating overwhelming feelings of fear, anger, helplessness and feelings of failure (Rayner and Warne, 2015).

Self-harm continues to be a significant public health issue (Hadfield et al, 2009; Doyle et al, 2015). For patients who self-harm, while it may be a spontaneous reaction to a periods of distress without immediate implications, it can contribute to the development of long-term mental health problems, including suicidal intent in later life (Hawton et al, 2012; Moran et al, 2012). The medical model approach adopts a 'reactive' attitude towards illness, which is in contrast to the biopsychosocial model that adopts a 'proactive' and 'holistic' approach to treatment, taking the whole needs of the client into consideration (Gross, 2005; Norman and Ryrie, 2013). Since negative attitudes and responses from staff have led to much antipathy and the assigning of stigmatising labels to individuals who self-harm, it is important to have an understanding of factors that contribute to staff's unhelpful responses to enable the development of strategies that can ameliorate staff attitudes and responses. Such factors includes the perception that patients who self-harm are 'attention seeking' and 'manipulative' (Dickinson and Hurley, 2012; Egan et al, 2012), frustration experienced by staff (Hadfield et al, 2009; Conlon and O'Tuathail, 2012), the perception that clients are untreatable and working with them is a waste of time (Dickinson and Hurley, 2012), thoughts of being a failure resulting from feelings of helplessness to address the emotional aspects of self-harm (Hadfield et al, 2009) and burnout experienced by staff (Sabin-Farrell and Turpin, 2003).

Vicarious traumatization

Tabor (2011) suggests that vicarious traumatisation can disrupt a persons' emotional, cognitive, physical and psychological schemas, resulting to negative interactions with people. Linked to vicarious traumatisation are burnout, secondary traumatic stress, compassion fatigue and traumatic countertransference, which can lead to a range of emotional reactions (McCann and Pearlman, 1990; Figley, 1995; Pearlman and Saakvitne 1995; Jenkins and Baird, 2002). The traumatic effects of clients' self-injury on staff may be a contributory factor to the display of antipathy. Staff dealing with people who self-harm may themselves experience burnout or other lasting psychological effects and may become traumatised over the course of their career (Sabin-Farrell and Turpin, 2003; Tabor, 2011), therefore, staff must be provided with support and training on self-harm which is needed to

enhance self-awareness, help with recognition of their strengths and weaknesses, identify signs of burnout, vulnerability and to seek supervision and support.

Education and training in self-harm

A plethora of both empirical and academic research have been carried out on the subject of self-harm and it has been observed that the majority of studies reported negative attitudes from staff, whereas a few reported positive attitudes (McCarthy and Gijbels, 2010; Conlon and O'Tuathail, 2012; Rayner and Warne, 2015). However, all studies for the present review that reported both negative and positive attitudes highlighted the need for education and training.

A key theme that has consistently emerged throughout the literature is the need for education about self-harm. As a result of the complexities associated with self-harming behaviours, staff need to be adequately trained to meet the needs of clients. Muehlenkamp et al (2013) asserted that staff may experience difficulties responding positively to clients if they lack knowledge, skills and guidance. In addition, Egan et al (2012) suggested that training is essential in gaining knowledge and confidence to be able to treat patients who self-harm effectively.

Berger et al (2014) argued that school teachers play a pivotal role in recognising early warning signs of challenges adolescents face in school and should carry out interventions promptly to avert factors that precipitate self-ham. A few participants from the study found previous training they had was too brief, with less focus on self-injury and acknowledged the need for more training. Therefore, due to the prevalence of self-harm behaviour in schools, teachers require ongoing training and support with resources and policy guidelines that should include both pre-service and in-service education (Berger et al, 2014).

Studies conducted by Muehlenkamp et al (2013) in Belgium on attitudes and training towards self-harm revealed that professionals who received training reported significant improvement in knowledge of working with clients who self-harm. Training thus contributed to increased levels of knowledge about self-harm and empathy. Correspondingly, studies carried out in the Netherlands between 2009 and 2011 by Kool et al (2014) to investigate the effect of training in improving communication and practical skills in caring for patients who self-harm revealed that participants had a better understanding of clients' emotions and behaviours and also had a change in attitude, enabling them to show a more positive attitude towards patients who self-harm. These findings are consistent with findings from a report on the efficacy of a self-harm training programme in Ireland by Arensman and Coffey (2010), which revealed that participants became more aware of self-harm, with enhanced positive attitudes and confidence as a result of the training received.

With education and training, staff will be able to reconceptualise repetitive self-harm and recognise their own beliefs around failure. Since staff may conceptualise the repetition of self-harm as attention seeking and manipulative, they may consider patients as untreatable and view themselves as

failing to meet their needs (Hadfield et al, 2009; Conlon and O'Tuathail, 2012; Dickinson and Hurley, 2012). Thus, it is proposed that people who engage in repetitive self-harm be considered similar to patients with a chronic physical illness such as diabetes. Staff would not expect a patient with diabetes to attend hospital once and then not return for further treatment. They would also be less likely to attribute self-blame for this and show unhelpful rejecting responses. Likewise, people who self-harm may present to hospitals more regularly. The understanding and recognition of how negative emotions and thoughts may affect the behaviour of staff providing care for people who self-harm merits being included in the curricula for self-harm education.

Holistic and therapeutic care

The concept of holistic care requires that care be given to individuals, adopting a biopsychosocial approach (Brooker and Waugh, 2007). This needs to be coupled with a non-judgmental stance, promoting person-centeredness and ensuring clients are involved in decisions about their care (National Institute for Health and Clinical Excellence, 2013). Holistic care further promotes building and maintaining continuity of therapeutic relationships. Rogers (1957) considered that the use of empathy, genuineness, warmth and unconditional positive regard promotes therapeutic gain, which might impact positively on the patient.

Promoting resilience in self-harm

Given the distresses experienced by individuals who self-harm, it is important for staff to promote resilience in practice**.** Resilience is the ability to adapt in the event of experiencing difficulties or facing adversities, which can be achieved by 'overcoming the odds', 'sustaining competence under pressure' and 'recovering from trauma' (Fraser et al, 1999). The early responses that trigger self-harm behaviours in clients across the lifespan requires that staff provide care and communicate compassionately and therapeutically with clients. Barker (2009) found that therapeutic communication involves listening effectively, which allows nurses to fully understand the patient experiences and avoid being judgmental.

Staff support and supervision

Given the complexities involved in effectively working with clients who self-harm, resources to support staff must be made available to enable them provide care effectively, manage their stresses and anxieties, build resilience and avert negative attitudes. Burns and Bulman (2000) suggested that supervision, which involves critical reflection, enables practitioners to realise their potential and help them to improve the standard of care provided to patients. Ongoing clinical supervision is therefore vital in supporting staff to improve their clinical performance, personal and professional development (Clegg, 2001; Mullarkey et al, 2001).

Therefore, there is a need in practice for ongoing staff supervision and support (Karman et al, 2015) including further training to help foster therapeutic care (Gross, 2005). This will enable staff to continue to build trust and rapport (Brooker and Waugh, 2007) and avoid negative beliefs about

clients who self-harm. In turn, staff will be able to manage their thoughts, feelings and behaviours (Brooker and Waugh, 2007) and promote acceptance and understanding (Callaghan et al, 2009), thereby averting the display of antipathy towards clients.

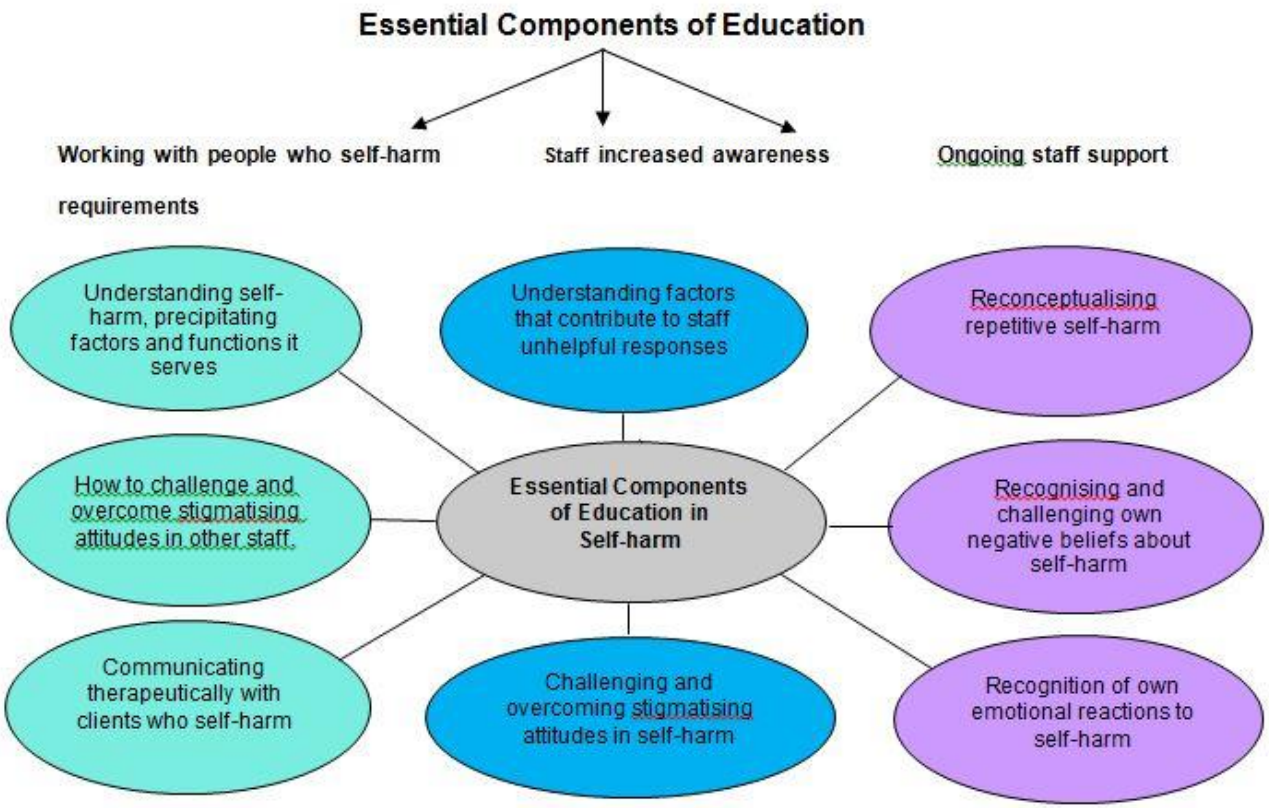
Recommendations for practice

Self-harm: education and training

Education and training has been identified in this literature review as paramount to contributing to quality of care received by individuals who self-harm. In current practice, existing policies need to be re-examined and stakeholders are to ensure that adequate educational programmes and targeted skills that currently address the challenges that individuals who self-harm face are incorporated as part of the curricula for self-harm education and training (Arensman and Coffey, 2010; Muehlenkamp et al, 2013; Kool et al, 2014). Furthermore, in understanding and meeting the needs of individual who self-harm, future research will need to be conducted in relation to reliance on the medical model as opposed to the biopsychosocial model of care. Training for staff should therefore include an awareness of the functions that self-harm serve, issues around confidentiality, theoretical knowledge and practical ways in working with clients who self-harm. This will enable staff to fully understand the complexities involved in working with this client group in order to provide care effectively and holistically.

Figure 1 highlights the essential components of education and training for working effectively with clients who self-harm.

Figure 1. Essential components of education in self-harm.



These essential components provide the basis for understanding the complexities of self-harm as a phenomenon. Since education and training are essential in effective care provision for clients who self-harm (Saunders et al, 2012), it is not enough for staff to have a surface knowledge about self-harm and effective client care. Training content must be structured to help staff have an in-depth understanding of the emotional pain and distress clients who self-harm experience, including how they can be helped to overturn negative views, attitudes and beliefs about self-harm into positive views. This will help staff to work holistically and therapeutically with clients.

Additionally, since most emergency department staff providing care do not have training in the mental health field, they may experience difficulties providing comprehensive psychosocial interventions (McAllister et al, 2008). This is evident as a meta-analysis by Rayner et al (2019) on emergency department staff attitudes towards self-harm revealed that staff did not provide patients the psychosocial support they required to manage

their conditions. It will therefore be beneficial for training designed for emergency department staff to include modules on psychosocial care and interventions.

This review established that despite training received, some nurses and professionals still reported negative attitudes towards clients. Therefore, self-harm training programmes must be monitored and continuously evaluated to ensure that training curricula are constantly updated with the aim of improving staff attitudes. Follow up of post-training assessments must also be conducted to measure the long term impact of training on staff.

Supervision and reflective practice, which involves the continuous analysis of experiences that promotes self-awareness and personal development (Johns, 2013), must be included in training curricula to help staff think more critically about providing care therapeutically and avoid unhelpful responses towards clients. Moreover, continuity must be maintained after training completion, by continuous staff development and support, regular clinical supervision and yearly refresher course to enhance understanding and enable staff explore further difficulties involved working with clients who self-harm.

Promoting resilience in practice is essential to help patients build the strength to deal with distressing emotions rather than resorting to self-harm (McAllister, 2003). The training curricula on self-harm should therefore include how staff can develop more strategic approaches to client communication, focused on helping clients to build their own solutions to difficulties experienced, enabling them overcome stressful situations thereby, helping clients to gain strength and resilience (McAllister et al, 2008).

Furthermore, apart from clinical and non-clinical staff, there are other stakeholders who have been overlooked in most of the literature reviewed. The patient and family dynamics experiences at home, and within the community to an extent, shape the behaviour and attitudes of some patients who self-harm. Being a highly stigmatised behaviour (Rayner, et al, 2005), self-harm may have cultural implications both for the patient and on families. Therefore, there would be need for more attention to be paid to the home setting, for parents to be educated about identifying early signs and triggers in children and young people under their care to facilitate early intervention.

Nursing care and practice

Throughout this review, another constant theme that has emerged is the need for both professional and non-professional staff to be supported to enable them provide care effectively. This review identified limited resources and lack of staff support as a contributory factor to ineffectiveness and hostility towards patients who self-harm (O'Donovan and Gijbels, 2006; Cooke and James, 2009; Timson et al, 2012; Berger et al, 2014). To effectively manage self-harm and support staff, the CARE framework as proposed by McAllister (2003) requires implementation of the following:

- Containment: support from managers and leaders ensuring the availability of resources for staff working with self-harm clients. Identifying gaps in services and effectively managing care
- Awareness: address negative beliefs and attitudes, reflecting with staff in team meetings and during supervision and enabling them to critically analyse their practice.
- Resilience: facilitate staff to build confidence, vicarious resilience and the provision of counselling services to staff who are traumatised by clients' experiences, promoting their health and wellbeing.
- Engagement: to promote reflective practice and experiential learning which enhances personal and professional development that improves clinical practice (Burns and Bulman, 2000; McAllister, 2003; Tabor, 2011).

Additionally, agreed guidelines that must be strictly adhered to should be made available to all hospitals and other health care settings (Saunders et al, 2012). The need to constantly challenge practice is also vital, to avert negative attitudes, responses and facilitate positive attitudes towards clients who self-harm.

Conclusions

The powerful meanings conveyed by self-harm to the individual provides reason for a compassionate and therapeutic approach to be implemented in care provision. The need for education and training, availability of resources, effective provision of care and support for both clients and staff is central to effective interventions and positive outcomes. The subject of self-harm is multifaceted; negative and unhelpful attitudes and responses from staff require further research and understanding. The quality of care for individuals who self-harm will be improved if negative attitudes can be understood, identified and changed. Given the complexities in care provision, the need for education, training, regular supervision and staff support cannot be overemphasised. This is crucial to addressing staff attitudes, treat staff experiences of frustration and helplessness with compassion and contribute to increased knowledge and skills that foster feelings of hope and recovery for individuals who self-harm.

Conflicts of interest

The author declares that there are no conflicts of interest.

Funding

There was no specific funding for this review.

Key points

- Self-harm incidence accounts for one of the top five causes of acute hospital admissions in the UK.
- It is commonly documented that people who self-harm may be given stigmatising labels and may have experienced negative attitudes and unhelpful responses from staff.
- There is an absence of a detailed review on staff attitudes, beliefs, responses and the effect these have on care provision for individuals who self-harm.
- Negative attitudes are still held by staff towards patients who self-harm, which is indicative of gaps in staff knowledge and suggest a lack of specific training on core competencies and skills required to provide care effectively.

References

Allen S. Self-harm and the words that bind: a critique of common perspectives. J Psychiatr Ment Health Nurs. 2007;14(2):172–178. https://doi.org/10.1111/j.1365-2850.2007.01060.x

American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th edn. Arlington (VA); 2013

Arbon P. Understanding experience in nursing. J Clin Nurs. 2004;13(2):150–157. **https://doi.org/10.1046/j.1365-2702.2003.00861.x**

Arensman E, Coffey C. The efficacy of a self-harm awareness training programme. 2010. http://www.hse.ie/eng/services/list/4/Mental_Health_Services/NOSP/Research/evaluationselfharm.pdf (accessed 3 December 2020)

Barker P. Psychiatric and mental health nursing: the craft of caring. 2nd edn. London: Hodder Arnold; 2009

Beck CT, Polit DF. Essentials of nursing research: appraising evidence for nursing practice. Philadelphia (PA): Wolters Kluwer/Lippincott/Williams & Wilkins Health; 2013

Berger E, Hasking P, Reupert A. Response and training needs of school staff towards student self-injury. Teach Teacher Educ. 2014;44(4):25–34. https://doi.org/10.1016/j.tate.2014.07.013

Brooker C, Waugh A. Foundations of nursing practice. Edinburgh: Mosby; 2007

Burns S, Bulman C. Reflective practice in nursing: the growth of the professional practitioner. 2nd edn. Oxon: Blackwell Science

Callaghan P, Playle J, Cooper L. Mental health nursing skills. Oxford: Oxford University Press; 2009

Cleaver K, Meerabeau L, Maras P. Attitudes towards young people who self-harm: age an influencing factor. J Adv Nurs. 2014;70(12):2884–2896. https://doi.org/10.1111/jan.12451

Clegg A. Occupational stress in nursing: a review of the literature. J Nurs Manag. 2001;9(2):101–106. **https://doi.org/10.1046/j.1365-2834.2001.00216.x**

Conlon M, O'Tuathail C. Measuring emergency department nurses' attitudes towards deliberate self-harm using the self-harm antipathy scale. Int Emerg Nurs. 2012;20(1):3–13. https://doi.org/10.1016/j.ienj.2010.08.001

Cooke E, James V. A self-harm training needs assessment of school nurses. J Child Health Care. 2009;13(3):260–274. https://doi.org/10.1177/1367493509337440

Critical Appraisal Skills Programme Tool. 10 questions to help you make sense of qualitative research. 2013. http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf (accessed 3 December 2020)

Davison G, Neale J, Kring A. Abnormal psychology. 9th edn. New York: Wiley; 2004

Dickinson T, Wright K. Stress and burnout in forensic mental health nursing: a literature review. Br J Nurs. 2008;17(2):82–87. https://doi.org/10.12968/bjon.2008.17.2.28133

Dickinson T, Hurley M. Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. J Adv Nurs. 2012;68(1):147–158. https://doi.org/10.1111/j.1365-2648.2011.05745.x

Doyle L, Treacy M, Sheridan A. Self-harm in young people: prevalence, associated factors and help seeking in school going adolescents. Int J Ment Health Nurs. 2015;24(6):485–494. https://doi.org/10.1111/inm.12144

Egan R, Sarma KM, O'Neill M. Factors influencing perceived effectiveness in dealing with self-harming patients in a sample of emergency department staff. J Emerg Med. 2012;43(6):1084–1090. https://doi.org/10.1016/j.jermermed.2012.01.049

Fraser M, Richman J, Galinsky M. Risk, protection and resilience: toward a conceptual framework for social work practice. Soc Work Res. 1999;23(3):131–143. https://doi.org/10.1093/swr/23.3.131

Figley CR. Compassion fatigue as secondary traumatic stress disorder: an overview. In: Figley CR (ed). Compassion fatigue: coping with secondary traumatic stress disorder in those who treat the traumatized. New York (NY): Brunner/Mazel; 1995:1–20

Gerrish K, Lathlean J (eds). The research process in nursing. 7th edn. Oxford: Wiley; 2015

Gross R. Psychology: The science of mind and behaviour. 4th edn. London: Hodder and Stoughton Educational; 2005

Hadfield J, Brown D, Pembroke L, Hayward M. Analysis of accident and emergency doctors' responses to treating people who self-harm. Qual Health Res. 2009;19(6):755–765. https://doi.org/10.1177/1049732309334473

Harris J. Self-harm: cutting the bad out of me. Qual Health Res. 2000;10(2):164–173. https://doi.org/10.1177/104973200129118345

Hawton K, Saunders KEA, O'Connor RC. Self-harm and suicide in adolescents. Lancet. 2012;379(9834):2373–2382. https://doi.org/10.1016/S0140-6736(12)60322-5

Hay A, Majumder P, Fosker H, Karim K, O'Reilly M. The views and opinions of CAMHS professionals on their role and the role of others in attending to children who self-harm. Clin Child Psychol Psychiatr. 2015;20(2):289–303. https://doi.org/10.1177/1359104513514068

James K, Stewart D, Bowers L. Self-harm and attempted suicide within inpatient psychiatric services: a review of literature. Int J Mental Health Nurs. 2012;21(4):301–309. https://doi.org/10.1111/j.1447-0349.2011.00794.x

Jenkins SR, Baird S. Secondary traumatic stress and vicarious trauma: a validational study. J Trauma Stress. 2002;15(5):423–432. https://doi.org/10.1023/A:1020193526843

Johns C. Becoming a reflective practitioner. 4th edn. Chichester: John Wiley & Sons Limited; 2013

Karman P, Kool N, Poslawsky IE, van Meijel B. Nurses' attitudes towards self-harm: a literature review. J Psychiatr Ment Health Nurs. 2015;22(1):65–75. https://doi.org/10.1111/jpm.12171

Kool N, Van Meijel B, Koekkoek B, Van der Bijl J, Kerkhof A. Improving communication and practical skills in working with patients who self-harm: a pre-test/post-test study of the effects of a training programme. BMC Psychiatr. 2014;14(1):64. https://doi.org/10.1186/1471-244x-14-64

Lewis S, Lumley M, Grunberg P. Early maladaptive schemas and non-suicidal self-injury among young adults: a preliminary investigation. Couns Psychol Q. 2015;28(4):386-402. https://doi.org/10.1080/09515070.2015.1074887

Lindgren, B., Wilstrand, C., Gilje, F., & Olofsson, B. (2004). Struggling for hopefulness: A qualitative study of Swedish women who self-harm. Journal of Psychiatric and Mental Health Nursing, 11, 284–291.

Madge N, Hewitt A, Hawthorn K et al. Deliberate self-harm within an international community sample of young people: comparative findings from the Child and Adolescent Self-Harm in Europe study. J Child Psychol Psychiatry. 2008;49(6):667–677. https://doi.org/10.1111/j.1469-7610.2008.01879

McAllister M, Creedy D, Moyle W, Farrugia C. Nurses attitudes towards clients who self-harm. J Adv Nurs. 2002;40(5):578–586. https://doi.org/10.1046/j.1365-2648.2002.02412.x

McAllister M. Self-harm in the emergency setting: understanding and responding. Contemporary Nurse. 2003;15(1–2):130–139. https://doi.org/10.5172/conu.15.1-2.130

McAllister M, Zimmer-Gembeck M, Moyle W, Billett S. Working effectively with clients who self-injure using a solution-focused approach. Int Emerg Nurs. 2008;16(4):272–279. https://doi.org/10.1016/j.ienj.2008.05.007

McCann IL, Pearlman L. Vicarious traumatization: a framework for understanding the psychological effects of working with victims. J Trauma Stress. 1990;3(1):131–149. https://doi.org/10.1007/bf00975140

McCarthy L, Gijbels H. An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. Int Emerg Nurs. 2010;18(1):29–35. https://doi.org/10.1016/j.ienj.2009.05.005

McHale J, Felton A. Self-harm: what's the problem? A literature review of the factors affecting attitudes towards self-harm. J Psychiatr Mental Health Nurs. 2010;17(8):732–740. https://doi.org/10.1111/j.1365-2850.2010.01600.x

Mackay N, Barrowclough C. Accident and emergency staff's perception of deliberate self-harm: attributions, emotions and willingness to help. Br J Clin Psychol. 2005;44(2):255-267. https://doi.org/10.1348/014466505X29620

Mitten N, Preyde M, Lewis S, Vanderkooy J, Heintzman J. The perceptions of adolescents who self-harm on stigma and care following inpatient psychiatric treatment. Social Work Mental Health. 2016;14(1):1–21. https://doi.org/10.1080/15332985.2015.1080783

Moran P, Coffey C, Romaniuk H et al. The natural history of self-harm from adolescence to young adulthood: a population-based cohort study. Lancet. 2012;379(9812):236–243. https://doi.org/10.1016/S0140-6736(11)61141-0

Muehlenkamp J, Claes L, Quigley K et al. Association of training on attitudes towards self-injuring clients across health professionals. Arch Suicide Res. 2013;17(4):462–468. https://doi.org/10.1080/13811118.2013.801815

Mullarkey K, Keeley P, Playle JF. Multiprofessional clinical supervision: challenges for mental health nurses. J Psychiatr Ment Health Nurs. 2001;8(3):205–211. https://doi.org/1046/j.1365-2850.2001.00376.x

National Institute for Health and Clinical Excellence. Self-harm in over 8s: long-term management [CG 133]. 2011. https://www.nice.org.uk/guidance/cg133/chapter/Introduction (accessed 31 August 2021)

National Institute for Health and Clinical Excellence. Self-harm [QS34]. 2013. http://nice.org.uk/guidance/qs34 (accessed 27 June 2020)

Nock M. Self-injury. Annu Rev Clin Psychol. 2010;6(1):339–363. https://doi.org/10.1146/annurev.clinpsy.121208.131258

Norman I, Ryrie I (eds). The art and science of mental health nursing: a textbook of principles and practice. Maidenhead: Open University Press; 2013

O'Donovan A, Gijbels H. Understanding psychiatric nursing care with non -suicidal self-harming patients in acute psychiatric admission units: the views of psychiatric nurses. Arch Psychiatr Nurs. 2006;20(4):186–192. https://doi.org/10.1016/j.apnu.2005.12.007

Pao PN. The syndrome of delicate self-cutting. Br J Med Psychol. 1969;42(3):195–206. https://doi.org/10.1111/j.2044-8341.1969.tb02071.x

Patterson P, Whittington R, Bogg J. Measuring nurse attitudes towards deliberate self-harm: the self-harm antipathy scale (SHAS). J Psychiatr Ment Health Nurs. 2007a;14(5):438–445. https://doi.org/10.1111/j.1365-2850.2007.01102.x

Patterson P, Whittington R, Bogg J. Testing the effectiveness of an educational intervention aimed at changing attitudes to self-harm. J Psychiatr Ment Health Nurs. 2007b;14(1):100–105. https://doi.org/10.1111/j.1365-2850.2007.01052.x

Pearlman LA, Saakvitne Karen W. Trauma and the therapist: countertransference and vicarious traumatization in psychotherapy with incest survivors. New York (NY): W.W. Norton; 1995

Rayner G, Warne T. Interpersonal processes and self-injury: a qualitative study using Bricolage. J Psychiatr Ment Health Nurs. 2015;23(1):54–65. https://doi.org/10.1111/jpm.12277

Rayner G, Allen S, Johnson M. Countertransference and self-injury: a cognitive behavioural cycle. J Adv Nurs. 2005;50(1):12–19. https://doi.org/10.1111/j.1365-2648.2005.03344.x

Rayner G, Blackburn J, Edward K-L, Stephenson J, Ousey K. Emergency department nurses attitudes towards patients who self-harm: a meta-analysis. Int J Mental Health Nurs. 2019;28(1):40–53. https://doi.org/10.1111/inm.12550

Rees N, Rapport F, Thomas G, John A, Snooks H. Perceptions of paramedic and emergency care workers of those who self-harm: a systematic review of the quantitative literature. Journal of Psychosomatic Research. 2014;77(6):449–456. doi: https://doi.org/10.1016/j.jpsychores.2014.09.006

Rees N, Rapport F, Snooks H. Perceptions of paramedic and emergency staff about the care they provide to people who self-harm: constructivist meta-synthesis of the qualitative literature. J Psychosomatic Res. 2015;78(6):529–535. https://doi.org/10.1016/j.jpsychores.2015.03.007

Rogers CR. The necessary and sufficient conditions of therapeutic change. J Consult Psychol. 1957;21(2):95–103. https://doi.org/10.1037/h0045357

Royal College of Psychiatrists. Self-harm, suicide and risk: helping people who self-harm. 2010. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr158.pdf?sfvrsn=fcf95b93_2 (accessed 31 August 2021)

Sabin-Farrell R, Turpin G. Vicarious traumatisation: implications for the mental health of health workers. Clin Psychol Rev. 2003;23(3):449–480. https://doi.org/10.1016/S0272-7358(03)00030-8

Sandy PT. Motives for self-harm: views of nurses in a secure unit. Int Nurs Rev. 2013;60(3):358–365. https://doi.org/10.1111/inr.12038

Saunders K, Hawton K, Fortune S, Farrell S. Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. J Affect Disorder. 2012;139(3):205–216. https://doi.org/10.1016/j.jad.2011.08.024

Schmidt NA, Brown JM. Evidenced-based practice for nurses: appraisal and application of research. 3rd edn. Burlington (MA): Jones and Bartlett Learning; 2015

Skodol A, Bender D, Morey L et al. Personality disorder types proposed for DSM-5. J Personality Disorders. 2011;25(2):136–169. https://doi.org/10.1521/pedi.2011.25.2.136

Stuart H, Arboleda-Florez J, Sartorius N. Paradigms lost: fighting stigma and the lessons learned. New York (NY): Oxford University Press; 2012

Tabor PD. Vicarious traumatisation: concept analysis. J Forensic Nurs. 2011;48(1):1–12. https://doi.org/10.1111/j.1939-3938.2011.01115.x

Timson D, Priest H, Clark-Carter D. Adolescents who self-harm: professional staff knowledge, attitudes and training needs. J Adoles. 2012;35(5):1307–1314. https://doi.org/10.1016/j.adolescence.2012.05.001

Verheul R. Personality disorder proposal for DSM-5: a heroic and innovative but nevertheless fundamentally flawed attempt to improve DSM-IV. Clin Psychol Psychother. 2012;19(5):369–371. https://doi.org/10.1002/cpp.1809

Weiner B. An attributional theory of motivation and emotion. New York (NY): Springer-Verlag; 1986

Wheatley M, Austin-Payne H. Nursing staff knowledge and attitudes towards deliberate self-harm in adults and adolescents in an inpatient setting. Behav Cognit Psychother. 2009;37(3):293. https://doi.org/10.1017/s1352465809005268

Wood S, Craigen L. Self-injurious behaviour in gifted and talented youth: what every educator should know. J Educ Gifted. 2011;34(6):839–859. https://doi.org/10.1177/0162353211424989

Appendix 1

Search matrix

Author (year)	Study design, sample characteristics and aim	Results	Recommendations
McAllister et al (2002)	Cross-sectional study 352 nurses across accident and emergency departments, hospitals and other smaller To identify components of nurses' attitudes towards clients who self-injure	A general negative attitude was reported towards clients who self-harm especially among nursing staff working in larger hospitals	Education and training need was identified, to provide nurses with practical knowledge in carrying out assessments, responding therapeutically to patients and adhering to practice regulations
Egan, Sarma and O'Neil (2012)	Predictors of perceived personal effectiveness of dealing with self-harming patients.	Knowledge and confidence identified as significant contributors to perceived effectiveness in dealing with self-harming patients	Knowledge of self-harm and confidence dealing with patients leads to positive perceived effectiveness in responding to patients' needs.
O'Donovan and Gijbels (2006)	In-depth semi-structured interview 8 psychiatric nurses in acute psychiatric admission units To gain an understanding of the practices of psychiatric nurses in relation to individuals who self-harm	Participants felt frustrated and hindered by lack of time, inconsistencies of nursing staff and dominance of the medical model	The unpredictability of the acute environment made it difficult for nurses to carry out plans or engage in therapeutic activities. Many factors impacted on the care provided to people who self-harm, such as lack of support structure, clear local and national policies and guidelines

Patterson et al (2007a)	Self-harm Antipathy Scale questionnaire 153 mental health nurses, general nurses and social workers To measure nurses attitudes towards self-harm	Findings from this study revealed that participants with previous knowledge of self-harm reported significantly lower antipathy	The consultation with a panel of 10 clinical and academic expert to examine the Self-harm Antipathy Scale questionnaire instrument coupled with the use of intuitive approach for participants over 12 separate study days added strengths to the study validity
Patterson et al (2007b)	Quasi-experimental design Qualified healthcare professionals, majority of which are mental health nurses To testing the effectiveness of educational intervention aimed at changing attitudes to self-harm	Significant reduction in antipathy towards self-harm among course attenders evident	Reduction in antipathy was linked to educational intervention, which plays a vital role in influencing attitudes
Cooke and James (2009)	Mixed methods design 21 secondary school nurses. To identify and analyse school nurses' training needs	Respondents felt frustrated working with young people who self-harm. They focused more on physical manifestation of self-injury rather than underlying causes	Training needs that includes both theoretical and practical knowledge for school nurse were identified. School nurses with previous training on self-harm reported it provided little help. Therefore, there is a need for ongoing training to enable care to be delivered holistically
Hadfield et al (2009)	Qualitative design	Concerns highlighted by doctors included lacking the skills to address emotions of people who	Training needs to addresses how doctors respond to emotional distress of people who self- harm. Including

	5 qualified doctors working within two accident and emergency departments To explore emergency department doctors responses in treating people who self-ham	self-harm. They therefore silence their emotional responses and mirror cultural and societal responses to self-harm	colleagues with previous self-harm experiences among accident and emergency staff to help doctors have better understanding of self-harm to enable them offer helpful responses
Wheatley and Austine-Payne (2009)	Cross-sectional design 76 nurses in an adult secure inpatient setting To investigate the relationship between unqualified care staff perception of self-harm behaviours and emotional responses and helping behaviours of staff	Staff reported negative attitudes when working with clients who self-harm. The inclusion of unqualified staff among participants for this research was appropriate since their beliefs, level of negativity and needs were identified	Findings from this study suggests training and ongoing supervision as essential to support staff and help them feel less negative towards patients.
McCarthy and Gijbels (2010)	Quantitative and correlational design 8 emergency department nurses To examine emergency department nurses attitudes towards individuals who self-harm	No correlation between gender and being in an emergency department	Key findings reveal that nurses held positive attitudes, especially those with postgraduate education, towards people who self- harm. Education was identified as a contributory factor to positive attitudes. Ongoing in-service training and postgraduate education recommended.
Conlon and O'Tuathail (2012)	Quantitative design 87 registered general nurses	Overall results from the questionnaires indicated slight negative antipathy over positive attitudes. The research indicate	Key findings from this study suggests negative attitude towards patients who self-harm can be influenced by individual

	Measuring emergency department nurses attitudes towards self-harm using the Self-harm Antipathy Scale questionnaire in the Republic of Ireland, and to test the effectiveness of an education intervention, aimed at changing attitudes towards self-harm	that nurses who had previous knowledge about self-harm reported lower antipathy than those who did not	characteristics and situational factors. Education and training on self-harm at both undergraduate and postgraduate level was identified as vital to promoting empathy and positive attitudes towards those who self-injure
Dickinson and Hurley (2012)	Self-report questionnaire using Self-harm Antipathy Scale 47 registered nurses and 22 nursing assistants To compare registered nurses' and nursing assistants attitudes', working with young people who self-harm, within secure units in the United Kingdom	Results from this study indicate that nurses displayed high levels of antipathy towards young people who self-ham. The research indicated that nurses who received education in self-harm, displayed lower levels of antipathy towards the young people	Key findings suggests nurses registered before 1976 and who do not train as mental health nurses showed higher levels of antipathy towards those who self-harm. Nurses working in secure units therefore need to improve in their communication skills and promote therapeutic relationships
Sandy (2013)	Qualitative design using semi-structured interviews 25 registered nurses To explore nurses understanding of the motives for self-harm in a secure adolescent unit in England	Results of the study indicate multiple factors precipitate self-harming behaviors. Motives for self-harm as acknowledged by users include, the regulation of distress, punishing the self, cleansing of the self and to avert death	Findings from this research suggests that nurses perceive individuals who self-harm as manipulators and attention seekers. These beliefs may increase the individuals risk to further self-harm
Cleaver et al (2014)	Mixed methods approach using triangulation	Uncertainty of the period of adolescence identified as having a significant influence on the care that young people who self-harm receive	Previous studies did not address self-harming behaviours in young people within the context of being a young person. Education and training on self- harm identified as important in

.	Purposive sampling of 7 registered nurses and 5 ambulance staff from a pediatric accident and emergency department To determine the attitudes of emergency care staff towards young people aged 12-18 who self- harm and to investigate how being a young person influences attitudes		addressing the values and attitudes staff hold towards young people who self-harm
Hay et al (2015)	Qualitative thematic design 18 CAMHS professionals Exploration of experiences and perceptions of staff engaged in assessing and caring for children and young people who self-harm, within Child and Adolescent Mental Health Services	Clearly defined roles acknowledged by staff as pertinent in ensuring better service delivery. Participants acknowledged interventions carried out by CAMHS as more therapeutic as opposed to the attitudes of other professional outside CAMHS who perceived interventions and resources provided for children who self-harm as a waste due to the perception that children who self-harm carry out the act deliberately	Networking between agencies was identified by professionals as central to help effective communication between multidisciplinary teams
Dickinson and Wright (2008)	Peer reviewed indexed Journals Exploration of stress and burnout in inpatient forensic mental health nursing to identify	Main stressors experienced by forensic nurses are identifies as interpersonal conflicts, workload and lack of involvement in decision making.	Staff are to have access to support systems and managers in forensic settings to promote an open and honest culture to enable staff express their feelings openly or in confidence. Also to encourage staff

	stressors and highlight recommendations.		to rotate wards to increase both their personal and professional development, which may include training on psychosocial interventions.
Stuart et al (2012)	Fighting stigma and lessons learnt	Stigma reduction requires well developed plans.	Improved knowledge about mental illness will eradicate stigma.
Mitten et al (2016)	Cross-sectional design using open-ended interviews Perceptions of adolescents who self-harm, on stigma and care, following inpatient psychiatric treatment	Experiences and reports of stigmatisation from both clinicians and other patients	Attention to be paid to perceived stigma in mental health settings
Mackay and Barrowclough (2005)	Application of Weiners (1980, 1986) Attributional Model of helping behavior to A&E's staff care to patients presenting with self-harming behaviours 89 A&E Medical and nursing staff	The greater the attributions of controllability, the more negativity is shown towards the patient and less propensity to help.	Training to be offered to A&E staff to improve their emotional response in the management of patients who self-harm
Rayner et al (2005)	Countertransference and self-injury	Negative emotional responses from professionals may interfere with the effectiveness of therapeutic relationships	Knowledge of countertransference may reduce negative thoughts and behaviours, resulting to improved client care

Rayner and Warne (2015)	Emotional, cognitive and behavioral effects of self-injury on nurses as helpers Qualitative design using narrative enquiry and reflexivity Purposive sample using pair of 3 clients and staff Exploration of interpersonal processes surrounding self-injury First international study to explore the relationships between self-injury and the cycle of shame	Interpersonal trigger, followed by anger directed to self and staff and the experience of shame resulting to self-injury to numb internal experiences	Further research on interpersonal relationships and cycle of shame in individuals who self-injure required