“That Heart-Sink Moment”: An Interpretative Phenomenological Analysis of Accident and Emergency Doctors’ and Nurses’ Responses to Treating People who Self-Harm.

by

Joanne Hadfield

Volume I

Submitted for the degree of Doctor of Psychology (Clinical Psychology)

Department of Psychology
School of Human Sciences
University of Surrey

July 2007

© Joanne Hadfield 2007
Portfolio - Volume I

Contents

Pages:

Acknowledgements ................................................................................................................................. 4

Academic Dossier

Adult Mental Health Essay
The Course Team is attempting to Involve Service Users and Carers in many Aspects of the Surrey Clinical Psychology Training Programme. With Reference to the Evolving Literature on Involvement in both Training and Research, Explore Ways of Involving Users and Carers in the Programme. What Issues and Dilemmas Might Such Involvement Create? ................................................................................................................................................... 5

Professional Issues Essay
To Consult or Not to Consult.....What is the Role of Consultation in Clinical Psychology Practice? Critically Discuss in Relation to your Clinical Experience so Far ....................................................................................................................... 26

Problem Based Learning Reflective Account – Year 1
The Relationship to Change ...................................................................................................................... 48

Problem Based Learning Reflective Account – Year 2
Child Protection, Domestic Violence and Learning Disabilities ........................................................................................................... 57

Problem Based Learning Reflective Account – Year 3
Universality in Diversity ........................................................................................................................... 70

Summary of Case Discussion Group Process Account – Year 1 ................................................................................................................. 82
Summary of Case Discussion Group Process Account – Year 2 ................................................................................................................. 84

URN: 3445275
Clinical Dossier

Overview of Clinical Placements…………………………………………………………..86

Summary of Adult Mental Health Case Report 1
Summary of Cognitive Behavioural Therapy with a 19 Year Old Woman Presenting with
Emetophobia………………………………………………………………………………..90

Summary of Adult Mental Health Case Report 2
Summary of Cognitive Behavioural Therapy with a 24 Year Old Woman who Experienced
Distressing and Threatening Voices………………………………………………………….95

Summary of Learning Disabilities Case Report 3
Summary of Time-Limited Dynamic Psychotherapy with a 44 Year Old Woman who was
described as having a Learning Disability and was Sterilised Against her Will…………….100

Summary of Child and Adolescent Mental Health Case Report 4
Summary of Cognitive Behavioural Therapy within a Narrative Framework with an 11 Year
Old Boy Presenting with Obsessions and Compulsions……………………………………104

Summary of Older People’s Case Report 5
Summary of Neuropsychological Assessment with a 73 Year Old Woman Presenting with
Memory Difficulties…………………………………………………………………………109

Research Dossier

Service Related Research Project
Audit of the Referral Process within a Primary Care Mental Health Team and Use of the
Stepped Care Approach for Psychology Referrals……………………………………….114

Qualitative Research Project (Abstract)
Little Angels or Tiny Tearaways? The Role of Psychologists in Reality TV……………….144

Research Log Checklist…………………………………………………………………146
Major Research Project

"That Heart-Sink Moment": An Interpretative Phenomenological Analysis of Accident and Emergency Doctors’ and Nurses’ Responses to Treating People who Self-Harm....................148
Acknowledgements

I would like to thank Louise Pembroke for her vested interest in my development throughout the last three years, her support and her encouragement. I am very grateful to all the course team and in particular Dora Brown, Mark Hayward and Arlene Vetere. Furthermore I would like to say a big thank you to my friends, family and boyfriend, Gareth, who have all been great support throughout this part of my journey.
THE COURSE TEAM IS ATTEMPTING TO INVOLVE SERVICE USERS AND CARERS IN MANY ASPECTS OF THE SURREY CLINICAL PSYCHOLOGY TRAINING PROGRAMME. WITH REFERENCE TO THE EVOLVING LITERATURE ON INVOLVEMENT IN BOTH TRAINING AND RESEARCH, EXPLORE WAYS OF INVOLVING USERS AND CARERS IN THE PROGRAMME. WHAT ISSUES AND DILEMMAS MIGHT SUCH INVOLVEMENT CREATE?

November 2004

Year 1

Word Count = 5000
New Government initiatives emphasise the importance of involving service users and their carers in all aspects of mental health services (Department of Health, 1999). This has led to consideration of how to include service users/carers in both the delivery of mental health services and the training of mental health professionals. As a body, Psychology advocates that the service user is the expert of their own experience. Thus it should follow that psychologists can learn a great deal from the experiences of people who use their services.

Currently the Clinical Psychology Training Programme at the University of Surrey is considering ways in which to have greater service user and carer involvement. A working party comprised of service users, members of the course team, a third year trainee and professionals working within local services, is focusing on this process. In the following content, I shall discuss ideas and issues that have arisen from the literature on service user and carer involvement in research and training. I shall use the term carer to encompass carers, family members and significant others in the service user's close social network. In addition, I will offer my own ideas for greater service user/carer involvement on the Surrey course and also draw on my experiences, which will be written in italics.

Firstly I will explore the historical context from which service user/carer involvement arose. I shall then consider how mental health professionals’ attitudes may influence the extent of involvement and discuss the activities of the Surrey working group. Following this, I will explore ways in which service users/carers may be involved in: (i) training; (ii) curriculum, teaching and selection of trainees; (iii) clinical placements; (iv) research; and (v) evaluation and monitoring of the programme.
The involvement of service users and carers in the development of mental health services is an area that relates to both my personal and professional experience. My own approach is that since mental health problems lie on a continuum, anyone may experience mental health difficulties at some point in their lives. Therefore forums for reflecting on these experiences and sharing these amongst the people delivering mental health services would provide valuable information for how services can best meet the needs of those who use them.

My experience to date has been within adult mental health services, therefore this will be the main focus of my essay. However, the issues and dilemmas discussed here may also be relevant to other client groups. There may also be different considerations when thinking about involvement of other client groups such as people with learning difficulties.

The Historical Context of User Involvement in Britain

Campbell (1996) suggests that the history of user groups in the UK dates back to the second half of the nineteenth century, when the work of the Alleged Lunatics' Friend Society and of early feminists contributed to public protests against the label of "mad" being used as a means of social control. He reports that the current user movement has flourished since 1985, due partly to the increasing awareness of the civil rights of those with mental illness in the 1970s and 1980s, and also the policy of de-institutionalisation. More recently there has been a further change in mental health politics, influenced by the involvement of representatives from user groups in the production of new health policies. The focus of these has been the promotion of user involvement and the de-stigmatisation of people who use mental health services. There has been Governmental recognition of the importance of involving service users and their carers in all aspects of service provision. For example, the National Service Framework for Mental Health (DoH, 1999) states that service users and their carers should be involved in the planning, delivery and evaluation of
Academic Dossier

adult mental health essay

care. Also the Department of Health requires that service users are involved in the teaching, curriculum design, and assessment of NHS training courses in addition to contributing to research (Department of Health, 1999 cited in Curle & Mitchell, 2004).

The Ten Essential Shared Capabilities (Hope, 2004) describe essential skills for working within mental health. These include the ability to work in partnership with service users and carers in order to provide “service user centred care”. Emphasis is placed on valuing difference and diversity in this partnership and being able to work positively with any tensions that may arise. Valuing and involving service users is also strongly advocated by the British Psychological Society (BPS). With regards to the training of clinical psychologists, the BPS accreditation criteria for courses state that, at the outcome of training, trainees will have skills, knowledge and experience in working effectively with service users and the social systems of which they are part of, including advocacy, voluntary and user-led groups (BPS, 2002, cited in Harper, Goodbody & Steen, 2003).

Despite the Government’s promotion of user involvement and also that of professional bodies such as the BPS, “the collective involvement of service users has received a mixed reception” (Campbell, 2001: p.87).

Mental Health Professionals’ Attitudes to Service User Involvement

Rush (2004) highlights that there are differing assumptions, which promote or limit user involvement in nursing practice. His historical analysis of user involvement in mental health nursing suggests that this tension has been longstanding and does not just lie within the different views of mental illness, but also within mental health legislation. For example, the Government advocates user involvement but also has legislation by which people with mental health problems
may be compulsorily treated within mental health services. Therefore service users and professionals may differ in their views of mental health problems and who should be responsible for mental healthcare, which can impede service user involvement.

Further research of mental health nurses', psychologists' and psychiatrists' views on service user involvement suggests that there are mixed views and highlights concerns about the representativeness of those service users/carers who are willing to be involved and also the different agendas that service users/carers may bring (see Felton & Stickley, 2004; Soffe, 2004 and Summers, 2003). For instance, some professionals said that they feel that they will be blamed for shortfalls of the NHS. Thus in working with service users/carers, it may be useful to have some guidelines concerning the aims of the group. Also, a rota could be put in place so that input can be received from a wide range of perspectives. Although it is important to acknowledge that these views may be barriers to service user/carer involvement, all 3 studies had small sample sizes and therefore are not representative of the views of all mental health nurses, psychologists and psychiatrists. Also, the people who agreed to participate in these studies may have done so because they had particularly strong views on this topic.

In my experience, some professionals are ambivalent about the extent to which user involvement should be developed and similar concerns have arisen about blame. My experience of user involvement is rather tokenistic as it was a meeting where staff (mainly junior staff) and users on an inpatient ward discussed issues surrounding the way the ward was run. However, the feedback from some of the users was that they found the meeting a useful forum to appropriately express their views regarding their care. I feel that if such meetings included more senior staff, concerns could be discussed more effectively and decisions regarding care could be made collaboratively. Furthermore, the users would experience a greater sense of being heard which was very
important to the users that I worked with as they felt heavily discriminated against. Therefore, in the working group meetings, it would be useful to ensure that decisions about how to take forward ideas regarding service user/carer involvement are made jointly. Service users/carers and course members (staff and trainees) could also produce some ground rules as to how they will work together.

The formation of the Surrey working group suggests that the Surrey course team are actively contemplating how to have greater service user/carer involvement through including service users/carers in this process. Although psychologists may be considered to have different models of mental health from those of other mental health practitioners, Soffe’s (2004) research suggests that psychologists share similar views to other mental health professionals as to the dilemmas and issues that user involvement may create. The Surrey working group has begun to discuss some of these in relation to how greater involvement can be achieved on the clinical training course.

**Surrey Working Group**

The Surrey working group was formed from inviting service users, carers and different members of multi-disciplinary teams (MDTs) within local services to attend meetings to discuss user involvement. Emma Harding is a member of the Surrey working group and also works as a User Involvement Worker. She raised that it would be tokenistic and disempowering to have more of the course team than service users in any form of collaborative working. Harding (2004) reports that service users would like to be involved in meetings about the delivery of services and be supported and trained to express their views whilst also integrating the different views of those who they are working with. Furthermore, being the only service user/carer can feel intimidating unless there have been opportunities to get to know other members of the teaching team. This may be compounded if the service user or carer is also the only Black person or young person in
the room (Tew, Gell & Foster, 2004). Therefore it would be useful to discuss within the working group possible ways in which the course can be mindful as to avoid reinforcing any experiences of stigmatisation.

The group has also discussed the dilemma created by the power imbalance between service users/carers and those who work within mental health services, although the two are not mutually exclusive. Felton et al. (2004) found that mental health nurse tutors at one research site perceived service user involvement in mental health nurse education to be ineffective. They suggest that these views may function to protect the lecturers from a potential loss of power due to the service user's/carer's status being elevated with the role of "teacher", which may be perceived as threatening to some lecturers. This may also reinforce the "them and us" barrier that may protect lecturers from recognising their own vulnerability to mental health difficulties (May, 2001).

I am aware that one member of the working group, who is also a member of the course team, is currently holding the post of Service User Development Worker until the course is able to secure funding for the post. I feel that paying service users/carers for their input to the course is one way of helping to empower those involved. I think that it would also be important for agendas to be set jointly between those within the working group and that equal value be placed on each member's suggestions. However, there are certain criteria that the course has to meet in order to receive accreditation from the BPS. Therefore workshops on these criteria may aid inclusion, minimise potential areas of conflict and may serve to meet the concerns of professionals and service users/carers about involvement in the training course.

Goodbody (2003) and Harper et al. (2003) discuss issues that arose in a series of workshops on "user-involvement in training" held at a conference of the Group of Trainers in Clinical Psychology.
Psychology (GTiCP). These included the dilemma of power and inequalities and how multiple voices, which may challenge the notion of professional expertise, can be heard. Suggestions included that trainees be provided with experiential learning from working with service users and carers outside of their role as “therapist”, such as receiving teaching from service users and carers, working together on research proposals/projects and also through access to user groups and independent sector providers.

Goodbody (2003), Harper et al. (2003), May (2001) and Perkins (2002, cited in Goodbody, 2003) all suggest that it would be helpful for teachers, staff and trainees to be able to share experiences of difficulty which would help to tackle the “them and us” barrier to user involvement within mental health services. However, they also raise the dilemma of how to provide a “safe” forum to do this. This may be advocated through more open discussion and advertising of valuing clinical psychology training applications from people with experience of mental health problems.

Clinical Psychology Training

Rachel Perkins and Rufus May are both Clinical Psychologists who have experienced mental distress. However, both assert that they were not able to share their experiences with other trainees due to fear of being perceived to be unable to cope with the course and being stigmatised by their peers (see Division of Clinical Psychology, 2000). Goodbody (2003) emphasises that the model of reflective practice within clinical psychology aids the development of skills for working with service users/carers and understanding of peoples’ experiences. Therefore, through learning from both our own experiences of difficulty, seeking help, inequality and discrimination, and the experiences of others, clinical psychologists can enhance their personal and professional development. If clinical psychology training courses were more open to applications from people with experience of mental health difficulties and also to discussion of difficulty amongst trainees,
then as trainees we would have greater access to a wealth of resources that would aid our work with our clients.

In 2002, the Department of Health issued a report calling for an end to the discrimination and stigma of people who experience/ have experienced mental health problems in employment within the NHS (Department of Health, 2002, cited in Felton & Stickley, 2004). May (2001) suggests that clear statements need to be made within recruitment to clinical psychology that people with mental health problems will not be discriminated against.

I think that it's important to develop service user/carer involvement in the Surrey training course by actively promoting that the course values any experience of mental health problems in people applying for training. A statement to this effect could be put into Surrey's entry in the handbook of clinical training courses. Also, the Occupational Health form is written in a socially exclusive manner such that it suggests that people with experience of mental health difficulties may not be able to cope with the course. This form could be written using more inclusive language. Rufus May's and Rachel Perkins' openness about their experiences highlight that there are people who experience/ have experienced mental health difficulties who are Clinical Psychologists. I feel that there may be trainees currently on the Surrey course who could provide valuable reflections about their experiences (either as service users, carers or both) which other trainees could learn from. I think it would be difficult for trainees to talk about their experiences amongst their year group even with the support of the course, therefore the small case discussion groups may provide a more "safe" forum.

There are also other ways in which service users and carers would like to be involved in clinical psychology training. Both the University of Exeter (Curle & Mitchell, 2004) and the University of
Manchester (Steen, 2004) clinical psychology training courses have set up advisory groups from representatives of all the stakeholders in training (including service users, carers, trainees, academic staff, and representatives from the NHS). Some of the issues that were raised in both groups were greater involvement in teaching, curriculum design and selection of trainees.

**Curriculum, Teaching and Selection of Trainees**

Harper *et al.* (2003) report that at the GTiCP conference, tutors discussed benefits of working with service users and carers. These included giving trainees different perspectives on what is important to the therapeutic relationship and how to best meet the needs of those whom they are providing a service to. Service users are the largest group of stakeholders involved in the training of clinical psychologists, yet are the least represented voice (Steen, 2004).

Within advisory groups at the University of Exeter (Curle & Mitchell, 2004) and the University of Manchester (Steen, 2004), service users/carers expressed that greater involvement in teaching and the curriculum would help give trainees different ways of thinking about mental distress. From these groups, both courses have created new teaching slots for trainees, run by consumers of services. It was acknowledged within both groups that users do not all have the same views and therefore do not represent the views of all service users and carers. Similarly, service users and their carers may have very different views. Steen (2004) reports that the University of Manchester working group developed a database to serve as a consultation network in order to address the issue of representativeness. Furthermore, Harper *et al.* (2003) suggest that trainers could invite organized bodies or groups to give lectures to trainees. These ideas could be considered by the Surrey course.

*My experience of service user involvement in training has been in training that used the Psychosis Revisited package (Basset, Cooke & Read, 2003). Service users led a session in which they shared*
their experiences of mental illness and the services that they received with MDT members who worked with service users with psychosis. The feedback from all those who participated in the training was very positive, some MDT members stated that they valued the opportunity to hear the experiences of service users and that this was a powerful form of highlighting areas of practice that could be improved on. The problem-based learning (PBL) exercises within the Surrey training programme are also based on experiential learning. These exercises could involve trainees working together with service users/carers in thinking about clinical psychology services. Different groups of service users/carers could be invited to join in different exercises. Again, there could be clear rules set about what this role would involve and service users/carers would not have to give the presentation if they did not feel comfortable doing so.

Despite research highlighting service user and carer interest in greater involvement in the training of mental health professionals, there might be concerns about the generalisation of learning that occurred at the place of study, to the workplace. For example, McAndrew and Samociuk (2003) used an evaluative case study of the initial formation of a group of service users and mental health nurse students, in which the purpose of the group was to reflect on mental health issues. Prior to the formation of the group, they found that a concern of some of the service users was that the students would perceive the involvement of service users as part of their training and separate from their professional roles on the ward. Harper et al. (2003) suggest that trainees could have sessions in a base used by user groups; this may aid the transfer of what they have learnt to their work.

One difficulty in involving service users and carers in clinical psychology training is payment for their input. Many service users/carers receive benefits which may be affected by payment for their work with the Surrey course. Curle & Mitchell (2004) report that the Exeter advisory group
discussed payment and an agreement was made about providing travel expenses. However, the service user/carer may not feel valued if they are the only members of a group who are not paid for their time. The Community Care Needs Assessment Project (CCNAP, 2001) has provided guidelines for involving people in developing health and social services. They suggest that service users/carers should be given explanations as to how payments will affect their benefits and advised to seek specialist advice from welfare rights or the Citizens Advice Bureau if their benefit claim could be jeopardised. Therefore, it would be important for the Surrey working group to discuss what funding is available and how they might pay service users/carers for their work.

Research has also highlighted that service users/carers would like greater involvement in the selection of trainees (e.g., Curle & Mitchell, 2004 and Steen, 2004). The Exeter course has included service users’ views about good and bad qualities in a clinical psychologist in the programme handbook and also has user involvement in selection. However, the Manchester course has had mixed feedback about involvement in selection.

I feel that it would be useful to have service users/carers involved in the selection process as they would be able to select for qualities which they have found to be useful in a clinical psychologist. Maybe training could be provided for those involved in the selection process about clinical psychology issues that are also important for applicants to have experience or be aware of. Thinking back to my interviews, I feel that if the interview panels just added a service user/carer ad hoc, this would make the interview process even more daunting for the applicant due to the number of people assessing them. Furthermore, clear guidelines would need to be agreed on about how service users/carers would be involved at each level of selection. Service users/carers would also need to adhere to the same bounds of confidentiality as the course staff.
Confidentiality would also be an important issue if service users/carers had greater involvement in trainees’ clinical placements.

Clinical Placements

The BPS suggests that trainee clinical psychologists gain experience of working with service users and carers outside of the role of “therapist” whilst on clinical placement. I.e., working with users and carers at service or strategic level and consultation with user-led and voluntary groups (BPS, 2002, cited in Harper et al., 2003). In working with user groups trainees would gain experience of working with people with severe and enduring mental health problems. Such experience is a prerequisite of qualification and therefore places high demand on placement supervisors to provide diverse placement experiences. Therefore, working with user groups would help to lessen this demand and provide greater diversity within placements.

One of the trainees on the Surrey course has a service user as her mentor. This was arranged by her placement supervisor and she has commented that she has found having a service user mentor to be extremely valuable in understanding how people access and experience clinical psychology services. Workshops could be provided by the course, facilitated by both course staff and service users, about what the role of a mentor involves. One possibility is that trainees could also be involved in these workshops such that any dilemmas or issues that arise can be discussed and worked on. For example, it would be unfair for both the service user and the trainee if either felt unable to talk about their experiences or felt worried about confidentiality.

Service users/carers could also provide valuable information about barriers to clinical psychology services and produce ideas for the focus of research within mental health services.
Research

Wykes (2003) provides examples of the benefits of service user involvement in mental health research through reflecting on her own experiences of collaborative research. She suggests that research projects can benefit from service user involvement in the design, methodology, data collection and evaluation of research, for which funding and training are important. Her experiences have been that user involvement can change the focus of research such that outcome measures are based on service users’ perceived needs being met. This in turn aids understanding of the efficacy of different therapies and/or different services that are provided. Furthermore, Wykes (2003) adds that outcomes that are important to service users reflect important trade-offs between different risks and benefits associated with engaging in an intervention. Therefore service user outcome measures can improve the validity of the study through capturing both satisfaction and treatment efficacy.

Greater involvement of service users in research may also help to empower service users and aid good relationships with researchers (Townend & Braithwaite, 2002). Service users can help in recruiting participants and could be trained in different research skills such as interviewing techniques. This may decrease the power differential between interviewer and participant such that the participant may be able to speak more openly about their experiences. For example, Simpson and House (2004) found that service users reported being less satisfied with services when interviewed by other users for service evaluation research.

Despite the benefits of user involvement in research, there are also costs. Trivedi and Wykes (2002) illustrate that involving service users can increase the amount of time taken to carry out and write up the project and there are also additional financial costs. They suggest that training...
service users, just as researchers are trained, may help to decrease potential conflict and aid compromise as to the value of researching different areas.

One limitation of the research studies I have referred to are that they are based upon the experiences of academics who have worked with service users on different research projects. Therefore it would be useful to study service users’ experiences of being involved in mental health research and also whether involving carers has similar benefits.

I have no experience of working with service users/carers in research other than involving service users as participants. Therefore I may not be aware of the dilemmas and tensions that could arise from such work. However, my view is that through working with service users, researchers may experience a trade-off between feeling challenged on their work and producing research that will have a greater validity and impact on mental health services. This may help understanding as to the dilemmas service users face in deciding whether to engage in treatments that are offered.

User involvement in research does not only have beneficial implications for services and those who use them, but also for the accessibility and dissemination of research to a wider audience. One possibility that the course could consider is training and involving service users/carers in the research components of the course. Service users/carers could provide consultations on trainees’ research proposals and all other aspects of research in conjunction with the course research supervisors.

In addition to working within the course programme, service users/carers could also be involved in the evaluation and monitoring of the course.
Evaluation and Monitoring the Course

There is little literature surrounding service user involvement in the evaluation and monitoring of services. As the course needs to meet certain criteria, training would be important to facilitate understanding of these. Service users could liaise with the course team as to what they feel would be important in the assessment process. Perhaps essay titles could be sent to service users/carers for feedback as to what they feel would be some of the important points to include. Service users/carers could also be invited to the PBL presentations and could give their feedback to the tutors.

Mixed feelings about involvement at this level arose from the Manchester working group (Steen, 2004). Concern was raised that service users/carers may not be in a position to contribute to evaluation and monitoring of the course as they do not have the required knowledge, and also that the power imbalance might adversely influence consumers' assessments. However, in contrast, it was also proposed that this would help to reduce the “them and us” barrier and support the course to provide training that focuses on meeting the needs of those who use clinical psychology services. As there are differing views it would be important to consider these complex issues within the working party.

In summary, the literature on service user/carer involvement in mental health research and the training of mental health professionals suggests that benefits can be gained from such inclusion. However, it also highlights the complexity of issues that such involvement can create. Historically, the user involvement movement has challenged mental health professionals’ conceptualizations of mental health and service provision. More recently, the Government has produced new mental health policies which promote user/carer involvement in all aspects of
service provision, including the training of mental health professionals and in research. The evidence that there are mixed views from those working within mental health services, and amongst those working within clinical psychology, suggests that there are potential barriers that need to be considered and also strategies put in place to try and resolve such tensions.

Research suggests that power imbalances, tokenism, representativeness and "them and us" thinking are issues that are important when considering service user/carer involvement and in ensuring that collaboration is a positive and productive learning experience for all. The Surrey working group has begun to consider some of these issues and has applied for funding to employ a Service User Development Worker who will aid greater service user/carer involvement in the training programme.

I have suggested ways in which these issues may be thought about when considering training; curriculum, teaching and selection of trainees; clinical placements; research; and evaluation and monitoring of the programme. These include providing training and support so that service users/carers have understanding about the way that the course is run and the accreditation criteria that it needs to meet. Also, I feel that there needs to be clear outlines of people's roles and expectations so that everyone's views are respected, conflicts of opinion are discussed openly and all involved are motivated to work through any tensions. Payment for involvement conveys the message that the individual's experiences are valuable and taken seriously by those providing mental health services, although advice may need to be sought as payments can jeopardise benefits. Furthermore, advocacy of valuing applications for training from people with experience of mental distress and support for sharing these may help broaden the resource of information amongst trainees.
Developing service user/carer involvement poses a challenge that involves a shift in the cultural perspective of clinical psychology training, a shift that is beginning to occur. The training course at Surrey promotes the reflective practitioner model and benefits of experiential learning. Therefore more open discussion with people who have used/use mental health services would help diversity of clinical experience, research skills and provide valuable insight into the effects of the services that they contribute to. In order to achieve this we need to start placing greater value on learning from those who are using the services:

"If 'user involvement' is to be more than rhetoric, surely it is time both systematically to ascertain users' goals and to accord them the status currently enjoyed by the priorities of clinicians?" Perkins (2001: p.10).
References


24

URN: 3445275

Service User and Carer Involvement in Clinical Psychology Training


TO CONSULT OR NOT TO CONSULT............
WHAT IS THE ROLE OF CONSULTATION IN CLINICAL PSYCHOLOGY PRACTICE?
CRITICALLY DISCUSS IN RELATION TO YOUR CLINICAL EXPERIENCE SO FAR.

December 2005

Year 2

Word Count = 5000
In 1989 the Management Advisory Service Review of Clinical Psychology Services (cited in Quarry & Burbach, 1998) highlighted the need for clinical psychologists to share their skills and knowledge with other National Health Service (NHS) professionals. The report recommended the development of a "consultant psychologist" role which would involve both co-ordinating psychological services and providing consultations to other healthcare professionals. Following this, the Division of Clinical Psychology (DCP, 2001) published a document highlighting the need for psychologists to work with systems and organisations to help develop psychological services since psychologists alone could not meet the demand. It would appear however, that despite an endorsement of the consultancy role at a professional body level there is still ambivalence as to the importance of such a role amongst individual clinical psychologists.

My personal reflections on the role of consultation in clinical psychology practice shall be written in italics to discern it from the views expressed in the literature. In considering the costs and benefits of psychologists providing consultation services I thought to myself, "What do we actually mean by consultation?" My very limited understanding was that it involved offering advice at a systemic level to other NHS staff in order to provide a different way of viewing "the problem". My experience of psychologists offering consultations has been where they have been asked if they will consult with staff teams who feel "stuck" with a client or family that has been labelled as "difficult". In each case it has been prevalent that the manager has requested the consultation. Whilst reflecting on these experiences I felt ambivalent about my views of whether clinical psychologists should consult. I was torn between feeling that clinical psychologists should promote systemic ways of thinking about "the problem" to help facilitate a non-blaming, more understanding and more caring culture within the NHS, and wondering whether consultation could effect long-term change in a system that often strives to maintain the status quo. I also questioned as to how often psychologists challenge their own beliefs as it would be very
hypocritical to encourage our colleagues to adopt a different view if we did not allow for critical analyses of our own understandings.

In the following text I shall try and broach some of the questions I have outlined above. Firstly, I will consider the different definitions of consultation and consultancy whilst highlighting the implications these have for clinical psychologists adopting these roles. Secondly, I shall review the development of the argument as to why clinical psychologists should take on this role. I will then consider 3 areas in which clinical psychologists may provide consultations: (i) consultations with families; (ii) internal consultations with mental health and learning disabilities teams/organisations within the NHS; (iii) multi-agency consultations. I will explain how both the literature and my personal reflections impacted on my view of whether clinical psychologists should consult.
Defining Consultation and Consultancy

Reber (1995) suggests that consultation in clinical psychology consists of 2 or more clinicians combining their efforts in developing a healthcare plan for an individual. Since clinical psychologists generally work in multi-disciplinary teams (MDTs) and contribute to care planning within their teams, it would be difficult to argue that consultation should not be and is not already a major role of clinical psychologists.

Christie and Daycock (2003) describe consultation as:

...a process of interaction between professional persons the consultant and consultee, who invokes the consultants help, which might introduce an understanding of a patient’s situation or behaviour with which they are having some difficulty and which they have decided is in the other’s area of special competence. The work involves the management or treatment of one or more patients or clients of the consultee, or the planning or implementation of a programme to cater for such clients (p.15).

Christie and Daycock’s (2003) definition suggests that consultation involves a business orientated approach in which people engage in contracts specified for a particular piece of work considered to be within the consultants area of speciality. Although the consultee is considered to have requested the help of the consultant this may not be the case. For example, I have found that the manager of a service often requests consultation from clinical psychology on behalf of his/her staff. It may be that the staff do not want to engage in work with the psychologist as they see the consultation as symbolic of their work being devalued or criticised. My concern is that consultations may, in effect, place the psychologist in the position of the “authoritative expert” which could further isolate psychologists from their colleagues. In my experience of working on
inpatient units there was an expressed view that psychologists were privileged and did not understand or listen to nursing staff’s concerns. I learnt that it is extremely important that psychologists form good relationships with their colleagues so that the team have positive experiences of working with psychologists and therefore may be more receptive to applying psychological principles to their work. I also learnt that it is important to support staff to explore different ways of understanding and responding to distress in order to promote self-produced change rather than change enforced by the psychologist.

Consultancy work is considered to focus on service development in a broader sense (e.g. policies and creation of new services) whereas consultation involves entering into a relationship regarding the management of a specific case (Huffington & Brunning, 1994). From these definitions of consultation and consultancy, it is emphasised that the relationship between consultant and consultee is collaborative. This is conducive to the finding that social support is an important factor in facilitating change (see Prochaska & DiClemente, 1992).

Huffington and Brunning (1994) suggest that internal consultancy (consulting within an organisation to which you are a member) can become a way of empowering those involved in the process and can give people a sense of ownership and of managing change. Since clinical psychologists are generally discontent with the dominance of the medical model in services it would seem that both consultancy and consultations would aid dissemination of the benefits of psychological models and provide staff with experiences of collaborative working. If consultancy and consultation are important roles within clinical psychology, why is this so and why do some clinical psychologists feel ambivalent about developing these roles?
Why Should Clinical Psychologists Adopt a Consultancy Model?

Bruning and Huffington (1990) appeared to spark off the debate by suggesting that clinical psychologists need to develop the consultancy role in order to ensure that psychological services are provided, demystified and contribute to developing better healthcare services for the population. They suggest that, in addition to there being a social need for clinical psychologists to develop the consultancy role, there is also political pressure on psychologists to market their specialised skills such that the profession fills a niche within NHS services that is not met by other (less costly) professionals. Certainly, the implementation of the Agenda for Change pay-scales forces professionals to demonstrate their specialist skills in order to ensure higher bands of pay. Internal consultants are also a lot less expensive than external consultants and therefore are more cost-effective which is especially important considering the business climate within the NHS (Huffington & Brunning 1994). Brunning and Huffington (1990) recognise that there are many challenges to the role of the internal consultant but state that carefully planned and agreed interventions can have a positive and rewarding outcome.

Despite the suggested benefits of consultation, evidence from the USA suggests that psychologists fail to offer consultations where they are needed, perhaps due to job dissatisfaction or low self-perceived professional skills which appear to be more prominent to psychologists who do not tend to consult with other members of the team (Clayton & Bongar, 1994). The USA literature places an emphasis on the consultation being important in ensuring legal and ethical standards of care are provided (Arredondo et al., 2004; Clayton & Bongar, 1994), yet legal and ethical standards of treatment are not one and the same and different professionals have different ethics. A further difficulty with offering consultations is that it is the responsibility of the consultee to implement any resulting action. Psychologists tend to (but do not always) offer an alternative view to the medical model, yet this is still the most dominant discourse within the
Academic Dossier

NHS and may therefore impact on whether the psychologist’s advice is followed or implemented by the consultee.

Perhaps my own ambivalence reflects where I am in my training and not feeling skilled enough to provide formal consultations. I have found change within staff teams to be very difficult even when advice has been sought from experienced psychologists. Furthermore, it has been suggested that culture changes within the NHS are often resisted in order to tolerate the stress caused by the constant structural and organisational changes (see Menzies, 1959). It may be that organisations keep the same ineffective and sometimes abusive practices in order to try and defend against the anxieties and discomfort change can cause. This also relates to my ambivalence about consulting since I wonder whether psychologists really can change “the system”? A personal difficulty that the role of consultation poses is that I find it extremely frustrating and upsetting when I express an opinion about something I feel passionate about and I am not heard or listened to. Consultation would therefore involve facing and tolerating my own anxieties about not being heard and failing to make a difference.

The practice of consultation can involve taking individuals out of their comfort zones (Arredondo et al., 2004) and there will also be individual differences as to the areas in which psychologists feel competent enough to offer consultations. Through training, clinical psychologists develop clinical and research skills which can aid understandings of, and curiosity around, processes of change. It can therefore be argued that they have the skills to provide consultations to other healthcare staff regarding facilitating change and developing practices informed by psychological models. Psychologists also have knowledge about the context of the NHS system and thus the implementation of any changes has a better chance of succeeding as the need to change remains within the ownership of the organisation (Huffington & Brunning 1994).
Academic Dossier

Having observed one of my supervisors offer informal consultations to other members of the team, I have realised that it is important that psychologists are able to facilitate and support areas of good practice. Team members can often feel demoralised as their skills and areas of good practice are not acknowledged. This can lead to people with invaluable skills leaving the NHS due to job dissatisfaction and thus minimises potential for change. Although my supervisor does offer support to the whole staff group, I have noticed that it is only certain members of the staff group who consult her. I feel that there is suspicion amongst some of the staff team as to whose interests she holds in mind and whether she will try and enforce her own views on to them. This is a barrier that psychologists can encounter when offering internal consultations and can impact on their feeling valued within the team. I think that it is important psychologists take time to work alongside staff to help lessen some of these anxieties about seeking help from psychologists. I do realise, however, that not all staff will have positive experiences of working with psychologists but hopefully having the opportunity to do so will help psychologists to be seen as willing to consider different viewpoints to their own.

Consultations with a clinical psychologist may be sought by a family, a staff team or at an organisational level with regards to overall service delivery. Similarly to staff teams, families may seek consultation for advice as to how to support and care for a family member whom they perceive to be experiencing difficulty.

Working with Families

Bromley (1998) highlights that many people with learning disabilities live with and are cared for by their parents therefore clinicians may work within family settings. Consulting with families where there is a person who has learning disabilities can often involve supporting the family and the individual with learning disabilities to find ways of managing and working through changes.
that occur throughout the life-cycle. As Vetere (1993) notes, for families where there is a member with learning disabilities each stage can have different meanings and may lead to increased family stress or conflict. The clinical psychologist could therefore help the family think about how life-cycle factors impact on each family member and explore ways of coping with the associated changes.

*I am currently working within a Community Team for People with Learning Disabilities and through my work I have realised how important offering consultations to families can be. For example, I am currently working with a client, who I shall call Sarah, who was sterilised because it was felt by her family that she could not care for a child. It was assumed that Sarah understood and consented to the sterilisation at the time of the operation, however Sarah has stated that she did not understand the consequences of the operation and is very upset that she can not have children. I do not intend to blame Sarah’s family or the doctor that conducted the operation but wonder whether consultations from a psychologist may have facilitated discussion between Sarah and her family about her wish to have children and her abilities to parent. Although I can not say for certain whether this service would have made a difference it saddens me that the opportunity was not there for Sarah and consequently my supervisor and I are now offering consultations to the family regarding helping Sarah and her family manage her grief regarding her loss of being a mother.*

The literature regarding consultation with individuals and their families suggests a model based on systemic and solution-focused ideas. In this model clients are offered between 1 and 3 appointments with 2 clinicians (usually one of which is a psychologist). In these appointments clients are encouraged to explore social understandings of their difficulties and to use their strengths in overcoming these difficulties. If the client requests further input after these sessions,
attempts are made to offer the form of intervention that the client feels would be most helpful. In Newham, an individual therapy model was replaced with a consultation model for all initial assessments in an adult mental health service (Partridge et al., 1995). This resulted in a significant reduction in the team’s waiting list, a reduction in the number sessions required for intervention, less stress for the clinicians in making decisions about psychological interventions and also provided clients with a greater sense of safety, especially when disclosing abuse.

One criticism of the consultation model was that it might not be as useful for people with more complex needs. In response to this view, Joscelyne and Godwin (2005) used a consultation model with high priority clients (children and their families deemed by health professionals to have higher levels of difficulty) in a Child and Adolescent Mental Health Service (CAMHS). They compared the outcome of clients offered consultations with clients offered an assessment and intervention with an individual clinician. Their findings supported those of Partridge et al. (1995) in that, the model reduced waiting list times, improved clients access to other services and decreased the number of intervention sessions needed. It could be suggested that, in the consultations, clients may have felt under increased pressure not to ask for further input from the CAMHS team, therefore it would have been useful to investigate whether the clients found the consultation model helpful.

A Child and Family Consultation Service (CFCS) investigated the experiences of children aged between 7 and 11 of receiving consultations with their families (Rosen-Webb & Morrissey, 2005). They used focus groups to gain the children’s views coupled with the use of score cards, drawings and written exercises to facilitate the discussion. They found that the children gave ratings of high satisfaction with the service but also found that the children had worried about attending the focus groups because they felt that the reason for them going was that they had been
naughty which may have influenced the ratings they gave. In addition, the older children tended to offer ideas in the discussion which the younger children then repeated.

_I have not yet worked within a CAMHS team and have very limited experience of working with children with learning disabilities. I have only had one session with my supervisor acting as a co-therapist, however, in thinking about what it might be like offering consultations to families I feel it would be important to think about how I would make sure that I heard the voice of the person who feels most disempowered. I think and would hope that having another professional in the room would reduce the likelihood of a psychologist “taking sides” as I realise that a family may have expectations of the consultations being an opportunity for their feelings of the individual being “the problem” to be reinforced by the professionals. Working alongside another colleague and having a reflecting team would aid transparency of some of the processes occurring in the session and would also be a useful way of learning skills from the family and also more experienced professionals._

Psychologists may also work indirectly with families by offering consultations to the staff that are working with them. One advantage of this is that the psychological input builds on existing relationships rather than introduce another person to the system which is useful in terms of thinking about attachment theory and may produce longer term changes.

**Consultation and Consultancy Services within NHS Organisations**

Moore (2004) explored the views of residential support workers within a learning disabilities service for children towards working with clinical psychologists. He found that the views were generally positive and the ratings were positively correlated to increased personal contact with a psychologist. The return rate of his questionnaires was very low which may reflect how
psychologists are viewed generally but the findings do suggest that consultations with other professionals can aid working relationships and how psychologists are perceived. Low response rates have also confounded the findings of other studies that have attempted to investigate the effectiveness of psychological consultation services (see Christie & Daycock, 2003; Freir & Sutton, 2003). Although benefits have been found, it has been suggested that it is still felt to be stigmatising to meet with a psychologist, even on a professional level, and that in consultations there is a pressure to offer a practical solution (Dowling & Manning, 2004; Frier & Sutton, 2003).

*In my own work I often experience a pull towards offering a client a practical solution which can hinder exploration of new ways of thinking about things. Through supervision I am realising the importance of having the space to reflect on my relationships with both clients and other team members to be aware of how these impact on the service that I offer. Consultations may help provide a space for other professionals to think about the organisations they work in and how they impact on their work. In addition, since front line staff may constitute a greater number of people from disadvantaged groups, offering consultations can aid feedback to higher level managers of the diverse needs that services need to meet with regards to both staff and clients. Consultations would also contribute to the individual development of each psychologist as this work would help inform understanding organisations and factors that aid or hinder change.*

McBrien and Candy (1998) suggest that consultation with staff in learning disabilities services involves working as “an authority” who tries to persuade those involved in the person with learning disabilities’ social system different ways of working with the individual. To do this involves not only giving advice but also working with other advice givers. They comment that this role can be a double-edged sword in that it can give a sense of status or can be frustrating and disempowering depending on how the consultation is managed. If the psychologist is seen as “an
authority”, however, can this power differential really aid change? Quarry & Burbach (1998) suggest that it is arguable whether clinical psychology can provide good consultancy services since they believe that training does not adequately address learning about organisational psychology. They do however, suggest that consultancy based on offering training and supervision to other professionals can be a way of influencing practice.

Clinical psychologists may be reluctant to consult because internal consultancy can throw up many dilemmas. For example Hill-Tout (2005) suggests that where relationships breakdown the consultant still has to work with the people involved in the consultation and that professional hierarchies may impact on the consultant’s work. She emphasises that it is important that the psychologist has the opportunity to assess the organisation’s capacity to change and can choose whether to offer consultations. In addition, if a psychologist feels that their advice is not being received they could fall into the trap of blaming the staff and further isolate themselves within the NHS. Clinical psychologists offering consultancy need to be aware of hidden agendas, attitudes and beliefs held within the staff team that may hinder the advice being followed, and also ethical issues of intervening with regards to whose problem it is.

Consultancy seems to be entrenched with the potential for blame to arise and undermine the work between the clinical psychologist and the staff involved in the consultation. This worries me with regard to my current consultancy work with staff on an inpatient unit for people who have been labelled as having a learning disability and mental health problems. The focus of the work is how the unit staff can address issues of consent and capacity. Another trainee and I are working with the staff to think about guidelines for ensuring clients’ liberties are safeguarded within all aspects of the service. This consultancy work has arisen via the request of the manager and the clinical psychologist. Addressing consent is also a legal requirement under the Mental Capacity Act
(Department of Constitutional Affairs, Department of Health & Welsh Assembly Government, 2005). This creates a large power differential between ourselves, as consultants, and the rest of the staff on the unit. Being part of the team however, has given me the opportunity to learn about the staffs' skills in addressing some of the difficulties they have experienced on the unit. I'm hoping that highlighting these examples in the training that we will offer will help the staff to feel that psychologists do value and listen to them.

McBrien and Candy (1998) suggest that, in offering consultations, clinical psychologists should appreciate that they are only needed if they are able and committed to offer support and advice and are considerate of the difficulties that individuals, teams and organisations face within. Since there is an increased emphasis on the need for closer integration between primary and specialised services (Department of Health, 1999) psychologists may also consult with professionals outside of the service within which they work. In addition, with better links between healthcare, education and social services psychologists may offer consultations to non-NHS professionals.

Multi-Agency Consultations

Ross and Hardy (1999) suggest that mental health clinicians could help facilitate General Practitioners' (GPs) identification and referral of people with mental health difficulties. They suggest a bi-directional model of consultation in which a clinical psychologist can aid psychological services within primary health care and in which GPs can inform clinical psychologists of the level of need for mental health services within their catchment area. This would form a symbiosis which should (ideally) help people to have easier access to psychological services and also psychological services adapting to provide for the needs of the local communities.
I think that psychologists and GPs could benefit from consulting each other. In my Service-Related Research Project I looked at new guidelines for the referral process to a Community Mental Health Team (CMHT). It became apparent that the CMHT received a large number of referrals from the GPs which did not meet the team’s criteria and which the GPs felt unable to manage in primary care. I found that although the team offered mental health input to the GP surgery it would have been more useful to offer the GPs consultation and supervision to aid their confidence in their work with people with less severe mental health difficulties. I got a sense from the team that the GPs would not want this but the opportunity had not been offered to the GPs and so it is difficult to draw any conclusions as to whether the GPs would have found it useful.

Elphick (2004) found that although GPs viewed clinical psychologists to have a role in offering consultations on some specific cases, they did not perceive psychologists to have a role in the education, training and supervision of other primary care staff. Health visitors’ roles also involve working with people who have mental health needs and so may benefit from support from psychologists. Research has shown that consultation from child clinical psychologists can help health visitors feel less isolated and increase their confidence in working with children where there are concerns about the child’s behaviour (Prior et al., 2003).

Thirlwall and Silver (2005) report on a consultation service provided by CAMHS clinical psychologists for their local Permanence Team, whose aim was to find permanent placements for looked-after children. They suggest that psychologists’ knowledge about human development and the impact that early life experiences can have can be valuable in aiding understanding of individual children’s needs. The social workers in the permanence team were interviewed regarding their views of the effectiveness of the service. It was generally found that the service was helpful although some of the social workers expected that the psychologists would offer
direct contact with the children and their carers. It was also emphasised that the psychologists had difficulties in gaining funding for the service despite positive feedback from the Permanence Team and continuing demand for the service.

Bremble & Hill (2004) reflected on their experience of multi-agency consultation between CAMHS, primary care and social services regarding a family where the different professionals felt very concerned for the welfare of each family member. They suggested that multi-agency consultation can provide containment of anxieties and opportunities for collaborative learning which they found dispelled the need to pass the cases on to different services. Both consultation and consultancy services therefore may aid the provision of integrated services where there is less potential for clients and their families to be lost in referrals to many different services and less potential for diffusion of responsibility regarding the care and services offered amongst a large professional network.
Summary and the Development of My Own Stance

Consultation and consultancy both involve clinical psychologists engaging in work with their colleagues in thinking about how change in practices can be accomplished through harnessing the skills of the consultees. One argument for why clinical psychologists should consult is that it offers the opportunity for other professionals and/or families to deconstruct the view of the psychologist as “expert” which facilitates sharing of skills and knowledge, greater collaborative working and dissemination of psychological understanding of difficulty. In contrast, this role may involve tolerating frustrations when change does not occur, advice is not implemented and when there are different agendas from higher levels of management regarding expected outcomes of the work.

Using a systemic model of consulting with families can encourage the family to draw upon the strengths within their support network and therefore empower the family. It may also help the clinicians to maintain a more open standpoint since the reflecting team could highlight when a dominant viewpoint is being heard and perhaps there might be different views which are not. The literature suggests that there is a demand for psychologists to provide internal consultation within the organisations to which they belong and that use of this role can aid other professionals' views of psychologists. There is however, still stigma and suspicion around meeting with clinical psychologists even amongst professionals within the NHS. In addition, better relationships between different agencies may help the clients feel that there is more comprehensive and cohesive help available and reduce the potential for them to be passed amongst and between different services.

It should be noted that I have mainly reflected on aspects of consultation and not so much on consultancy. One area in which psychologists can have an impact on service delivery is on the
development of governmental policies and legislation. This is a further area that could be explored to extend the debate.

I think that clinical psychologists do have a role in trying to facilitate psychological services within the NHS. Through modelling systemic approaches, psychologists may contribute to services which recognise the skills and strengths of its members and also those who access the services. I believe that through contact with our colleagues and acknowledgement of areas of good practice, the NHS system may feel supported in considering and implementing different ways of working. This process may be difficult and involve tolerating our own frustrations but I feel there is a need for change within services. By reflecting on our own practices and denouncing the position of "expert" we might be able to provide other professionals with alternative ways of working that may enhance confidence in their own abilities as to how to support people who can arouse anxieties within themselves. Part of my own ambivalence about psychologists offering consultations may be that change can be extremely difficult within a system that endorses hierarchical power relationships and dominance of the medical model both of which can contribute to psychologists feeling disempowered, isolated and unable to contribute to change.

Albee & Fryer (2003) highlight why change can be difficult within systems and therefore may contribute to psychologists' reluctance to consult:

".......effective and far reaching prevention needs organisational, institutional and social change. This is not only expensive but also involves conceding power and control, anathema to corporations and governments (p. 73)."
References


To Consult or Not to Consult?


46

URN: 3445275
To Consult or Not to Consult?


THE RELATIONSHIP TO CHANGE

March 2005

YEAR 1

Word Count = 1994
The Problem Based Learning (PBL) exercise consisted of trainees working in our Case Discussion Groups to produce a presentation on “The relationship to change”. This was the first time that the groups had met and this influenced the way that the group to which I belonged approached the task. In reflecting on the process of the group exercise I am going to focus on how the group changed and how I changed within the group. We used the Stages of Change Model (Prochaska and DiClemente, 1992) in our thinking about change and as the basis of our presentation. I will consider the usefulness and the weaknesses of the model in applying it to my clinical work on placement. With the hindsight of clinical experience, I have learned about the importance of the therapeutic relationship (two-way relationship) as a vehicle for change. However, there can be an expectation that the psychologist is the agent of change. We did not consider this in our presentation but I feel that this would be an important aspect to include. In addition, I shall discuss the process of change within systems and the importance of considering our clients' social systems when working towards change.

Formation of the Group

The group was assigned the task of producing a presentation on “The relationship to change” which we all felt was a vague topic. It was the first time that the group had met and therefore we were all eager to please one another and I very much felt the need to be liked and accepted. This made it difficult to critique other members. The roles of chair and scribe were assigned on the basis of the first two names on the group list since no member voiced a preference for a particular role. Furthermore, out of the 6 sessions we had to complete the task, 3 sessions were facilitated by a member of the course team (tutor). When the tutor brought new ideas to the group these were incorporated into the presentation. I was aware of the power differential between the tutor and myself and that the tutor had much more experience/knowledge. This probably added to my discomfort when I noticed the tutor keeping notes in the sessions that she attended. Even when the
tutor was not present every effort was made to report back on what the group had worked on and feedback was sought.

This is also similar when meeting with a client. There is a power differential and therefore the client may feel the need to please and be accepted by the therapist. Writing notes in the session may also make the client feel more anxious. Furthermore, I have found that I feel a need to be accepted by the client especially since I am required to meet with a certain number of clients in order to pass the placement. Therefore I find it difficult to discuss more challenging material when I meet with a client.

Due to there being a time-limit of 6 sessions to produce the presentation, I felt anxious that the group should be quick to produce an idea. I sense this contributed to the group being very task-oriented to the detriment of reflecting on the changes that we were experiencing at the time. This may also occur within the clinical setting in that many interventions are time-limited. Thus the work could become very task-focused with little reflection on the therapeutic process, which the research suggests is fundamental to a positive outcome.

Although the exercise was about shared learning and working in groups it was interesting that most of the groups were very protective of their presentations and therefore did not share their resources with people in different groups. Within our group, when one group member brought up problems with the Stages of Change Model (SoCM) the rest of the group tried to convince her to stick with the idea and include the limitations. This has highlighted the influence of majority views and group membership within and between groups which is useful when thinking about how I work within a team.
The Stages of Change Model

Prochaska and DiClemente (1992) suggest that the process of change involves 5 stages: “Pre-contemplation”, “Contemplation”, “Preparation”, “Action” and “Maintenance”. Relapse is also considered a normal part of learning and change. We chose this model since we felt that it encompassed many factors from different theories of change. For example, the cognitive-behavioural model suggests that the rationale for the work should be provided to aid the client’s consideration of change, thus facilitating contemplation and preparation. Also, I have found the SoCM to be useful in contemplating how motivated people may be when engaging in psychological work.

Since I began my placement in a Primary Care Mental Health Team (PCMHT) I have realised that services may not meet the needs of somebody who is at the pre-contemplation or even contemplation stage. For example, if somebody does not attend 2 appointments they are discharged. This has ethical implications for people who access services but are ambivalent about change.

One area that we did include in our presentation was the idea that change is difficult. I found the exercise difficult and at times struggled with seeing the benefits because it was a change advocated by the course rather than being a self-selected change. With hindsight I realise that clients may also feel apprehensive if they perceive their expectation of change to differ from that of the psychologist or if the change is reinforced by external agencies rather than being something they have contemplated themselves. I have found that change is dependent on how the individual experiences the outcome of putting change into action. For example, I am working with a client who compulsively checks. After what I considered to be small decreases in the frequency of his checking, his mood appeared to significantly improve and he began to involve himself in more
social activities. He did not want to make further changes to his rituals as he perceived the costs to greatly outweigh the benefits.

In our group’s presentation we aimed to highlight that change can be difficult through presenting the processes that can help or hinder change within the SoCM. We focused on change for our clients and also our own changes from first studying psychology to becoming a trainee. However, change can also be seen as a two-way process between therapist and client as part of collaborative working. This would have been a helpful area to reflect on in the group’s presentation.

The Therapeutic Relationship

The SoCM does not consider therapist variables in its postulation of how change occurs, although it does consider the importance of helping relationships. Through working with clients in a PCMHT I have gained a greater understanding of the importance of managing difficult emotions within the relationship and I have learned that I also change with my clients. In supervision I reflect with my supervisor upon how I can use my experiences with a client to aid progress within therapy. Just as the therapeutic relationship is fundamental for change to occur, I have also found my relationship with my supervisor to be important as my learning in supervision contributes to how I interact with my clients. Similarly the group changed when it received input from the tutor and our relationships with the tutor were important to how the presentation progressed.

I felt that the group expected the tutor to give us her guidance and that she held the “right way” as to how the exercise should be approached. I definitely felt that I agreed without question to everything that she contributed without exploring what had influenced her views. With regards to my clinical work, I thought that conflict was always detrimental to the therapeutic relationship. However, I have learned that open discussion of differences in opinion can be beneficial in
helping clients to reach their goals. This relates to the SoCM in that movement through the different stages of change does not occur in a one-way sequential process and relapse does not indicate failure but is an important learning experience.

Since beginning my placement I have experienced that the psychologist may be expected to be the agent of change within mental health services. This can be especially pertinent when change involves a reduction in risk. This may influence the focus of work to be on the costs of not changing, yet the expected change in behaviour may not be valued within the client's social network and can impede change outside of the therapeutic setting.

**Change within Social Systems**

Our group focused mainly on the process of change within an individual. Prior to training, my experience had been working with people on inpatient units where family members and/or friends rarely visited and had less of an influence on the clients' social environment. However, since being on placement I have learned the importance of considering mental health difficulties within the client's social context. For example, I am working with the mother of a client. She is involved in her daughter's cleaning and washing rituals and part of my work is supporting her through the process of change with her daughter. Although both view the rituals as problematic they also function to keep them in a very close relationship. Therefore, exploration of investments in maintaining the status quo can elicit useful work on raising awareness of the costs and benefits of change not only for the client but also within their relationships with others. This is an area where I feel I have little experience and would like to learn more about working with social systems, such as families, in order to gain a greater understanding of the process of change within social networks.
When I first started my placement, the team was undergoing change in that it was moving address and also merging with another team to form the PCMHT. Different team members coped with this in different ways. It was a particularly tense time and some people went on sick leave consequently increasing the workload for other members of the team and there being less support available to the clients. Following the move, the new PCMHT adopted a different way of working which was not initially adhered to due to difficulties within the team's relationships. This emphasised to me the importance of social support in the action and maintenance of change within teams and how this can have implications for our clients.
Thinking back to the exercise, I feel that, as a group, we were considerate of one another and shared our anxieties. However, we became very task-oriented to the exclusion of reflecting on our relationship to change within the actual exercise and how this could aid our thinking in working with clients. We chose to focus our presentation on the SoCM. This model has been useful in my clinical work in thinking about clients’ views of change and also how change may be difficult. However, we did not consider how we may change with our clients. The SoCM emphasises the influence of a client’s social network in supporting change but it does not consider change within a system. Through working with a carer I have recognised the importance of thinking about difficulty in the context of relationships and how change affects those within a client’s social system. This is also relevant in thinking about my role within a team.

I feel that reflecting on the PBL exercise has encouraged me to think more creatively about how I can use my own experiences to aid my clinical work. Also, it has highlighted the role of reflective practice in my personal and professional learning. However, I am aware that reflection may be more difficult at times of increased anxiety, time pressure and also when teams or groups are concentrating on practical tasks. Thus reflecting on the PBL exercise has helped contribute to my own relapse prevention and will hopefully help me to maintain this change in my learning style.
References

CHILD PROTECTION, DOMESTIC VIOLENCE, PARENTING AND LEARNING DISABILITIES.

March 2006

Year 2

Word Count = 1999
As part of the Problem Based Learning (PBL) exercise, the group was given an example of a case where Mr and Mrs Stride, both of whom were described as having learning disabilities, had their 3-year-old twin daughters (Sally and Sarah) placed into short-term foster care. The children were considered to be at risk of emotional abuse and neglect whilst living with their parents and were placed on the child protection register under these 2 categories. The scenario was that the children’s Guardian had approached us, as clinical psychologists, to help the Court decide on the care of the children. Mr and Mrs Stride were described as “passionate in their commitment to have the children returned to their care” (see Appendix 1 for the information given about the family). In contrast, the Local Authority felt it was best that the children be placed for adoption.

In the following account, I will briefly describe the processes the group went through in terms of formulating the family’s situation and outline our beliefs about what constituted “the problem”. I shall describe the 4 main themes that arose when I reflected back on how the group approached the exercise. Firstly, I shall describe how we struggled with positioning ourselves within the network surrounding the family. Secondly, I will reflect on the group’s vision of empowering services and the influence of my ideals on my work with people with learning disabilities. Thirdly, I will consider how our personal experiences impacted on our approach to the exercise. Finally I will discuss how, by focusing mainly on Mr and Mrs Stride’s experiences, we neglected thinking about the children’s wishes.

It was the group’s consensus that the term “learning disability” is a socially constructed label. By describing Mr and Mrs Stride as people with learning disabilities, I aim only to highlight the different experiences they have probably had due to having this label.
Positioning Ourselves within the System

There were many different agencies working with the family, all with varying opinions as to what would be best for the children. This was a very complex system and therefore the group began by assigning tasks aimed to unpick possible factors contributing to the family’s experiences and the risk to the children. None of the trainees had experience of working with children or people with learning disabilities. We each, therefore, took one of the following areas to look into: the system around the family; parents with learning disabilities; child protection; the socio-political impact of poverty; assessment of risk within a family where there is domestic violence. This was useful in helping us to gather information and think about how we would position ourselves within the professional system surrounding the family (see Figure 1).
We struggled with how to incorporate the differing views about Mr and Mrs Stride's parenting skills. We felt the different agencies had compartmentalised roles and there was little sense of how they all formed an integrated support network. At the time I underestimated the impact that multi-professional networks can have. Since working in a learning disabilities service, I have formed relationships with professionals within educational, health, social, residential and voluntary agencies. It has been both interesting and frustrating to see how power dynamics between different professionals (including myself) can impact on the support offered to the client. It is easy for conflict of opinions to arise between professionals regarding who holds the “right” view. I have found that this can lead to blame towards professionals with less power (e.g.
residential staff) and mirrors the disempowerment the person with a learning disability experiences. I have realised how delicately power relationships need to be managed and how little these are reflected on amongst teams. I believe that it is important for me to critically appraise my own role within the professional system in order to be, as Frosh (2003) suggests, aware of what psychological work reveals about the relationship between the psychological and the social; power and dominance; and the unquestioned assumptions about “human nature” that are made.

Empowerment: Ideology or a Reality?

A significant theme we focused on was the disempowerment of the family. We felt Mr and Mrs Stride needed to meet standards of parenting that were much higher than for parents without learning disabilities. Booth and Booth (1994) highlight the scrutiny under which parents with learning disabilities are placed, by services designed to support them. This has been reinforced by my experience on my current placement. It seems as though consent has only become a fairly recent issue in thinking about the rights of people with learning disabilities and other vulnerable groups. This became apparent when a case was presented to the European Court of Human Rights (2004) where the rights of a man with a moderate learning disability were infringed because he appeared to be “compliant” with inpatient treatment (the “Bournewood” Judgement). Consequentially, the Mental Capacity Act (2005) became legislation to protect the rights of people considered likely to acquiesce.

I have struggled with my own feelings of anger as to how services have violated the human rights of some of my clients. This has been especially pertinent to my work with a client who was sterilised against her wishes in the early 90s, and who blames herself for being sterilised. I have experienced just how different I am in terms of having the power to make my own choices about my body. I have struggled with how I work within services that endorse practices that do not fit
with my own moral and ethical values. This was also a prominent theme within the group. We often took a critical approach which left us questioning what we could do to change the more unhelpful aspects of services and how we would manage feelings of failure when things don’t change. McBrien and Candy (1998) highlight that change within learning disabilities services will be enhanced by committed psychologists, who can tolerate the frustrations of working in complex organisations. This provoked me to think about the value of ensuring I have support from colleagues in constructively managing my dissatisfactions with my role in organisational systems.

When the Professional is Personal

Although the trainees in the group had met together for over a year, the facilitator was new to the group. It was probably quite difficult for her initially as she was not aware of our relationship with her predecessor, with whom we became very task-focused when we did a different PBL exercise. We were very reluctant to become too task-focused early on in the formation of our ideas and therefore, probably seemed resistant towards some of her suggestions. She asked us about our expectations of her and what we had learnt from our experiences with her predecessor. This helped to emphasise the importance of understanding clients’, and other professionals’, previous experiences of services and of psychologists. For example, if people have had experiences of services being abusive (whether racially, physically, sexually and/or emotionally) they might find it more difficult to talk to a white, middle class professional who represents those services. I have learnt that these are potential barriers to collaborative working and can have a personal impact if not explored.

I feel the group’s ethos with respect to the Stride family, was influenced by one group member who spoke about a family member with a learning disability. The task, therefore, was very personal to her. She highlighted that social stigma also contributes to the sense of failure and
difference experienced by many people with learning disabilities. We decided that the problem was the responsibility of a system much more complex than that surrounding the family. Each of us felt very strongly that it was a societal issue. It may seem very idealistic to expect change to occur at this level but we each felt we had a responsibility to highlight the huge impact stigma and poverty have on disempowering people with learning disabilities. This was in no way an excuse for any violence, but it helped our understanding of factors that can contribute to the strains of parenting within families where a parent or parents have a learning disability.

**Domestic Violence: What about the Children?**

Risk was a very difficult area, especially when we thought about the children being in a household where there was domestic violence. It is never possible to be sure of what is better for a child, a life in care or being in a family where they may be abused or witness abuse. This leaves professionals having to cope with lots of unanswered questions (Frosh, 2003). We were concerned about the impact poverty had on the family’s coping skills and access to support. We held an assumption that the risk to the children would be reduced by long-term support from services carefully set-up to help Mr and Mrs Stride understand the needs of their children. Cotson, Friend, Hollins and James (2001) highlight the necessity for an assessment of children in need to be multi-disciplinary, and that the roles of different specialist services should be outlined as to how they are complimentary to protect against splitting between the services. Our group acted very much as the champions of the rights of Mr and Mrs Stride, probably because we had all just completed our adult placements. This impacted on thinking about the rights of Sally and Sarah, the 2 children. Reflecting on this has highlighted my duty of care and legal responsibility to ensure the protection of any children who may be at risk.
Cotson et al. (2001) suggest that people with learning disabilities are more likely to have experienced some form of abuse. This may affect their own parenting skills, and ability to protect themselves and their children from future abuse and exploitation. Mrs Stride had been brought up in care and both Mr Stride and her previous partner had been violent towards her. I think that because the children were aged 3, we found it difficult to think about how we might include their wishes. In my clinical work, therefore, I need to be mindful of any behaviours which may indicate that the person has been abused, especially in children, or people with communication difficulties.

It was really difficult to position ourselves within such a complex professional network surrounding the Stride family. It was difficult to incorporate many opposing views and understand how these impacted on the services the Stride family received. I have discussed how conflicts of power between professionals can lead to unsupportive services that are confusing for the client. I have also reflected on my role within services that can disempower people. Through this, I have learnt the importance of having peer support in managing my frustrations when practices do not change. This led me to discuss how previous experiences affect the relationships between myself, my clients and other colleagues. Finally, a criticism of our presentation was that we did not focus on how to consider the wishes of the children. I need to be mindful of my responsibility to protect any children, whether or not they are my clients.

I would not change our presentation and feel that we offered something new to think about in terms of the social and political aspects of our work, especially when thinking about working with families where there are child protection concerns and one or both parents have a learning disability. I do, however, believe that we neglected exploring the children's wishes. I realise that managing risk can be very anxiety provoking, especially where there are children involved. I felt that the impact of stigma and poverty contributed to the risk to the children, which are important
considerations for services working with parents with learning disabilities. This could help highlight potential goals for service development. We felt that it was important to do everything possible to keep the family unit together, managing the risk through services providing cohesive support long-term, an ideal agenda that is not a governmental priority.
References


APPENDIX 1

Problem Based Learning Exercise

Child Protection, Domestic Violence, Parenting, and Learning Disabilities

The Family

The Stride Family

Live locally
Supportive

Mr S

26

Raised in the
care system
Mrs S

40

42

Twins

Sally

Sarah

3

3

14

16

No contact with mother and father

The Professional Network

= Domestic Violence

Child Protection, Domestic Violence and Learning Disabilities
The Problem

The twins, Sally and Sarah Stride, were placed in short term foster care, following a recommendation of a full child protection case conference, and enacted at an initial Court hearing, that the children continued to be at risk in the care of their parents. The children were on the child protection register, under the categories of emotional abuse and neglect. The children's Guardian has approached you, and asked you to help the Court by conducting a full risk assessment, and if appropriate, to help the Court develop a rehabilitation plan for the children. This is a joint instruction by all parties to the proceedings. However the Local Authority wishes to place the children for adoption, before it is too late, in the belief that Mr and Mrs Stride will never be able to care adequately for their children. Mr and Mrs Stride are passionate in their commitment to have the children returned to their care.

Whose problem is it? Why?

Some Background Information......

Mr and Mrs Stride are white English. They live on State benefits. Mrs Stride is described as a woman with learning disabilities, in the mild range. Mr Stride attended a school for children with special educational needs. Mr and Mrs Stride do not read and write English. It should be noted that many long reports have been written about them, their children, their care of their children and so on. Their solicitors read the reports out loud to them, usually once, and sometimes on the morning of a Court hearing.

Mrs Stride has two older children living with separate adoptive families. She is not able to have contact with them at the moment, as it was a closed adoption. This is because her first husband was extremely violent to her, and threatened violence to the previous social workers. Social Services staff feared for the safety of the adopters if their whereabouts were known. Mrs Stride promised herself it would be different with this marriage and for these children.

Mr Stride has physically assaulted Mrs Stride, during disagreements. She minimises his behaviour, saying it is nothing compared to what her previous husband used to do to her. The two children have witnessed these arguments and assaults.

Mr Stride's parents are supportive. They buy clothes and toys for the children, and occasionally buy food shopping for the family. Apparently, they are unable to look after the children, because Mr Stride's mother suffers from a painful rheumatic condition. Mrs Stride was raised in the Looked After Children system, and has no contact with her family of origin.

Mr and Mrs Stride live in conditions of deep poverty. They do not have many household appliances that work, and it seems that Mrs Stride struggles to understand the workings of the second-hand appliances donated to them by family. It would seem that Mr Stride understands their workings, but is not prepared to use them. Social Services staff are most concerned about physical neglect of the children's needs. Family Centre staff say they have tried to engage both Mr and Mrs Stride in parenting classes, but the couple do not attend on a regular basis. The Family Centre appointed a family worker to visit the home, and show Mrs Stride 'how to keep house'. The family support worker has not
been trained to work with parents with learning disabilities. The Social Worker says the Department has offered the family everything, and it makes no difference to the care of the children.

Mr and Mrs Stride are desperate about the loss of their children. They want them to come home. They fiercely resent the foster carers, and the supervisor of their contact with the children. The children's Guardian believes the parents can learn to be 'good enough' to satisfy Social Services requirements. Mrs Stride was referred to the local AMH service for help with feelings of despair and depression. She is taking anti-depressant medication, and is seeing a CPN for counselling.

Prompt Questions

.....something about paying attention to the professional network (liaison, communication, respective roles)
.....something about safety, risk assessment and risk management
.....something about parenting and LD
.....something about child witnesses to domestic violence
.....something about the effects of poverty and class discrimination
.....something about literacy and verbal comprehension (effects of anxiety and stress on memory and comprehension, and willingness/ability to express concerns, and say, 'I don't understand these reports')
.....something about resilience, adversity, depression and coping
.....something about the role of grandparents in the care of children
.....something about children of parents with learning disabilities
.....something about gender issues and scripts
.....something about psychologists, child protection and the legal system
UNIVERSALITY IN DIVERSITY

February 2007

Year 3

Word Count = 1994
For our final Problem Based Learning (PBL) exercise, we were given a scenario that related to working with older people. The scenario was of a family where there were concerns that the father may be developing dementia (see Appendix 1). Whilst discussing the scenario we realised that there were many aspects of the family’s story that resonated with us, due to similarities within our own families or with the experiences of friends. The main themes that arose for me were: ageing, bereavement and loss, immigration, cultural and religious beliefs, loyalties, and responsibilities to others and for oneself. We were mindful of not making too many assumptions about the family based on the limited information that we had. We decided to try and understand more about the family members, and their different positions, by interviewing people who shared some similar experiences to those of the different members of the Khan family. We interviewed people we knew and presented their stories via a video.

In the following account I will concentrate on four main areas of personal learning that have arisen from reflecting back on the process of the PBL exercise. The first is the value of learning from others’ experiences in challenging our own assumptions; the second theme is understanding tensions and loyalties within the context of intergenerational relationships; the third is how to be sensitive to cultural differences and provide services that respect the needs of people from different cultures; the fourth is understanding the value of social support in contributing to personal change. When I discuss the impact of these four areas on my clinical work, I shall use the term client to describe both individual clients and their family members.

Perspectives from Personal Experience

We were confused by the conflicting information given in the written content of the exercise and that displayed in the genogram. Our rationale for making the video therefore, was to emphasise the value of exploring people’s experiences in order to challenge our own a priori assumptions.
We felt it was important to remain curious as to what was important to each family member and to how they each defined “the problem”, if they defined it as a “problem” at all. Michael White emphasises the importance of “bearing witness” to people’s stories and suggests this can be a vital process of change (White, 1995). We wanted to further this idea and suggest that listening to clients is also a powerful way in which clinical psychologists develop their own therapeutic skills. We wanted people to connect with the interviewees’ stories as a way of bringing to life the scenario of the Khan family and possible challenges that clinical work might pose. Unfortunately though, we did not maximise this opportunity for learning as we did not invite the audience to reflect on their responses to hearing these stories.

In listening to the interviewees, I realised that everyone’s stories were very different as to how I expected them to be and they really highlighted the interviewees’ resilience in managing family tensions. This made me think about the importance of checking out any assumptions we have with our clients and asking about how they have coped. Since being on placement, I have realised that asking about how people have coped can help to validate people’s attempts to change their situation and especially show older people that you respect their life experience. It can also contribute to more empowering narratives about people’s lives.

Making the video and being on placement has raised the issue of how I provide the opportunity to hear marginalised voices, especially considering that many of my personal experiences of distress have been related to not being heard, understood and/or believed. This has been demonstrated to be a barrier to services to people from marginalised groups (e.g. Marshall & Yazdani, 1999). On my older people’s placement I’ve realised that carers and/or family members can often speak on behalf of an older person. The intention behind this appears to be trying to help the older person, yet it can also disempower them. This has provoked thought about how I create a context for
listening to people who may feel marginalised and has highlighted the importance of considering the family context when trying to understand people's experiences.

**Intergenerational Family Relationships and their Contribution to Change.**

In our presentation, we interviewed people across the adult age range about their family relationships. It would have been interesting also to interview children but, given the time, this was more difficult in terms of consent. I felt it was significant that all the interviewees spoke about legacies within their families and tensions caused by different expectations particularly with regards to their obligations to others. This seemed to fit with some of theory underlying contextual therapy (see Hargrave & Pfitzer, 2003), which suggests that everyone strives for a sense of justice and that a sense of injustice arises when there is an imbalance between the obligations we have and our entitlement to needs (e.g. love and trust). Hargrave and Pfitzer (2003) propose that there is no balance between parents and their children as parents have more obligations however, this is balanced with the entitlements they received from their own parents. Distress therefore, arises when these intergenerational obligations and entitlements are not balanced.

I felt these ideas fitted with many of the stories of our interviewees as difficulties were spoken about where loyalties to a parent’s expectations contrasted with the formation of their individuality. For example, one interviewee spoke about feeling that her entitlements to support from her mother had been affected by her adopting different spiritual and religious beliefs from that of her mother. Similarly, it is interesting that on my older people placement, I am working with a few clients for whom not having grandchildren is a source of tension in their relationships with their adult children. Furthermore, two interviewees spoke about changes in parents' abilities to meet their obligations in older age, where the parent may become cared for rather than the
carer. I'm not sure how contextual therapy addresses this issue but it does highlight the importance of exploring how obligations and entitlements are managed across different family generations and how they change over time. I think it's also important to note that all of the interviewees highlighted the influence of culture, to some degree, in understanding the context of tensions and loyalties within families.

**Sensitivity to Cultural Differences: Are We Really Worlds Apart?**

When our group first began to discuss the scenario we decided that we did not want to assume that the main theme we needed to address was that the family were Muslim and therefore stereotype the family. I think my experiences on placement and of doing the PBL exercise have reiterated the importance of being curious around experiences but being careful not to assume that a person’s experiences must be different from our own or from other clients’ just because they have a different cultural background. For example, for the PBL exercise, I interviewed a friend’s father who had migrated from India to England in the 1960s. I was struck by how he did not seem to ascribe importance to his beliefs as a Hindu in helping me to understand his wishes for his children.

Halsey and Patel (2003) suggest that for clinical psychologists to provide culturally sensitive services, we need to be aware of our own personal motives, values and beliefs and how these might be impacting on our understanding of our clients’ needs. They highlight four positions clinical psychologists can take which, although intended to be helpful, may provide barriers to providing culturally sensitive services. Two of these particularly stood out for me in terms of our approach to the PBL exercise; these are the “exotic” and the “colour-blind” positions. As a group, we spoke about finding a balance between the “colour-blind” position (ignoring the possible impact of a person’s cultural and religious beliefs) and the “exotic” position (the assumption that
if someone is from a different cultural background, this makes them the subject of interest because their experiences would be completely different to our own. I’ve learned that it is difficult to achieve this balance and is something I need to consider more in supervision not only in terms of being culturally sensitive, but being considerate of a whole range of factors that are important to an individual and/or their collective identity. The group’s facilitation of these conversations has shown me how important supportive relationships are in my development.

Taking Risks: Who’s Going to Help Me Take that Leap?

By taking the risk of presenting a non-traditional approach to the scenario, we were inadvertently challenging the concept of there being a “best way” of understanding the family’s situation. We were not sure how this would be received by our audience and I think it shows our progression as a group as, over the past 3 years, it has become easier for us to reflect on the relationship between power and knowledge and the influence of our own roles within this. I have found it to be extremely important that all members of our group have contributed to supportive relationships where we feel able to critically reflect on our contributions to power relationships.

I have enjoyed deconstructing the concept of “evidence” and reflecting on how certain types of knowledge become valued over others. Dallos and Draper (2000) define social constructionism as a framework for thinking about theories rather than a theory in itself. It is an approach that considers how knowledge comes into being and provides a critical way of thinking about “truths” and evidence. I think that adopting this constructionist position within our group has been really helpful because it’s given me more confidence as to how I raise questions with my colleagues as to understanding the political and social impact of our work and the services we work in.
Through our group’s approach to the PBL exercise, I have realised the importance of having the space to be able to reflect with my peers about the kind of clinical psychologist I want to be. This is not easy and sometimes it means looking at the things I haven’t done very well and being honest about the impact of my work on my personal life and vice versa. As with clients, this takes a trusting relationship with people who can be open and honest with you without denigrating what you say. Consequently, I hope that our group will continue to support one another post-qualification and that this experience will motivate me to find similar support from groups of people with a vested interest in adopting a more critical approach to services whether they contribute to and/or receive services, and/or are a carer.
In summary, the PBL process over the past three years has been a helpful process in thinking about a multiplicity of learning models and how we approach understanding our clinical work. In this final PBL exercise, our group presented, by video, the stories of people who shared both similarities and differences with the Khan family. Doing the interviews highlighted how the therapeutic relationship is a two-way process in which I take as much from my clients’ experiences as that to which I may contribute. I have also moved from a more individual approach to my work and realised the importance of intergenerational family relationships in understanding people’s experiences. Overemphasising or underestimating difference can be problematic and is a tricky balance to achieve. This has highlighted the need for supervision which provides a space for me to reflect on this conflict both personally and professionally. Finally, I feel very privileged to have had a supportive group that has provided a safe context for us to grapple with more personally and ethically challenging issues. I hope to seek similar support throughout my development as a clinical psychologist to help me further understand the political, ethical and social aspects of my work and the services that I contribute to.
References


APPENDIX 1

Title: Working with Older People

Problem Based Learning Exercise

The Problem

The youngest daughter, has contacted Social Services about her father’s health. She is concerned about her father who has been suffering from short-term memory problems. He has been leaving the kettle on and saucepans on the stove to boil dry. He has been neglecting himself and his physical health is deteriorating. He has lost some weight and he has been eating out-of-date food.

The youngest daughter is urging Social Services to do something and also asking her older sister, to return from Pakistan to help sort out a solution for their father’s care.

Some Background Information

is 72 years old. He migrated to the UK from Pakistan in his mid 30’s. He is a retired bus driver. He learned English after coming to the UK.

His wife died of cancer 9 months ago. did not speak English and spoke only Urdu. She was primarily a home maker, working occasionally as a private dress maker.

have 2 daughters and . Both daughters were born in the UK and have had English education. The eldest daughter, had an arranged marriage in Pakistan where she lives with her family. Her husband is a shop-keeper. They have 3 children. eldest son Imran is currently contemplating coming to the UK to University.

the younger daughter married a European and was disowned by the family. She had no contact with her father till her mother passed away 9 months ago. and her husband have no children. She is University educated. She and her husband are both journalists and fairly mobile, travelling 3-4 days a week throughout Europe and sometimes at short notice.

were both religious and had links with the Muslim community. However, and fell out with the mosque about they way they responded to his wife’s death. He has stopped going to the local Mosque but continues to pray at home.

Prompt Questions

...something about who speaks English, who speaks Urdu and who speaks both?
...something about the rift with the community in the Mosque and the potential for mediation?
...something about understanding religious faith and appropriate culturally sensitive solutions?
...something about grief and mourning – individual, family and community based?
...something about impact of migration and loyalties to country of origin and host country?
...something about the possibility of going back to country of origin?
...something about appropriate residential care and relationships with staff and other residents?

79

URN: 3445275
Universality in Diversity
...something about assessments, short term memory, self-care and differential diagnosis?
...something about assessing risk to self?
...something about relationship with social services and other professional systems?
...something about the role of the Psychologist, MDT, etc?

Date: 16th May 2006
About to come to UK to study

International Correspondent

Joumei (Jounesi)

University of Sheffield

Speaks English + Urdu

Arranged marriage

Speaks Urdu

Home-maker

Mr. Khan

Arranged marriage

Live in Pakistan

Relied on driver

Deed of consent 4 months ago

Home-maker and part-time driver

Pakistan

Joumei (Jounesi)

University of Sheffield

Speaks English + Urdu

Arranged marriage

Speaks Urdu

Home-maker

Mr. Khan

Arranged marriage

Live in Pakistan

Relied on driver

Deed of consent 4 months ago

Home-maker and part-time driver

Pakistan
SUMMARY OF CASE DISCUSSION GROUP
PROCESS ACCOUNT – YEAR 1

September 2005

Year 2

Word Count = 298
The case discussion groups (CDGs) were formed at the beginning of the first year with the purpose of providing a forum to discuss and reflect on clinical work. The CDG to which I belonged consisted of 5 trainees and a member of the course team (tutor). The CDG met throughout the trainees' first placement within adult mental health services. Initially, I felt uneasy as I did not know the other group members and found myself being curious around their values and passions. It felt as though we were all apprehensive as to how the other group members' perceived us because we all tended to agree with one another's views. I believe that the CDG became more cohesive as the group validated the experiences and anxieties that we each shared. This was done in a fairly formal format since we were not sure how to use the group and the tutor suggested that we might start with each person presenting a piece of clinical work. This provided a forum for us to draw upon others' expertise and also to explore universalities in our experience.

As the group progressed, I felt that it was important that the group shared the responsibility for what was brought to each meeting, rather than rely on ideas provided by the tutor. However, not everyone in the group agreed and this highlighted the importance of individual members of a system sharing a rationale for change in order for this to occur and be maintained. As the group progressed, the members began to share more personal information which was important to normalising experiences of distress and understanding the impact our work has on ourselves. I think the CDG was helpful in reflecting on what we bring to the therapeutic relationship and the services we work in.
SUMMARY OF CASE DISCUSSION GROUP
PROCESS ACCOUNT – YEAR 2

July 2006

Year 2

Word Count = 297
The CDG remained the same throughout the trainees' second year except for the facilitator, who was a regional clinical psychologist external to the course team. In comparison to the CDG in the first year, the group had clearer ideas as to how we wanted to use the meetings. This involved understanding the political context of our work and the ethical dilemmas this can pose. It was important to feed this back to the facilitator and discuss with her how our ideas had arisen so that she could understand the history of the group and our expectations of her role. I felt this helped her accommodate our philosophies into her style of working. The CDG was a useful forum to think about power relationships with colleagues, particularly supervisors. This was helpful in thinking about how we provide opportunities to hear the voices of those who feel disempowered and who are marginalised within society.

The group tended towards thinking about their roles within services rather than individual pieces of clinical work. We thought about our professional development and how we manage dominant cultural discourses within the NHS that we believe to be unhelpful and that challenge our personal ethics. We focused on injustices that people can experience within NHS services, society and Western culture and how we address these. Exploring power, how it is gained and how it is used was helpful in considering how we help empower the people that we work with in a way that is meaningful. This led us to consider endings and how to acknowledge the privilege of joining people, families and larger systems in their journeys through difficulty. We commemorated the ending of the second year CDG by giving one another cards with personal messages of what we valued about one another's membership.
OVERVIEW OF CLINICAL PLACEMENTS

September 2004 – September 2007

Years 1 - 3
1) **Adult Mental Health Services**

I worked within adult mental health services for twelve months. This involved working across Primary Care Mental Health, Early Intervention in Psychosis, Assertive Outreach and Psychiatric Rehabilitation and Recovery services. The variety in my placement gave me the opportunity to work across both inpatient and community settings. The main theoretical models that were used to inform my work were the cognitive-behavioural and psychodynamic models. I also worked with adults from a range of backgrounds and of a variety of ages. This placement helped to gain a grasp of how different services are organised and how care is offered across different services. I enjoyed helping people to explore the meaning they attributed to their own recovery.

2) **Community Learning Disabilities Services**

My work with people with learning disabilities was varied in that I worked with both adults and children living in their own homes, supported accommodation, residential settings and inpatient settings. I also worked with families and individuals from diverse backgrounds. The placement lasted for six months. My experiences on this placement highlighted how societal responses to people with learning disabilities can contribute to their distress and appearing less skilled than they are. It helped me to think about how to empower people who historically have been given little or no choice about their own lives. The main theoretical models I used to inform my interventions were cognitive-behavioural, behavioural and psychodynamic. I also integrated systemic approaches to help me in my work with families and with multiple agencies. I was given the opportunity to co-chair a network meeting for professionals involved in a young woman’s care who felt divided in their approaches to helping the young woman.
3) **Child and Adolescent Mental Health Services**

I worked with children, young people, families and professionals within a looked after children’s service whilst placed with a Child and Adolescent Mental Health Team. The placement was for six months and ideas from systemic, cognitive-behavioural, behavioural and psychodynamic models were used to inform my thinking and work with individuals, families and professional systems. I had the opportunity to chair a network meeting for all the professionals involved with a family where the son was not eating and was regularly unwell. This helped to highlight the different stories that can get constructed and documented about people who access different services and how these can powerfully impact on the care they receive. Furthermore, I was involved in consultations to a looked after children’s team.

4) **Older People’s Services**

My older people’s placement lasted for six months and I worked with older people across the different generations of older age. This placement helped me to think about the experiences of later life and the impact dementia can have on people and their families. I worked with people who lived within their own homes and also people who were inpatients. I learned about the use of psychometric assessments to aid diagnoses of dementia and the ethical implications involved in doing this. The placement provided me with the opportunity to integrate approaches from systemic, cognitive-behavioural and behavioural models. This placement highlighted the potential roles clinical psychologists can have when working with medically oriented teams and the importance of helping professionals to value the experiences of people accessing their services.
5) *Systemic and Family Therapy Services*

I worked across two family therapy services with families and couples using systemic and narrative approaches. I worked with a range of people with diverse experiences and worked jointly with another colleague. This was helpful in giving me the opportunity to observe how others work and also in being able to offer multiple perspectives. I also gained an understanding of a range of systemic ideas ranging including structural, strategic and more social constructionist approaches such as narrative therapy. It was interesting to explore how the people I worked with had coped with trauma and the legacy this can have for couples and families. These placements have helped me to understand the powerful roles relationships play within a person’s experience and how change occurs. I was also involved in offering consultation to families and other professionals which included consultations to psychiatric rehabilitation and recovery services, eating disorder services, older people services and adult mental health services.
SUMMARY OF COGNITIVE BEHAVIOURAL THERAPY WITH A 19 YEAR OLD WOMAN PRESENTING WITH EMETOPHOBIA.

May 2005

Year 1

Word Count = 987

Please note that all names are fictitious and any identifiable information has been changed in order to maintain confidentiality.
Lisa Jones is a 19 year-old woman who was referred to psychology for help with her fear of vomiting. Lisa had previously met with the Dietician and Psychiatrist at the Child and Adolescent Mental Health Service (CAMHS) due to concerns that Lisa had been restricting her food intake.

Assessment
Lisa’s mother died from lung cancer in 1992, when Lisa was 7 and her brother was aged 3. Lisa felt that although a part of her was angry that her mother died at a young age, this was in the past and she needed to get on with her life. Lisa said that her family did not express their emotions and she never cried because she didn’t like to be perceived as weak. Lisa had experienced a fear of vomiting since she was aged 10, following an incident when she was sick at school and upset by the subsequent fuss. This reminded her of the fuss that people made around her when her mother died.

Lisa feared the physical act of vomiting and also was worried about seeing other people vomit. She experienced this fear most of the time, except for when she was at home. Lisa attributed her fear of being sick to a fear of losing control. Her fears prevented her from socialising with her friends and impacted on her employment such that she avoided going into work or made excuses to leave if she noticed herself feeling nauseous. She used strategies such as talking very quickly when anxious, and not eating when she knew that she was going out, to prevent or relieve thoughts that she might be sick. On assessment, Lisa’s scores on standard measures of anxiety and depression fell within the severe range.

Formulation
Lisa’s early experiences of emotions not being expressed and the death of her mother appeared to have contributed to beliefs that she should control her emotions. The incident where she vomited
at school precipitated feelings of anxiety about not being able to cope, which were associated with the physical sensations of feeling nauseous and being in social situations. When she felt nervous, talking faster was a strategy that she used to temporarily relieve her feelings and avoid her anxiety.

Lisa avoided going to unfamiliar places and eating before going out to pre-empt thoughts about being sick. Her avoidance probably contributed to the maintenance of her fear as it prevented her from evaluating the outcome of feeling nauseous, reinforced her overestimation of the probability of her vomiting, prevented her from assessing how people responded to her when she felt nauseous and also reinforced her perception that she could not cope when she felt distressed.

**Intervention**

Lisa and I worked within a cognitive-behavioural model for specific phobias as Lisa said that she wanted to explore practical strategies for managing her fears. She wanted to be able to go out without restricting her food intake and feel less anxious in social situations. We therefore constructed a hierarchy of situations that she avoided due to her fears and ranked these in order of difficulty. This provided us with a list of increasingly difficult exposure tasks for Lisa to work towards. Lisa started with the least anxiety-provoking situation and stayed there until her level of fear significantly reduced. As she mastered one situation, she moved onto the next situation in the hierarchy. Lisa also exposed herself to increasingly graphic pictures of people vomiting until she noticed her level of fear decrease to a tolerable level.

Lisa and I explored her beliefs about being weak and not being able to cope such that we thought about how she had managed difficulty in the past. Lisa discovered that the evidence supporting these beliefs was far outweighed by the evidence against her belief that she was weak and could
not cope. We also used logical reasoning techniques to explore biases in the way she appraised threat and the likelihood that she would vomit.

Outcome

At the end of the sessions, Lisa had repeatedly exposed herself to most of her hierarchy of avoided situations. She ate breakfast and lunch on workdays, and reported that she had put on weight for which she had received lots of positive comments from her friends and family. She had also looked at half of the pictures of people vomiting within a week’s practice, and had watched a film with her family which contained a scene where one of the characters vomited.

Lisa reported that her estimation of the probability that she would vomit when anxious had significantly decreased. Furthermore she had been able to challenge her thoughts when at work and had not taken any leave over the past 2 months. She said that she felt more confident in her abilities to cope and had written out a list of her achievements so far as a reminder.

Post-intervention Lisa scores on the BDI-II and the BAI significantly decreased such that her scores fell within the minimal range for both. As part of her relapse prevention plan, Lisa set herself some further goals to aid the progress she had made. We arranged a follow-up session for and agreed that change will have been maintained if she is regularly going out to places outside of work and her home, and if her anxiety and depression scores remain within the minimal range. Lisa hoped that she would have made further progress signified by enrolment on a course and having travelled to London on a train to go on a shopping trip with her step-mother. Lisa’s achievements both within and between sessions suggested that she would have probably maintained change at follow-up and made steps towards furthering her progress. Lisa expressed concerns about her parents’ relationship which could hinder Lisa’s progress in the future.
However, her strength and determination to work on the anxiety suggested that she would be able
draw on these resources at times where she may feel unable to control what is happening.
SUMMARY OF COGNITIVE THERAPY WITH A 24 YEAR OLD WOMAN WHO EXPERIENCED DISTRESSING AND THREATENING VOICES.

September 2005

Year 1

Word Count = 984

Please note that all names are fictitious and any identifiable information has been changed in order to maintain confidentiality.
Iona Williams is a 24 year-old woman, referred for help with coping with hearing voices, by her Care Co-ordinator within the Early Intervention in Psychosis (EIIP) team.

**Assessment**

Iona reported that between the ages of 9 and 16, she experienced 3 separate episodes of bullying which included verbal threats of violence, physical bullying and verbal insults. She also had a relationship with a man whom she felt did not value her. Iona established a good group of friends at the age of 17 and went to University at the age of 18. After she graduated her parents separated which left Iona feeling vulnerable. She began to hear voices one month after the separation. In April 2003, Iona first heard a voice outside her house which said “nosey and big mouth, she’s got to go”. She thought that it was the voice of a neighbour who she believed was a drug dealer and inferred that he planned to kill her. Iona moved back home and was admitted to the local hospital. At this time the voices stopped and Iona moved back to her university town.

The voices returned in June 2004 which Iona attributed to moving back to her family home with her boyfriend. Iona’s mother lived locally with her new partner and Iona’s father had moved to Thailand. He rented the family home to Iona, her siblings and to other tenants whom Iona did not know. At the end of 2004 Iona felt unable to cope and cut her arm with a razorblade. Iona attributed this to her medication which was changed. Following this, Iona did not experience thoughts of self-harm and felt the new medication helped to dampen the voices. Iona’s mother found it upsetting when Iona talked about the voices and told Iona that her personality had changed for the worse since she began taking medication.
On assessment, Iona reported that she experienced the most dominant voice several times a day and the voices were very quiet, fairly mumbled, fairly distressing and slightly distracting. She identified her voices as malevolent and omnipotent. She tended to resist her voices.

**Formulation**

Iona's experiences of being bullied, and being in a relationship that she was uncomfortable in, may have contributed to beliefs that other people are threatening and the expectation that bad things happen to her. Her cousin also heard voices and it is therefore possible that there was vulnerability to this experience within the family. Her parents' separation, difficulties in her relationship and financial debt after leaving University were stressful events that preceded the onset of hearing voices. It was apparent that her voices were triggered by anxiety and reflected her concerns about the worst happening. They caused her to feel distressed and isolated from her peers and confirmed the belief that other people have the power to hurt her. Iona said she felt stuck because the voices upset her but she believed that if she ignored or disbelieved the voices they would kill her. This conflict reinforced her belief that she was not able to cope, enhanced her sense of hopelessness and contributed to the voices' threat.

**Intervention**

Iona and I used the cognitive model to consider her relationship with her voices but were also mindful of the influence of her social relationships. Iona said she wanted to have more control over, be less frightened of, and find ways of coping with, her voices. We started by normalising her experience and explored the strategies she used to cope with the voices. These included: shouting back at the voices, talking to somebody she trusted and going to the gym. We planned how Iona could use the most advantageous strategies more systematically to cope with her voices.
We also set up experiments to test out Iona’s level of control over the voices, and set limits to when she would listen to them. Iona said these helped her to experience some level of control and the voices had been less frequent. We explored her beliefs about her worth and found examples of where she possessed some of the characteristics that she liked in other people. We also tried to weaken the power of the voices by exploring the voices’ possible reasons for and against harming her. Furthermore, we thought about stories of recovery and talked about her strengths, values and aspirations for the future.

**Outcome**

At the outcome of the sessions, Iona said she had realised that there was no reason why the voices would want to kill her and the voices’ threats had “toned down”. She explained that the voices had not given her a time period in which she would die for the last 2-3 weeks of our working together. She felt more able to stand up for herself against her voices and people in the “real” world, although she believed the voices continued to be a significant threat.

Post-intervention Iona’s scores suggested that she experienced the dominant female voice(s) several times a week and that they were fairly quiet, fairly clear, fairly distressing and slightly distracting. Furthermore, they were malevolent, omnipotent and she tended to resist the voices. Iona experienced the voices less frequently post-intervention but her beliefs about the voices’ malevolence, omnipotence and her distress were not significantly different pre and post-intervention.

I believe that my work with Iona mainly helped her to feel valued and that change with regards to her managing her voices could occur. I arranged for Iona to meet with my supervisor for a follow-up appointment to review her needs for longer term psychological input. I believe that Iona had
started to make some changes in the way she perceived her voices and herself. I anticipated that, with further support, Iona would feel hopeful about her recovery. Furthermore, I learnt from Iona that it was really important for her to have choice in how we constructed the sessions. This appeared to contribute to the development of our relationship.
SUMMARY OF TIME-LIMITED DYNAMIC PSYCHOTHERAPY WITH A 44 YEAR OLD WOMAN WHO WAS DESCRIBED AS HAVING A LEARNING DISABILITY AND WAS STERILISED AGAINST HER WILL.

April 2006

Year 2

Word Count = 996

Please note that all names are fictitious and any identifiable information has been changed in order to maintain confidentiality.
Lydia Taylor is a 44 year old woman who was referred to the Community Team for People with Learning Disabilities (CTPLD) by her sister, Sarah, who requested that Lydia receive counselling for the grief she experienced in response to having been sterilised.

Assessment

Lydia reported that she is the youngest of three sisters and that from a young age, she had always felt different from her sisters. Her mother protected her from making her own choices in her life because she was “disabled”. Lydia felt that her mother always treated her like a child and she blamed herself for feeling angry towards her mother. Lydia said she “idolised” her grandmother, who had lived in the family home prior to her death, as she treated Lydia no differently from her sisters.

Lydia was sterilised in 1991 as Lydia’s mother and sisters were concerned she was not reliably using contraception and they felt she would not be able to cope with being a parent. Lydia said that nobody asked her how she felt about the sterilisation and did not understand what the operation entailed. Following the sterilisation Lydia thought a lot about children and having a baby. She would collect baby clothes and hide these from the rest of her family. However, her sister would find these and remove them from Lydia’s home as she felt that having these clothes was unhelpful for Lydia.

Lydia felt that she would have been a good mother as she would be able to give a child “lots of love and attention”. She often cried at night, wondering what it was that she had done to deserve being sterilised. Lydia commented that, since she was sterilised, she had felt like a jigsaw puzzle with a piece missing. Her aims for our work were to feel more confident in her relationships with her family, and relieve some of the anger she had hidden away inside of her
**Formulation**

When she was a child, Lydia experienced herself as different from her sisters because she was “disabled”. She felt angry about this and felt that her mother cared more about her sisters than her. She learned to hide her feelings because when she did express them, she would hurt and upset her mother. This helped Lydia to maintain a close relationship with her mother and feel loved however, she also felt angry that her mother did not love her for who she was and did not recognise her abilities.

When Lydia was sterilised she felt unable to say “no” and suppressed her anger and grief over the sterilisation to avoid upsetting her family, similarly she hid baby items that she had bought to help her manage her grief. Lydia said that she found it hard to let her family know about the things which upset her and often put her family’s feelings before her own. Lydia also put my feelings before her own in the therapeutic relationship. If I asked her to tell me more about something or if I asked her to repeat what she had said, she blamed herself for not explaining herself properly.

**Intervention**

Lydia and I worked together to try to help her express some of her anger using a psychodynamic approach. Lydia explained she was especially worried about expressing her anger about being sterilised to her mother as she did not want to upset her. We reflected on Lydia’s feelings of guilt as stemming from when she was a small child and that she had learned to hide her feelings as a way of keeping a good relationship between her and her mother. I thought that Lydia was concerned that I would get upset if she expressed how she was feeling. I offered this as a hypothesis to Lydia and emphasised that I would not get upset if she became angry or upset in our sessions.
We also explored the meaning behind buying baby clothes. Initially Lydia said that she did not know why she did this and felt it wasn’t helpful. However, she later acknowledged that the clothes helped her when she felt upset and she felt angry when she had these taken away from her. My supervisor offered some consultation sessions to Lydia’s sister so that Lydia could be supported in mourning for her loss. Following Sarah and my supervisor’s session, Lydia and Sarah had a long discussion about how Lydia felt about having been sterilised, and they made a basket together in which Lydia placed her favourite baby items. I felt this helped Lydia to share her grief with her sister and have the importance of her loss acknowledged by the family through their agreement that the basket would not be taken from her.

**Outcome**

Lydia said that she felt proud of herself for speaking to both Sarah and her mother about her anger at being sterilised. She reported that, although she was very tearful, she did not hurt her family by telling them how she felt. Both Sarah and her mother told Lydia that she could go and talk to them if she ever felt upset. In addition, Lydia said she felt that she had been able to express quite a lot of her anger. Lydia acknowledged that there might be times where she hides her feelings and we spoke about how she could find other ways of expressing her emotions on these occasions. Lydia reported that since Sarah had helped her to make the baby basket, she felt that she did not need to hide her grief, she experienced less of a need to buy lots of baby items and she felt less guilty about the items she had bought.

Lydia spoke about the achievements that she had made during therapy and commented that she had exceeded her family’s expectations in that she was living independently in her own flat. I felt that Lydia had begun to gain confidence in expressing her emotions and this would continue to develop with the support of her family.
SUMMARY OF COGNITIVE-BEHAVIOURAL THERAPY WITHIN A NARRATIVE FRAMEWORK WITH AN 11 YEAR OLD BOY PRESENTING WITH OBSESSIONS AND COMPULSIONS.

September 2006

Year 3

Word Count = 995

Please note that all names are fictitious and any identifiable information has been changed in order to maintain confidentiality.
Bryn Jones is an 11 year old boy who was referred to the Child and Adolescent Mental Health Service (CAMHS) by his General Practitioner (GP). Bryn’s mother, Hazel, had taken him to the GP due to concerns that he was becoming more withdrawn and developing more elaborate rituals.

**Assessment**

Bryn is an only child. He was born by assisted delivery and weighed six pounds. Hazel experienced post-natal depression and she initially found it difficult to bond with her newborn son. Hazel stated that Bryn had sleeping and feeding difficulties as an infant, which resolved as he became a toddler. When Bryn was aged 9 months, David (Bryn’s father) became the main carer and Hazel returned to work. This changed however, when Bryn was aged 8. Hazel was made redundant and therefore she became the main carer whilst David returned to work. It was around this time that Bryn’s rituals and intrusive thoughts first appeared.

Bryn’s intrusive thoughts concerned what would happen if he threw himself off a building or scratched his eye on a piece of barbed wire. Bryn coped with these thoughts by telling his Mum about them and ignoring them. He reported he did not feel compelled to perform any action to neutralize the thoughts. Bryn also worried about going to school because he found it “boring” and “pointless”. When he got ready for school, Bryn cleaned his feet and then needed to make sure that his socks “felt right”. Bryn would get frustrated and angry if he could not do this. Bryn cleaned his feet 2-3 times a day as he did not like the feel of having anything on the bottom of his feet. He also felt compelled to go to the toilet and open his bowels before he left the house. Bryn said he was not distressed by the rituals. However, if he did not go to the toilet before he left the house he would worry about needing the toilet, whilst out, and there not being one. Bryn was often late for school due to his rituals.

Summary of cognitive behavioural therapy within a narrative framework with an 11 year old boy presenting with obsessions and compulsions.
Formulation

Bryn’s mother experienced post-natal depression which may have made it difficult for Bryn to form a secure attachment with her in the early years. This may have contributed to uncertainty within Bryn about how his needs would be met. He could have therefore developed beliefs about being responsible for his needs being met as a way of preventing himself from feeling distressed and helpless if this did not happen.

The rituals and intrusive thoughts appeared to begin when Bryn experienced a change in his main carer and routine. Bryn make have experienced feeling responsible and guilty for this event despite having no control over it. However, beliefs about personal responsibility can offer a sense of agency and contribute to the development of compulsions. Prior to going to school, Bryn worried about what would happen and performed rituals (which involved cleaning his feet, going to the toilet to open his bowels, and repeatedly putting different pairs of socks on until they “felt right”) to reduce these worries. The anxiety-reducing effects of the rituals acted to maintain the belief that he would be responsible for anything bad happening if he did not perform the rituals.

Intervention

Bryn, Hazel and I initially met to focus on cognitive-behavioural approaches to OCD. We then integrated ideas from structural therapy in helping Hazel and Bryn to get him to school on time and also used social stories to aid Bryn’s understanding of why people expect him to ask when he wants something.

Bryn reported that he wanted to decrease the length of the rituals so that he would have more time to do the things that he enjoys but also worried about feeling uncomfortable if he did make any changes. We made an anxiety hierarchy of the amount of anxiety he would feel on leaving the

Summary of cognitive behavioural therapy within a narrative framework with an 11 year old boy presenting with obsessions and compulsions.
house for different periods of time without performing his ritual of going to the toilet. Bryn agreed to begin at the bottom of the anxiety hierarchy and to try go out for five minutes without performing the toilet ritual. However, he was encouraged by his father to start near the top of the hierarchy. Following this, Bryn said he did not see the benefit of working on the hierarchy and did not want to attend any further sessions.

Hazel asked to continue meeting with me to focus on how she could help her son to get to school on time and with his difficulty talking to adults. This involved creating social stories for Bryn about asking adults for something he needs. Bryn then agreed to attend the sessions again and we discussed the boundaries between him and Hazel in terms of their responsibilities for Bryn going to school. Bryn and Hazel agreed to make a timetable together to help Bryn get to school on time. This incorporated time for one performance of each of the rituals.

**Outcome**

At the end of the sessions, Bryn’s principal obsessions and compulsions were similar to those pre-therapy, although Bryn said that he no longer experienced fear that harm would come to himself and/or others. Instead he experienced worry about being responsible for something terrible happening, although he did not know what that was. Bryn’s ratings of the severity, frequency and period of taken up by the obsessions and compulsions had slightly decreased post-therapy. Bryn and Hazel suggested that the most helpful aspects of our work were that I had helped them to explore different strategies for managing the rituals and worry, and also understand that other families also experienced similar difficulties.

A further outcome of the sessions was that we discussed the possibility of some of Bryn’s difficulties being consonant with Asperger’s Syndrome. We explored the possible impact on Bryn
of receiving a diagnosis compared to not. Hazel decided that she would like her son to be assessed and therefore he was placed on the waiting list to be seen by one of the psychiatrists.
SUMMARY OF NEUROPSYCHOLOGICAL ASSESSMENT WITH A 73 YEAR OLD WOMAN PRESENTING WITH MEMORY DIFFICULTIES.

April 2007

Year 3

Word Count = 893

Please note that all names are fictitious and any identifiable information has been changed in order to maintain confidentiality.
Sally Williams is a 73 year old woman who was referred to the Older People’s Community Mental Health Team (Older People’s CMHT) by her General Practitioner (GP) due to concerns about both her long-term and short-term memory, particularly her retention of information, and her ability to judge new situations. She was initially seen by the Specialist Registrar and referred for a neuropsychological assessment to clarify the type of dementia she may be experiencing.

**Presenting Problem**

Sally said that she had been experiencing a few memory problems, such as forgetting where she had left objects such as her glasses. She said that she felt her memory problems were probably related to the ageing process. Her son (Paul) and daughter (Jill) presented different views. They explained that Sally repeated conversations that she had just had and also forgot details from the past such as her friends’ names. They were also concerned about her vulnerability as there had been an occasion where she had not been able to judge the potential risks in trusting a travelling salesman and had left the man with her granddaughter for a short time unsupervised. Sally did not remember the occasions that Paul and Jill spoke about and appeared to be embarrassed about her difficulties.

Sally gave written consent to engage in the assessment and also stated that she wanted to know the outcome and understand that there was a possibility that the tests could suggest that her memory problems are consistent with dementia.

**History of Difficulties**

Paul and Jill felt that Sally’s memory difficulties had worsened gradually over the past year. Sally explained that she had no history of serious illnesses and no psychiatric history. This was corroborated by Paul and Jill. She described herself as having been “fairly” healthy throughout
her life. She had had 3 general anaesthetics as a child and a young adult. Sally said that she had not used illicit drugs and drank alcohol on special occasions. She said that she had always drunk very little alcohol.

Sally had a CT scan and blood tests prior to the assessment which were all reported to be normal.

Sally is right-handed. Sally reported meeting all developmental milestones and worked as a district nurse until the birth of her children. She lived on her own as her husband had died 3 years previously. She had no difficulties with activities of daily living and Jill described her as a “fairly happy person”.

**Hypothesis**

As Sally’s decline in memory was reported to be gradual, there did not appear to be any vascular risk factors and she did not present as depressed, it was hypothesised that her neuropsychological profile would be consistent with the early stages of Alzheimer’s disease (AD). The literature suggested that she would therefore show impairments in short-term episodic memory, recognition memory, category fluency, executive functioning and attention.

**Assessment Battery**

In order to test the working hypothesis the following tests were used:

- Wechsler Test of Adult Reading
- Wechsler Adult Intelligence Scale-III
- Logical Memory I & II of the Wechsler Memory Scale-III
- Rey Complex Figure
- Hopkins Verbal Learning Test-Revised
Clinical Dossier Summary of Older People Neuropsychological Case Report 5

Trail Making Test
Boston Naming Test-2nd Edition
Controlled Oral Word Association Test
Hospital Anxiety and Depression Scale

Findings

Sally's general functioning fell in the average range and indicates no significant decline from her estimated premorbid functioning. She performed to expectation in areas such as verbal comprehension, perceptual organisation, immediate memory for visual information, copying of a complex figure, visual spatial construction, visual and verbal reasoning and letter fluency. However, on observing her copy the Rey Complex Figure, she was not able to organise the figure into its component geometric shapes. She performed slightly below expectation on working memory, verbal learning, verbal recognition and semantic fluency. Her letter fluency ability was slightly better than her category fluency which has been found in people with AD.

Sally's overall performance on the memory tests suggests significant impairment in the consolidation of new information and rapid forgetting of information when there is a delay (poor retention scores). She also had significant difficulties with speed of processing and mental shift / complex cognitive processing which may also indicate AD. However, studies have shown that people with AD do not show improved recall on recognition tasks. Sally's recognition score slightly improved her recall which may suggest a vascular aetiology.

It is possible that Sally's anxiety about the outcome of the assessment may have contributed to her performance on the tests. Although she did not score highly on the anxiety subscale of the HADS, she may have been minimising her difficulties due to embarrassment and wanting to stay as
independent as possible.

**Recommendations**

I fed back the findings of my assessment along with my medical colleague who gave Sally a diagnosis of early AD. We informed the family of local support networks and I gave Sally some practical techniques to aid her memory. I also arranged for Sally to be reviewed in 6 months time as she did not currently meet the criteria for the prescription of acetylcholinesterase inhibitors, which slow down the process of dementia. Sally and her family were also very upset and I felt they needed further support in place should Sally show any further deterioration. It was explained that they could contact the service prior to this should Sally, Paul or Jill be worried about any aspect of her mental health or general functioning.
AUDIT OF THE REFERRAL PROCESS
WITHIN A PRIMARY CARE MENTAL
HEALTH TEAM AND USE OF THE STEPPED
CARE APPROACH FOR PSYCHOLOGY
REFERRALS.

June 2005

Year 1

Word Count = 3000
Abstract

The Primary Care Mental Health Team (PCMHT) was given local guidelines as to a stepped care approach model of working in July 2004. The aim of this audit was to evaluate whether referrals met criteria for access to the PCMHT, whether psychology referrals met the criteria set out within the stepped care approach and to provide the team with some recommendations. Sixty-four referrals made within the month of November 2004 were audited. Four referrals fell outside of the remit of the PCMHT prior to assessment. Forty-one referrals had an initial assessment of which 25 referrals were accepted by the PCMHT. Two referrals did not meet the criteria for the PCMHT due to having mild difficulties with minimal impact. Twelve referrals were made to psychology, all of which met the criteria of moderate to severe level of impact on daily functioning and at least moderate severity and/or complexity. This suggests that the stepped care approach is being used effectively by the PCMHT. The findings suggest that greater information in the referral letters regarding impact, severity and complexity may help the team to identify inappropriate referrals prior to offering an assessment. Mutually agreed definitions for measuring impact, severity, complexity and risk would help the team to identify those most in need of more intensive interventions and those who could use services within primary care. Consultation with service users and carers might help the team and referrers to consider the effectiveness and most useful approach to this model of working.

Acknowledgements

Many thanks must go to the professionals of the PCMHT for offering their perceptions of the practical functioning of the stepped care approach and for giving feedback as to the findings of the audit. I would also like to thank my field supervisor and university supervisor for their help and support with this audit.
Introduction

The National Service Framework (NSF) for Mental Health (Department of Health, 1999) highlights goals for improved mental health services that meet the needs of service users. The Mental Health Policy Implementation Guide (Department of Health, 2001) outlines eligibility criteria and a potential service model for Primary Care Mental Health Teams (PCMHTs). The model proposed a system for closer integration between primary and specialised services. This was developed within the PCMHT and local guidelines for the management of referrals to the PCMHT were circulated on 5th July 2004. The criteria for referral to the PCMHT are that the person is aged 18 to 65 years and has a moderate to severe level of symptomatology with a moderate to severe impact on their life (e.g. occupational and social functioning).

The PCMHT that was audited is a newly developed service, formed from merging two Community Mental Health Teams (CMHTs). The aim of the PCMHT's stepped care approach is to meet the holistic needs of people with mental health needs by covering the NSF goals of promotion, prevention and intervention (Department of Health, 1999). The service is provided by a multi-disciplinary mental health team established within primary care in order to improve accessibility to services for service users. The purpose of the stepped care approach is that the service user is offered the least intensive intervention required to meet their needs. In implementing this new model, training was provided for Mental Health Practitioners (MHPs) to offer brief interventions informed by Cognitive-Behavioural Therapy (CBT).

The model of the stepped care approach suggests that if a service user presents no signs of improvement from brief CBT they may be referred for more specialist help from a CBT therapist or specialist psychologist. This may be for individual therapy, group work or family intervention (see Appendix 1). If a service user is deemed to have a severe and complex presentation they can...
be directly referred to specialist psychological services by the PCMHT professional who conducted the initial assessment (usually the MHP). Newman (2000) emphasises the importance of the assessment process in identifying service users who may not benefit from less intensive interventions in order to reduce the cost of providing resources that the service user will not gain from.

The following are general guidelines when considering a referral for intervention by a psychologist working in the PCMHT:

- Recurrent physical or psychological problems, which have not responded to previous attempts at intervention.
- Usually have undergone intervention by a MHP and/or had a brief course of CBT.
- Problems of at least moderate severity and present for minimum of 6 months.
- Moderate to severe impairment in occupational, social and/or familial functioning.
- Complex psychological problems such as
  - Recurrent moderate to severe depression and anxiety
  - Post Traumatic Stress Disorder
  - Obsessive Compulsive Disorder
  - Self-harm, interpersonal difficulties or abnormal help seeking behaviour

The following problems are often not appropriate for referral:

- Primary drug and alcohol problem
- Primary eating disorder
- Major forensic risk
To date there has been no audit of the referrals to the PCMHT and to psychology, therefore it is important to the psychology team to audit whether referrals are receiving the intervention most appropriate to their needs\(^1\).

**Aims**

The aims of the audit were to evaluate whether (i) the referrals received met the PCMHT's criteria, (ii) psychology referrals met the criteria within the stepped care approach and (iii) to provide recommendations to the service.

\(^1\) See Appendix 2 for confirmation that this project constitutes an audit and therefore does not require ethical approval.
Methods

Design of the Study

The study is an audit of referrals to explore whether the criteria suggested within the stepped care approach were adhered to.

Data

Sixty-four referrals made between 01.11.04 to 30.11.04 inclusive were audited.

Procedure

The referrals were obtained from the team’s referral book in which all referrals and their outcomes were documented. The majority of referrals were assessed by a professional within the PCMHT except for when a referral was deemed inappropriate based on the referral letter, and no assessment was offered.

Firstly, details from the referral letters were documented. Where information was available, the impact of the person’s mental health difficulties on their social functioning, occupational functioning, close relationships and daily living skills were rated as negligible, low, moderate or high by the auditor. In addition, severity and complexity were rated as low, moderate or high by the auditor. Two separate ratings were given for each measure of impact, severity and complexity, one based on information from the referral letter and the other based on information from the assessment. Each rating is not mutually exclusive.

Ratings regarding risk of violence (towards others), self-harm, self-neglect and risk to children were recorded from the assessment. The Trust’s standardised risk assessment comprises of these 4 categories, each had been rated as negligible, low, moderate or high by the team member who
conducted the initial assessment. Information about duration of the mental health problem(s), whether the person had already had a course of CBT and whether the primary problem fell outside the remit of criteria of the PCMHT (e.g., an eating disorder) were also documented from the initial assessment.

**Measures**

The appropriateness of the referrals to the PCMHT was measured against age, impact of difficulties, severity and complexity as documented in the referral letter and was then assessed against these factors from the information documented in the initial assessment. The appropriateness of referrals to psychology within the stepped care approach was assessed against age, impact of difficulties, severity, complexity, risk, duration of the mental health problem(s) and previous interventions. This was measured by the information documented in the assessment since there was a greater wealth of information in the assessment and it is on this basis that the team made decisions about the person’s needs.

- **Impact of mental health difficulties**

Impact of mental health difficulties was rated on 4 domains (see Table 1).
**Table 1** – Definitions used to rate impact from information in the referral letters and initial assessment documentation.

<table>
<thead>
<tr>
<th>Social functioning</th>
<th>Occupational Functioning</th>
<th>Close relationships</th>
<th>Daily living skills</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Negligible</strong></td>
<td>No indicators of impact on social functioning.</td>
<td>No indicators of impact on occupational functioning.</td>
<td>No indicators of impact on close relationships.</td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Some difficulty but able to engage in conversation with others.</td>
<td>Some difficulty at work but continuing to stay in employment.</td>
<td>Difficulty within close relationships but able to keep some close relationships.</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Unable to have contact with people outside of their own close network / family.</td>
<td>Recently lost employment or gave up employment due to mental health difficulties.</td>
<td>Close relationships deteriorated and loss of many close relationships.</td>
</tr>
<tr>
<td><strong>High</strong></td>
<td>No contact with other people.</td>
<td>Out of employment for over 1 year due to mental health difficulties.</td>
<td>No close relationships.</td>
</tr>
</tbody>
</table>

- **Severity and complexity of mental health difficulties**

Severity was based on the extent of distress and disruption it caused the person, and complexity was based upon the number of factors contributing to the person’s difficulties and the interaction between these (see Table 2).
Table 2 – Definitions used to rate severity and complexity as documented by the referrer and assessor.

<table>
<thead>
<tr>
<th>Severity</th>
<th>Complexity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Some distress and disruption but normal lifestyle maintained.</td>
</tr>
<tr>
<td></td>
<td>Difficulties mainly in one area (e.g., being in social situations).</td>
</tr>
<tr>
<td>Moderate</td>
<td>Frequent distress preventing engagement in activities which had previously been part of normal routine</td>
</tr>
<tr>
<td></td>
<td>Difficulties in a number of areas (e.g., occupation, relationships) but able to access support.</td>
</tr>
<tr>
<td>High</td>
<td>Prolonged distress such that able to manage very little of normal routine.</td>
</tr>
<tr>
<td></td>
<td>Difficulties in many areas of life (e.g., finance, housing, relationships, drug and alcohol use) which exacerbate the person’s problems.</td>
</tr>
</tbody>
</table>

- **Risk**

Risk was measured using the 4 categories in the Trust’s risk assessment conducted at the initial assessment.

- **Duration of mental health problems**

Duration of mental health problems was rated as either less than 6 months or greater than 6 months where information was available.
Results

Referrals made to the PCMHT

A total of 4 (6%) referrals were assessed as inappropriate by the service based on the referral letter. Four referrals were directly allocated to a Psychiatrist in the PCMHT without assessment. In addition, 7 (11%) people did not attend the initial assessment appointment and were discharged from the team. There was no information found regarding assessment and outcome for 6 (9%) referrals.

Sixty-one referrals (95%) were made by GPs, 1 by a Senior House Officer, 1 by a Health Visitor and 1 by the Crisis Assessment and Treatment Team (CATT).

No gender was recorded for 1 referral, 22 were men and 41 were women aged between 16 and 82. No ethnicity was stated for 53 referrals, 8 were of White-British ethnicity, 2 were from other ethnic groups (other was not defined) and 1 was of Asian or Asian British Indian ethnicity.

• Impact

Information regarding impact of mental health problems on social functioning, occupational functioning, close relationships and daily living skills was included in 31%, 44%, 44% and 33% of referrals respectively. Five referrals had less than moderate impact on all 4 domains.

• Severity and complexity

Information regarding severity and complexity was found in 50% in 31% of referrals respectively. All of the referrals had at least moderate severity and or complexity where information was available.
Assessment Process

Of 64 referrals, 41 had initial assessments: 14 were conducted by a MHP, 9 by an Occupational Therapist (OT), 8 by a Doctor, 6 by a Psychologist and 4 by a Social Worker (SW). An additional 2 referrals were recorded to have been assessed by a MHP but no record was found, however 1 of these was given self-help material and support from the Care-Co-ordinator (MHP, OT or SW).

- Impact

There was agreement between the referrer and assessor regarding impact on social functioning, occupational functioning, close relationships and daily living skills for 50%, 76%, 53% and 61% of referrals. For all categories, except impact on daily living skills, the assessor identified a greater number of people whose mental health problems impacted on their daily functioning and noted the impact to be greater (see diagrams 1-4).
Diagram 1 – Impact on social functioning as identified in the referral and assessment.

Diagram 2 – Impact on occupational functioning as identified in the referral and assessment.

Audit of the referral process within a PCMHT and use of stepped care approach for psychology referrals.
Diagram 3 – Impact on close relationships as identified in the referral and assessment.

Diagram 4 – Impact on daily living skills as identified in the referral and assessment.
• Severity and complexity of mental health difficulties

There was agreement between the referrer and assessor regarding severity and complexity for 61% and 46% of referrals respectively. The referrers tended to overestimate level of severity and underestimate the level of complexity in comparison to the assessors (see diagrams 5 & 6).

Diagram 5 – Severity of mental health difficulties as identified in the referral and assessment.
Diagram 6—Complexity of mental health difficulties as identified in the referral and assessment.

Outcome of Assessment

Following an initial assessment, 11 (27%) referrals were discharged as the difficulties were mild in both complexity and severity, and had little impact on the person’s daily functioning. Of these, 7 were given self-help material and 4 were given information about counselling services.

Five (12%) referrals were referred on to other specialist services within the Trust, of which one was also offered support from the PCMHT Care Co-ordinator.

A total of 25 (61%) referrals were accepted by the PCMHT (see table 3 for the interventions offered). Of these, 22 (88%) had at least a moderate level of severity and complexity and 16
(64%) had at least a moderate level of impact in at least 1 domain of daily functioning. Two referrals with mild difficulties and minimal impact were given Care Co-ordinator support.

Table 3 – Interventions offered by the PCMHT for the 25 referrals

<table>
<thead>
<tr>
<th>Support from Care Co-ordinator</th>
<th>Medical outpatient</th>
<th>Anxiety management</th>
<th>Self help</th>
<th>Relaxation</th>
<th>OT</th>
<th>Psychology</th>
<th>EDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from Care Co-ordinator</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medical outpatient</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Anxiety management</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Self help</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Relaxation</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>OT</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychology</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>EDS</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>TOTAL</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>12</td>
</tr>
</tbody>
</table>

Psychology Referrals

From the initial assessments, 12 people were referred to psychology of which 1 person had previously had CBT. Reasons for referral comprised: anxiety (3), PTSD (2), agoraphobia (2), depression (1), depression and anxiety (1), panic (1), sexual abuse (1) and low mood (1). In addition, 6 had a previous service history whilst 6 appeared to be first presentations. No referrals had major forensic risk or a primary eating disorder or substance misuse.
• Impact

Criteria for referral to psychology are that the client's difficulties have a moderate to severe impact on daily functioning. All 12 referrals had at least moderate impact in one domain of daily functioning, the most frequent was impact on social functioning (see diagram 7).
Diagram 7 – Referrals to psychology where a moderate to severe impact of the client’s difficulties on their daily functioning was identified in the assessment.

- Complexity and severity

All 12 referrals were noted to be at least moderate in complexity and/or severity (see Table 4).

Five met criteria for direct referral to psychology.

Table 4 – Severity and complexity of presenting problems for the 12 psychology referrals.

<table>
<thead>
<tr>
<th>Complexity of mental health difficulty</th>
<th>Mild</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity of mental health difficulty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mild</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Moderate</td>
<td>1</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>High</td>
<td>-</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
• Risk

There was a risk of violence, self-harm, self-neglect and risk to children for 0, 3, 1 and 0 referrals respectively (see diagram 8). Four (33%) referrals had at least 1 risk factor present.

**Diagram 8** – Referrals to psychology where risk factors were identified in the assessment.

• Duration

The difficulties that clients experienced had been present for greater than 6 months for 10 (83%) of the referrals. No information was available for 1 referral, whilst the other had a brief but severe presentation.

• Previous interventions

One referral had previously had a course of CBT.
Discussion

Referrals to the PCMHT

The findings suggest that initial referrals to the team often do not include information regarding the impact on daily functioning, severity or complexity of the person’s mental health difficulties. This would be useful information for the team in order to identify inappropriate referrals prior to offering an assessment. The PCMHT could contact GPs and emphasise the importance of this information in being able to offer the best intervention for the service user’s needs. The Trust could work with current service users and carers to draw up a brief guide for GPs as to useful questions to ask when thinking about service users’ mental health needs.

Where information was given in the referral, the referrer underestimated the level of impact in comparison to the team member who conducted the assessment. With regard to the severity and complexity of the mental health difficulties, the referrer overestimated severity and underestimated complexity in comparison to the assessor. Barkham, Gilbert, Connell, Marshall and Twig (2005) found the Clinical Outcomes in Routine Evaluation – Outcome Measure a useful assessment tool for measuring severity, impact and risk based on self-report by service users within primary and secondary care. Items from this could be used by the referrer and assessor to aid understanding of the level of impact.

Assessment Process

There was little information recorded regarding the ethnicity of the person referred. This would be important for the team to record in order to consider different cultural needs. Following an initial assessment, moderate to high levels of severity and complexity were the most important criteria for the offer of an intervention by the PCMHT. Two clients who did not meet the PCMHT criteria

---

2 See Appendix 3 for information regarding feedback of the audit to the PCMHT.
were nevertheless offered Care Co-ordinator support. It may be useful for the team to have defined ways of measuring impact, severity and complexity in order to implement the stepped care approach most effectively. Consultation with service users and carers may help the team to construct useful ways of measuring these.

**Psychology Referrals**

Moderate to high levels of severity, complexity and impact, and also duration of symptoms exceeding 6 months were the most frequent indicators for referral to psychology. Of the 12 referrals made to psychology, 1 had had a course of CBT which is inconsistent with the stepped care approach. An audit of team caseloads conducted in same month suggested that the MHPs were offering regular CBT interventions. This discrepancy may therefore be due to the MHPs full caseloads and lack of capacity for new interventions. Computer based interventions for anxiety and depression could be offered for those service users with milder presentations and who are able to use a computer such that MHPs are able to offer brief interventions for those who would benefit most from this.

One limitation of the audit is that there is no standardised way of measuring risk, impact, severity and complexity. Thus the ratings of the auditor may be based on definitions that are different from those that the referrer and/or assessor may have used. In addition, the referrals that were audited were made in the month when the physical merging of the 2 CMHTs that functioned as the PCMHT occurred, therefore this is not necessarily a representative sample of how referrals are managed within the PCMHT.

The purpose of implementing the stepped care approach was to decrease the caseloads of team members in PCMHTs by promoting the treatment of people with mild to moderate mental health
difficulties within primary care. Further research could compare referrals pre and post the implementation of the stepped approach to see whether this aim was met. It would also be useful to involve service users’ and carers’ perspectives of the efficacy of this model in improving access to services.
References


Audit of the referral process within a PCMHT and use of stepped care approach for psychology referrals.
Appendix 1 – Stepped Care Approach

Pages

- Model of the Stepped Care Approach (Trust Guidelines)......................................................135
**Research Dossier**

**Service Related Research Project**

**Member of the public experiencing difficulties**

**GP**

**Self-Help**
- First presentation
- Mild Problem
- Requires minimal input
- Maintaining high level of daily functioning, e.g. still working
- Motivate and has capacity to work on problems independently
- No evidence of risk to self or others

**Mental Health Development Worker**
- Refer to self help
- Sign post to other services
- Brief intervention

**MHP Triage Assessment**

**Brief CBT from MHP**
- Clearly defined presenting problem/clear focus to work
- Symptoms present for less than six months
- Moderate to mild impact only on daily functioning
- Having little or no difficulty in forming relationships
- Ability to notice, think about and discuss thoughts
- Ability to differentiate between thoughts and emotions
- Have a high degree of responsibility for the progress of treatment
- Feels that looking at thoughts, feelings and behaviours is a helpful approach
- Is optimistic that change can occur
- Low risk factors, but presentation suggests some intervention is required to prevent further deterioration

**Specialist Psychological Services**
- Problems are recurrent, experienced for longer than six months and have not responded to previous attempts at intervention
- Typically have undergone an intervention by a MH Practitioner and had a brief course of CBT
- Problems are at least moderate in severity, and result in moderate to severe impact upon daily functioning.
- Problems may be complex such as psychosis, bi-polar, self-harm, interpersonal difficulties or abnormal help seeking behaviours
- Less of, or no obvious clearly defined difficulty at outset
- May have difficulties in engaging in therapeutic work, and in building relationships
- Struggles to identify thoughts, or distinguish thoughts from mood
- Risk factors present, may require care co-ordination from core team also.

---

**Audit of the referral process within a PCMHT and use of stepped care approach for psychology referrals.**

**URN: 3445275**
Appendix 2 – Confirmation that the Project does not Require Ethical Approval

- Ethical Scrutiny Form Signed by Clinical Supervisor..................................................137
University of Surrey
PSYCHD CLINICAL PSYCHOLOGY
Service Related Research Project
Ethical Scrutiny Form

The nature of the proposed project is such that I am satisfied that it will not require scrutiny by the trust’s ethical committee.

Name of Supervisor: ...................................
Signature of Supervisor: ....................................

Name of Trainee: ....................................
Title of SRRP: Audit of the Referral Process within a Primary Care Mental Health Team and Use of the Stepped Care Approach for Psychology Referrals

Date: 07.07.05

140
URN: 3445275
Audit of the referral process within a PCMHT and use of stepped care approach for psychology referrals.
Appendix 3 – Feedback of Audit to PCMHT

- Information Regarding the Feedback of the Audit to the PCMHT ..................................139
- Memo from Team Co-ordinator following Feedback of the Audit to the PCMHT.......140
Feedback of the Audit to the PCMHT

Discussion of the findings of the audit:
I fed back the findings of the audit to the PCMHT on 28.06.05. I felt that the team received my findings well and highlighted the difficulties that they have in accessing resources for interventions for people with mild mental health difficulties. They suggested that the team was under pressure to take on cases where the difficulties were considered to be mild as there were only 2 part-time Mental Health Development Workers covering 15 GP practices. It was raised that impact, severity, complexity and level of risk were difficult concepts to measure and that these tended to be static rather than dynamic concepts which made it difficult to assess the most appropriate intervention at the time that they were referred to the PCMHT.

The team also discussed their experiences of the stepped care approach and it was suggested that the Mental Health Practitioners’ (MHPs) caseloads were increasing. The MHPs said that found it very difficult to offer brief interventions as their time was taken up with monitoring cases awaiting specialist psychological input in addition to their roles of assessing referrals to the PCMHT.

I felt that the reflections of the team helped to emphasise the practical difficulties in implementing the model and also the difficulties that the MHPs were having in making mental health services more accessible within primary care.

Recommendations:
The following are recommendations that I gave to the team in order to try and help with the management of referrals to the PCMHT:

• To provide a guide for GPs as to useful information to ask their patients when considering whether their needs would be best met by referral to the PCMHT (impact, severity, complexity and risk).
• Agreed definitions as to how to rate severity, complexity, impact and risk.
• Consultation with service users and carers as to the most helpful ways of measuring impact, severity, complexity and risk.
• Computer based and self-help resources for those with more mild presentations (especially those with mild depression and/or anxiety).

The team suggested that the GPs may not read a guide as to when a referral to the PCMHT may or may not be most useful to a person presenting with mental health difficulties. It was suggested that perhaps the PCMHT could employ service users to consult with GPs as to the most useful things that a GP could offer for a person presenting with mental health difficulties of differing, severity, complexity, impact and levels of risk.
Memo

To:
From:
Date:

Dear,

I am sorry to have taken so long to reply to your email but it arrived whilst I was on holiday.

I would like to thank you for your very informative presentation of your audit on the 28th June 2005.

I would appreciate a copy of the audit recommendations in order to revisit to see if there are any further changes we need to implement from your findings.

I look forward to receiving the recommendations.

Many thanks

Primary Care Mental Health Team Coordinator
PCMHT

Audit of the referral process within a PCMHT and use of stepped care approach for psychology referrals.
Little Angels or Tiny Tearaways?
The Role of Psychologists in Reality TV.

May 2006

Year 2

Qualitative group research project

Abstract word count: 114
Abstract

With the increasing involvement of psychologists in a host of ‘reality TV’ programmes that have pervaded our culture in recent years ethical dilemmas and other issues have been highlighted by qualified clinical psychologists. However, less is known about the opinions of trainee clinical psychologists who are developing as professionals within this climate. Six trainee clinical psychologists participated in a focus group to explore their perspectives. Interpretative phenomenological analysis (IPA) was used to analyse the data. Five main themes emerged, these were: public views; credibility; accessibility; professional identify and ethics/responsibility. The emerging themes reflected some of the concerns of qualified practitioners which have implications for individual practice and for the profession as a whole.
## Research Log Checklist

<table>
<thead>
<tr>
<th></th>
<th>Research Log Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Formulating and testing hypotheses and research questions</td>
</tr>
<tr>
<td>2</td>
<td>Carrying out a structured literature search using information technology and literature search tools</td>
</tr>
<tr>
<td>3</td>
<td>Critically reviewing relevant literature and evaluating research methods</td>
</tr>
<tr>
<td>4</td>
<td>Formulating specific research questions</td>
</tr>
<tr>
<td>5</td>
<td>Writing brief research proposals</td>
</tr>
<tr>
<td>6</td>
<td>Writing detailed research proposals/protocols</td>
</tr>
<tr>
<td>7</td>
<td>Considering issues related to ethical practice in research, including issues of diversity, and structuring plans accordingly</td>
</tr>
<tr>
<td>8</td>
<td>Obtaining approval from a research ethics committee</td>
</tr>
<tr>
<td>9</td>
<td>Obtaining appropriate supervision for research</td>
</tr>
<tr>
<td>10</td>
<td>Obtaining appropriate collaboration for research</td>
</tr>
<tr>
<td>11</td>
<td>Collecting data from research participants</td>
</tr>
<tr>
<td>12</td>
<td>Choosing appropriate design for research questions</td>
</tr>
<tr>
<td>13</td>
<td>Writing patient information and consent forms</td>
</tr>
<tr>
<td>14</td>
<td>Devising and administering questionnaires</td>
</tr>
<tr>
<td>15</td>
<td>Negotiating access to study participants in applied NHS settings</td>
</tr>
<tr>
<td>16</td>
<td>Setting up a data file</td>
</tr>
<tr>
<td>17</td>
<td>Conducting statistical data analysis using SPSS</td>
</tr>
<tr>
<td>18</td>
<td>Choosing appropriate statistical analyses</td>
</tr>
<tr>
<td>19</td>
<td>Preparing quantitative data for analysis</td>
</tr>
<tr>
<td>20</td>
<td>Choosing appropriate quantitative data analysis</td>
</tr>
<tr>
<td>21</td>
<td>Summarising results in figures and tables</td>
</tr>
<tr>
<td>22</td>
<td>Conducting semi-structured interviews</td>
</tr>
<tr>
<td>23</td>
<td>Transcribing and analysing interview data using qualitative methods</td>
</tr>
<tr>
<td>24</td>
<td>Choosing appropriate qualitative analyses</td>
</tr>
<tr>
<td>25</td>
<td>Interpreting results from quantitative and qualitative data analysis</td>
</tr>
</tbody>
</table>

URN: 3445275
Research log checklist
<table>
<thead>
<tr>
<th></th>
<th>Presenting research findings in a variety of contexts</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Producing a written report on a research project</td>
<td>✓</td>
</tr>
<tr>
<td>28</td>
<td>Defending own research decisions and analyses</td>
<td>✓</td>
</tr>
<tr>
<td>29</td>
<td>Submitting research reports for publication in peer-reviewed journals or edited book</td>
<td>✓</td>
</tr>
<tr>
<td>30</td>
<td>Applying research findings to clinical practice</td>
<td>✓</td>
</tr>
</tbody>
</table>
“THAT HEART-SINK MOMENT”: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF ACCIDENT AND EMERGENCY DOCTORS’ AND NURSES’ RESPONSES TO TREATING PEOPLE WHO SELF-HARM.

Submitted: 23rd July 2007

Year 3

Word Count = 20,000
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Abstract</td>
<td>151</td>
</tr>
<tr>
<td>2) Acknowledgements</td>
<td>152</td>
</tr>
<tr>
<td>3) Introduction</td>
<td>153</td>
</tr>
<tr>
<td>i. Increasing Prevalence of Self-harm within the UK</td>
<td>153</td>
</tr>
<tr>
<td>ii. Definitions of Self-harm</td>
<td>154</td>
</tr>
<tr>
<td>iii. Personal Experiences of Self-harm</td>
<td>157</td>
</tr>
<tr>
<td>iv. Healthcare Professionals’ Relationships with Health and Illness</td>
<td>164</td>
</tr>
<tr>
<td>v. Healthcare Professionals’ Responses towards People who Self-harm</td>
<td>165</td>
</tr>
<tr>
<td>vi. Assumptions Guiding the Research</td>
<td>173</td>
</tr>
<tr>
<td>4) Method</td>
<td>176</td>
</tr>
<tr>
<td>i. Participants</td>
<td>176</td>
</tr>
<tr>
<td>ii. Procedure</td>
<td>177</td>
</tr>
<tr>
<td>iii. Ethics</td>
<td>178</td>
</tr>
<tr>
<td>iv. Analysis</td>
<td>179</td>
</tr>
<tr>
<td>5) The Interpretative Lens of the Researcher</td>
<td>181</td>
</tr>
<tr>
<td>6) Results</td>
<td>185</td>
</tr>
<tr>
<td>i. Treating the Body</td>
<td>186</td>
</tr>
<tr>
<td>ii. Silencing the Self</td>
<td>198</td>
</tr>
<tr>
<td>iii. Mirroring Social and Cultural Responses</td>
<td>202</td>
</tr>
<tr>
<td>7) Discussion</td>
<td>208</td>
</tr>
<tr>
<td>i. Treating the Body</td>
<td>208</td>
</tr>
<tr>
<td>ii. Silencing the Self</td>
<td>210</td>
</tr>
<tr>
<td>iii. Mirroring Social and Cultural Responses</td>
<td>213</td>
</tr>
</tbody>
</table>

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
iv. Limitations .......................................................................................................................216
v. Clinical Implications .......................................................................................................216
vi. Future Research ..............................................................................................................218

8) Reflections of the Researcher ............................................................................................219
9) References ...........................................................................................................................220

Appendices
Appendix A – Information Forms Given to Potential Participants........................................233
Appendix B – Participant Consent Form ................................................................................237
Appendix C – Participant Demographic Information Form .....................................................239
Appendix D – Semi-Structured Interview ..............................................................................242
Appendix E – Ethical Approval Obtained for the Study ............................................................244
Appendix F – Example of Analysed Transcript .....................................................................249

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
Abstract

Self-harm is a prevalent phenomenon that doctors and nurses working in Accident and Emergency (A&E) departments are regularly faced with. A&E can often be the first and only point of contact with services for people who self-harm. It is argued here that the care A&E doctors and nurses provide is fundamental to decreasing the high risk of suicide amongst this group. The phenomena that impact on the relationships between people who self-harm and the A&E staff treating them, have been relatively neglected as a focus of research. This thesis presents a qualitative study exploring how doctors and qualified nurses in A&E respond to treating people who self-harm. In total, eight doctors and qualified nurses working in A&E were interviewed and the data was analysed using Interpretative Phenomenological Analysis. Three main themes were extracted: treating the body, the self within treatment, and cultural and societal influences on treatment. The experiences described within these themes highlight both facilitative and unhelpful aspects of the relationships between people who self-harm and A&E staff. It is suggested that clinical psychologists, people who self-harm, carers and A&E doctors and nurses could work collaboratively to provide A&E staff with the opportunity to reflect on how they can offer integrated treatments that meet the short-term physical and emotional needs of people who self-harm. Furthermore, research that explores what responses help to decrease the distress underlying self-harm would help to inform the practice of healthcare services both in contributing to lessening the risk of suicide amongst this group and addressing unhelpful discourses that act as barriers to services.
Acknowledgements

I would like to thank Louise Pembroke, Dora Brown and Mark Hayward for all their help, encouragement and advice throughout the process of this research. Their individual and collective contributions have been invaluable not only in terms of reading through drafts, but in helping me to think about the wider social and political contexts of conducting research that has both social implications and implications for the provision of healthcare services. I would also like to thank Arlene Vetere for her initial consultation on the project. Furthermore I am very grateful to the A&E doctors and nurses who participated in my study and thank them for their willingness to speak to me about their practices. Many participated at the end of a long shift and I am very appreciative for having the opportunity to learn from their experiences. Finally I would like to thank my friends, family and boyfriend Gareth, for their support.
Introduction

Increasing Prevalence of Self-harm within the UK

Self-harm has long been an area of public concern but it is only recently, with its increasing prevalence, that it has become the focus of governmental agenda and healthcare guidelines. Previous research studies focusing on the prevalence of self-harm have mainly included self-poisoning (ingestion of toxic substances) and self-injury (physical harm caused by the individual to the self) in their definitions of self-harm. However, there are variations between the studies as to how the term self-harm is used and whether self-harm is differentiated from harm where there was suicidal intent. In reviewing the previous research, most definitions of self-harm used appear to be those that include self-injury and self-poisoning regardless of intent. Where definitions vary, the definition provided will be described. It is noticeable that few studies have looked at self-injury exclusively (Friedman et al., 2006).

It is reported that self-harm accounts for 170,000 presentations at Accident and Emergency (A&E) departments in England and Wales annually (Hawton & Fagg, 1992). More recently it has been estimated that approximately 25,000 young people (aged between 10 and 19) are admitted to hospital in the UK each year following self-harm (Hawton et al., 2000), and this rate is increasing (Hawton et al., 2003). One study found that out of a sample of 13 A&E nurses, on average, each nurse encountered more than one person who had self-harmed on each shift worked (Holdsworth et al., 2001). Self-harm is therefore a prevalent presentation that doctors and nurses in A&E are regularly faced with. In addition, increased risk of suicide has been associated with repeated acts of self-harm (Hawton & Fagg, 1988) and it has been estimated that, in the UK, 35-50% of people who self-harm go on to commit suicide in the future (Morgan et al., 1994). Accessibility of services and the usefulness of treatments offered to people who self-harm therefore, can help to reduce the high rates of suicide amongst this group of people, which is part of the government’s
Research Dossier

National Suicide Prevention Strategy in England (Department of Health, 2002). One way to improve services for people who self-harm, this thesis will argue, is if healthcare staff have a good understanding of the multiple meanings self-harm can have for the person accessing their services. However, the different definitions of self-harm found in the literature will be examined first.

Definitions of Self-harm

Historically, there have been variations in the dominant understandings of, and clinical interest in, self-harm (Shaw, 2002). Currently, there are a number of definitions of self-harm that are most commonly used within healthcare services. One term that is often used within mental health services is “deliberate self-harm”. This term is used to refer to forms of harm caused to the self, whether physical injuries or ingestion of harmful substances, which do not cause death. “Deliberate” implies that the person intentionally performed the act in the knowledge that it would harm the self and therefore has important implications for how healthcare staff might understand why people self-harm. The term “deliberate” was also used to describe self-harm in young people in a recent national report (Mental Health Foundation, 2006). However, the validity of the use of this term has been questioned by Bracken & Thomas (2000). They propose that within mental health services, it is often assumed that self-harm occurs through a lack of control which is contrary to the concept of self-harm being “deliberate”. Another definition used within the National Institute of Clinical Excellence (NICE) guidelines for self-harm is any act of self-injury or self-poison regardless of intent (NICE, 2004). Further variations in the definition of self-harm can be seen within the literature written by professionals who orient towards different theoretical models.
For example, Dialectical Behaviour Therapy (DBT) is a psychological treatment offered to people who self-harm and have a diagnosis of Borderline Personality Disorder (BPD). In DBT, self-harm is considered to be a form of suicidal behaviour (Swales et al., 2000). It emphasises that the role of the healthcare worker is to help the person to stop self-harming and reduce their risk of suicide. However, this conceptualisation can be unhelpful since it has been suggested that decreases in self-harm do not reflect a decrease in the distress underlying the behaviour (Johnstone, 1997). Allen (2004) suggests that a more helpful approach that professionals can adopt is to reframe self-harm, which has traditionally been seen as a “dysfunctional behaviour pattern”, as survival strategies. She emphasises that this is endorsed by systemic ideas which consider the multiple contexts of interpersonal difficulties.

Another perspective is the feminist approach to self-injury offered by Shaw (2002). She defines self-injury as the physical act of effecting physical bodily harm on the self that is non life-threatening, which is encompassed within the broad category of self-harm but distinct from other forms of self-harm such as self-poisoning, and from suicide attempts. Shaw also suggests that self-injury occurs as the result of societal responses to women which act to silence and objectify. Services are embedded within these social and cultural contexts and therefore it has been suggested that not only can professionals’ responses to and understandings of self-injury be unhelpful, but they can mirror societal responses to women’s self-injury through the processes of silencing and objectifying. These responses act to further contribute to the distress underlying self-injury and perpetuate the need for women to self-injure (Creswell 2005a, 2005b; Shaw, 2002). Understanding healthcare professionals’ conceptualisations of, and the context of their responses to self-harm, therefore has important implications for how they offer care to this group.
The impact of different definitions of the term self-harm has also been highlighted by those with personal experience of self-harm. Cresswell (2005b) highlights that this has occurred as part of self-harm activism in England, which began in 1988 and developed from mental health and feminist movements. It was within these movements that the concept of people with personal experiences of distress being “survivors” was first introduced. Cresswell (2005a) explains that as a consequence of self-harm activism, a number of publications have been produced by survivors of self-harm which contain personal narratives about their experiences, which he refers to as the “testimony of the survivor” (p.1668). These personal definitions challenge medical understandings of self-harm and the language that is used to describe this. For example, people with personal experience of self-harm have highlighted that it is a survival strategy, a way of gaining control, a secretive act which people go to great lengths to hide and a way of expressing distress (Pembroke, 1994, 1998; Spandler, 1996). The following account of self-injury, by Maggy Ross, highlights the struggle between survivors’ accounts of self-harm and those used by healthcare professionals:

“I’ll tell you what self-injury isn’t – and professionals take note. It’s not masochistic. It’s not attention seeking. It’s rarely a symptom of so-called psychiatric illness. It’s not a suicide attempt......So what is it? It’s a silent scream. It’s a visual manifestation of extreme distress. Those of us who self-injure carry our emotional scars on our bodies” (Pembroke, 1994, p. 14).

The differences between professionals’ understandings of self-harm and those of people with personal experience may contribute to barriers to accessing help. Furthermore, Johnstone (1997) suggests that the development of better services for people who self-harm has been limited by the relative omission of the views and experiences of people who self-harm in considering the most helpful approaches for professionals in offering treatment. The NICE guidelines for self-harm
were developed to improve service responses and emphasise the importance of respecting the person who has self-harmed (NICE, 2004). However, Barker and Buchanan-Barker (2004) note that the views of people with personal experience of self-harm are not included in the evidence-base for the guidelines themselves. Greater understanding of the experiences of people who self-harm, and any treatment they may have received within healthcare services, could contribute to understanding those responses from professionals’ that are helpful and those which are unhelpful.

**Personal Experiences of Self-harm**

Literature produced in collaboration with or by people with personal experience of self-harm has highlighted that there are a multiplicity of reasons why people self-harm. There are, however, commonalities in that self-harm is experienced as a way of preventing suicide, coping with distress and expressing something which is unspeakable (Arnold, 1995; Marshall & Yazdani, 1999; Pembroke, 1994; Solomon & Farrand, 1996; Spandler, 1996). Self-harm has also become increasingly associated with traumatic experiences in childhood, particularly, but not exclusively, childhood sexual abuse (Crowe, 1996; Connors, 1996). Further research that explores the relationship between self-harm and other forms of trauma, such as domestic violence, would help to further elucidate relational processes which contribute to and maintain self-harm.

Most of the research regarding the personal experiences of people who self-harm focuses on the experiences of women who have received treatment for their self-harm. Men’s experiences and those of minority groups such as ethnic minorities, lesbian, gay or transgendered people, and people who have not come to the attention of services have been relatively neglected (Mental Health Foundation, 2006; NICE, 2004). Below there is a brief review of the research beginning with women’s experiences within healthcare and prison services, experiences of Asian women, experiences of men, and finally the experiences of gay men and lesbian women:

157

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
• Women's experiences in mental health services

Limitations in service provision have been highlighted in research focusing on women's experiences of the responses of mental health services to their self-harm. Borderline Personality Disorder (BPD) is a diagnosis that is often given to women within mental health services who self-harm (Allen, 2004; DSM-IV, 1997; Johnstone, 1997; Shaw & Proctor, 2004). Interviews with women about their experiences of living with a diagnosis of BPD suggest that conceptualisations of their self-harm within services, such as self-harm that is perceived as manipulation, are unhelpful as they reinforce stigma and prevent understanding of the many different reasons women may have for self-harming (Nehls, 1999).

Lindgreen et al. (2004) interviewed nine Swedish women with a history of self-harm regarding their experiences of care from psychiatric staff and their desired treatment. The themes that arose suggested that a lack of feeling valued by staff can lead to increased self-harm, lack of trust in services and feelings of worthlessness. However, being listened to, shown care and staff being able to see beyond their self-harm were suggested as helpful to the women both in managing their distress and engendering hope for the future. Similarly, Weber (2002) interviewed nine women who were on a locked psychiatric ward in the United States. The women suggested that nursing staff could help them to prevent their self-harm by talking to them about their experiences, encouraging them to use helpful distraction techniques, offering comfort and reassurance whilst being able to recognize when people may be re-experiencing traumas in the form of flashbacks, and helping the women to hold and express hope.

The research regarding women's experiences in mental health services suggests that staff's understandings of, and responses to, their self-harm can either help decrease or further contribute to the distress underlying their self-harm. Solomon and Farrand (1996) suggest that the meaning
of self-injury can vary in different contexts. They interviewed women who were not in receipt of mental health services and the women’s responses suggested that their self-injury was not a way of communicating their distress to others. However, they suggest the meaning of self-injury may differ for women in receipt of mental health services and whether they receive care within the community or as an inpatient.

• **Women's experiences in prison**

Implications for services have also been raised in research regarding women’s experiences of self-harm in prison. The research has mainly focused on survivors of a potentially lethal act of self-harm. For example, Borrill *et al.* (2005) interviewed 15 women who had survived such an experience. The staff’s responses that the women considered to be helpful following the act were staff having made the effort to: talk without pushing the women to talk about things that were too painful or private, listen empathically and offer support. Negative comments focused on staff’s lack of understanding and time to listen. Confidentiality when talking about self-harm was also identified as important to the women since they explained that previous experience of abuse of trust could make it more difficult for the women to express their distress. This highlights the significance of previous treatment as to how people who self-harm experience and engage with healthcare professionals, especially since people who self-harm have often had contact with healthcare professionals prior to those working in mental health and residential services.

• **Women's experiences in A&E**

A&E is another way that people may access treatment for self-harm. In fact, A&E departments can be the first and only source of help for some people who self-harm (Mackay & Barrowclough, 2005). Harris (2000) conducted a correspondence study with women who regularly self-harmed mainly by cutting. The women suggested that A&E professionals often perceived their self-harm
to be illogical and as an indication of the women being “mentally ill” and out of control whereas they perceived their self-harm to be a logical way of gaining control and relieving distress. The women also reported that they had undergone traumatic and unpleasant experiences when receiving treatment in A&E. This often related to the women being blamed and humiliated for their self-harm. These responses have also been documented in other research studies and in the accounts of people who have received treatment for their self-harm in A&E (Pembroke, 2000, 1998a, 1998b, 1994; Spandler, 1996; Van Loon et al., 2004; Warm et al., 2002). Such responses are considered to be harmful in their effects on the person’s feelings of shame, stigmatisation, low self-worth and self-hatred which are associated with self-harm (Pembroke, 1994) and thus can contribute to increases in the likelihood of further self-harming (Harris, 2000; Van Loon et al., 2004).

The need for improvements within services for people who self-harm, and the importance of A&E as often being a first point of contact, has been acknowledged by the Department of Health (NICE, 2004). Recommendations for the improvement of services have included providing training for healthcare professionals to be able to speak sensitively and confidentially with people about potential reasons underlying their self-harm (e.g. sexual abuse), for professionals and service users to have a shared understanding of self-harm that is distinct from suicidal behaviour, that support is available without judgement or blame, that opportunities are offered to the individual to explore the meaning of their self-harm within the context of their own life (e.g. personal, social and cultural contexts), and that professionals value and believe the person’s experiences (Arnold & Magill, 1996; Currie & Blennerhassett, 1999; Lindsay, 1999; NSHN, 2000, NICE, 2004; Van Loon et al., 2004; Warner, 2004).
Although research regarding people’s experiences of being treated for self-harm in A&E has suggested that this can be unhelpful, it could be that people who have had negative experiences are more likely to participate in this type of research. Furthermore, it does not consider the experiences of people who self-harm who may not access services. Marginalised groups based on, for example, gender, ethnicity and sexuality, may experience many further barriers to services.

- Self-harm amongst young Asian women

The cultural context within which a person self-harms has been raised as important particularly in terms of the form and meaning of self-harm. For example, it has been suggested that self-poisoning and self-immolation are more common forms of self-harm in Eastern cultures (Laloe & Ganesan, 2002). Within the UK, it has been found that Asian women are at higher risk of self-harm, particularly attempted suicides, than White British people (Muntaha, 2004). Research has focused on the experiences of Asian women and how these may be both similar to and different from the experiences of White British women who self-harm (Chew-Graham et al., 2002; Marshall & Yazdani, 1999).

The results of this research indicate that young Asian women attribute similar meanings to self-harm as White British women in that the meanings were multiple and included relief from distress, a way of coping, a way of effecting change, a way of taking control. In contrast, overdoses were defined as being a way of “ending it all” (Marshall & Yazdani, 1999). Explanations that appeared to be specific to Asian women included pressures that arise from cultural expectations and values which centre on the family, intergenerational differences and misunderstandings around the cultural context of their self-harm (Chew-Graham et al., 2002; Marshall & Yazdani, 1999). From interviews with young Asian women it has been suggested that they would access services only at a point of crisis, due to a lack of trust in the providers of
services and feeling that their experiences would be stereotyped based on a lack of understanding of Asian culture (Chew-Graham et al., 2002). Furthermore, concerns about professionals’ responses, stigma, and expectations that abuse does not happen to Asian women, in addition to concerns about the impact on the family, prevent young Asian women accessing services (Marshall & Yazdani, 1999). Bhardwaj (2001) also suggests that wider socio-political aspects of distress (such as racism, poverty and the women’s experiences outside of the family context) may be ignored.

From interviews with service providers it has been suggested that few policies have looked into how to provide sensitive services for socially disadvantaged groups, such as people from ethnic minority groups (Bhardwaj, 2001). Research that considers the experiences of other marginalised groups of people who self-harm is explored below:

- **Self-harm amongst men**

Although the experiences of self-harm amongst men have been relatively neglected, research suggests that the prevalence of self-harm amongst men is increasing (Hawton et al., 1997). It has generally been accepted that self-harm is more common amongst women than men. However, no significant gender differences have been found amongst college students in the US (Gratz et al., 2002) and in older people aged over 65 years (Pierce, 1987). In addition, older men have been found to be at a higher risk of suicide than women (Harwood et al., 2000). It is therefore important to understand the processes which may lead men to self-harm.

Miller and Bell (1996) highlight that the impact of gender inequalities on men’s mental health has received little consideration compared to women’s mental health. They suggest that social values around masculinity have specific consequences for men in terms of predisposing men to control
their experiences of emotion through controlling the external environment. They may also deny men of distressing experiences, such as being raped, through discourses around what can and cannot happen to men (Elliott, n.d.). The emphasis is that men should stay silent and strong which can contribute to men's capacity to harm whether the harm is directed towards themselves and/or others. Miller and Bell (1996) propose that connections between childhood abuse and self-harm are beginning to be made for men, although there are difficulties in hearing men's voices due to services perpetuating social expectations of men. The risks of silencing men are apparent in the higher suicide rates in men than women (Office for National Statistic, 2003). Since gay men may be perceived to contravene social expectations around masculinity, it could be suggested that they may be at an increased risk of self-harm compared to heterosexual men.

- **Sexuality and self-harm**

Although little research has focused on the relationship between sexuality and self-harm, Skegg et al. (2003) found that risk of self-harm, regardless of suicidal intent, was higher amongst young people who experienced some level of attraction to the same sex compared to people who reported that they had only been attracted to people of the opposite sex. Self-harm was highest amongst the participants who experienced a greater degree of same-sex attraction. However, men with less of a degree of same-sex attraction had significantly higher rates of self-harm compared to females with similar degrees of same-sex attraction. This suggests that men may experience greater discrimination due to being attracted to other men than women who are attracted to other women. One limitation of this study is that it did not specifically focus on how the young people defined their sexuality. Therefore, further research is needed to understand the relationships between sexual behaviour, sexual identity and self-harm.
In a recent cross sectional study across England and Wales, gay men and lesbian women were found to be more likely to have consulted a mental health professional in the past, self-harmed and used recreational drugs than heterosexual men and women (King et al., 2003). This highlights the importance of understanding the relationship between social responses to gay men’s and lesbian women’s sexuality, their experiences of distress and their increased risk of self-harm.

The research highlights that responses to self-harm have an important role for the person in terms of accessing treatment and the way in which treatment is experienced. Both helpful and unhelpful professional and social responses have been highlighted. However, the research does not offer an understanding of why professionals may respond in unhelpful ways.

**Healthcare Professionals’ Relationships with Health and Illness**

Radley & Billig (1996) suggest that the way in which people talk about health defines their social acceptability to others and illustrates the person’s claims to being ill or healthy. Judgements of acceptability and accountability therefore have important implications for the relationships between healthcare professionals and the people accessing their services. Radley (1994) suggests that the treatment of people who are ill depends on the construction of negotiated meanings around illness and agreement as to how the patient’s situation shall be defined. In accessing medical help, the person makes a claim to be in need of treatment and becomes a prospective patient. Doctors and nurses can legitimize or invalidate this claim.

Radley (1994) suggests four criteria that can be used by healthcare professionals in their judgement of the legitimacy of the patient’s claims to requiring the professional’s clinical skills: i) patient’s motivation to get well, ii) relationship between healthcare professional and patient (i.e. whether the professional already knows the patient and details of their history), iii) demographic
characteristics of the patient, iv) perceived awkwardness of the patient. This implies it is not only the validity of the person’s claims but their perceived worthiness to treatment that are important to medical staff’s responses. Furthermore, treatment can be influenced by the medical staff’s perceptions of the patient’s deviance from social norms. Radley (1994) suggests these staff perceptions are based along two interacting dimensions: i) whether the person has broken a social rule where there is either no excuse for breaking it or where there is an explanation, and ii) whether the person is perceived to have acted knowingly or cannot be held responsible for their actions. “Bad” patients are those people who are held to be responsible for their situation and could have brought it about knowingly, which may include people who self-harm.

In offering treatment, Radley (1994) suggests that doctors can also experience conflict between meeting expectations of the patient regarding diagnosis and treatment, and at the same time acknowledging him or her as a person who has rights and status outside of the medical context. This involves maintaining the integrity of the patient as a person despite physical treatment often objectifying the body. The responses of healthcare professionals to people who self-harm, and their experiences of offering treatment, are therefore fundamental to the services that people who self-harm receive.

**Healthcare Professionals’ Responses towards People who Self-harm**

As suggested in the accounts of women with experience of receiving treatment for their self-harm, professionals’ responses can be variable. In trying to understand the factors that might contribute to professionals’ responses, the ways in which services are organised within Western cultures has been considered, particularly in terms of the dominance of the medical model. Johnstone (1997) proposes that unhelpful responses to self-harm within psychiatry are maintained by some of the ways in which medical psychiatry conceptualises self-harm. These include the view of self-harm
as indicative of an underlying psychiatric illness with a yet unknown biological aetiology. She suggests that diagnoses such as BPD can overlook the social context of difficulties; rather they place the problem within the individual. This can prevent exploration of the continuum along which self-harm occurs from the more socially acceptable forms such as drinking, smoking, piercing and tattooing to the less socially acceptable forms such as cutting and burning. Why there are these differences in acceptability is also not considered. Furthermore, medical and mental health staff may not be given support in exploring, understanding and managing the strong emotions self-harm can elicit within them. Allen (2004) suggests that mental health services can replicate responses that may have characterised the person’s early experiences such as inconsistency, abuse of trust and intrusiveness. She also suggests that service responses might also be shaped by resource limitations such that people who self-harm are likely to be blamed and punished when they are asking for help that is perceived to be beyond the resources available. Consequently, it is of value to understand what responses self-harm evokes in healthcare professions in order to attend to how professionals’ responses can replicate relationship patterns that perpetuate self-harm.

Compared to the research regarding women’s experiences of self-harm, there have been relatively few research studies regarding the experiences of those who provide healthcare services. Most of the research focuses on quantitative research methods that assess the attitudes of healthcare staff who work with people who self-harm. Below there is a brief description of research undertaken from the perspective of professionals who treat self-harm:

- **Medical staff (psychiatric and non-psychiatric doctors and nurses)**

Medical staff’s understandings of self-harm and the experiences that may contribute to self-harm have been the focus of a number of research studies (Crawford *et al.*, 2003; Jeffery & Warm,
Psychiatric and non-psychiatric doctors and nurses who were involved in the care of young people who self-harm (defined as both self-poisoning and self-injury), were not aware of the higher risk of self-harm amongst young gay men and young people who had been sexually abused. Doctors however, had the most knowledge about self-harm amongst young people (Crawford et al., 2003). Medical staff’s knowledge of self-harm has also been compared to that of other healthcare professionals. In one study, psychiatrists and medical workers were found to have a poorer understanding of self-harm compared to people who self-harm, psychology workers and social/community care workers (Jeffery & Warm, 2002). This may have been due to differences between medical, social and psychological models of self-harm such that the latter two place more emphasis on understanding the experiences that led to the self-harm. Both studies highlight a greater need for training and awareness-raising for medical staff, yet they offer little to understanding how the medical staff’s level of knowledge translates to their practice.

Crawford et al. (2003) also assessed medical staff’s attitudes towards young people who self-harm and found that the staff generally had positive attitudes. The staff’s scores on the attitudinal measure were positively correlated with their perceptions of their effectiveness in helping the young people such that those who felt most effective had less negative attitudes. Furthermore, the psychiatrists experienced more worry about being blamed for what might happen to young people who self-harm. Perceptions of effectiveness and responsibility appear to be important factors which contribute to how medical staff may respond to people who self-harm. The importance of staff feeling helpful has also been demonstrated in a research study which focused on the psychiatric response to self-harm on an inpatient unit for women (Aldridge, 1988). It was found that helping the psychiatric staff to understand women’s self-harm in terms of their past histories helped to decrease the staff’s distress when responding to the immediate consequences of self-harm. Furthermore, the frequency and the severity of the self-harm on the ward decreased through
the staff and the women working together to negotiate helpful ways of managing self-harm in which the self-harm was not stopped. This supports the idea of the utility of a shared understanding of self-harm between healthcare professionals and people with personal experiences.

Huband and Tantum (2000) specifically looked at the attitudes to self-injury (defined as self-inflicted cutting, slashing, hitting or burning) of mental health staff. They used responses to a vignette to assess the staff's attitudes towards a young woman who had cut herself on several occasions, but did not appear to experience any suicidal ideation or difficulties typically ascribed to major depression and/or psychosis. They found that perception of control was the most important factor underlying the staff's attitudes towards the young woman, with the less tolerant staff viewing the woman as having intentional control over her self-injury. Furthermore, 75% felt that self-injury was difficult to manage and 65% of the staff reported that it would be difficult to build a relationship with the woman.

In considering service delivery, some good practice guidelines for working with people who self-harm have been produced through consultation with both service providers and people who self-harm (Lindsay, 1999). Harm-minimisation approaches have been suggested as helpful strategies to consider alongside psychological and social support (Lindsay, 1999; NSHN, 2000; Pembroke, 1998b). This encompasses practical approaches to reduce the severity of harm when coping is not possible by other means and has recently been publicly debated within the nursing profession (Royal College of Nursing Congress, 2006).

The literature is mixed as to staff's attitudes towards, their level of understanding of, their responses to, and their willingness to work collaboratively with people who self-harm. However,
it has been noted that unhelpful responses and attitudes can and do occur when people access healthcare services for their self-harm. McAllister (2001) suggests that not only can unhelpful responses have negative consequences for people who self-harm but also for nurses themselves in terms of understanding the complexities surrounding self-harm, dissatisfaction in their interactions with people who self-harm and feelings of helplessness. If this is the case, why do some staff respond negatively towards people who self-harm? McAllister and Estefan (2002) propose that disempowering responses from nurses may function to help this oppressed group experience some sense of control over the distress and sense of hopelessness that can be felt when working with people who repeatedly self-harm. Furthermore, Crowe (1996) suggests that nurses may feel frustrated when a patient continues to self-harm as they perceive this as signifying deterioration or a lack of improvement and therefore feel thwarted in their efforts. These indicate that how nurses perceive their experience of working with people who self-harm influences the treatment that they offer.

The research concerning healthcare professionals' responses to people who self-harm has mainly included professionals from secondary services, such as mental health services, which may not be the first services that people who self-harm access. A&E is often the first point of contact with services for people who self-harm (NICE, 2004; MHF, 2006). Understanding A&E staff's responses to self-harm is essential to understanding the impact they have on whether people who self-harm seek help in the future.

- **A&E staff**

Anderson (1997) compared qualified community mental health nurses' attitudes towards “suicidal behaviour” (which was defined as any behaviour which nurses may define as “attempted suicide” and “deliberate self-harm”) with those of qualified nurses working in an A&E department, using a
questionnaire measure. He found that the nurses' attitudes were generally positive and did not significantly vary between the two groups. The relationship between length of experience and attitudes however, differed between the two groups. The more experienced A&E nurses held more positive attitudes than those with less experience yet the converse was found amongst the community mental health nurses. It was not clear what might be contributing to this differential effect of experience but one possible explanation may be due to the differing contexts of A&E and community mental health services. Community mental health services are less available due to people being seen for longer and therefore, over time, community mental health nurses may repeatedly experience not being able to offer help when it is needed or feel greater responsibility for co-ordinating all aspects of care through the system of care co-ordination. In contrast, A&E nurses may be able to hold more hope due to seeing people when they want help and viewing the treatment of the emotional aspects of self-harm as within the responsibilities of mental health services.

More recently, research has looked at what might contribute to how A&E doctors and nurses respond to people who self-harm. For example, Mackay and Barrowclough (2005) used Weiner's (1980, 1986 cited in Mackay & Barrowclough, 2005) attributional model of helping to assess qualified A&E doctors' and nurses' care of patients presenting with self-harm. They found that the A&E staff's attitudes towards people who self-harm and thus their willingness to help were mediated by attributions of controllability for the self-harm and optimism that the person who had self-harmed could change their behaviour. The greater the attributions of the individual's controllability for self-harm, the more negative the staff's emotional responses towards the person, and the less willing the staff were to help. Furthermore, the higher the ratings of the stability of outcome (e.g. belief that self-harm would likely be repeated), the less optimistic the staff were about the success of their input. This is supported by the finding that people who...
repeatedly self-harm often evoke feelings of helplessness and frustration in A&E nurses (Holdsworth et al., 2001).

Mackay and Barrowclough (2005) also found that the male staff expressed greater irritation and frustration, less personal optimism and less willingness to help than female A&E staff. The medical staff (both male and female) expressed greater irritation, less personal optimism and less helping behaviour than their nursing colleagues, and they also saw less of a need for training. One possible reason for this difference is that medical staff are taught to offer medical treatment in an objective manner and therefore they may believe that the treatment they offer is not influenced by their views of the person. Furthermore, the focus of treatment is on the physical aspects of self-harm and A&E medical staff may believe that treating the emotional aspects is not within their role so training in this area is not needed. One limitation of this study is that it used predetermined measures of factors that might influence A&E staff’s perceptions of, and the care they offer to, people who self-harm. There may also be a range of other factors that might contribute to their perceptions and treatment of people who self-harm, such as the form of self-harm used.

One UK study has specifically focused on A&E doctors and nurses’ attitudes towards people who self-harm by cutting (Friedman et al., 2006). The staff’s attitudes were measured using a questionnaire and it was found that although a large proportion of the staff felt that cutting was associated with distress, 77% felt people used cutting as a way of seeking attention and therefore a form of manipulation. It was suggested that staff felt deskillled in managing people who self-harm by cutting as they had little training in this area, 51% suggested they felt frustrated when working with this group. In those staff without previous training in self-harm, longer experience of working in A&E was correlated with higher levels of anger towards patients and less sympathy. This contrasts Anderson’s (1997) findings. A further questionnaire-based study by
McAllister et al. (2002) explored Australian emergency department nurses’ attitudes towards working with people who self-harm. They found that the nurses' attitudes were generally negative and four factors related to the nurses’ attitudes: i) the nurses’ perceived confidence in their assessment and referral skills, ii) their perceived ability to deal effectively with people who self-harm, iii) empathic approach, and iv) ability to cope effectively with legal and hospital regulations that guide practice. One limitation of these studies is that the relationship between attitude and practice was not researched. Furthermore, the quantitative approach to measuring attributions, attitudes, emotional responses, optimism for change and willingness to help does not allow for conflicting attitudes or emotions to be measured and limits the responses to pre-defined criteria.

Opportunities for healthcare staff to reflect on the personal responses self-harm can elicit within themselves has been suggested as a way to improve the care offered to people who self-harm (Barker & Buchanan-Barker, 2006; Hussain, 2005). Furthermore, it has been found that critical reflection of the possible reasons for somebody's self-harm can help A&E nurses to feel less anxious, frustrated and helpless in working with people who repeatedly self-harm (Holdsworth et al., 2001). At the annual conference of the Royal College of Psychiatrists in 2005, it was suggested that professionals should admit their feelings of disgust and anger towards people who self-harm (Hussain, 2005). The rationale for this was to help raise professionals’ awareness of the influence these feelings can have on the treatment they offer so that they are able provide approaches that are not critical, punitive or hopeless. However, it was also raised that A&E staff do not receive support in doing this and there can often be conflict between professions as to the best way to treat people who self-harm, which can lead to less integrated care and support.

Although research has begun to focus on the responses of A&E towards people who self-harm, studies are limited in that they have mainly involved researcher-led approaches. A search of the
literature has revealed no studies that specifically explore A&E staff’s responses to meeting with people who self-harm in their work and how they decide on the treatment that they offer. The studies focusing on A&E staff’s responses have mainly involved quantitative designs where there is an emphasis on breadth of data rather than depth. Furthermore, quantitative designs usually impose the researchers’ understanding and assumptions of the phenomenon under investigation on participants (Lincon & Guba, 1999).

A qualitative perspective was adopted within this study to gain further insight on A&E qualified doctors and nurses responses to treating people who self-harm. Harris (2000) suggested that qualitative research can focus on the exploration of the meaning of self-harm through the use of a small sample size and in-depth interviews. Qualitative research also helps to understand the social context in which self-harm not only occurs but also within which self-harm is responded to by healthcare professionals. Jarman et al. (1997) highlighted the rarity of the application of qualitative methods to further comprehend healthcare professionals’ understandings and experiences of the treatment of different forms of emotional distress. In this study, a qualitative approach to data collection and data analysis was adopted to answer the research question of how A&E doctors and nurses respond to treating people who self-harm and the meaning they attribute to these experiences. In this case, the qualitative approach allowed the research to be participant-led, as opposed to researcher-led, and ask about the responses of staff who treat people who self-harm in A&E.

Assumptions guiding the research

A qualitative perspective was undertaken as an underlying assumption of the research was that the way in which people experience and understand events is influenced by the meaning that they attribute to the event and therefore, people can experience the same events or phenomenon in
different ways. A central concern of the research was to gain an understanding of how people make sense of their lived experiences. It was also assumed that a person's account of their experiences has some relationship, albeit an unknown one, with their thoughts, feelings, schemas and beliefs about the event and/or object of investigation. These assumptions encompass both a relativist ontology, which emphasises that a diversity of interpretations can be applied to an experience, and a symbolic-interactionist view, which suggests that meanings are negotiated within a social context (Willig, 2001). Interpretations of these experiences are therefore influenced by the interaction between the narrator and the person who hears the account (i.e. participant-researcher in the case of research). This fits with a constructivist-interpretivism axiology (Ponterotto, 2005) as constructivists suggest that the researcher's values and lived experience cannot be separated from the research process; therefore the researcher should acknowledge and state their own position, thoughts and feelings with regard to the phenomenon under study.

The assumptions guiding this research overlap with an interpretative phenomenological approach. Interpretative phenomenological analysis (IPA) was chosen as the method of data analysis as the aim of IPA is to explore how participants make sense of their personal and social world (Smith, 2003). Therefore, and following Lincoln and Guba's (1999) suggestion that only one broad research question be stated when undertaking research from a qualitative perspective, the study asked:

How do qualified doctors and nurses in A&E respond to treating people who self-harm?

IPA is underpinned by ideas from two branches of philosophical thought: phenomenology and hermeneutics (Smith & Eatough, 2006). These contribute to the knowledge that IPA aims to
produce, or its epistemology. Phenomenology is concerned with the way people gain knowledge of the world and focuses on the content of individuals' conscious experiences of the world. Furthermore, it is interested in the diversity of people's experiences and the underlying meaning of these experiences (Smith et al., 1999). It therefore endorses a relativist view of the world. A central assumption of IPA is that people have relatively stable ways of perceiving their experiences and these are influenced by language, thoughts, feelings and physical experiences (Smith & Osborn, 2003). The task of the research therefore, is to try and access people's beliefs, schemas and cognitions which influence their perceptions of experience (Dallos & Vetere, 2005).

The phenomenon that the research was interested in investigating was the treatment of people who self-harm in A&E. It was assumed that by interviewing A&E staff about their experiences of treating people who self-harm, the researcher would gain some insight into the staff's perceptions of people who self-harm and their experiences of treating people who self-harm in A&E.

IPA adopts the hermeneutic approach which espouses that meaning is hidden and is accessible through reflection. Smith & Osborn (2003) suggest that IPA involves a double hermeneutic process in which interpretation occurs both within the individual's understanding of their experience and also with regards to the researcher's interpretation of meaning from the individual's account. IPA therefore endorses a constructivist ontology in that it assumes that meaning around an experience is interpretative for both the participant and researcher (Dallos & Vetere, 2005). It considers the research process to involve a dynamic interaction between interviewer and participant (Jarman et al., 1997). This is consistent with the assumption that the interpretation of the meanings made within the A&E staff's accounts would be influenced by the researcher's own thoughts and feelings about people who self-harm and the treatments offered to this group within A&E.
Method

Participants

Purposive sampling was used to recruit qualified A&E doctors and nurses who had experience of treating people who self-harm. In this study eight participants were chosen because the researcher felt it was important to be able to perform a detailed case-by-case analysis and this number also falls within the recommended maximum sample size of ten participants for analysis (Smith et al., 1999). The participants were recruited via two A&E departments in which the Head Consultant and the Nurse Manager of each distributed the information sheets regarding the study to their staff (see Appendix A). Members of staff who were interested in participation staff contacted the researcher directly and requested whether they would like to be interviewed at home or at the hospital. The researcher obtained forthcoming work rotas from the Head Consultant and Nurse Manager and informed them when she would attend the hospital to conduct interviews. This enabled the Head Consultant or Nurse Manager to book a room for the researcher when participants requested the interviews be conducted at their place of work.

Eight qualified doctors and nurses working in the A&E departments of two hospitals were interviewed: five (63%) were qualified doctors and three (37%) were qualified nurses. Five of the participants (63%) were female and three (37%) were male. Furthermore, the average number of years the participants had treated people who self-harm was 5.6 years (range 1-25 years). Table 1 highlights the demographical characteristics of the participants. The names used to identify the participants in the study are fictitious.
Table 1 – Demographical characteristics of the participants.

<table>
<thead>
<tr>
<th>Name</th>
<th>Sex</th>
<th>Age range</th>
<th>Ethnicity</th>
<th>Profession</th>
<th>Number of years had been treating people who self-harm.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Siobhan</td>
<td>Female</td>
<td>20-29</td>
<td>White Irish</td>
<td>Nurse</td>
<td>3</td>
</tr>
<tr>
<td>Rachel</td>
<td>Female</td>
<td>20-29</td>
<td>White British mixed (White South African and Welsh)</td>
<td>Medical doctor</td>
<td>2 ½</td>
</tr>
<tr>
<td>Tim</td>
<td>Male</td>
<td>20-29</td>
<td>White British</td>
<td>Medical doctor</td>
<td>5</td>
</tr>
<tr>
<td>David</td>
<td>Male</td>
<td>50-59</td>
<td>White British</td>
<td>Medical doctor</td>
<td>25</td>
</tr>
<tr>
<td>Mabait</td>
<td>Male</td>
<td>20-29</td>
<td>Filipino</td>
<td>Nurse</td>
<td>2 ½</td>
</tr>
<tr>
<td>Leah</td>
<td>Female</td>
<td>20-29</td>
<td>White British</td>
<td>Nurse</td>
<td>4</td>
</tr>
<tr>
<td>Faye</td>
<td>Female</td>
<td>20-29</td>
<td>White British</td>
<td>Medical doctor</td>
<td>2</td>
</tr>
<tr>
<td>Emma</td>
<td>Female</td>
<td>20-29</td>
<td>White British</td>
<td>Medical doctor</td>
<td>1</td>
</tr>
</tbody>
</table>

All those who volunteered to participate in the study were interviewed. The two hospitals had, in total, approximately ninety qualified doctors and nurses working in A&E who were eligible to participate.

**Procedure**

Interviews were conducted at the participant’s place of work, in a separate consultation room, or at their home. They involved a semi-structured interview that gave the researcher flexibility to explore the experiences that the participants discussed whilst also recognising the participants as experts in their experiences of treating people who self-harm (Smith & Osborn, 2003).

The semi-structured interview was developed in collaboration with the researcher’s supervisors, one of whom is a survivor-activist in the areas of voice-hearing and self-harm. She has many experiences of being treated in A&E following self-harm and has consulted others who self-harm in producing literature for healthcare professionals. Through discussion regarding the aims of the research, we identified the following as a range of issues the interview should cover: understandings of self-harm, emotions evoked in response to self-harm, influences on treatment...
decisions and changes in responses. Questions and prompts appropriate to these areas were then constructed by the researcher and revised through a process of feedback from her supervisors.

Prior to the interview, the participants were asked to fill out a consent form (see Appendix B) and also a demographic information form (see Appendix C). Each interview began with more general open-ended questions about self-harm in order to aid the building of trust and rapport between the interviewer and the participant. The aim of the interview was to facilitate the participants in giving their accounts of treating people who self-harm in A&E in a sensitive and empathic manner, recognizing the interview as being an interaction between two human beings (Fontana & Fry, 2000). The interview schedule (see Appendix D) included questions about the participants’ understandings of the term “self-harm”, their definitions of self-harm, their experiences of people who self-harm, their understandings of the reasons why people self-harm, their feelings towards people who present to A&E following self-harm, factors that contribute to the decision-making process around the treatment they offer, how working with people who self-harm has affected their perceptions of people who self-harm, their views of how people who self-harm should be treated and how they treat people who self-harm.

The interviews lasted between 40 minutes and 1 hour and 15 minutes. All the interviews were audio-recorded and transcribed verbatim.

**Ethics**

Ethical approval for the research was gained from both the University Ethics Committee and the Research and Development Committees for the two hospitals from which the participants were recruited (see Appendix E).
Ethical dilemmas were raised concerning the recruitment of the participants and in ensuring anonymity. Although names and other information that would make the participants and their places of work identifiable were changed, it was difficult to ensure total anonymity because the Head Consultant and Nurse Manager knew who was on shift at the times the researcher conducted interviews at the hospital. This was managed by assuring the participants that no confidential information would be shared with the Head Consultant and Nurse Manager as to who was interviewed. Furthermore, the researcher offered participants the option to be interviewed in their own home. Prior to the interview, participants were told they could stop the interview at any time.

**Analysis**

Interpretative Phenomenological Analysis (IPA) (Smith, 1996; Smith, *et al.*, 1999; Smith & Osborn, 2003) was used to analyse the data. (See Appendix F for an analysed transcript.) The initial stage of the analysis involved repeatedly reading the transcripts and making notes on the transcripts regarding key phrases and comments in the left-hand margin. These included summaries of content, connections between what had been said in different parts of the transcript and initial interpretations (Touroni & Coyle, 2002). The researcher then documented the emerging themes from these notes and wrote them in the right-hand margin. The emerging themes were then listed on a separate page and the researcher identified those that clustered together, and the links occurring between them, to produce a set of superordinate themes. This involved the researcher fully engaging with the text, linking the themes with what was said and drawing on her own interpretations (Smith *et al.*, 1999). This ensured that the emergent themes were grounded in participants’ accounts (Elliot *et al.*, 1999).

The analysis involved repeatedly examining the transcripts in this way and then adapting or changing the superordinate themes accordingly to create a list of master themes supported by the
participants’ accounts. The researcher then used the first master list to analyse subsequent transcripts. When new themes emerged, these were tested against earlier transcripts and superordinate themes were adapted accordingly such that the master-theme list evolved with the analytic process.

In assessing the quality of qualitative research, it has been suggested that transparency around the position of the researcher, grounding the analysis in examples from the data, checking the credibility of the themes with the participants and being transparent about the position of the researcher and the analytical process are important (Elliott et al., 1999). This study followed these guidelines such that the analytical process has been made clear, the results are grounded in the data and that the credibility of the main themes were subjected to the opinion of the participants. All of the participants requested electronic feedback of the analysis and the researcher encouraged the participants to respond with their views of her analysis. It was explained that differences of opinion would be acknowledged in the research. Two participants replied and stated that they were generally happy with the analysis and asked for further inclusion of information about their experiences of working in A&E and limitations of the service. The researcher agreed to this as it helped to contextualise the data. This also informed the analysis through highlighting the researcher’s attention to possible function of the explanations A&E staff offered as to their role in treating people who self-harm.

In the following results, interpretations are illustrated by extracts from the participants’ transcripts to allow readers to assess the persuasiveness of the analysis. In these quotations ellipsis points (....) indicate where material has been omitted and clarificatory information appears within square brackets [ ].
The Interpretative Lens of the Researcher

IPA endorses that the researcher is an active participant in the research process and influences the interpretation of the meaning with the participants’ accounts (Smith & Osborn, 2003). Therefore, as Mauthner and Doucet (1998) highlight, it is important for the researcher to adopt a reflexive approach in order to make explicit how they are positioned in relation to the participants, and to acknowledge the role that their own values and experiences play in interpreting the participants’ accounts and in producing hypotheses about the meaning of these in relation to the phenomenon being explored. In the following narrative, I shall try to describe my position as the researcher and acknowledge the values and experiences which have contributed to my analysis and understanding of the participants’ accounts.

I am a twenty-seven year old heterosexual female with a history of self-harm, mainly cutting. This remained hidden until I was treated in A&E following an overdose at the age of seventeen. My experience in A&E was a pertinent lesson in how a person’s view of the self, their relationships and their trust in others can be undermined by not being heard or valued, particularly at times of high emotional arousal. This contributed to my passion for understanding people’s experiences within the meanings that they attribute to these, however their distress is experienced or coped with, and led me to a career in psychology.

I am also a trainee clinical psychologist and therefore work with people who self-harm. For a long time I have struggled between hiding my scars from others and accepting them as part of me, as part of the experiences that have helped me to develop and understand my ethics. This struggle has been particularly relevant to my development as a psychologist, has motivated me to think about the contribution I make to the services I work in, and has led me to be interested in qualitative approaches to research. In considering service provision for people who self-harm, I
am both an “us”, as a service provider, and a “them”, as a person who self-harms. This position of being both is where I have experienced conflict as for some professionals these positions are seen as mutually exclusive. In reflecting on my approach to this research, I wondered whether some of the A&E staff had also experienced similar conflicts. It is my belief that A&E doctors and nurses can feel disempowered and find it difficult to challenge dominant practices when treating people who self-harm, despite holding different personal views. I hoped that this belief would help me to remain curious around, and value, the challenges A&E doctors and nurses face in offering treatment to people who self-harm.

Another important influence in this research has been the support of my supervisors, each of whom are interested in the social aspects of experiences. Louise Pembroke is one of my supervisors and her involvement was based on her role as a survivor-activist within the areas of hearing voices and self-harm. Through sharing her experiences of being treated for self-harm in A&E, I became aware of the advice that A&E doctors and nurses could give to people who self-harm around wound care. Louise also helped me to think about potentially different responses to self-harm being evoked when a person has been given a psychiatric diagnosis, particularly schizophrenia. This led me to explore this area further in the interviews with the A&E nurses and doctors. My interest in the influence of age, gender, the person’s perceived level of control and responsibility, and the form of self-harm used, on the staff’s experiences of offering treatment may have contributed to other potential factors not being explored, such as a person’s ethnic background, sexual orientation or where on the body they had harmed themselves.

Prior to conducting the interviews, I thought that the A&E staff would potentially be quite honest due to viewing me as a professional who also works with people who self-harm and therefore possibly shared similar experiences in my attempts to help. However, they might also be reserved
in their answers due to concerns about how I would view them because I did not work in A&E. During the interviews I felt that the A&E staff were more open and gave much more rich responses once I had explained, and demonstrated in my questioning, that I wanted to try and understand what it was like to work in A&E and treat people who self-harm. This suggested that they were able to feel more comfortable once I was able to show some appreciation of the challenges they face working in A&E. Interviewing the participants helped me to gain an understanding that many of the participants wanted a better life for people who self-harm, one that meant they no longer needed to self-harm. This reminded me of my own discomfort around knowing that someone is in so much pain and distress that self-harm becomes a way of coping. I also learned that when the staff had negative views of people who self-harm, it often related to feelings of powerless to knowing what to do. These understandings may have been offered as part of being interviewed by somebody from a psychology background but I felt that these explanations were sincere, especially because it can be difficult for professionals to admit to one another that they do not know what to do.

In addition to differences in professional backgrounds, there were age, gender and cultural differences between myself and some of the participants. I think that awareness of these differences contributed to me focusing more on how these differences might influence the participants’ responses to treating people who self-harm in the interviews, and less so on areas of similarity. With regards to gender, I hoped that being a female would aid the male participants to speak about their personal responses to self-harm. However, I was also aware that social ideals around masculinity may have constrained the male participants’ accounts of their feelings towards treating people who self-harm.
I began the interviews thinking that most of the staff would have negative views of people who self-harm and view us as wasting their time and their resources. However, I had hoped to be proved wrong and I realised that my expectation was neither true nor false but narrow in terms of appreciating the variety in A&E staff’s experiences of treating people who self-harm. Coming from the position of being a trainee clinical psychologist, I think I also took for granted the training and support I have received in talking about distress with people. This was highlighted when many of the A&E staff spoke about feeling uncertain of their skills in being able to talk with the person about the experiences underlying their self-harm.

I was aware of the differences between the focus of my work with people who self-harm and that of my participants’, which directed me to pay attention to information about their training, their motivations for working in A&E, their professional identities and any opportunities available to them for reflecting on the impact of treating people who self-harm in A&E on themselves. Reflection of the impact on the self of treating people who self-harm was part of what was asked in the interview and although self-reflection is endorsed within psychological models, I was aware this may have been a new experience for the A&E doctors and nurses I interviewed. I therefore tried to encourage the participants to help me understand their experiences of treating people who self-harm and followed their responses, as far as possible, in exploring what they considered to be important. This encouragement could have been a possible source of bias while conducting the research.
Results

Three main themes emerged from the data with regards to how A&E staff respond to treating people who self-harm. These were: treating the body; silencing the self; and mirroring social and cultural responses. These are summarised in table 2.

Table 2 – Summary of themes

<table>
<thead>
<tr>
<th>Theme 1: Focusing on the body</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of A&amp;E</td>
<td>Limited responses: physical treatment, not trained / role to address distress. Dissatisfaction with responses.</td>
</tr>
<tr>
<td>Treating people who take severe overdoses</td>
<td>Identification with reasons, more caring vs anger and blame due to family members’ distress.</td>
</tr>
<tr>
<td>Treating people who attend A&amp;E for the first time</td>
<td>More effective, caring, understanding, offer choice. Help to prevent further self-harm through involving other services.</td>
</tr>
<tr>
<td>Treating people who frequently attend A&amp;E</td>
<td>Helpless, angry, frustrated, sad, disheartened, ineffective. Blame services and/or person for repeated self-harm.</td>
</tr>
<tr>
<td>Treating people with a psychiatric diagnosis</td>
<td>Apprehension about talking to the person about their distress – role of psychiatric services.</td>
</tr>
<tr>
<td>Treating people whose self-harm is perceived as manipulation</td>
<td>Anger. Offer basic physical care but responses perceived as useless and showing care unhelpful as can reinforce person’s self-harm.</td>
</tr>
<tr>
<td>Treating people under the age of sixteen</td>
<td>Empathy, wanting to help, agitation with services for not responding to young person’s distress and risk.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 2: Silencing the self</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges to motivations behind working in A&amp;E</td>
<td>Trivialize person’s self-harm as a way of coping with discomfort about perceived inability to help.</td>
</tr>
<tr>
<td>Protection of self from distress</td>
<td>Limit conversations about the person’s reasons for self-harming to prevent own responses of distress. Focus on body.</td>
</tr>
<tr>
<td>Contribution of personal experience</td>
<td>Difference from silencing - use of personal experience can contribute to more hopeful and satisfying responses.</td>
</tr>
<tr>
<td>Revisions to clinical responses</td>
<td>Difference from silencing - responses perceived to be more helpful when revised through talking with people who self-harm about their experiences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Theme 3: Mirroring social and cultural responses</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of self-harm</td>
<td>Helplessness due to lack of training, responses influenced by those of senior colleagues.</td>
</tr>
<tr>
<td>Working within the medical culture</td>
<td>Dominant discourse – professional responses distance oneself from the emotional impact and that focus on treating the body.</td>
</tr>
<tr>
<td>Secrecy within the profession</td>
<td>Stigma contributes to secrecy amongst professionals.</td>
</tr>
<tr>
<td>Societal responses</td>
<td>Isolate and remove control / sense of agency.</td>
</tr>
<tr>
<td>Cultural differences</td>
<td>Responses to emotional aspects – family vs psychiatric services.</td>
</tr>
</tbody>
</table>
1. **Treating the Body**

The first theme concerned the main priority of the A&E staff’s responses being to treat the body when treating self-harm. This encompassed seven sub-themes which offer greater insight into the limitations of responding only to the physical aspects of the person’s self-harm. These are: the role of A&E, treating people who take severe overdoses, treating people who attend A&E for the first time, treating people who frequently attend A&E, treating people with a psychiatric diagnosis, treating people whose self-harm is perceived as manipulation, and treating young people under the age of sixteen. The staff appeared to suggest that this narrow focus of their role often left them in the uncomfortable position of feeling ineffective in their attempts to help.

i. **The Role of A&E**

When treating people who self-harm in A&E, most of the doctors and nurses spoke about the focus of their role being to offer physical treatments based on the person’s wounds or level of poisoning, and also to manage risk. Many of the participants’ accounts suggested that addressing the emotional aspects of self-harm was the role of their psychiatrically trained colleagues, and was not within their expertise. They would therefore refer the person to the psychiatric team once they had given the required physical treatments:

*We in accident and emergency will just deal with their physical side whether that is external or internal.... If they’ve taken tricyclic antidepressants or heroin, whatever, they’ll all be treated the same way medically. The psychiatric aspect of it doesn’t come into the situation until you’ve treated them.... But similarly with the external harmers, you treat their cigarette burns, you remove the needles that they’ve placed in, or staples, and you stitch up their wounds, but, you know, we’re...*
not treating them psychiatrically. Those have to be transferred on because there's nothing that we can do. (David)

Some of the participants however, suggested that they felt frustrated with the limited responses they could give. Many also pointed out that A&E may be the only access to help some people who self-harm have which implies that there are missed opportunities to offer more helpful responses:

I think it's [self-harm] one of those things in A&E that kind of gets overlooked, it could be a lot better, it could be improved a lot better. But it's almost that people don't want to go down that road because it's all a bit, that's not to do with us because it's a long-term thing and it's psychiatric and it's separate, which I don't really think it is because that's, they'll come into A&E more often than not and we're the people that they see so it is really, really difficult. (Leah)

Furthermore, a few of the participants suggested that narrow definitions of self-harm used within A&E may undermine the staff's perceptions of their skills in being able to respond to emotional distress due to conceptualising this as a response available only from mental health professionals:

I'd say self-harm is a person carrying out an action which has adverse effects on them, physically and emotionally, is what I'd describe as self-harm. Alcoholics, drug abusers, people that cut themselves, people that burn themselves and people who overdose as well. I see all those things as deliberate self-harm.... But at work we sort of classify the deliberate self-harm and the people that need for sort of psychiatric review, assessment and possibly further support as people who take
Overdoses and people that cut themselves; the people that have made a sort of good
going attempt to shorten their life. (Faye)

Most of the A&E staff spoke about the medical treatment they offer to people who self-harm as
being standardised such that everyone receives the same level of physical care. However, as
outlined in the following sub-themes, there were differences in the staff's accounts of their
responses to people who self-harm.

ii. Treating people who take severe overdoses
Many of the A&E staff defined overdoses as a form of self-harm and conceptualised people's
reasons for taking severe overdoses as being different from those who take overdoses that are less
life-threatening in the short-term. Some of the doctors and nurses felt that people who take severe
overdoses have more valid reasons for receiving help and therefore they may offer greater support
than purely attending to their physical health:

He [patient] suffered from a stroke, rendered, I think, paraplegic, so basically the
quality of his, he's a learned man, he's a professional so he logically lucid thinks.
It's quite emotional really because when I dug deeper into why he took an
overdose.... The first thing he has done after ingested it, he waited for an hour or
two hours and the first thing he has done is to phone the sister and ask why it didn't
work. So I see the authenticity because he just phoned the sister and said, "Why
didn't it work?".... For a fifty-four year old chap whom we could consider not very
old here in England, I think that's very frustrating and I, and I believe in his
principal... And basically he, he gave me some thoughts to ponder on about life...I
actually visited him and I rarely visit patients after A&E.... I don't forget that man.

(Mabait)

Understanding of the person’s reasons however, was not the only influence on the staff’s responses. A few of the A&E staff suggested that they would experience discomfort if the person had family members in attendance with them, and blame the person for causing their family undue distress:

*I probably get more, not angry, but, not upset either, but more irritated with people who have taken large overdoses with the clear intent to, actually wanting to kill themselves. You speak to them and say, “Well, what about family?” and all the rest of it and they go, “Oh well, whatever” and don’t give you a reason....because it’s the people who don’t take their family into consideration that do irritate me slightly. I’ve seen it from the other side and when it happens and you’re left with the family which has been, kind of, ripped apart. It is a bit....it’s almost selfish, it’s just not, there’s so many other ways round it. (Tim)*

iii. Treating people who attend A&E for the first time

On a person’s initial attendance to A&E following self-harm, most of the A&E staff spoke about placing greater emphasis on showing care, openness to understanding what difficulties the person is experiencing and showing hope that things can change whilst also offering physical care. Many of the A&E staff implied that they wanted the person to stop self-harming but that they could only do this indirectly by referring the person to other services:
And if I don't make them feel that: a) what they have done is important and b) something can be done about it and that there are other forms of help that they can get to avoid this happening again, then this is blatantly not going to be an isolated incident. I think, because you get people coming in and saying, “Oh yeah, I always come in and no-one ever pays any attention to me, they stick stickers on me and send me home” and that sort of thing, and I don’t want somebody to say that about one of their consultations with me. (Faye)

Understanding self-harm as an expression of distress that could not be expressed verbally was a common understanding of self-harm when it was the person’s initial attendance or when they attended A&E infrequently. It was also considered to be fundamental to offering helpful responses. Socialising family members to this understanding was also felt to be an important response that A&E staff could offer:

I mean mostly your job in A&E is dealing with calming relatives down and very much so with self-harm because the family are often, you can often see them being quite angry with the “stupid wife” .... And you’re you know, always trying to keep a level between them so that it doesn’t descend into worse relationships.... or allow that person to say why they are doing it and let the family hear it because you sometimes just think these people just don’t have a voice and they’re not expressing why, why they are doing it and how crap they are feeling. Sometimes I think it is easier for families and the patient and relatives to speak when you’re in the room. (Emma)
Empathy was a common response for the A&E staff when working with people whose self-harm was considered to be an expression of distress. The significance of this response appeared to be that some of the A&E staff would offer the person a greater degree of choice in their treatment:

But it's natural, when you empathise with somebody, it goes out. You tend to more caring and all that. When you for example, take bloods, you would, if it's a normal kind of thing [when self-harm is an expression of unspeakable distress] and it's a secondary thing for them that they've done self-harm [when self-harm is a way of getting a desired response from another person], you would just chose the best vein regardless of it's, if that, that part is painful or not because my response would be, “You see, if I am going to let you chose the vein, the tendency is I might miss. I would have to do it again and that might be more painful because that will be two stabs.” But if you are empathic and they say, “Please don't take it on my right arm”, you say, “Which arm do you want it taken from?” [Patient] “Take it from my left.” You, even if you don't see a vein in there, you will spend time looking for it because you know you will inflict pain if you go into the right. So that's the natural thing that comes out if you have empathy. You tend to accommodate their comfort.

(Mabait)

Many of the A&E staff suggested that they felt more skilled in responding to this group because the person and/or family may be more receptive to the solutions that they offer:

I mean there are the one or two things where I think, maybe, maybe I'll just help nip something in the bud.... I had this, it was an awful night, I was really, really busy and.... she'd [a young female patient] been having problems sleeping so she'd
taken all sorts of tablets and her dad had found the empty tablets and asked her about them.... I had a long chat with the girl and it turned out that been having lots of problems at school and the story wasn’t quite so straight forward.... I said to her, “Can we talk to your parents together? .... and she was like, “Yeah, yeah” and she was so glad that she didn’t have to.... By the end of it they were all crying and hugging and agreed to go to the GP to sort out some counselling and I just; it’s the first thing she’d ever done and I just hope that they went home and actually did all of that and that nothing more serious will ever happen. But that you know, you know you can sort of get through to these people but it’s going to take you half an hour. (Faye)

As is suggested in Faye’s account, it arose that many of the A&E staff felt less hopeful about the effectiveness of their responses in consultations with people whom they had repeatedly treated for self-harm.

iv. Treating people who frequently attend A&E

Many of the staff spoke about finding it difficult to understand the reasons why people frequently self-harmed and regularly attended A&E for treatment. Any physical treatment offered was considered to be futile as any healing would be undone through the repetition of self-harm. Furthermore, feelings of helplessness and frustration appeared to be exacerbated when people who self-harm decline their offer of being seen by someone from psychiatric services:

I can’t lie; sometimes it just gets frustrating especially if you have already seen them three or four times in the week. It’s like, “Why? What do you want from me?” And it’s just because you are doing the same thing over and over and stitching them
up although you've just stitched them up and whatever.... It's more frustrating when they turn up and they don't, they don't really want to engage in the service..... Because you do just feel like you're just on a treadmill. You keep going and you're not getting anywhere in dealing with these patients. You're just kind of like you know, feel a bit stuck and kind of like you're just wasting your time and their time because you are not really getting anywhere with it. (Emma)

Many of the participants reported feeling sad and disheartened when treating this group because their responses could not prevent the person from further self-harm. This seemed to leave the A&E doctors and nurses feeling ineffective in their attempts to help:

When I first started I was just absolutely shocked by these people. I was just like, "This is absolutely awful, these poor people, what can be done to help them?" And I, I didn't get why some of the more experienced staff and nurses were saying, "Why are you spending so much time with them? Come on, stitch them up and patch them up, they'll be back next week." I felt that if we spent ten more minutes talking to them, then maybe we can, you know, sort something out. And I soon realised that, to a greater extent, the more experienced staff were right.... it's quite disheartening to feel like you're not really making a difference in that respect. (Faye)

Many of the A&E staff responded to this group by blaming psychiatric services for the person's repeated self-harm. The participants' accounts suggested that they experienced mental health professionals to be unsupportive and dismissive of the A&E staff's attempts to help. This seemed to contribute to intensified feelings of hopelessness:
The only area that, apart from the area I mentioned about manipulative patients, that presents that heart-sink moment for me is if I realise that I am actually going to have to contact psychiatric services for this patient... if I do get through to someone, or if they turn up, the response, I think it's fair to say, more often than not, more than half the time is, [mental health professional] "No, no, no, they can just go home." [Rachel] "Well, are we going to manage anything?" [Mental health professional] "No, no, no, they're always like this.... there's nothing we can do. Oh, we could start some treatment but we'll do that next week." [Rachel] "Well, do you feel that, maybe, actually, they present quite a harm to themselves?" [Mental health professional] "Yes, I'm sure they'll end up killing themselves, but it's alright" and I quote directly from a month ago, [mental health professional] "It's alright because you have documented everything so it'll be okay." I said, "Well, not for them."

(Rachel)

v. Treating people with a psychiatric diagnosis

Many of the A&E staff made a distinction between self-harm as a response to social difficulties (such as poor relationships, loss of a loved one, poverty and poor housing) and self-harm as a response to difficulties that they attributed to certain psychiatric diagnoses, mainly difficulties considered to be characteristic of people diagnosed with schizophrenia and bipolar affective disorder. In exploring their responses, many of the A&E staff suggested they felt happier offering physical treatments to this group of people because they viewed this group as less able to control their self-harm:

*It tends to be people who have serious mental illness that are very depressed and, or things like that and you think, okay, they don't really know what's, they do know*
what’s going on but because of their mental health problems they don’t have the insight to make a rational decision some of the time, well actually, you know, we’ve got to do it for them. You don’t mind, or I don’t mind as much dealing with that because you kind of think, well that’s fair enough, that’s part of the course. It’s the same way that you can’t get really angry at someone who has angina to go on with chest pain. You know, it’s not their fault as it were. (Tim)

Sympathy was a common response to treating people with psychiatric diagnoses. This may be because their self-harm was viewed to be a response to mental illness and so the responsibility for offering effective treatment lay with psychiatric services:

If someone has been labelled or diagnosed with a psychiatric diagnosis, let’s say schizophrenia or something like that, and they happen to be either taking overdoses frequently, or cutting themselves or harming themselves in some other way, then clearly their treatment is not working. So, you know, you feel, if you like, sorry for them that you can’t do more. (David)

Despite concerns about the support psychiatric services can offer to people with these types of diagnoses, many of the A&E staff expressed apprehension about talking to the person about their self-harm and commented that they might make things worse if they did:

The severe schizophrenia.... well you can dig deeper into them but don’t attempt because they panic and you lose the chance, or the opportunity, for someone who specialises in that particular illness to get the trust. So you don’t dig deeper, don’t attempt if you’re not sure you’re going to get there, because basically you would
sense that this is beyond my capacity to dig deeper in. I don’t know basically the
signs for me to hold back on whatever things I am trying to do. (Mabait)

vi. Treating people whose self-harm is perceived as manipulation

Many of the A&E doctors and nurses discussed having worked with people where they felt that
the person’s reason for self-harm was to gain power over others in order to get what they wanted.
Here the person’s reasons for self-harm, and for receiving treatment, were judged to be less valid:

Yes, it’s funny but I’ve attended to self-harmers that just have these superficial
lacerations, and most often than not when you ask them, “What’s the reason behind
it?” you eventually dig up the fact that they’ve lost a boyfriend or something like
that, and the boyfriend doesn’t call them any more so they want to know or they
want their boyfriend to know that they are in hospital, so they self-harm. So as I’ve
said, it’s a way of getting attention of someone. Those I think are the fraud ones.
(Mabait)

Many of the participants reported that they experienced this group to be more difficult to treat
because doing so often evoked anger within them. One consequence of this is that the A&E
doctors and nurses would spend less time with the person:

I’m intensely irritated by people who do it purely for manipulative reasons, and I
become very angry, very, very quickly, although I don’t believe I show this
outwardly. But I, although I hope I offer the same service, I do tend to spend less
time with the people that I find manipulative and on rare occasions, I do actually
ask other healthcare professionals to see it after me because I do find it difficult to

196

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
make an objective assessment of a patient that I find manipulative, because I dislike
them so much. (Rachel)

vii. Treating young people under the age of sixteen
Many of the A&E staff expressed concerns about the lack of services available to address the
emotional needs of people under the age of sixteen who self-harm. The participants suggested
that their responses towards this age group were more empathic due to understanding the young
person’s problems as being in response to a lack of care, and in some instances abuse from people
who hold responsibility for the young person’s well-being. However, this also contributed to
agitation when other services did not respond with a sense of urgency to the young person’s
distress:

So a lot of the youngsters, teenagers, who were perhaps, abused one way or the
other, may resort to cutting and that sort of thing.... There’s very little for child,
there’s very little effective let’s put it that way. I mean we’ve, you know, sometimes,
if it’s a place of safety type of order that we need then I’ve known kids of twelve and
thirteen to be kept down here for two days whilst we try and find a place.... I mean,
we had a lad a few months back that tried to hang himself.... He was okay, he was a
lovely lad, but he needed to be overseen. But, you know, I phoned the Consultant
Psychiatrist who, who was not in the position to come and see him, let’s put it like
that. And in the end, I got the hospital management to get a hold of their PCT, the
primary care trust for the area that he comes from, in order for them to get them to
fund a private child psychiatric bed. But that takes hours and hours, and sometimes
days, and it shouldn’t. (David)
This highlights the importance of understanding A&E staff's responses in the context of the feeling evoked within the self.

2. *Silencing the Self*

The second theme concerned A&E staff's personal responses to treating people who self-harm. This theme consisted of four sub-themes: challenges to motivations behind working in A&E, protection of the self from distress, contribution of personal experiences and revision of clinical responses.

i. *Challenges to motivations behind working in A&E*

Many of the staff spoke about their motivations for working in A&E being to resolve crises, to cure and/or offer solutions to physical problems and to help people to feel better. It appeared that self-harm often confronted the staff with dilemmas around their role, especially when faced with repeated self-harm. Treating self-harm seemed to directly challenge the doctors' and nurses' reasons for working in A&E and left many of the A&E doctors and nurses feeling disillusioned with their abilities to help. Trivialising the person's self-harm appeared to help the staff disregard their own discomfort:

*I'd say I think that the way that people deal with self-harm in A&E and it is again a defence mechanism.... sometimes the whole team can be very flippant about self-harm. They're like, "Oh they're back again.".... but I think that is in a sense used as, I think it is that whole frustration of not being able to deal with it because they often are the patients that you just think, God, I'm not getting anywhere, I'm not getting anywhere with it, and so you can get quite flippant with it and frustrated.... it is one of those topics that is interesting because people can make a joke out of it*
and can be very much you know, kind of dismissive. But I think it is stemmed from the pure frustration and not you know, all doctors want to heal and go, “There you go.” You know, send them home and they’re all cured which is just you know, you’re just not able to do. (Emma)

ii. Protection of the self from distress

Many of the A&E doctors and nurses implied that addressing the emotions underlying self-harm could potentially have adverse effects on the self. Attempts to distance the self from the person’s distress by limiting discussion with the person about contributing factors to their self-harm were described as important responses when offering physical treatment. Identification with the person’s distress may have been perceived as having risks for the self in terms of evoking unpleasant and distressing feelings similar to those experienced by the person seeking their care:

I guess not knowing too much is good because they’re not giving you so much that then you feel that duty bounds to continue the conversation to try and work things through with them because you just don’t have the time to be able to do that.... I guess in some senses it’s for your own sanity as well because you don’t want to hear you know every day someone’s awful, awful life, life story. You just think well I’d be doing that if, you know, if my life was that awful. So I suppose in some ways it is some kind of self-preservation. (Emma)

This highlights how focusing on treating the body silences the person who has self-harmed and can act as a protective strategy that prevents the A&E staff from experiencing distress. However, as emphasised in the first theme, it also disempowers staff through limiting their ability to offer a helpful response when people repeatedly self-harm. In contrast, a few participants spoke about
how their personal responses to people who self-harm had helped them to feel more confident in their abilities to help.

iii. Contribution of personal experience

A few of the A&E staff spoke about how personal experiences of self-harm, prior to their training, had enabled them to offer more hopeful and satisfying responses when treating people who self-harm. Understanding the person’s reasons for self-harm, education around wound care, some degree of choice regarding the wound care and considering different ways of managing the distress were common aspects of the responses offered by the few doctors who had spoken about personal experiences of friends and/or family members who had self-harmed:

* I'm not necessarily unique but unusual in that I enjoy seeing patients who have deliberate self-harm, and I've never come across another doctor that does.... I find it a very satisfying consultation; usually it is very easy to make a large difference in someone’s life who's deliberately self-harming.... I enjoy talking with these people and I enjoy bringing people forward, making a difference and handing control back, and managing in different ways..... Certainly with the large majority of patients, I try to give them the fullest time possible in managing their condition and I will offer whatever means possible. So I’ll explain several different management strategies, several different plans and discuss through with them and give them an option.... I think knowing of friends or family members who have deliberately self-harmed has affected the way that I have been able to offer treatment to patients that I am now treating who self-harm (Rachel)
Most of the participants however, spoke about having had very little experience of self-harm prior to their employment within A&E. Many however, reflected on how their experiences as A&E staff had contributed to revisions in their responses to people who self-harm.

iv. Revision of clinical responses

Many of the participants suggested that changes in their responses to treating people who self-harm had occurred due to changes in their attitudes and their understandings of the reasons why people may self-harm. It seemed that significant factors in this process were talking with people who self-harm and accepting self-harm as a response to a multitude of factors that can cause distress. Consequently this process appeared to contribute to the participants reviewing their responses when treating people who self-harm, to the further development of their general clinical skills and to the participants feeling more hopeful about their ability to give a helpful response:

*Before I came to A&E,... I didn't have any experience on a personal level with anyone that self-harmed at all.... It's only from working here and seeing people and talking to people; and you get some people that will be very open about why they've done it and what goes through their heads and I think it's give me definitely more of an insight into the, people's behaviour and people's thoughts about it.... I think it's made me more, it's made me look at the way I address not only self-harm patients but all patients.... I'm very, I'm more aware of when I'm speaking to self-harm patients for the first time, like when I'm in triage [initial assessment of people who attend A&E], I'm more aware of being approachable so that they don't think that no-one is going to be interested.... I think it's really important to think, "Judge each new situation separately because it could be something completely different."*
could be the final thing where they say, “This is it now, I’m not going to come in any more because I want to get sorted out.” (Leah)

The later 2 sub-themes suggest that reflection on how the self responds to people who self-harm can help A&E staff to respond in a way that is experienced as more satisfactory and does not ignore the feelings that are evoked within the self.

3. **Mirroring Social and Cultural Responses**

The third theme concerned how A&E staff’s responses can mirror the social and cultural responses to people who self-harm that they have been exposed to. This theme was formed through combining five related sub-themes which were: prevalence of self-harm, working within the medical culture, secrecy within the profession, societal responses to self-harm within Britain, and cultural differences in responses to self-harm.

i. **Prevalence of self-harm**

The increasing prevalence of self-harm was discussed by many of the A&E staff and it appeared that they were not aware of, or prepared for, the magnitude of this problem prior to working in A&E. Three factors seemed to be important in underlying the staff’s responses of helplessness in decreasing the prevalence of this problem. These were: i) a lack of training around self-harm, ii) being exposed to unhelpful discourses around self-harm from more experienced staff, and iii) the potential for perpetuating unhelpful responses unintentionally:

> You get to see probably a few people, every shift that you are on, that are coming in. So obviously it’s a massive problem.... I think a lot of the time we don’t get education on it specifically.... I’ve never had any training about self-harm patients
or any psychiatric patients' problems at all really...you don't really get any
training or any opportunity to go on study days to learn anything about it, which I
think would help because if you don't know about it, obviously it's very difficult to
deal with. And it's very easy to have the attitude, especially when you get people
who have worked in A&E for years and years and years, I think they can get very
cynical about it and then that affects the newer nurses that are coming in because
there's someone saying, "Oh you don't need to worry, you don't have to be that
caring for that patient because we're used to it and this happens all the time and
you need to get more hardened up to it".... with some people it does kind of make
them judge those people differently because of, they think, "Oh, this is how we are
supposed to behave in this situation," and it gets that whole vicious circle of
behaviour, which is not very helpful at all. (Leah)

ii. Working within the medical culture

The culture within which A&E doctors and nurses work, appeared to be important in most of the
participants' accounts of their responses. They commented on how expectations held within both
the medical doctor and nursing professions about what constitutes a professional response,
influences how they can respond to people who self-harm. The main areas that arose within this
sub-theme were expectations of coping, being able to distance oneself from the emotional impact
of self-harm, managing risk, and being able to separate work from one's personal life.
Professional expectations therefore, encourage both silencing of the self and focusing on treating
the body:

*I think you just have to [manage], or I just have to get on with it unfortunately.....
So to have that protocol there ensures the patient's safety really, more than ours*
because you're saying, "Well, we've got the best information available to us, it recommends that we do this."...... It ensures that you are giving best treatment and also it's good because by having a set protocol you're removing any emotional thoughts about the patient yourself. You're not saying, "Well, you know, they've only taken a bit of this" and feel "Well, I can't be bothered; I'm not going to do it."

....You'll still give them the best medical care that you can. That's the only fair way of doing it really..... no matter what you think, you know what you have to do. It's probably the same way soldiers were. (Tim)

iii. Secrecy within the profession

A few of the A&E staff commented on the potential for doctors and nurses to self-harm. However, most implied that self-harm was not something they would turn to personally. It was suggested that stigma around self-harm was prevalent within their professions and this may contribute to secrecy amongst colleagues about personal experiences and the perpetuation of unhelpful responses:

I mean, obviously doctors and nurses working in the hospital are quite stressed environments. And like being a lawyer, a farmer, or I think it's in the forces, are some of the most stressful things you can do. And they talk about the levels of alcoholism and suicide attempts being far higher, suicide rates sorry, being far higher in all these professions. I must say that I've never come across anyone that's obviously hurting themselves in some way. But I expected to see a lot more of it in my colleagues. I mean, obviously they are cleverer at covering things, if they are taking pills, if they are drinking, if they're cutting themselves.... But if any of the
nurses are having these problems, it certainly doesn’t show in their sympathies towards the people that come in with this sort of difficulty. (Faye)

iv. Societal responses to self-harm within Britain

The stigma around self-harm was also discussed by many of the participants in the context of societal responses to self-harm within Britain. Common societal responses to self-harm discussed were social isolation and the removal or withholding of any forms of control for the person. It seemed that the participants felt society disempowers people who self-harm through removing their sense of agency. Furthermore, it was suggested service responses to self-harm could mirror these societal responses:

There’s a lot of sad people out there, you know, who come from poor backgrounds and they’ve got no expectation in life at all, they’ve left school early and so they are protected from that point of view. They go and work in a shop, a, you know, factory floor or a line or something, you know, an assembly line and they’re always overseen. They’re told what to do, they’re told how to do it, they don’t have to cope; they just exist. Now that’s not right in my opinion, you have to give people, put them into stressful situations in order for them to learn to cope; otherwise they will always come back to the copers.... We often do, you know, we take everything away from patients, call them what you will, and you don’t have that in a lot of countries.... You see in this country we try to do too much for people. (David)

David’s account suggests that he viewed self-harm to signify that the person is not coping and has little control over their life. Therefore, taking away people’s control is an unhelpful response. Many of the participants agreed with this being an unhelpful response. However, unlike David,
they viewed self-harm, in some contexts, as a way of gaining control and therefore as a form of coping:

*I would say for the person that does it for a form of relief and I feel it's the only way that they can see, they get, they reach a point and they, this is the only thing that is going to help them and this is the only thing that is going to see them through for that time and that place.... So it is a sense of control for them or something that they can actually do to try and help themselves through whatever it is.* (Siobhan)

v. Cultural differences

A few of the staff spoke about cultural differences in responses to self-harm. These differences seemed to be centred around expectations as to who provides support to the person following treatment of their injuries. These were reflected on in terms of comparing experiences of working in other countries, such as Africa and the Philippines, to their experiences of working in A&E in England. One area that was highlighted was the importance of addressing the emotional aspects of self-harm because ignoring this could cost the person their life through suicide. For example, Mabait compares his nursing training and work in the Philippines with his experiences of working in A&E in England:

*Well, as I've said, we cater to the more critically mentally ill in the Philippines and we just put them aside, those deliberate self-harmers and that's the sad part because they would eventually be the ones who would be prone to committing suicide eventually. So, yeah, what they do, they slash their wrists as well and we just treat it clinically as a laceration, we suture them up and get the family to come in and support them emotionally. ....So when I came here, it's basically a whole new...*
experience for me because, as I've said, the structure is all laid out for psych [psychiatric] patients. It changed my view in such a way that, you know, they're right. You have to give importance to these people because basically, added to my experience in the Philippines, they're the ones most likely to end up with more severe cases and more difficult problems to treat like they will hang themselves..... [Working in A&E in England] gave me the view that, yes, this is a problem and it's good that it is being addressed here in the UK. (Mabait)

It therefore appears that the social and cultural contexts within which A&E staff work can contribute to and reinforce the staff's responses of treating the body and silencing the self whilst offering treatment.
Discussion

In the following discussion, the findings of how A&E staff respond to treating people who self-harm will be considered in addition to the limitations and clinical implications.

Treating the Body

An overarching theme within the participants' responses was the idea of treatment of the mind being separate from treatment of the body, the later being the focus of treatment for self-harm in A&E. Although in some situations, the A&E doctors and nurses discussed offering more than the physical treatment required (e.g. involving family members in supporting the person), it was apparent that many of the A&E staff felt it was not within their role or their expertise to explore with the person the meaning behind their self-harm. The responsibility for responding to the emotional aspects of self-harm was felt to be placed on psychiatric services.

The A&E doctors' and nurses' descriptions of their responses to treating people who self-harm highlighted that a multiplicity of factors contributed to the treatment they offered and their responses were context-dependent rather than reflecting generally positive or negative attitudes. This is demonstrated within the theme of treating the body where the A&E staff explained that their judgements regarding: the validity of the person's reason for self-harm, frequency of the repetition of self-harm, form of the self-harm, extent of the self-harm, age of the person who has self-harmed, the perceived function of the self-harm in relation to others within the person's social network, and their related perceptions of their own abilities to help would have some influence on their responses. This adds to Mackay and Barrowclough's (2005) findings that A&E staff's attributions of controllability for the self-harm, and beliefs about whether the self-harm will be repeated, affect their willingness to help. Furthermore, it supports Radley's (1994) view that treatment responses to people who are "ill" depend on the construction of negotiated
meanings around illness and agreement of these between the person accessing treatment and the person or people offering treatment. The A&E doctors' and nurses' accounts suggest that they experienced empathic responses to people whose requests for treatment were viewed as valid, and for who the meaning behind their self-harm was explained and deemed understandable.

In offering treatment to people who self-harm, many of the A&E staff felt limited in their responses due to the focus of their role being to treat the body. This left the A&E staff feeling helpless. When the A&E staff spoke about treating people who had psychiatric diagnoses, people under the age of sixteen, and people whose self-harm was felt to be an understandable response to their experiences, distress was evoked when there was felt either to be a lack of provision, or a lack of support, from psychiatric services. In contrast, nurses spoke about feelings of anger, frustration and irritation towards people whom they viewed as not wanting psychiatric help, whom repeatedly self-harmed and frequently attended A&E for treatment, or for whom self-harm was felt to be a way of controlling other people in their social network. When treating these groups, blaming the person for not communicating what they needed or blaming the person for wasting their time and resources were common responses. These responses may be influenced by A&E staff experiencing helplessness when both their physical treatments and offer of referral to psychiatric services are deemed ineffective. For example, Allen (2004) suggests healthcare staff are more likely to blame the person for their self-harm if the help they are asking for is judged to fall beyond the provisions available to the service.

Feeling deskilled in being able to address the emotional aspects of self-harm was a common response amongst the A&E staff. This has also been found in a similar study which interviewed doctors and nurses involved in the care of young people who engage in “suicidal behaviour” (Anderson et al., 2003). The term suicidal behaviour included overdoses, ingestion of other toxic
Research Dossier

substances, self-suffocation, self-strangulation and drowning, and it was found that the doctors and nurses felt unable to talk to the young person about their experiences as they believed that they did not have the intervention skills to do so. This highlights the importance of empowering A&E doctors and nurses to be able to talk with people about distress and to promote this as a valuable response which aids well-being. For example, Holdsworth et al. (2001) found that a series of reflective workshops, which focused on risk and professional responses to self-harm, helped A&E nurses to feel more confident in addressing immediate risk and the emotional needs of the person. Furthermore, reflective spaces could help A&E doctors and nurses to consider how they can offer something that is helpful to the person, even if the self-harm continues. This highlights that the important contribution of the sense of self to A&E staff’s responses to treating people who self-harm

Silencing the Self

In explaining influences on how A&E staff respond to treating people who self-harm, the participants felt that their personal responses were important. Self-harm appeared to challenge many of the doctors’ and nurses’ wishes to be able to help people out of medical crises through the use of physical treatments, and thus their reasons for wanting to work within A&E. This contributed to discomfort around their role and ability to help people who self-harm. In a similar study, Anderson et al. (2003) found that the doctors and nurses involved in the care of young people who engage in “suicidal behaviour”, often experienced frustration and understood their responses in terms of the value they placed on the young person’s life. Suicidal behaviour was viewed as a potential waste of life and opposed many of the doctors’ and nurses’ views of their role being to preserve and maintain life. In addition, one barrier to the nurses and doctors being able to experience empathy was that they viewed the young person’s experiences as being very
different to their own. This emphasises that responses of helplessness can be perpetuated through A&E staff perceiving the experiences of people who self-harm as being distinct from their own.

Many of the A&E doctors and nurses suggested that understanding the person’s distress could have adverse effects on the self and therefore it was important to find ways of distancing the self from this. Focusing on the physical aspects of care was one strategy that the A&E staff used to detach themselves from their emotional responses. Byrne and Heyman (1997) suggest that A&E nurses may find it difficult to manage patients’ anxieties due to the number of conflicting demands on them. The focus on the physical aspects of treatment therefore, helps A&E nurses to block difficult conversations around distress when they feel unable to provide solutions, and prevents the self from experiencing discomfort. The provision of reflective workshops where these responses can be openly and critically discussed have been reported as useful in decreasing discomfort around treating people who self-harm for A&E staff in the UK (Holdsworth et al., 2001), and nurses and related healthcare staff in Australia (McAllister & Estefan, 2002).

A few participants discussed that personal experiences of friends and/or family members who had self-harmed helped them to experience greater satisfaction in their treatment of people who self-harm. This may be due to having a personal understanding of what can be helpful. Although McAllister et al. (2002) found no significant associations between personal experience of self-harm and attitudes towards self-harm for Australian emergency department nurses, they did find that if the staff perceived themselves as skilled to address the needs of people who self-harm, they were more likely to feel worthwhile working with this group of people and less likely to demonstrate negative attitudes. One contribution to A&E doctors and nurses feeling deskilled in working with people who self-harm is that they have little opportunity to receive direct feedback

211

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
from their patients as to what is helpful. Moreover, people who self-harm may not feel able to offer this feedback due to fear that it will affect the care they receive.

Through distancing themselves from the experiences of people who self-harm, A&E doctors and nurses may miss opportunities for sharing their skills in physiology and wound care. One participant highlighted that this helped her to have more satisfying interactions when treating people who self-harm. Furthermore, people who have received treatment in A&E following self-injury have advocated for the inclusion of education regarding physiology and wound care in their treatment (Pembroke, 2007, 2000, 1994; Spandler, 1996). Advice around how to limit the damage of self-harm is a contentious topic that is beginning to be debated by healthcare professionals. This could also be considered by A&E professionals as a potential response to people whose frequent self-harm is a survival strategy when all other strategies are experienced to be ineffective. This may raise ethical dilemmas in staff and therefore, as suggested by Hussain (2005), open discussion of the impact of treating self-harm on the self is important in supporting A&E staff to consider how they involve people who self-harm in decisions about the treatment they receive.

It was apparent that treating people who self-harm could have important implications for the self in terms of helping the A&E staff to develop their clinical skills. This involved incorporating feedback from people who self-harm about the usefulness of their responses. Training for A&E doctors and nurses provided in collaboration with survivors of self-harm may be one way in which feedback can be given and areas of helpful practice illuminated. For example, the involvement of service users in training focused on self-harm has been reported to help A&E nurses and related healthcare professionals feel more confident in negotiating treatment options with people who self-harm (McAllister & Estefan, 2002). Furthermore, survivors of self-harm
may be able to help A&E doctors and nurses explore ways in which they do achieve their wishes of aiding healing even when self-harm is repeated. The perspectives of carers could also be included to help A&E staff explore how they work with friends and family members. This may also help highlight potential barriers to accessing services.

**Mirroring Social and Cultural Responses**

Dominant discourses held within the medical culture and wider society were also considered as influences on the participants’ responses to treating people who self-harm. Many participants explained that their training had not prepared them for how they might offer helpful responses and that this made them more susceptible to being influenced by unhelpful attitudes held by their senior colleagues. Freidman *et al.* (2006) highlight that previous training in self-harm decreased the amount of anger A&E staff felt towards people who self-harm by cutting. This was particularly significant for the more experienced A&E staff who reported higher levels of anger than less experienced staff when they didn’t have any previous training. Training that focuses on how A&E staff understand their responses to self-harm is therefore important in addressing unhelpful discourses present within the medical and nursing cultures.

When the participants were discussing influences on their responses to treating people who self-harm, discourses around how to respond professionally appeared to be important. These expectations involved being able to offer the most effective, evidence-based physical treatments without being influenced by feelings towards the person who has self-harmed. The medical culture therefore endorses responses of treating the body and silencing the self. These responses may be understood within the context of Western medicine which endorses mind-body dualism. For example, Bates *et al.* (1997) explored the effects of the cultural context on healthcare providers’ treatment of, and responses to, chronic pain and illness. They interviewed people...
receiving treatments in two medical centres, one in the US, where the primary emphasis was on physical treatments, and the other in Puerto Rico, where integrated treatments that focused on physical, emotional and spiritual well-being were offered. They found that the dominant discourse within Western medicine around mind-body dualism could contribute to patients feeling isolated and their experiences being misunderstood, or even pathologised, when medical treatments stopped being effective. The social-cultural context of care therefore has implications for how self-harm is responded to.

The repetition of self-harm may be perceived by the A&E staff as their medical treatments being ineffective and therefore treatment needing to be offered by mental health services. If repetition of self-harm occurs whilst the person is receiving treatment from mental health services, then it is this that is deemed ineffective. The potential for blame between psychiatric and A&E services when working with people who self-harm, has also been highlighted in research in Sweden which explores psychiatric nurses’ experiences of caring for people who self-harm (Wilstrand et al., 2007). However, when self-harm is not considered to be due to a mental health problem, then responsibility for preventing further self-harm is placed within the person and medical treatment is viewed as futile as the person is considered to experience some gain from self-harming that medical treatment cannot address. Both responses can contribute to the person who has self-harmed feeling undermined, staff feeling helpless and the relational context of their difficulties ignored.

Western views of being able to treat the mind and the body separately propose that A&E doctors and nurses can offer physical treatments to people who self-harm that are detached from both the emotional experience of the person they are treating and their own emotional responses. Silencing of their own responses may inadvertently impact on the care A&E staff offer to people who self-
harm and contribute to maintaining unhelpful discourses due to the function these can have in decreasing A&E staff's own discomfort (McAllister & Estefan, 2002). These discourses were also felt to isolate colleagues who may have personal experience of self-harm and further contribute to barriers between A&E staff and people who self-harm.

Social isolation, disempowerment and the removal of control from a person were considered to be unhelpful societal responses to self-harm, which can be mirrored within the responses of healthcare services. A few participants proposed that A&E staff could offer more helpful ways of treating people who self-harm through talking with the person about their distress, and showing a willingness to try to understand the self-harm in the context of the person's life. This would offer a more empowering response that would act against the common societal response of silencing the individual (Shaw, 2002). Conceptualising self-harm as a form of control was felt by many of the participants to aid a helpful response to people who self-harm. The risk of removing the person's control was also emphasised but within the context of the responses of mental health and social care services. However, some of the A&E staff explained that they would offer limited choice to people who repeatedly self-harm, or whose reasons for self-harm were perceived to be invalid. This implies that the A&E staff were not aware of how their own practices may be influenced by societal responses.

Cultural influences on the healthcare treatments offered, were discussed as influencing the participants' responses, particularly in terms of addressing the relationship between self-harm and suicide. The cultural differences in the A&E staff's responses to treating people who self-harm concerned differences in the emphasis placed on risk. It was raised that in the UK, a great deal of emphasis is placed on risk when assessing someone who self-harms. In contrast, in the Philippines responsibility for managing risk may lie within the family. Differences in practices in the
assessments of self-harm where highlighted, although in both cultural contexts it was felt that understanding the meaning behind the distress had greater relevance for either the family or mental health services compared to the A&E staff. It could be suggested that the emphasis on risk within Western healthcare services may contribute to overly defensive practices that disempower people perceived to be at risk. Allen (2007) suggests that collaboration with a person who self-harms is fundamental to ensuring that healthcare providers do not respond in a paternalistic way based on defensive practice, nor undermine someone’s distress by assuming to know the meaning of the person’s self-harm without exploring this with the person themselves.

Limitations

As Touroni and Coyle (2002) suggest, it is not the aim of most qualitative approaches to research to produce findings that are generalisable to the population being studied. In contrast, the aim is to obtain an in-depth analysis of the accounts of a small number of participants. Any conclusions drawn from this study therefore, are specific to the group of participants and cannot be generalised to all A&E doctors and nurses however, they are transferable. The sample of A&E doctors and nurses was similar to MacKay and Barrowclough’s (2005) sample in that around one-third (37%) of the participants were male and two-thirds (63%) female. The participants were also similar to the sample in Friedman et al.’s (2006) study in terms of the average number of years they had treated people who self-harm (5.6 years) since this corresponded with the number of years the participants had worked in A&E. Most of the participants were in the early stages of their careers.

Clinical Implications

A&E doctors and nurses play a key role in the way that people who self-harm perceive the responses of healthcare services and whether they access help. It was apparent that the A&E
doctors and nurses wanted to be able to provide helpful responses to people who self-harm. However, they did not feel that they could meet the person’s emotional needs due to the emphasis being to treat the body. When the A&E staff discussed their responses, treating the body, silencing their emotional responses, and the influences of their social and cultural context, appeared to be important themes within the participants’ accounts. However, it was noticeable that there was little opportunity for the A&E staff to reflect on how they respond to treating people who self-harm.

The NICE guidelines for self-harm recommend that all healthcare professionals who work with people who self-harm should have training to help them understand and care for people who self-harm (NICE, 2004). This research corroborates the recommendation by suggesting that A&E staff need training that addresses how they respond to the emotional distress underlying a person’s self-harm, how they meet the person’s needs, how they acknowledge their personal responses, how they manage feelings of discomfort and distress, how they respond to risk and how their responses many be influenced by social and cultural discourses regarding people who self-harm. Allen (2007) proposes that a social constructionist approach can be helpful in facilitating healthcare workers’ reflections on their responses to self-harm as this endorses the view that all knowledge and discourses are situated within historical and cultural contexts. Clinical psychologists receive training in how to help individuals, families, teams and organisations to explore their experiences in terms of personal, political and cultural values and therefore, could provide these opportunities through training and consultation to A&E services. The inclusion of colleagues with personal experience of self-harm could help A&E staff explore personal understandings of self-harm, and how they can provide helpful responses that address both the physical and emotional needs of the person. Including carers could also help A&E staff to consider how they address the relational context of self-harm. Furthermore, A&E staff could be encouraged to explore aspects of their own
coping responses which could be constructed as self-harm, to decrease barriers between themselves and the people they treat.

Consultation to other NHS professionals has been suggested as a way in which clinical psychologists may help to empower healthcare staff in responding to distress and give them a sense of ownership in managing change (Huffington & Brunning, 1994). However, medically trained staff may feel that clinical psychologists do not have a role in their training (Elphick, 2004). Therefore, reflective workshops and consultations provided in collaboration with colleagues from the nursing and medical professions, who promote critical reflection, may highlight the benefits of offering treatments to people who self-harm that treat the mind and body as a whole and model joint working. In addition, the provision of support in being able to reflect on the personal impact of working with people who self-harm, and good supervision, may contribute to A&E staff feeling more skilled in addressing the needs of people who self-harm.

**Future Research**

Further research that focuses on the phenomena that decrease people’s experiences of distress in relation to their self-harm, would be useful in removing some of the silence around self-harm and in facilitating helpful responses within families, communities and healthcare services. This should consider the diversity of experiences amongst people who self-harm. In addition, research that focuses on the relationship between self-harm and suicide is needed to help address the risk of suicide for this group.
Reflections of the Researcher

My experiences of A&E staff are that they do not intend to offer unhelpful responses to people who self-harm but inadvertently may do. This study highlights that A&E staff are disempowered by the medical model when treating people who self-harm. The medical model of self-harm emphasises that A&E staff should treat the body, silence their own responses, and to individualise distress rather than consider distress in a relational context. The dominance of the medical model in the A&E staff's training therefore neglects areas of knowledge that may empower A&E doctors and nurses in their interactions with people who self-harm. These understandings fit with my own views due to having met A&E staff who are able to offer more helpful responses by focusing more on the person's distress rather than just the self-harm, being open to understanding their own role in a treatment relationship, and by being willing to share expertise in their relationships with people who self-harm.
References


URN: 3445275

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.


http://www.psychminded.co.uk/news/news2005/June05/Staff%20should%20admit.htm


Appendix A:

Information Forms Given to Potential Participants

- Information forms regarding participation in the research study..........................234
PARTICIPANT INFORMATION SHEET

Accident and Emergency (A&E) Staff's Responses to Treating Self-harm.

You are being invited to take part in a research study. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. This information sheet tells you about the purpose of this study and what will happen to you if you take part.

Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

1. What is the purpose of the study?
   My name is Jo Hadfield and I am a trainee clinical psychologist at the University of Surrey. As part of my doctoral thesis, I am conducting research exploring qualified A&E staff’s understandings and experiences of treating people who self-harm. My aim is to try to understand these experiences. My purpose is not to judge the work that A&E staff do. Self-harm can elicit many different feelings within people and I believe that it is important to understand how this impacts on the A&E staff who provide the treatment.

2. Why have I been chosen?
   You have been invited to participate in the study as you are a qualified doctor or nurse working in an A&E department. I have contacted the Head Consultant of your department who has given me your contact details. I am looking to recruit 10 participants altogether from both Hospital and Hospital.

3. Do I have to take part?
   Taking part in the research is entirely voluntary. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw from the research at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect any aspect of your employment within A&E.

4. What will happen to me if I take part?
   - I will arrange to meet with you at a location convenient for you. We will need a quiet room which we can use to conduct the interview.

   - You will be asked to fill in a consent form and a demographics form which will ask you to identify your age, sex, ethnic origin, profession and period of time that you have worked in A&E.
• You will participate in a face-to-face interview, which will last for approximately 60 minutes. The interview will be audio-taped and you will be asked about your experiences of treating people who have self-harmed in A&E.

• At the end of the interview I will offer you the opportunity to either meet with me again or leave your e-mail details with me so that I can feed back my analysis of the interview content and gain your views.

5. What do I have to do?
If you agree to take part, it will be expected that you will attend the interview at the arranged time and place. It is important that you answer the interview questions as openly and honestly as you can as to aid understanding of your views and experiences.

6. What are the possible disadvantages of taking part?
Self-harm can raise different feelings and responses in healthcare professionals. It is possible therefore, that the interview may raise something that causes you to feel discomfort or distress. If this happens, I will stop the interview, discuss your feelings with you and give you the details for your Staff Support Service should you wish to talk this through further. I can not offer you any counselling as this falls outside of the remit of my role as a researcher.

7. What are the possible benefits of taking part?
Participating in the study will help to further understanding of A&E staff’s emotional responses to and beliefs about treating people who self-harm. It may also highlight areas of good practice and any potential difficulties with the treatments that are offered. The research therefore, could have implications for furthering A&E services for people who self-harm and aid understanding of possible barriers to services and/or resources.

8. Will my taking part in the study be kept confidential?
All the information about your participation in this study will be kept confidential. Nobody other than the Chief investigator (Jo Hadfield) will have access to identifiable information. The audio-tape will be assigned a number in order to identify which interviews correspond to the demographic information given. The Chief investigator will transcribe the content of the interview word-for-word. Nobody other than the Chief investigator will have access to the audio-tape. All the transcripts will be assigned fictitious names and any identifiable information will be changed in order to maintain confidentiality. In addition, only the Chief investigator will have access to the information that identifies who you are and will keep this information confidential.

The transcripts will be stored on a university computer. They will be password protected and anonymised. During transcription, the audio-tape will be stored in a locked cabinet within a locked room at the university. The demographic and consent forms will also be stored in this way. Once I have transcribed the interview, the audio-tape will be deleted. Following completing the research, electronic forms of the transcripts and the demographic and consent forms will be stored at the University of Surrey for 10 years.
following which, they will be destroyed. All data will be kept in accordance with the Data Protection Act 1998.

9. Contact Details:
If you would like any further details, please contact:

Jo Hadfield  
Trainee Clinical Psychologist  
PsychD Clinical Psychology  
Psychology Department  
University of Surrey  
Guildford  
GU2 7XH

E-mail: psm2jh@surrey.ac.uk  
Telephone: 07977 922090

This research is being supervised by:

Dr Mark Hayward  
Academic Tutor  
PsychD Clinical Psychology  
Psychology Department  
University of Surrey  
Guildford  
GU2 7XH

E-mail: M.Hayward@surrey.ac.uk  
Telephone: 01483 689441

If you have any concerns that you feel you do not want to speak to myself (Jo Hadfield) about, then please contact Mark Hayward.

10. Who has reviewed the study?
This study has received ethical approval from the University of Surrey Ethics Committee.

You may keep this information sheet and the enclosed consent form. If you wish to participate, please contact Jo Hadfield (details above).

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET.

Participant information sheet -version 1  
May 2006
Appendix B:

Participant Consent Form

- Informed consent form signed by the participants prior to being interviewed...238
CONSENT FORM

Accident and Emergency (A&E) Staff's Responses to Treating Self-harm.

Name of Chief investigator: Jo Hadfield, Trainee Clinical Psychologist

Please initial

box

1. I confirm that I have read and understand the information sheet dated May 2006 (version 1) for the above study. I have had the opportunity to ask questions and have had these answered satisfactorily.

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

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

4. I would like to arrange another meeting with Jo Hadfield to receive individual feedback regarding her analysis of the interview.

OR

I would like to receive an electronic copy of Jo Hadfield’s analysis of the interview. My e-mail address is:

Name of Participant __________________ Date __________ Signature __________________

Chief investigator __________________ Date __________ Signature __________________

When completed: 1 for participant; 1 for Chief investigator

Consent form – version 1
May 2006
Appendix C:

Demographic Information Form

- Demographics information collected from the participants prior to being interviewed........240
DEMographics Form

Accident and Emergency (A&E) Staff’s Responses to Treating Self-harm

Name of Chief investigator: Jo Hadfield, Trainee Clinical Psychologist

1. Sex:

   □ Male
   □ Female

2. Your age:

   □ 19 or under
   □ 20-29
   □ 30-39
   □ 40-49
   □ 50-59
   □ 60 or over

3. Which of these groups best describes you? Please tick one box only.

   White:

   □ British
   □ Irish
   □ Any other White background (please specify)

   Mixed:

   □ White & Black Caribbean
   □ White & Black African
   □ White & Asian
   □ Any other Mixed background (please specify)

   Black or Black British:

   □ Caribbean
   □ African
   □ Any other Black background (please specify)

   Asian or Asian British:

   □ Indian
   □ Pakistani
   □ Bangladeshi
   □ Any other Asian background (please specify)

   Chinese or Other Ethnic Group:

   □ Chinese
   □ Other Ethnic Group
   □ (please specify)

Identification Number:

Identification Number:

240

URN: 3445275

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
4. Your profession:

☐ Medical doctor   ☐ Nurse

5. Number of years you have been treating people who self-harm:


Thank you for completing this form, the information provided will be treated in confidence.
Appendix D:

Semi-Structured Interview Schedule

- Interview schedule used as a guide to the interview process...

Pages 242

URN: 3445275

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
Semi-Structured Interview:

Could you please describe what the term “self-harm” means to you?

Have you come across self harm? Could you describe your experiences then? Were you personally involved?

What do you think are some of the reasons why people self-harm?

How do you feel about people who present to A&E following self-harm?

Prompt: What about people who regularly attend A&E for treatment of their self-harm? If the person has a psychiatric diagnosis, how would you feel?

How do you decide on what treatment you offer people who have self-harmed?

Prompt: What are the most important factors for you in deciding what treatment to offer: previous history, extent of the self-harm, age, control, responsibility?

How has treating people who self-harm affected, if at all, the way you view people who self-harm?

Prompt: If so, in what way has it changed your attitude towards people who self-harm?

How do you feel people who present to A&E following self-harm should be treated?

How do you treat people who self-harm?

Prompt: What strategies, if any, do you use?
Appendix E:

Ethical Approval Obtained for the Study

- E-mail from Research Ethics Committee regarding requirements for ethical approval.......................................................................................................................... 245
- Approval letter from the Research and Development Committee of one hospital........... 246
- E-mail from the second hospital’s Research and Development Committee approving the research..................................................................................................................... 247
- Approval letter from the University of Surrey School of Human Sciences Ethics Committee................................................................................................................ 248
Dear Jo

I have discussed your proposal with the Chairman of the Ethics Committee. In the light of the fact that you will have no contact with patients, carers or patient data and you are having the project looked at by the University Ethics Committee, he agrees that it will not be necessary to submit your project to the Ethics Committee.

Regards

Co-ordinator
Research Ethics Committee

Tel-Internal:
Direct Line/Fax:
Email: ethics.committee@
Reference: 2006JH01

26 June 2006

Miss Joanne Hadfield
Trainee Clinical Psychologist
University of Surrey

Re: Secrecy, Self-harm and Distress: Accident & Emergency Staff's Responses to Treating People Who Self-harm

I am very pleased to inform you that Director R&D has approved your study and the R&D office has no objection to your proceeding with this study. However, the R&D Office would highly appreciate to receive final report of your study and any dissemination (s) from this work.

I hope the study goes well

Best wishes,

Yours sincerely,

Dr
Assistant Director R&D
E-Mail:
You forwarded this message on 29/05/2007 15:46.

Hadfield JK Miss (PG/R – Psychology)

From: Hadfield JK Miss (PG/R - Psychology):
To: Hadfield JK Miss (PG/R - Psychology):
Cc: 
Subject: RE: R&D application June 2006
Attachments:

Dear Jo

I have discussed your application with Dr , who is provided the trust with interim expert advice surrounding R&D. He informs me that he approved your proposal some time ago. I am meeting with him next Wednesday, and will put this decision in writing and ask Professor to sign it on Thursday.

Good luck with your Study.

Head of Practice Development & Education

-----Original Message-----
From: psm2jh@surrey.ac.uk [mailto:psm2jh@surrey.ac.uk]
Sent: 25 September 2006 14:43
To: 
Cc: 
Subject: R&D application June 2006

Dear,

I have been in continuous contact with Dr regarding my research application to the R&D committee. I applied for approval in June 2006. My research is regarding A&E staff's emotional responses to treating people who self-harm. Unfortunately, I have heard nothing from the committee and it is now nearly 4 months since I sent in the application. I have sent numerous e-mails and phoned the R&D department but there has been no answer and no answerphone on which to leave a message. I appreciate that it has been the summer and therefore people have been on leave which was why I tried to submit my application as early as possible.

If there are any problems with my application it would be useful for me to know as I am working to a tight deadline for my doctorate. As it states in my application, I have already made contacts with, and gained initial permission for my research from Dr and Dr to conduct my research within their departments. I have also built up a relationship with (Psychiatric Liaison Nurse) and have met some of the A&E staff at the hospital. I would still like to conduct my research with the staff at Frimley A&E pending your approval. I hope that you will appreciate that I can not wait for much longer without any indication of what is happening with my application as I will not have enough time to meet the deadline for my doctoral thesis. The implication of this is that I will not qualify. I would be extremely grateful if you could let me know what is happening with my application as soon as possible.

I look forward to hearing from you.

Yours sincerely,

Jo Hadfield
Trainee Clinical Psychologist

PLEASE NOTE:

This e-mail message is confidential and privileged. It is intended solely for the use of the individual or entity to whom it is addressed. If you are not the intended recipient, please accept our apologies; do not disclose, copy or distribute information in this e-mail or take any action on reliance of its content. To do so is strictly prohibited and may be unlawful. Please inform us that the message has been sent to you in error before deleting it. Thank you for your co-operation.

247

URN: 3445275

That Heart-Sink Moment: A&E Doctor's and Nurses' Responses to Treating People who Self-harm.
11 October 2006

Dear Joanne

Reference: 57-PSY-06
Secrecy, Self-harm and Distress: Accident and Emergency Staff’s Emotional Responses to Treating People with Self-harm

Thank you for your submission of the above proposal.

The School of Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the School Ethics Committee.

Yours sincerely

Dr
Appendix F:

Example of an Analysed Transcript

Pages

- Transcript with evidence of analysis in the margins ........................................... 250
Transcription of Emma (participant 08)

I: This interview is about your experiences of treating people who self-harm in your work in A&E. So could you start off by telling me what the term self-harm means to you?

E: Self-harm, okay, to physically abuse oneself. I suppose self-harm, God that's really difficult. For me it's kind of cutting, blood letting, but without the intention to commit suicide. So not aiming to cause actual death but as a release or, I don't know.

I: So it's kind of harm to the self but that's...

E: But that doesn't end up actually killing themselves.

I: Yes, or where there's no suicidal intent behind the actual harm?

E: Yes, I'd say so.

I: Okay, and you've said you've come across cutting.

E: Cutting, blood letting, have I seen anything else? I think that's it. Yeah just cutting and blood letting.

I: Okay, and can you explain to me how you have been involved in treating people who self-harm?

E: I have, self-harm it tends to be, you see the same ones over and over so you do kind of get to know them while they're doing it but generally most of my role would just be to assess them in a medical way, to suture their wounds, clean their wounds or check their blood levels to see whether they have made themselves anaemic, and then refer them on to the crisis team for mental health assessment. We, I've not ever assessed anyone formally for their mental health.

I: Okay, can you take me through your medical assessment? Have you got a general protocol or..?

E: I don't think there is a protocol but always history, so when you kind of did it, what you actually did, what you used. Have you done it before? Have you ever..? Also I've always wanted to know was it just to, as a release or was it for suicidal reasons? Have they ever tried to commit suicide.

URN: 3445275

That Heart-Sink Moment: A&E Doctor's and Nurses' Responses to Treating People who Self-harm.
suicide before? Mood at present, so trying to get an idea as how safe they are to let them go home. Assessment

Whether they are actually known to the self-harm team, or crisis team, and then just physical Physical examination of the wound. But there wasn’t a set protocol.

I: So that’s the general gist of your assessment.
E: Yep.

I: So it’s things like previous history, mood at present time...
E: Yep. Are they going to go home and do it straight away again?

I: Right, so it’s kind of risk that you assess as well.
E: Risk management yes.

I: And then what happens after your medical assessment?
E: If, if I’ve sutured them up or if they are stable then I’d say always document that they are medically fit for discharge but I ask them to wait to see the self-harm team or at least discuss it with the self-harm team because quite a few of them were very well know to them and then they wouldn’t be seen because it was just happening so regularly that it wasn’t deemed necessary that they needed to come in and see them straight away. And if they were then happy for them to go then they are allowed to go home. Otherwise they would wait to be seen by the self-harm team or crisis team and they would see them within the department.

I: Is the self-harm team the same as the crisis team or..?
E: No, it’s slightly different. Well the crisis team is out of hours and the self-harm team is in hours, but literally just for self-harm so no suicidal people.
I: Okay, and who forms the self-harm team?
E: The community psychiatric team. It’s CPNs, I don’t think there’s a psychiatrist I think it is CPNs.

I: You’ve said that mainly you have come across people who cut themselves and people who blood let. What’s been your most common experience in treating people who self-harm?
E: Cutting definitely. Tends to always be forearms, I have had some on the legs, but it tends to always be cutting. I mean, I suppose some people have taken overdoses but I think you do, you can kind of classify it as self-harm but I’m not sure, they’re more the ones that do want to kill themselves. They generally express, “Oh at some point I did want to kill myself.” I’ve seen loads of those. But I’d say cutting definitely. Always, you know, it tends to be always in the same place, normally on their arms.

1: Right and you’ve said that you kind of get to know people because it’s generally the same people coming in.

E: Yep.

1: How much of your general shift time do you spend working with people who self-harm would you say?

E: Not that much. Shift time, so I’d probably see maybe one a day and I’d see, it would be dealt with you, depending on how well you know them, how regularly they are coming into the department, you can probably spend about twenty to thirty minutes with them. If they are not really known then it takes a little bit longer with them because, but I suppose in the time that you are stitching them up you can have a good chat with them and that gives you a better idea. So, no, I’d say about twenty to thirty minutes really, sometimes even less.

1: And is that history taking that you do when you are chatting with them?

E: No, I’d always take a history and then kind of just slowly try, you know if I’m stitching them up then I just slowly try to have a chat with them just to see how kind of, whether they can hold a conversation, whether their, you know, what’s going on in their life, you know, do they seem to have anything to look forward to, anything that they are particularly you know, or anything that is particularly preoccupying them. So I think you can, when it’s kind of a casual chat it’s much easier to get things out of them than when you are like, “So what’s going on in your life, what’s
75 that?” Because that’s not very good or normal interaction. So I guess that time you know, you can make it span out a little bit longer if you think you are getting something from them.

76 “So it’s something about spending time with people, just getting to know sort of what might be underlying their self-harm in a way?”

77 E: Yep which I know is really difficult but I guess it is, not necessarily what is underlying it but, what things in their life put them at high risk of them doing it again or something more drastic next time. Because I guess in A&E it’s all about, it is all about risk management. It’s kind of saying can I send this patient back out into the community, are they not going to come having done something much more serious? Because I guess that’s why people turn up to A&E. Sometimes they are presenting to say, “Hang on a minute, I need some help” rather than just, “Can you stitch me up?” And I guess it’s giving you time to decide whether, you know, why have they presented now? Why have they cut themselves and come in? Because quite often they cut themselves and don’t come in and you’ll see a really old wound so it’s kind of why, why are they coming in now? So it just gives you a bit of time to talk to them about that.

80 I: Okay, and you’ve said that generally, in your experience, people that come in following self-harm, that they generally want help which is why they come in?

81 E: I don’t know. Some of them do and I think some of them don’t. I think, I mean some of them are brought in by their families and some of them seem to present not wanting help. I don’t know why they want.

82 I: Right so it’s a bit confusing?

83 E: Yeah because you kind of like, I know one girl used to, one girl in particular who used to come in practically every three days and she’d always cut herself and she’d then cut the stitches out and then re-present. Because kind of, you’d say, “What do you do, what do you want us to do for you?” you know, “Why? There’s no point keep coming in and stitching you up if you are not going to keep them in.” And she said that she didn’t know, didn’t know why she did it really. And you’d
say, “Do you want to see the DSH team?” “No, no, I don’t want to, I don’t want.” And it was just kind of, you couldn’t get to the bottom of it and it’s really hard in A&E because you don’t have the time to deal with it. So I don’t think all of them want help but may be some of them, some of them do.

I: Hmmm, it sounds like there’s something you have to work out and in a way that’s what you were asking that girl by kind of saying, “Why? What do you want us to do?”

E: And quite often it’s much easier to be open and honest with them and not skirt around the subject because it’s quite refreshing that a lot of the time they respond better to kind of open questions and then they will talk a bit more. But then some of them you know get pissed off with you for that kind of thing. And it is just, if you do, if you can just have that time to chat with them then you can kind of work out which way you can go with them sometimes. Because I suppose the whole, yes I see the point of A&E as to help prevent people from having to come back and use the system. You can’t, you’d hope that you can give them things that kind of, you know it might not stop them from doing it but another facility that’s better for them because A&E just doesn’t give you the right time or kind of environment for what they’re looking for. I think that’s the problem.

I: What do you think they are looking for?

E: That’s the tricky thing. I don’t know, I don’t think I really have enough training in DSH. I guess time, someone to talk through why they are doing it, what’s going on because in a sense, I guess a lot of the time it is someone saying, “There’s something not right in my life and this is my way of coping with it.” But not necessarily that they are screaming out for help, just may be that they can’t see an alternative. I mean I know some people have fantastic relationships with their CPN and I’ve found that that can give them the option you know, having a CPN or having someone in the community to turn to when they feel like doing it it must really help. But I don’t know it’s really hard.
I: You’ve said that you, you feel like you have not had enough training on self-harm. What has your kind of training involved?

E: I did, what was it? Four months psychiatric attachment but that was all inpatients. So you kind of, okay yes some of them self-harm but you don’t, it’s not very realistic because I guess you know, most people who self-harm are in the community and getting on with their lives. They’re not you know, under section or what ever. And I guess the biggest training I’ve had dealing with people is in A&E just on the shop floor. That has been my you know, learning curve basically.

I: What’s that experience been like?

E: I remember when. I think the first person I saw it was really scary because I was just like, didn’t know how much I needed to be able to deal with it and you know kind of, was I supposed to be finding out why they were doing it, was I meant to be dealing with their mental health issues. But I think you have to realise that your job is to, that can’t be your job because there is not enough time. You’re job is to make them medically fit and then refer them to the appropriate facility so that they can you know get more help on a long term basis because obviously the four hour ruling just means that you know, to give them, if you’re going to talk to them and try and talk through their issues then potentially they could then say, “Alright this person was really understanding I could go back and talk to them or come back and you know, if I need support I can come back to A&E” which is not really appropriate realistically. Although you can help you know may be you can get more info for the team you know, the team you’re going to refer on to. It’s just not appropriate is it? You need someone who can follow’ them up long-term if they want that.

I: So it’s kind of channelling people to the right services in a way?

E: Yes which is what A&E is all about which is why people get frustrated because I’ve had, God I suppose was she a self-harmer? She was kind of a self-harmer in the sense that she liked to use lots of anxiolytics to chill herself basically because she had very bad panic attacks and in a sense...
was self-harming because she was using them too much. And she said that she wrote a really
nasty complaint letter saying that we didn’t deal with her mental health issues but it was
completely unfounded because A&E isn’t there to deal with long-term, complex you know
chronic problems. But I can understand how people get really frustrated by us just kind of
patching them up and sending them back out again. So I guess it is, the point is to find them long-
term help so that they don’t keep coming back to us.

156  I: Hmm, hmm. Okay and through your experiences of working with people who self-harm, what
do you think are some of the reasons why people self-harm? Through talking to people what have
you learnt about what are some of the reasons?

159  E: Family problems, relationship problems. Not having, it tends to be not having, not being able
to, not have someone to turn to, to talk things through. From what I can see, anxieties, just to
relieve, a lot of people say you know it kind of stops their, the pressures or you know, it kind of
takes away the negative feelings they are having. If they cut themselves, it’s a release from what
I’ve heard. But from what, a lot of people you know, nasty horrible relationship problems tend to
be the things that people have discussed. Or you know, worries about money, worries about jobs,
just not knowing who to turn to and so they cut themselves.

165  I: So you’ve kind of said relationship problems mainly in your experience.

167  E: Yeah it does tend to be.

168  I: Can you tell me a little bit more by what you mean by nasty horrible relationship problems?

169  E: My technical term [laughs].

170  I: It sounds like a term that has helped you to understand what might contribute to self-harm.

171  E: Yeah, it tends to be people who’ve had you know kind of boyfriend, girlfriend troubles. A lot
of people who have had family issues, living in situations where there’s, I wouldn’t say you know
it’s kind of hard to say what kind of abuse but there’s obviously friction within the family you
know lots of aggression, people who are scared to be in the family you know, or be in the family

256

That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.

URN: 3445275
home. Or people who are in care because of family problems. So basically family and kind of
difficult to judge severity of prior self-harm

partners and those kind of problems I think have been mainly. But it's difficult to know quite
how, how bad they are because they seem to be, it's really hard to just kind of meet someone you
don't know and instantly say what's going on in your life you know. But kind of the insinuations
you get that they're not happy with someone, either their partner or family. People tend to vaguely
give you an answer rather than specific, specifics, which you can totally understand because
you've only just met them.

1 : So it's understandable in terms of people not being able to say exactly what's happening
because it's quite short and they've only just met you. How does that feel being on the receiving
end of that knowing that perhaps you don't know the whole ins and outs of what's happening or
that people are alluding to something but you're not quite sure?

E: It's difficult because you want, it's like you need to, it's nature to want to know what's going
on because you want to get to the bottom of it and you do always want to help. I know it's so naff
and stereotypical but..

1 : I don't think it's naff.

E: But you do want to help them, you do want to chat things through but then you just think Jesus
you know you don't actually properly have the time to sit down with these people or I can't build
up a rapport in twenty, thirty minutes to the point where I can help them really. So you kind of in
a sense I guess not knowing too much is good because they're not giving you so much that then
you feel that duty bounds to continue the conversation to try and work things through with them
because you just don't have the time to be able to do. So in some senses, and I guess in some
senses it's for your own sanity as well because you don't want to hear you know every day
someone's awful, awful life, life story. You just think well I'd be doing that if you know, if my
life was that awful. So I suppose in some ways it is some kind of self-preservation that you know

That Heart-Sink Moment: A&E Doctor's and Nurses' Responses to Treating People who Self-harm.
that their life’s shit and you can understand why they are doing it but you don’t want to know the whole detail because it’s just like otherwise you’d just be really depressed.

I: So it’s helpful to understand that’s why they are self-harming in terms of their life being quite shit or what have you, but at the same time because you’re not a long-term service, it’s difficult to get to, to kind of really understand those things and also in a way because you don’t get that follow-up with people you and knowing what’s happened to them, it’s a form of self-preservation?

E: Absolutely, I think so. Because that’s it, you never see them when I mean, you do hear of the odd one where you know somebody who has been there for a long time will say to you, “Oh it’s really good they’ve not been in for ages and that’s a really superficial cut and that’s fine. They must be, they’re doing really well.” But generally you don’t know what happens to them so yes, I guess it is self-preservation to not get too involved with people.

E: It tends to be the nursing staff, a couple of the registrars who are you know there longer, or the consultants who know people. And you know every A&E has their regulars. Yeah you know I suppose, the nursing staff tend to be able to tell you all about them. It’s always really good because it gives you a lot more insight into what’s going on.

I: So it’s kind of learning from your colleagues as well about perhaps people’s patterns if they’ve been to A&E over a longer-term?

E: Absolutely I mean and it gives you good, and again it goes back to risk management, they know I mean they can reassure you that that’s not normally like them, they wouldn’t normally be that bad. Or that’s really good for that person so it gives you extra insight into, into that kind of side of it.
I: So you’ve kind of spoken about every A&E having regulars. How do you feel about people who frequently attend A&E, how do you feel about people who frequently present to A&E following self-harm?

E: I can’t lie, sometimes it just gets frustrating especially if you have already seen them three or four times in the week. It’s like, “Why? What do you want from me?” And it’s just because you are doing the same thing over and over and stitching them up although you’ve just stitched them up and whatever. And you do get frustrated but then at the same time you do have to remember that it’s you know, it’s such a tricky thing to deal with and it’s not something that you can you know help people all the time with. You can’t cure you know, it’s not something you give a magic tablet for, that’s going to stop them. It’s more frustrating when they turn up and they don’t, they don’t really want to engage in the service. I think that’s when it gets really frustrating.

I: So when they don’t want further help.

E: Yeah and I think that, if you are a regular you tend to be not really engaging with the service. In some senses I suppose if you are engaging with the service then you are less likely to be constantly there because you will try and you know, well I hope that they try and talk to the teams and they may stop using A&E as the focus for getting treatment.

I: So you hope they will engage more in psychiatric services perhaps?

E: Yeah.

I: Would you feel any differently about people who kind of present for, or for what seems to be the first time, or people who perhaps don’t present quite as often?

E: Yeah, I mean that’s, I think in that sense that’s you know, you know you’re never going to feel frustrated with those kind of people because that’s, they need help, they need, they’re obviously, for someone who’s presented for the first time I guess it is that initial, you would think that this is their cry for help and them saying that something crap is happening and I need some extra support here. And I guess that’s when you’re more than happy to get the crisis team or DSH team.
involved and that makes it a lot easier. But it also, you’re always a bit more worried about sending
those kind of people home because you just think, well what’s pushed them over the edge, what’s
you know, will they be coming back in a much worse state? So they’re the ones that kind of, you
wouldn’t get frustrated with because you’d be a bit panicky.

I: So you would be a bit more worried because it was their first presentation and you’re not quite
sure what’s happening or what might happen.

E: Yeah and even if they don’t do it regularly, you’d still be worried because you’d be thinking
well why? Why now? Yeah what’s, what’s happening? Because it always scares you when people
self-harm because a lot of, I always get worried as well that people don’t really, some people
don’t seem to be able to gage what might kill them. And equally I know that often it’s that people
do things that they think are going to kill them and they don’t, equally some people do things that
they think isn’t going to kill them and you think I’m just a bit worried.

I: So it’s people who self-harm who might cause quite considerable damage and perhaps sort of
almost accidentally kill themselves rather than that being their intention that you worry about
most?

E: Yeah those are the kind of things that often worry me. But also, I think those people as well I
think the families get really distressed as well, it makes the situation so much harder because you
just like, because they don’t understand why they are doing it. And in A&E it’s just so hard to
have the time to sit down with the family and go through and be the mediator and you just feel a
bit kind of like this needs time to settle, someone to actually properly talk things through. It is a
lot of, I mean mostly your job in A&E is dealing with calming relatives down and very much so
with self-harm because the family are often, you can often see them being quite angry with the
“stupid wife” you know, “Why have they done that?” and “Why would you do that?” And you’re
you know, always trying to keep a level between them so that it doesn’t descend into worse
relationships.
I: So you do quite a lot of things really not only in terms of medically stabilising people but kind of managing conflict in relationships or distress in relationships.

E: Well may be not managing it but at least trying to not make things worse. It is, I guess you do, that sounds really kind of pompous because I don’t mean it in that, but I guess it’s not, it’s just trying to be a bit of human interaction, make it easier and just try to make, try to be non-judgemental and make the family aware that this isn’t a stupid cry for help that something’s going on and it’s something that needs addressing now before it gets worse or before it becomes inbuilt into their lifestyle, or in a sense if it is built into their lifestyle but it’s actually still something that’s big and happening, it needs dealing with rather than oh well, that’s it and that’s you know what they are going to do with the rest of their life.

I: So it’s kind of making them aware that...

E: And trying to give them an idea as to or allow that person to say why they are doing it and let the family hear it because you sometimes just think these people just don’t have a voice and they’re not expressing why, why they are doing it and how crap they are feeling. Sometimes I think it is easier for families and the patient and relatives to speak when you’re in the room sometimes. It’s like you’re asking the question so that you are allowing them to speak sometimes I think. But then that’s really difficult as well because sometimes you have to ask the family to leave because they just clam up and won’t speak which I can understand as well.

I: What about if somebody comes in who has a psychiatric diagnosis, would that affect how you might feel about them?

E: Yeah I suppose, again it goes back to my not very good, I don’t feel particularly confident in dealing with psychiatric illnesses because I’ve never actually done a job in a mental health unit, I’ve just been a student. And I think it makes you a bit more wary. I think it makes you just a little bit more unsure of yourself and kind of, but you want the back-up of that the psychiatric team will see them before you discharge. I mean it depends how, what, how extensive their history is and...
how much information you could get but I think it would make me definitely, it definitely makes
me more wary.

I: Would there be, it sounds like you are saying it’s dependent on their history, would there be
certain types of diagnoses that you would be more wary of or feel less confident with or is it more
about the extent of their history in terms of dealing with emotional difficulty?

E: I don’t think it would really depend on the diagnosis because thinking of any of them, manic
depression, schizophrenia, personality disorders, you always, you’re going to be concerned if
they’re self-harming. May be how long they’ve had it, whether they have been sectioned at any
time. If they can give you a good going kind of, if things have suddenly changed I think, if you
feel that their mental health has suddenly deteriorated then that would make me worry, if they
have not been taking their medication that would make me worry. I don’t know may be it’s an
excuse to get, may be it’s easier to get a mental health team to go and review if they have a known
diagnosis. So may be that would make me more inclined. But I think yeah, may be, may be I
would be more concerned that they were going to go and do themselves more damage. I may be
biased and prejudiced.

I: Well I think that that’s your experience and it sounds like it’s about managing, you have to
manage a hell of a lot of risks and a lot of concerns and perhaps if someone comes in with a
psychiatric diagnosis because you feel like you haven’t had much experience of working with
people, well particularly outside of studying, that you worry about their health or well-being so
therefore you want the back-up or support of someone else who has worked for longer in those
kind of services.

E: I think that’s what it is, that’s what it boils down to.

I: How do you decide on what treatment you offer to people who have self-harmed?

E: I’ve just always done I don’t know, as my seniors have done so kind of medically stabilising
them. If they’re then fine for discharge, making sure they’ve got some form of mental health
manic

URI: 3445275
That Heart-Sink Moment: A&E Doctor’s and Nurses’ Responses to Treating People who Self-harm.
back-up. Sometimes, it depends what they've done, I mean I do generally refer to the DSH team.

If it's like say it was the girl, the lady who was taking too many sedatives, I have actually spoken to the GP and asked the GP to refer on to, for therapy or something to offer CBT (cognitive behavioural therapy) I suppose. And that's been quite you know, that's been another option than just referring to the DSH team because some, not everyone wants to go and see the DSH and that's the other issue. You can't really just force people and it's not, you know most people aren't you know so unwell that they need sectioning or whatever it's not like you can, so you can't force them. So some people yeah you just get the, you write to the GP and say this is what's been happening, can you follow them up? But yeah it tends to be, for me it's always been the crisis, DSH or GP.

1: So can I just check, if it's out of hours it's the crisis team, the DSH team if it's in hours?

E: Yep.

1: So I guess that's Monday to Friday nine to five?

E: Yep.

1: And then GP if they don't see those teams?

E: Yep.

[Short interruption]

1: Are there kind of any other factors other than whether they want to see someone for follow-up or not that would influence your treatment decision? So what would be the most important factors, so for example would their age influence what you do or how you treat people?

E: Age no because I can't think of any age group where I wouldn't be concerned. They tend to be young girls, right yeah a lot of young girls and then middle-aged men. I've never really seen anyone elderly they all tend to be the suicide types rather than DSH. But no I mean if someone's deliberately self-harming then I'm always concerned. So yeah age wouldn't really bother me.
because yeah you could think of any age and if you are going to do that then it's going to make you obviously concerned. What was the other part of the question?

I: It was just whether that would influence your treatment decisions so if they're not an adult, if they are under sixteen, would there be any difference?

E: Yeah, yeah, if they are under sixteen then it's department protocol that they go over to go to the see the paediatricians to wait to be assessed by the, God what are they called? The paediatric community mental health team and I think, but I think that's just to await the paediatric team which doesn't happen during the night.

I: So if it's out of hours do they go to the paediatric ward?

E: Yes to the paediatric ward and I guess in a sense that gives them time to watch the parent-child interactions to see what else is going on but I don't think that's the main purpose for it, I think it's just to await assessment really rather than anything else.

I: So that would be slightly different, the follow-on services would be slightly different?

E: Yep, yep.

I: But everyone aged sixteen and above would go...

E: They would go more community wise rather than inpatient. I don't think I've ever had a self-harming patient admitted ever. It tends to all be community-led services.

I: Okay, right, and has that been your opinion that that's the most helpful follow-up for most people?

E: I'd say so because yeah, not many people want to be admitted to hospital for a start. Taking up an acute bed, unless they've got suicidal intention I guess isn't really that valid because they're not, I know they are self-harming but they're not really, they don't tend to be putting their lives at risk. And you're not really going to, you're ever going to offer these people twenty-four hour services anyway so you know, I guess follow-up in the community is the best way. I mean it might mean that they don't get as much therapy or access to whoever they want to talk to but I
guess that is the only option in the NHS. The only thing I would say is that I do, I have seen some
people that are, that have been like, “Oh I tried to get hold of the mental health team all day and
I’ve given up so I’ve cut myself and I’ve come in.” And you just think, you can see it’s pure
frustration that they can’t get hold of anyone. And I guess in that sense that’s when it’s difficult
with it being a community-led, a community team.

I: So perhaps when the support isn’t available at the time when the person needs it. So as you
said, some people come in because they can’t access support through their community mental
health team...

E: Or they know by doing that and they’ve come into A&E they won’t go home until they’ve
seen; they will demand someone to come in and see them. So I suppose in that sense people are
using the system well. I think there’s one service where people can actually drop in; I think that’s
at the [location of the service]. There’s like a drop-in service but I don’t know, I don’t think, I
think that’s in a certain age group but I’m not sure.

I: Is that like a mental health drop-in?

E: Yeah.

I: So anybody can go?

E: Yep, I think so.

I: Okay, what about how, your perceptions of whether they can control they can control their
self-harm or whether they are responsible their self-harm?

E: I think it depends on the patient really, because some people you can see that you know, they
are just desperate and they don’t have the control. Other people I think are a little bit more
calculated but that’s just from, but then people say, “Yeah, I haven’t been able to get through to
anyone so I’ve cut myself.” You know, you think, well hang on a minute you know, that is a bit
you know, you can see it’s not quite as irrational or as, it was a rational kind of decision to say,
"I'm going to do this because it will get me x, y and z." But yeah, no, I know that a lot of people that self-harm you know they can't control it.

I: Right so they are kind of out of control in a way?

E: Hmm.

I: For the people that do it because they haven't been able to get hold of people, or you feel that they've made a controlled decision to do that, would that kind of either influence the treatment that they get or the way you might feel about them?

E: Feel about them, yeah I guess it does. You can't help but feel a bit frustrated but I think that is your duty as an A&E doctor to be impartial to everyone. Okay it's easier to have a bit of sympathy and probably it's easier to build up a rapport with some people rather than others, but you can't be going round judging people, you can't really, you don't know the ins and outs, you can't decide. And everyone gets the same treatment because as standard it needs to be referred to the DSH team so in that way I guess just possibly in a way you might not be as keen to delve into the situation because you might just be a bit frustrated that their using your service to get what they want I guess.

I: So it's kind of standard treatment for everybody but that for some people perhaps it's, it's quite frustrating because either they are getting the care and it's not working out quite the right way so they've had to resort to self-harm or that you're treating them quite regularly and you're not quite sure how to help them?

E: Yeah exactly, you get frustrated because you're just thinking well what am I missing here, what you know, what else do they want? And that can get really frustrating.

I: Okay, you've kind of like, earlier you were sort of talking about when you first started in A&E and when you were working with people who self-harm. How do you think, you were talking about how it was quite a steep learning curve I think you said, I don't know if you used the word steep?
E: No I did.

I: How do you think sort of working with people who self-harm has affected, if at all, the way in which you view people who self-harm? Has that changed over time do you think with experience?

E: Yeah definitely. I guess I'm much more comfortable with working with people who self-harm. I'm definitely a lot less, you know like I don't pussy foot around it now. I feel much more comfortable to say, to ask them all that you know, “How long have you been doing it?” You know you treat it as an illness, as a illness sounds, well yeah as an illness, as a kind of this is what you do, this is what you know, and to clock it as though it’s you know the same as someone who say has asthma. So just ask the blunt questions, “How many times have you been in hospital with it? How you know, how?” And I think sometimes that’s kind of a release for the patients and some patients don’t really like it. I think you do end up, it becomes another condition that you’re dealing with so you are a lot more just kind of straight forward with it. Sometimes I think it’s just, the longer you treat it in A&E the more it does frustrate you because you’re seeing the same people again and again. Because you do just feel like you’re just on a treadmill. You keep going and you’re not getting anywhere in dealing with these patients. You’re just kind of like you know, feel a bit stuck and kind of like you’re just wasting your time and their time because you are not really getting anywhere with it. But yeah it just makes you more, I think it makes you more confident and more much more, and if I guess you start to see, feel more confident in how much of a risk is this patient to themselves, how much should we worry about them. You know, you just get your confidence with it.

I: So you’ve kind of got more confident, it’s easier to ask more open questions although it can be a bit frustrating when you see the same people coming in.

E: Yeah absolutely.

I: What’s it like when you first have to, thinking back when you first went into A&E, what’s it like having to speak to people who self-harm when you’re very new to it? What’s that like?
E: I think you just feel a bit of an idiot because you feel like you are prying into their personal life when you’re asking. Or you’re trying to avoid prying and so it’s all awkward and that makes them awkward and the whole thing just goes really badly. I think that’s why it’s much easier when you have more confidence to either be just blunt or know that this patient isn’t going to answer any of your questions so not go there. And it makes it, and if you’re confident to treat them as either the patient or you know, because I guess when, as soon as they have come to A&E they have become a patient and so you do have to treat it as though they have presented with an issue that they want dealing with by a doctor. And as soon as you make that switch it’s fine. But we’re all so confident in dealing with very medicalised issues that I think when it comes to mental health it is harder for us because we kind of don’t want to feel that we are being patronising or pigeonholing or you know, not having the confidence for dealing with these cases all the time. You just, you, I think you can end up just kind of getting all tongue-tied and making it all awkward for the patient so that they probably go home feeling worse rather than better.

I: It sounds like that with experience you get more confident at asking the questions you kind of need to ask as part of your assessment but also that you get a greater feel as to when to push people, not necessarily push people, but when it’s okay to ask those questions and when that might be unhelpful to that person at that time, or they might not answer you anyway, so you kind of get more of a feel for how people might respond to you?

E: Definitely. I think that’s a definite. Sometimes people want to open up and sometimes they don’t and you can completely understand it. I think if it’s a massively busy night and it’s all going a bit mad, you’re not going to have time to sit down and have a quiet chat with someone and that person isn’t going to want to open up to you but you know, if you have a bit more time and they can yeah, they do want to talk then you know, you do kind of learn to gage the situation. And it you know, and also after, the nursing staff are great because they, a patient may have been waiting...
a little while and they may have had a chat with them and they can say to you, “I think you know, ask them about this or ask them about that.” And I think it’s really, I think A&E, I think that’s what’s good about A&E; you can kind of come and observe someone a bit from a distance before you go in to talk to them or you can get information from the team. And it does help you gage how much you are going to get out of that like twenty, thirty minute consultation.

E: Oh absolutely. That is the beauty of A&E that you know, A&E nurses have been there, done it all for years and years and they’ve just got the perception. They are you know you’re greatest ally; they can go you know, you may be darting around but they’ve been with the patient for the full four hours. Well not the full four hours but they’ve had a bit more time and people often open up much more to the nursing staff than they will to the doctor. So just by listening to them and you know, getting information from them can really help.

I: They sound a good resource.

E: Invaluable.

I: If you could have your ideal way of treating people who self-harm, how do you think they should be treated?

E: It’s really difficult because it depends on whether it’s someone who has just started self-harming or whether it’s someone who has been self-harming for years because I think, it’s really ridiculous for me to make any comment because I just don’t know because I’m not really skilled enough in the area. But I just think, I’d say A&E isn’t the perfect setting for self-harm. I think in a sense. If people are coming into A&E because they’re self-harming and they’ve not been forced to come in, then I guess in some ways I presume that they’re looking for help and that they want someone to help them. So in that sense you need somewhere that’s quiet, somewhere that’s going to have some privacy, somewhere where someone has got time to talk to them and go through the issues you know, why are they doing it, what can, what do they want, or what do they think can
be done to help them not do it again? And A&E is just crap for that you know, you don’t have that. But again I think that, the whole idea of community support I think is really good if it did work because these people have got to get on with their lives, they’ve got to carry on, they can’t just run away from the issues, they’ve got to deal with them, and I guess having someone in the community to support them is the ideal way. But it’s got to be someone who they trust and who they get along with because I think sometimes that’s the issue.

I: Right so it’s in that service that it doesn’t work sometimes?

E: Yeah sometimes.

I: You’ve said that it kind of depends on whether they are somebody who frequently self-harms or whether they are coming in for the first time. Would you have different services for those almost like two different groups of people who self-harm?

E: Well I guess someone who’s acute you know, someone who’s just started, I guess I’d hope that they get more input and more acutely to try and stop them getting on that road of you know, as soon as they, to stop reinforcing the whole “I feel shit so I do this and then I feel better.” Because I think it’s like any habit isn’t it? If you cut it out earlier it’s going to be easier to stop that habit from forming. Whereas I think that people who do it much more chronically, it’s going to be much harder to break that habit so in a sense if you’ve got restricted resources available then I guess they’re the ones that possibly won’t benefit as much from being seen the next day. And having you know three or four sessions a week, it might be a much longer term thing.

I: So kind of more intensive input at the beginning when perhaps it’s first identified as a problem for people so that it might prevent them from self-harming again in the future.

E: Yeah I think so. Or at least help prevent it from becoming a long term problem. I think but then I don’t feel that I know because it’s literally like I package them up medically and I go there you go, so I don’t really know what happens out in the community, I can’t really.
I: Yeah. It’s interesting that you say that A&E is not the right kind of environment so that although you feel that you don’t know what happens further on, you’ve kind of got an understanding of what might be helpful for people at that kind of moment of crisis, at the time that they come into A&E.

E: Yeah, I think well, you hope so. I guess, I mean a lot of these people are distressed and you feel that they are looking for something because as I say, there a lot of people who self-harm that never come into A&E so you kind of think they are coming in for a reason. May be, I mean in some senses I guess A&E is kind of good for them because it is anonymous. You know, it isn’t the family GP that they have to go and see for everything else so in that sense I guess it is a good environment that they can come in, they can go and they don’t, but it’s, I guess it isn’t good in the long term sense of follow-up and it being quiet and a welcoming place. So I guess there are good points and bad points to seeing people in A&E.

I: Okay, and how do you treat people who self-harm? You’ve kind of talked about the medical treatment and it being about sort of about stabilising but I’m kind of thinking more about perhaps more of the personal impact you know how, what strategies do you use, if any, for managing working with people who self-harm?

E: Well, I think in treating them on a one-to-one basis personally I would always try to be very open, non-judgemental, just say it like it is, that’s what I have learnt to do. Because in that sense not to, not to try and offer sympathy or you know say, “Oh I completely understand” because they just think bullshit you know, people are just going to say bullshit because you don’t. But just to be kind of like right you know, just to take it and say you know that well I can least understand where they are coming from and just treat them like a normal human being because I think people always respond to if you just treat them on a level and not be patronising and I’ve seen so many people be patronising and you just think you know, if you can try to treat everyone as if they’re just a normal person, an everyday person as you are treating everyone else, then I think it’s easier.
And yeah, not to be all kind of like touchy feely and pussy footing around them, just to be like this is another condition that I'm treating. I think that's what I always try and do.

And you've kind of spoken a little bit about sort of having the responsibility of managing risk in a way, and it sounds like self-harm can make you quite concerned about people almost dependent on their histories as it varies. But how do you manage that, how do you kind of manage the impact of worrying about people or feeling concerned?

I think by the age old trick in A&E of always getting back-up, always kind of making sure that you have put another service there, that you have made someone aware that this patient, that this patient or person is a potential risk to themselves. I think that as long as you've done that you can't continue to worry. Otherwise you'd just eat yourself up; you'd be worrying about everyone.

I think you have to just say, "I've done everything I can, I've tried to go through with them what's happening, what services they can turn to. I've told them to come back if they need to" and I think at that point you just have to draw a line under it and say, "Right, now it's up to them and the other services that you have put in action." Because you, you know, you can't worry about everyone or else you'd really be worrying about everyone that comes into A&E. I mean no that, there are some that you still do worry about especially people, the things I get worried about are when people have kids are you just think how are things doing at home? And that's when you start thinking, I mean I have got social services involved sometimes depending on, I mean they'd have to be pretty you know, not looking after themselves at all. But yeah, if there's other people involved as well then that's when, that's when you start to worry but again I guess you always have to put another service in so that you don't worry.

So it's about putting another service in place so that you feel that the person is more supported or...

That they are more supported but also that you are covering your own back as well because you do have to think about your own kind of have you done your job properly. I mean you always
want to do your best for the patient but also you don’t want anyone to say, “Oh hang on, you saw this patient, you saw that they were a risk but you didn’t really do anything about it.” So yeah it’s for both reasons I guess.

I: So it’s kind of putting everything in place and then drawing a line underneath it.

E: Yeah because actually, you would spend your whole life eating yourself up and worrying about everyone of you didn’t learn to switch off.

I: Is it easy to switch off?

E: Easier with some than others. I think, I guess with, it’s the suicide cases that are much harder to switch off from rather than say the deliberate self-harm I guess because if someone has had a good go you know going at a suicide attempt then you just think, you know, it’s always really hard because you don’t like seeing someone that distressed. I hate seeing the families, it’s always really difficult because people are often extremely angry as well and I think that’s difficult to deal with in A&E because it’s not a calm place so it’s always a tough one.

I: Okay well that was kind of everything that I wanted to ask, it’s been really helpful thank you.

E: You’re going to listen back and go, what a moron.

I: No, not at all. But is there anything kind of that you wanted to say or that you feel is something really important that I haven’t covered that relates to your experience of treating people who self-harm in A&E?

E: I don’t think so. I’d say I think that the way that people deal with self-harm in A&E and it is again a defense mechanism, is to always but it’s the same with anything in A&E but sometimes the whole team can be very flippant about self-harm. They’re like, oh they’re back again. And then but I think that is in a sense used as, I think it is that whole frustration of not being able to do with it because they often are the patients that you just think, God, I’m not getting anywhere, I’m not getting anywhere with it and so you can get quite flippant with it and frustrated. But, but, it’s...
only from the frustration so I think you know, it is one of those topics that is interesting because people can make a joke out of it and can be very much you know, kind of dismissive. But I think it is stemmed from the pure frustration and not you know, all doctors want to heal and go there you go you know, send them home and they’re all cured which is just you know, you’re just not able to do. So that’s why I think it is you know, it is an interesting one to think about.

E: So perhaps there might be less satisfaction in terms of perhaps other people who come in with medical conditions that you feel like you can change or you can..

E: Yeah, well it’s much easier if you can you know, if you can chop it out and it’s gone and wow they’re cured, look at that. Whereas I think a lot of you know, seeing other people work a lot of people do get, they don’t deal with it well because it’s not in their nature to be like, well I can only do so much, you know they want to be able to cure it so they don’t get it so they get frustrated and it all just becomes you know, why are they wasting my time?

E: So it’s purely out of frustration really.

E: Yeah.

E: Perhaps going against the reason why you went in to the profession of being a nurse or a doctor in A&E?

E: Yeah.

E: Thank you.

E: Thank you.