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Investigating Nursing Staff Attitude and Coping Strategies on Deliberate Self-Harm in Patients diagnosed with Personality Disorders or Intellectual Disabilities and who are situated within Medium-Secure Hospitals within the United Kingdom.

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Contents Page

Acknowledgements	**Page 05**
Research Proposal	**Page 06**
Ethical Approval Letter	**Page 18**
Research Paper (5,979 words)	**Page 19**
Abstract	**Page 19**
Introduction	**Page 20**
Staff attitudes towards patients with Personality Disorder (PD) and DSH	Page 22
Staff attitudes towards patients with Intellectual Disability (ID) and DSH	Page 23
Coping strategies after managing DSH	Page 25
Current Research	Page 26
Aims	Page 27
Methods	**Page 28**
Participants	Page 28
Between-Subject Design	Page 28
Ethics	Page 29
Procedure	Page 29
Measures:	Page 31
1) Demographic Variable Questionnaire	Page 31
2) ADSHQ-DV	Page 31
3) WOCQ	Page 32
Results	**Page 32**

Mann-Whitney U Tests		Page 33
Linear and Multiple-Linear Regression		Page 34
Discussion		**Page 35**
Attitude		Page 35
Coping		Page 37
Attitude and Coping		Page 38
Strength and Limitations		Page 39
Implications		Page 40
Future Research		Page 41
Conclusion		**Page 42**
References		**Page 43**
Authorship Affiliations		**Page 51**
Appendices (Part 1)		**Page 52**
1.0	Ethical Approval	Page 52
2.0	Participation Information Sheet	Page 53
3.0	Consent Form	Page 60
4.0	**Questionnaires**	**Page 63**
4.1	**Demographic Questionnaires**	**Page 63**
4.2	**ADSHQ-DV**	**Page 65**
4.2.1	Cronbach Alpha	Page 70
4.3	**WOCQ**	**Page 71**
5.0	Debrief	Page 78
6.0	Tables	Page 82

6.1	Table 1	Page 82
6.2	Table 2	Page 82
6.3	Table 3	Page 83
6.4	Table 4	Page 84
6.5	Table 5	Page 85
6.6	Table 6	Page 86
7.0	Power Sample	Page 87
8.0	Z-Scores	Page 88
8.1	Z-Scores Attitude	Page 88
8.2	Z-Score Transformation ADSHQ-DV	Page 89
8.3	Z-Score Combined WOCQ	Page 90
8.4	Z-Score Within WOCQ	Page 91
8.5	Z-Scores Transformation WOCQ	Page 93
9.0	MANOVA Assumptions	Page 94
10.0	Durbin Watson Test	Page 94
11.0	Assumption of Multicollinearity	Page 95
12.0	Steins Formula	Page 95
13.0	Effect Size	Page 96
Executive Summary (1,000 words)		**Page 97**
Reflective Report (2,000 words)		**Page 104**
Appendices – Part 2		**Page 112**
14.0	Email from Medical Regional Director	Page 112
15.0	Passport Form	Page 113

16.0	Conformation from Hospital Director	Page 116
17.0	Instructions for Authors	Page 116
PowerPoint Presentation Slides		Page 117

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Above all, to Assistant Professor Lydia Bullock, Dr Shihning Chou and the University of Nottingham Faculty of Medicine & Health Sciences Research Ethics Committee for their support and understanding during constructing this research.

Research Proposal

Investigating Nursing Staff Attitudes and Coping Strategies on Deliberate Self-Harm in Patients diagnosed with Personality Disorders or Intellectual Disabilities and who are situated within Medium-Secure Hospitals within the United Kingdom.

Introduction:

Deliberate self-harm (DSH) is intentional damage to one's own body, without intention for death (McAllister et al, 2002). Statistics have shown that within the UK DSH has increased over the past 20 years, therefore making the phenomenon an international healthcare problem. Many Clinicians refer DSH complex and misjudged (Hawton et al, 2012), due to the repetitiveness hard to deter (Rayner and Warner, 2003) and that the frequency of DSH increased suicide-risk – despite no intentions to die (Hawton et al, 2012). Therefore, it is important that services and support for individuals engaging in DSH are improved (Department of Health, 2015).

Several research have suggested how DSH rates are known to be higher in forensic secure and institutional settings than in community or general-medical setting (Jeglic et al, 2005). Uppal & McMurran (2009) revealed that nearly 31% all incidents in secure hospitals were related to self-harm which is 1,749 incidents over 16-month period. However, Owens, Harrocks and House (2002) reported that risk of further self-harm showed

within 155 patients in the 12 months following an episode of non-fatal suicide, and that in four years following self-harm, the risk increased to 23%.

Secure hospitals have attempted to manage range of self-harm behaviours, when suicidal attempt maybe low. Access to items to help DSH tends to be unlimited, which increases risks (Sankar, 2011). Patients often find creative methods to self-harm (Runeson et al, 2010). For example, swallowing items or inserting foreign objects such as batteries or washing agents (Sankar, 2011). Due to this, prevalence could be higher in hospitalised services as self-harm is performed privately (Brown & Beail, 2009).

Majority of research have focused on individuals diagnosed with personality disorders **(PD)** or mental health in relation to self-harm. Previous research within prisons and A&E departments has attempted to understand why self-harm occurs within these populations (Sarkar,2011), yet avoiding how staff cope. Individuals diagnosed with PD display difficulties in emotion regulation which creates anger and low-moods. This could be a coping technique used as a means of expressing distress from trauma (Royal College of Psychiatrists, 2010). Prevalence for patients with PD tends to be much higher with inpatients in secure services, with rates of 67% meeting the diagnosis (Nock et al, 2006). When diagnosed with PD, hospitalised patients are often stigmatized by staff (Hauk et al, 2013) due to the attitudes they have towards then reluctant towards

treatment (Deans & Meocevic, 2006). According to Bodner et al (2015) nursing staff respond to patients with PD with less empathy and more negativity when they self-harm.

Existing research into staff beliefs about DSH in patients with Intellectual Disabilities **(ID)** is limited which could be explained from the difficulties staff have within this patient group (Dick et al, 2010). Most research have dedicated towards understanding aggressive behaviour as a form of challenging behaviour, but not specifically on deliberate self-harm in ID. Cooper et al (2009) found self-harm prevalence rate of 4.9% on 1,023 individuals with ID who were receiving inpatient support. Mesa & Tsakanikos (2014) investigated attitudes with inpatient psychiatric staff towards patients with mild ID compared to patients with mental health. Conclusions were made that staff were more negative towards ID population because they struggle to communicate and understand them.

Several authors propose that all individuals who self-harm experience negative attitude from healthcare staff. Wieners model of attribution states that the attributions individuals make regarding behaviour of others can influence emotional and helping response (Weiner 1985 cited in Hill and Dagnan, 2002). To date, research have concluded mixed reviews on how staff view self-harm. Some authors report negative attitudes, suggesting they have limited knowledge, skills and understanding (Shaw and Sandy, 2016) whereas, others provided positive

attitudes, stating they have hope in patient recovery if their behavioural patterns change (Totfhagen et al, 2014).

However, the effect of managing and dealing with self-harm is challenging for staff. Reports of negative attitudes and reactions such as anger, frustration, lack of empathy and uncertainty of how to react to self-harm (Gibb et al, 2010) have been shown. Staff have previously suggested that the reason for why they get emotionally affected is due to patient emotions which transfers onto themselves, which may make staff confrontational, which then may initiate DSH (Totfhagen et al, 2014). Exploring staff coping strategies after managing self-injury could help further training programmes to reduce levels of emotional reactions and burn-out towards staff and to explore how they can manage their own psychological wellbeing. When nursing staff manage verbal and physical aggression within inpatient units, they often find social debriefing from supervision or peers to be effective (Kerr et al, 2017). However, Chang et al (2006) reported that the best coping strategies for managing psychological wellbeing were escape-avoidance, distancing and self-control. Happell et al (2013) found similar results. When nurses cope with occupational stress they use strategies like avoidance, exercise, sleep and alcohol use. Which links towards escape-avoidance and distancing coping strategy. Nevertheless, some studies suggest that problem-focused coping strategies may prevent burnout, whereas avoidance or emotion-focused strategies contributes (Ceslowitz, 1989; cited in Chang et al, 2006). To date, no study within literature has

explored how staff cope after managing DSH in either of the two client-groups. Dealing with self-harm is referred to be traumatic. Staff are often put in the position of responsibility which may elicit clinical incompetence (Rouski and Tatum, 2017) and high volumes of emotional exhaustion (Gibb et al, 2010).

This study aims on exploring and comparing staff attitudes towards patients with either a diagnosis of ID or PD and DSH, within several medium-secure hospitals. Both attitudes will then be equated to previous literature on attitudes on working with patients with mental-health that self-harm. Gaining more knowledge of staff beliefs could give greater understanding in the way staff respond towards this challenging behaviour, within these patient groups. Exploring attitudes will aid training programmes for new and current nursing staff to increase understanding of patients with ID or PD behaviour to thereby enhance staff-patient relationship.

In addition, the study will explore staff coping strategies after managing with self-harm behaviours within the two population groups. The benefit of knowing the difference between the two groups on coping responses can aid understanding into what coping responses are beneficial for nursing staff when dealing with self-harm within either patient group. If staff cope with managing self-harm psychologically, the relationship between themselves and patients may improve, which will impact on recovery (Patterson et al, 2007). If staff are unable to cope with patients

according to their diagnosis, then the focus on training needs to be directed towards that patient group. Tofthagen et al (2014) suggested that improving patients' self-esteem by psychologically coping with challenging behaviours will help reduce patient distress and to aid them developing other coping acts alternative to self-harm. Furthermore, this study aims on exploring whether coping strategies influenced attitudes.

Hypotheses:

Hypothesis 1: All staff, despite whether working with patients with Intellectual Disabilities' or Personality Disorders' will show negative attitude towards their DSH behaviour.

Hypothesis 2: Nursing staff who work with patients diagnosed with either ID or PD will show no differences in attitude as to whether they can effectively deal with patients that DSH.

Hypothesis 3: There are differences between staff empathy and perceived confidence in assessing patients with ID that DSH, compared to those diagnosed with PD.

Hypothesis 4: After managing DSH, staff use 'escape-avoidance' in both client-group.

Hypothesis 5: Staff coping strategies is an influential factor into staff attitude towards DSH

Proposed Methods:

a) Participants

A G*power analysis for all analyses **(See Appendix 7.0),** showed the largest sample size to be 107 for a significant to occur (Multiple-Regression). This means that approximately 58 participants per group (PD Group and ID Group) is needed as minimum. On the other statistical analysis, the G*Power analysis states that the total sample size needed to obtain significance for coping strategies is fifty-four when alpha is 0.05, power is 0.95, 0.5 medium effect size, two groups (staff working with patients with LD and self-harm and staff working with PD and self-harm) MANCOVA analysis).

Nursing staff will be recruited through opportunity sampling from forensic medium secure hospitals that provides treatment for patients with personality disorders and Intellectual Disabilities (Learning disabilities') and who have been sectioned under the Mental Health Act, 2007. Nursing staff whom are above the age of eighteen and have either worked or currently work on an Intellectual Disability ward or a ward with patients diagnosed with Personality Disorder, will participate. Recruitment for participants will be gathered through social media, email (msxjai@exmail.nottingham.ac.uk) and through face-to-face verbal advertisement, which will explain purpose and process of the study (**See Appendix 14.0).**

If participants are approached face-to-face, which will be done through staff meetings or through staff canteen, they will be provided with the participation information sheet and a written link to the study. This way the participants are not encouraged to decide straight away on whether they will participate. This will also avoid social pressure.

Participants will be reminded that they have no obligation to participate. As participants are colleagues of the researcher, coercion could occur. To avoid coercion, personal attitudes towards self-harm will not be discussed and the discussion of doing research as part of a thesis will not be discussed, prior the research submission.

b) Procedure.

Two online links using the Bristol Online Survey will be created for both groups that would take approximately 20 minutes to complete. Group 1 (staff who work with individuals diagnosed with ID) and Group 1 (staff who work with individuals diagnosed with PD). Participants will self-select either link by which type of ward they work or have worked upon.

When clicking on either of the Bristol Online Survey links, all participants, despite what group they are in, will be shown an information sheet that states the reasons for why the study is being conducted and how valuable their contribution is **(See Appendix 1.0).** Participants at this stage will be asked to provide their own unique code so that data can be removed safely and anonymously, if they wished. Participants will also be informed

that there are no right or wrong answers and that their answers should be based on their own thoughts about the matter and that data missing, due to incompletion will be removed from the data set.

The participant will then accept, to proceed to the next page. If the participant does not accept, then they will be transported to another page which thanks them for their time. Participants will be reminded that they do not have to answer all the questions if they feel uncomfortable and that they can change any questions throughout the study, unless they confirmed their answers.

Participants that proceed further will be presented with a consent form that asks participants consent in continuing with the study **(See Appendix 2.0).** For participants refusing to consent, they will be thanked for their time and asked to close the study. All participants during this stage will be reminded that although they consent to participating, they can withdraw during or after participation.

The first questionnaire will follow, which consists four demographic questions based on their age, gender, job-role and length of experience within their setting **(See Appendix 3.1).** Research has shown that attitudes towards self-harm are related to several demographic and employment factors with older and more experienced staff positive towards DSH than younger, inexperienced staff (Samuelsson, Asberg & Gustavsson, 1997). However, the reverse has been reported (Friedman et al, 2006).

The ADSHQ-DV and WOCQ will follow which will contain the same questions, structure and design in both links **(See Appendix 3.2 & 3.3).** The only difference is to what patient group participants refer to. Both ADSHQ and WOCQ will have reminders after eight sets of questions, reminding them to refer to the patient-group they work with.

Lastly, the participant will receive debrief form **(See Appendix 4.0)** which will thank them for their participation, alongside a summary of research purpose and contact details involving the postal address for participants to post their unique code that will help remain confidentiality. Self-harm helpline and further support lines will be provided for participants so that if they are affected by anything in the study they can be provided with support. Participants will be advised to print out the debrief sheet, so they can refer to their unique code. If participants have any printing issues, then they can email any researchers to resolve this. For individuals that may not have responded to the advertisement of the questionnaires via email, reminder emails will be sent out to participants after a certain amount of time to thank those that have already participated and to remind those that have not. No participant will be pressured through emails or face-to-face to commit on participating to the research.

Furthermore, participants that have no access to the internet or devices will be provided a Samsung tablet from the researcher to obtain the questionnaires. This will be away from the wards and from other

participants in a quiet area. Researcher will also be away from the participant when they are conducting the research.

c) Measures

Three questionnaires will be administered to all participants. The first questionnaire will consist of demographic questions. These include question regarding their gender, age, job-role and length of experience **(LoE)** staff had within the service **(See Appendix 4.1)**. Secondly. the Dutch version (translated to English) of the Attitude towards deliberate self-harm questionnaire **(ADSHQ-DV**, Kool et al, 2015; **Appendix 4.2**) will be administered, following the Ways of Coping Questionnaire (**WOCQ**, Folkman & Lazarus, 1988; **Appendix 4.3**)

All questionnaires will be in the format of "Calibri (Body), size 12, colour black" so that participants can easily read the questions. A limitation with the psychometric properties is the number of items participants must answer. This may be too many for some participants. Participants are required to answer 33 items in ADSHQ and sixty-six items in WOCQ. However, participants are reminded that they can take a break from the questions and come back to them later.

The ADSHQ-DV will be used due to having high internal consistency, in comparison to ADSHQ (Kool et al, 2015). Overall score is known to be 0.623 with scores of Factors 1, α = 0.809; Factor 2, α = 0.471; Factor 3, α = 0.617 and Factor 4, α = 0.665.

d) Proposed Analytical Methods

Data will be analysed through SPSS. The ADSHQ-DV will be coded from Kool et al (2015) coding methods to gather data for the total attitude and from the four factors within. This would lead both data analysed through MANOVA. The WOCQ will further be analysed through MANOVA on both groups using the 8 coping strategies. Both analyses will answer the first four hypotheses as stated.

A Linear Regression will be conducted on all factors within WOCQ and demographic variables (age, gender, LoE and job-role) against the total attitude within ADSHQ-DV to test for multi-collinearly. From these factors, a Multiple-regression would be analysed to see what type of coping strategy or demographic variable influences attitudes. This would then answer the fifth hypothesis.

e) Estimated Timescale

The study will take approximately 5-months for data to be collected, analysed, and written up. Data will start being collected from April 2018 until May 2018. Data analysis and write up will begin July 2018.

Ethics Approval Letter

University of Nottingham
UK | CHINA | MALAYSIA

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5 April 2018

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Dear Mr Inger

Ethics Reference No: 248-1802 – please always quote	
Study Title: Investigating Nursing Staff Attitudes on Deliberate Self-Injurious Behaviour in Personality Disorders and Intellectual Disability Populations and the Coping Strategies' Nursing Staff use after managing with Deliberate Self-Injurious behaviours.	
Chief Investigator/Supervisors: Dr Shihning Chou, Associate Professor, Deputy Director, Dr Lydia Bullock, Assistant Professor of Forensic Psychology Centre for Forensic & Family Psychology, Division of Psychiatry & Applied Psychology, School of Medicine.	
Lead Investigators/student: Mr James A Inger, MSc Student	
Type of Study: MSc Forensic and Criminological Psychology questionnaire-based study: Internet-mediated research	
Proposed Start Date: 01/03/2018	**Proposed End Date:** 30/07/2018 3 mths
No of Subjects: 112-130	**Age:** 18+years

Thank you for notifying the Committee of amendment no 1: 27.03.2018 In summary as follows:

- To extend recruitment using social media to participants who work in other medium forensic hospitals in addition to Calverton Hill as previously approved. This will improve and broaden the data collected.

These have been reviewed and are satisfactory and the study amendment no 1: 27.03.2018 is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Rawl Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

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Research Paper

Nursing Staff Attitude and Coping Strategies towards Deliberate Self-Harm within inpatients diagnosed with Intellectual Disability or Personality Disorder.

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Abstract

Psychiatric nursing staff (N=139) working within UK medium-secure hospitals participated in exploring attitude and coping strategies towards deliberate self-harm within in-patients diagnosed with either an Intellectual Disability or Personality Disorder. Additionally, this study explored whether coping strategies, age, gender, job-role and length of experience influenced attitude. Using online surveys, the Ways of Coping Questionnaire and Attitudes Towards Deliberate Self-Harm Questionnaire (Dutch-Version) were administered. Results found that staff were negative towards self-harm and that two styles of coping strategies were significantly found. Seeking Social Support was significant for staff working with patients diagnosed with Personality Disorders, whereas Problem-Solving was significant for those working with Intellectual Disabilities. No significance was found between age, gender, job-role or length of experience. A significant regression was found between coping strategies and attitude, which accounted for 22.2% variation. Confrontative Coping strategy was found to be the only significant, positive relationship towards staff attitude.

Keywords

Attitude, Self-Harm, Intellectual Disability, Personality Disorder, Coping.

Introduction

Deliberate self-harm (DSH) is an international health-care problem (Hawton et al, 2012), defined by the National Institute for Health and Care Excellence as intentional injury cause by oneself, without intending to die (NICE, 2013). The phase is commonly used throughout research to dispute other self-harm behaviours such as accidental self-harm (Nobakht & Dale, 2017). DSH can take many forms, yet common methods include cutting, strangulation, inserting foreign objects, re-opening wounds and occluding airways (James et al, 2012). Nobakht & Dale (2017) identified 40.5% of adults (18 years and over) have engaged in self-harming behaviours, with males showing higher prevalence (48%) than females (33%).

Prevalence has often been debated throughout research which could be explained by the complexity. For example, Rayner & Warner (2003) stated how the repetitiveness, frequency and severity is difficult to measure as individuals may fluctuate from mild to severe and unique forms of DSH. Additionally, DSH can co-occur alongside other mental health, including eating-disorders, drug-abuse (Greydanus & Shek, 2009) and unintentional suicide (Hawton et al, 2012), which can increase by 23%, if DSH continues after four-years (Owens et al, 2002).

Over the past twenty-years, DSH within the UK increased by 9% (Hawton et al, 2012), leading to approximately, 24,000 psychiatric admissions per year (Shaw & Sandy, 2016).

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However, DSH rates are significantly higher within forensic settings compared to community services (Jeglic et al., 2005). Uppal & McMurran (2009) revealed that 31% of incidents in secure-services were related to DSH, which counts towards 1,749 incidents in sixteen-month period. However, this is not surprising, as many patients, despite becoming restricted to high-risk items, find alternative ways to pursue self-harm (Runeson et al, 2010). These include swallowing items, inserting foreign objects or refusing to eat (Sarkar, 2011). Nonetheless, with the current lack of awareness of such behaviour, research within secure-services are limited (Tofthagen, Telseth & Fargerström, 2014). This could be from the governments lack of investment in treatment or training (Sarkar, 2011; Royal College of Psychiatrists, 2010).

Several research have found that patients often feel that when staff show aggressive and confrontational personas, they avoid responding to patients' needs (Commons-Treloar & Lewis, 2008). Commons-Treloar & Lewis (2008) additionally states how this might make patients initiate further DSH, which could increase severity. Therefore, staff attitude is an important concept within patient recovery. Staff attitude could be influenced by attributions. This may influence their emotional and helping responses. In relation to DSH, the Wieners Attribution theory (Weiner, 1985) suggests attitude are influenced by whether others perceive the behaviour within control. Behaviours that are perceived beyond control would enable positive attitude, whereas behaviours within control would be negative (Dick et al, 2010).

Within the current literature, research have used qualitative research to explore attitude within acute-services upon DSH. Results have shown both positive and negative attitude, despite ages and experiences' (Shaw & Sandy, 2016; Gibb et al, 2010). Rouski, Hodge & Tatum (2017) and Tofthagen, Talseth

& Fargerström (2014) found staff who were positive towards patients recovering from DSH, helped patients adapt to alternative methods when facing cognitions that may have lead them to DSH. Lindgren et al (2011) further found positive attitude in staff who adopted supportive and fostering repertoires.

Authors who report staff showing negative attitude, proclaim how staff have limited knowledge about DSH (Shaw and Sandy, 2016), which leads them into perceiving that DSH will continue, irrespective of interventions. McAllister et al (2002) found negative attitude when implementing the Attitude towards Deliberate Self-Harm Questionnaire **(ADSHQ)** to Australian nurses within emergency departments. Staff portrayed negative demeanour, with no empathy, which was concluded by the years of experience influencing attitude. However, experienced staff were reported more supportive within Conlon and O'Tuathail (2012) research. Reversely, Gibb et al (2010) found no significance with experience and attitude towards DSH.

Staff attitudes towards patients with Personality Disorder (PD) and DSH

Throughout the literature upon DSH, research have lacked understanding as to the type of patients within secure-services that DSH. Bodner et al (2011) states that within secure-services 41% of individuals with Borderline PD diagnosis will engage in over fifty DSH incidents during their section. However, despite prevalence unknown, patients with other PD diagnoses, do DSH (Ayodeji et al, 2015).

Currently, studies have often found that based on the diagnosis alone, staff portray negative attitude, by believing that patients with PD cannot recover (Deans & Meocevic, 2006), potentially because of stigmatisation from their diagnostic label (Hauck et al, 2013). Therefore, staff

portray negative-regard, by ceasing to see each patient as individuals. This then results staff to avoid exploring reasons behind each behaviour (Commons-Treloar & Lewis, 2008). Showing negative-regard, will enable staff to conceptualise that patients who commit the same behaviours, do it for similar reasons, thereby they should be treated the same (Dickinson & Hurley, 2011). Negative-regard was shown in Bodner et al (2015) study where nursing staff claimed that they are less empathetic, and that they believe that when certain behaviours are portrayed, they signal attention. James & Cowman (2007) reported similar findings. They found that 80% nurses viewed those with PD difficult and dangerous, which made 84% of nurses find interacting with them difficult.

Throughout the decade, research exploring how staff within secure-services perceive DSH towards patients diagnosed with PD is limited. Yet, since prevalence for PD tends to be higher with inpatients in secure-services, with rates of 67% meeting the diagnosis (Nock et al, 2006), previous studies upon attitude towards DSH could have been reported in patients with undiagnosed PD.

Currently, research that has specifically explored DSH in patients with PD has found that staff report anger and frustration when they are faced with DSH (Deans & Menocevic, 2006; Bodner et al, 2011). Nevertheless, when ADSHQ-DV had been applied within US in-patients who are diagnosed with PD (See Hauck et al, 2013), attitudes were more positive in comparison to that of Bodner et al (2011) and McAllister et al (2002). Similar results were shown in Commons-Treloar & Lewis (2008) research where conclusions were made base on how staff understood the disorder and the patients' difficulties.

Staff attitudes towards patients with Intellectual Disabilities (ID) and DSH

The term ID is used frequently throughout research, in which the professional term

replaces 'Learning Difficulties' (BILD, 2018). Research has shown that individuals with ID are often misunderstood (Mesa & Tsakanikos, 2014). This may be because perceptions on changing behaviours like DSH is difficult (Lau & Cheung, 1999). Mesa & Tsakanikos (2014) investigated and compared staff attitude towards patients diagnosed with ID or mental health. They concluded that staff felt least confident at communicating or empowering patients with ID to overcome their challenging behaviours. This then, according to patients, influenced their recovery, as the patients felt worthless and disempowered (Donner et al, 2010).

Existing research into staff belief on individuals with ID and DSH is limited, which could be explained by staff perceiving DSH less priority than other forms of challenging behaviour, such as aggression and violence (Donner et al, 2010). However, because prevalence of DSH varies from 4.9% to 24% within ID inpatients units (Cooper et al, 2009) with common behaviours being head-banging, hitting, cutting and ligating (Chester & Alexander, 2018), DSH is conceptualised as a challenging behaviour, that needs further investigation, especially if attitude towards such population are misconstrued (Scior, 2011).

So far, research has explored staff belief in acute-services about why patients with ID DSH. Using Q-Methodology, Dick et al (2010) identified five positive viewpoints that showed how staff viewed DSH as a communicative way of modifying emotions. However, staff stigmatised patients, believing that DSH is part of their diagnosis, which they cannot control behaviours. James & Warner (2005) found similar results. Staff appeared to understand the nature of DSH in patients with ID, yet they became hostile by viewing the behaviour as a method for manipulation, which made them become less confident in responding to the behaviour.

Coping strategies after managing DSH

Responding to DSH within secure-services has been known to influence stress (Karman et al, 2015). Nursing staff are placed in positions of responsibility in which their duty is to protect patients from harm (Gibb et al, 2010). However, since majority of patients who DSH, self-harm in secret (Runeson et al, 2010), staff have reported how they have felt traumatised and incompetent to intervene (Patterson et al, 2007). They fear patients may commit suicide due to intensity becoming severe (Rouski and Tatum, 2017).

Gibb et al (2010) identified stress when staff within secure-services became frustrated when responding to DSH. They found that staff lacked empathy because of emotional transference. A term that implies a transfer of emotions from one individual to another (Hollway, 2016). This reflected upon Lazarus and Folkman (1984) model of stress that states, when individuals perceive potential stressors; perhaps threats of harm, they judge their ability to manage the stressor, which thereby influence attitude.

Therefore, how staff may cope after DSH could support the model and could influence attitude. However, there is limited research in relation to staff coping strategies and DSH within secure-services. Folkman et al (1986) identified eight forms of coping strategies that everyone may use when a stressful event occurs, yet this depends on how stressful that situation is perceived to that individual. All coping strategies can be found within **Appendix 4.3**.

Seeking social support has been found to be the common, yet effective strategy at decreasing stress in any given situation (Fawzi-AbuAlRub, 2004) and used more commonly when behaviours like aggression are present (Hill and Dagnan, 2002). However, Escape-Avoidance and Distancing has shown to increase wellbeing after a stressful encounter (Chang et al, 2006). Escape-Avoidance refers to wishful thinking, where one may

use self-comforting strategies to repress what occurred, whereas Distancing describes efforts to detach oneself from the situation (Folkman et al, 1986).

Further research has shown that Problem-Solving strategies has been beneficial towards managing stress, yet when compared to other strategies Escape-Avoidance remained more effective (Hill & Dagnan, 2002). However, Ceslowitz, (1989; cited in Chang et al, 2006); have suggested that Problem-Solving can provide reverse effect at contributing towards stress.

Current Research

Whilst previous research has largely focused on acute-inpatient admissions (See Mesa & Tsakanitos, 2014; Wilstrand et al, 2007) and emergency services (Conlon & O'Tuathail, 2012), there appears to be limited research within the literature on attitude within higher services on patients diagnose with either ID or PD. The limited research within medium-secure units (**MSU**) currently have provided either, qualitative research (Shaw & Sandy, 2016) or research providing small samples (Tofthagen, Talseth & Fagerström, 2014) which could be criticised by lacking validity. Participants may have felt pressured to respond positively rather than negatively when face-to-face with researchers (Dick et al, 2010). Therefore, it is pertinent that research relating to MSUs are quantitative.

The current research therefore aims on exploring nursing staff attitude within UK MSUs on inpatients diagnosed with either ID or PD. Broadening participants to several MSUs would give literature greater understanding in staff perceptions towards DSH.

To the authors knowledge, no current research has explored how staff within MSUs cope after DSH. Thereby, this study additionally explores this within both patient-groups, using Folkman and Lazarus (1988) coping strategies.

Furthermore, this study explores whether coping strategies influence attitude. Results from this may help MSUs develop concrete understanding as to what coping strategies staff currently use and to prepare new staff into using these strategies to benefit their wellbeing. In addition, if staff are aware of how they cope, this could lead to attitude changing (Wilstrand et al, 2007), due to less stresses, which in turn would improve patient recovery (Hauck et al, 2013). Additionally, this would help provide evidence for the government to invest in funding specified in treatment specifically for each patient-group and DSH within MSUs.

Aims

Five hypotheses that explores attitude and coping strategies staff within MSUs may have on both adult population groups have been conceptualised and are as follows:

Hypothesis 1: Despite whether working with patients with Intellectual Disabilities' or Personality Disorders', nursing staff will have a negative attitude towards DSH.

Hypothesis 2: Nursing staff who work with patients diagnosed with either ID or PD will show no differences in attitude as to whether they can effectively deal with patients that DSH.

Hypothesis 3: There are differences between staff empathy and perceived confidence in assessing patients with ID that DSH, compared to those diagnosed with PD.

Hypothesis 4: After managing DSH, staff in both groups use 'escape-avoidance' coping strategy.

Hypothesis 5: Coping strategies is a variable that influences nursing staff attitude towards DSH.

Method

Participants

Using G*Power 3.0.10 for all analyses, the largest sample-size showed that a minimum of 107 participants were needed (**See Appendix 6.0**). Participants were firstly collected through an inclusion criterion, that were mentioned during advertisements, before participation. Nursing staff must have met the criteria of working within an adult UK MSU with either patients diagnosed with PD or ID. However, due to the nature of secure-services, some staff may work across both patient types (Sarkar, 2011). Those who did, had to decide on what patient-group they predominately work with.

Nursing staff included Nurses, Healthcare Workers, Occupational Therapists and other staff who had regular contact with the patients. The exclusion criteria were staff that had medical knowledge towards patients. This included Psychiatrists and Psychologists. Although, Commons-Treloar & Lewis (2008) found no conflicting attitude between medical professionals and nursing staff, their input could potentially cause bias.

An opportunistic sampling method resulted in a total of 141 surveys completed, yet two participants failed to complete the key sections within the survey, leading to their data destroyed. Data from 139 nursing staff between the ages of 18-56 (Mean = 32) who worked within UK adult MSU with patients diagnosed with ID or PD was used in the analysis (Male =14, Female = 122). Full participant characteristics can be found in Table 1 and 2 **(Appendix 5.0).**

Between-Subjects Design

Data was collected online between 6th April to 30th May 2018, using two separate surveys facilitated by the Bristol Online Survey©. Both surveys were distributed anonymously through emails, media resources (Facebook, Twitter) and

discussion forums that related towards the target audience. This was so that coercion was avoided. The authors were aware that participants could be colleagues, which may have made them feel pressured to partake or respond biasedly.

Self-reported methods were used for practicality purposes. Analyses from the data would be easier to measure and quantify and that participants could report quicker their perceptions to each statement. Participants self-selected either survey, which depended upon the patient group (either ID or PD) they predominately worked with. All participants were reminded within the advertisements and again within the participation information sheet that they could only participate in one survey. This was to minimalize attitudes transferring from one survey to the other.

Both surveys contained three questionnaires which followed the same structure and content. These included a demographic questionnaire, the ATDSHQ and the WOCQ. All questionnaires adopted quantitative multiple-choice questions throughout.

Ethics

The study received approval from University of Nottingham Faculty of Medicine & Health Sciences Research Ethics Committee **(See Appendix 1.0).** No major ethical issues arose during the approval process and no means of deception was used within the study. Participants were reminded that the study was not timed, they were not obliged to answer all questions and that they could withdraw.

Procedure

After selecting the appropriate link, participants were presented with an online information sheet **(See Appendix 2.0),** which outlined the purpose, confidentiality, and the benefits the research may have. Researchers

professional contact details were provided so that participants could contact any researchers in case they had further questions.

Participants was reminded during this stage their rights to withdraw from the research by posting their self-made seven-character pseudonym to the address stated within the two-week timeframe. This was to ensure data could be withdrawn anonymously and due to the time constraints of the researchers'.

Following the information sheet, participants were presented with a consent form **(See Appendix 3.0)** which had to be accepted before the survey commenced. This provided evidence that they understood the nature of the research, before participation. Those that did not accept were thanked and were advised to close the survey. Three questionnaires followed consecutively **(from Appendix 4.0)** that periodically reminded them to refer to their patient-group. All questionnaires explained the purpose of that questionnaire before participants proceeded. Participants were further reminded that they did not have to answer all the questions and that they could change any questions, unless they confirmed answers. If participants decided to close the study, their responses would be incomplete, meaning their data would be destroyed.

A debrief sheet **(See Appendix 5.0)**, summarising the purpose of the research and contact details followed. A reminder of participants withdrawal rights and self-harm help-lines, if they do become affected, were additionally stated. Participants were advised to print out the debrief sheet so that they could refer to their personal pseudonym, if they decided to withdraw. Participants were reminded not to email the researchers their pseudonym, as this would breach confidentiality as their email-address would show,, but to post the pseudonym, using the postal address.

Measures

All three questionnaires contained the same questions, structure and design. The only difference is to what patient-group participants referred to. Participants were reminded that they must refer to their client-group when answering each question. Reminders were shown after eight questions on all questionnaires.

Demographic Questionnaire

A demographic questionnaire was used to provide an overview of participants characteristics of working within MSUs within their patient-group. Five questions were used to explore participants gender, age, occupation and length of experiences **(LoE)** of working within their patient-group **(See Appendix 4.1).**

Attitudes towards Deliberate Self-Harm Questionnaire – Dutch Version (ADSHQ-DV; Kool et al, 2015)

The ADSHQ-DV is an adapted version of ADSHQ (McAllister et al, 2002) that was translated from Dutch to English. Using 4-point Likert scale, the scale remained consisted to the original by showing the same 33 question-items that were used to measure four-factors relating to attitude. The only difference is how each factor were coded in relation to the four-factors (**See Appendix 4.2**). The ADSHQ-DV was used due to high internal consistency compared to the original, when results were analysed in Kool et al (2015) study. The overall Cronbach Alpha was 0.62, compared to 0.42 (**See Appendix 4.2.1**). The total score on the ADSHQ-DV was then calculated as the sum of the ratings for the 33 items (possible score ranged 33–132) to dictate the total attitude.

The Ways of Coping Questionnaire (WOCQ; Folkman & Lazarus, 1988)

The WOCS is widely used self-administered coping measure designed to identify coping strategies individuals use within stressful situations (Folkman & Lazarus, 1988, **See Appendix 4.3**). The current study adapted the wording of WOCQ to make it specific towards patients that DSH. Participants answer 66 questions through 4-point Likert scale based on how they cope after managing DSH within their patient-group**.** Items were scored following Folkman & Lazarus (1988) coding methods to obtain data for the eight coping strategies.

Rexrode, Petersen & O'Toole (2008) found that WOCQ has been consistently reliable throughout research. In their study, the reliability across subscales ranged from 0.60 to 0.75, which showed high reliability. Therefore, they concluded WOCQ appropriate scale for measuring coping to certain contexts.

Results

All data were tested using SPSS-24 for normality and parametric assumptions before analysis. Data for both attitude and coping strategies showed skewness to be beyond normal range (**Appendix 8.1 & 8.4).** Descriptive statistics for participants characteristics can be found in Table 4 and 5 **(Appendix 6.4).**

Firstly, one-way MANOVA assumptions were explored for both scales. From the four assumptions outlined within Field (2009; **Appendix 9.0**), both data-sets did not meet the Multivariate assumption of Normality. This equated data to be non-parametric. Since Field (2009) outlined no alternatives for MANOVA when tests do not meet parametric assumptions, transformations were used to avoid skewness (See Keselman, 2005). Despite transforming data, both data sets remained skewed (**See Appendix 8.2 & 8.5**). Therefore, MANOVA was terminated as results would become inaccurate (Field, 2009). Subsequently, Mann-Whitney U-

Tests (**MWU-T**) were analysed for both groups in relation to each factor within ADSHQ-DV and within WOCQ.

Mann-Whitney U-Tests

To answer the first hypothesis, results showed that staff overall attitude towards DSH of those working with ID (**Group 1;** Mdn = 65.00), did not significantly differ to staff working with patients diagnosed with PD (**Group 2**; Mdn = 65.00), U = 2186.0, z = -0.96, ns, r = -0.08. Both groups showed negative attitude, which was indicated by their mean score (Possible score ranges 33-132, Kool et al, 2015).

Each factor within the ADSHQ-DV were additionally explored using MWU-T, to help answer the second and third hypothesis. The MWU-T revealed significance in Factor 2. Staff in group 1 (Mdn = 20.00) had greater perceived confidence in assessing DSH, than those in group 2 (Mdn = 21.00), U = 2004.5, z = -1.736, $p < 0.05$, r = -0.08, small effect (Field, 2009). However, group 1 did not differ significantly in Factor 1: Dealing Affectively with Self-Harm (Mdn = 20.00); Factor 3: Empathy (Mdn = 12.00) and Factor 4: Coping effectively with hospital regulations (Mdn = 11.50) compared to group 2; Factor 1 (Mdn = 20.00), Factor 3 (Mdn = 11.00), Factor 4 (Mdn = 13.00). MWU-T showed Factor 1, U = 2403.00, z = -0.038, ns, r = -0.00; Factor 3, U = 2125.50, z = -1.218, ns, r = -0.10; and Factor 4, U=2054.50, z = -1.517, ns, r = -0.13.

Another MWU-T was conducted to explore each staff coping strategies in relation to both groups after managing DSH to help answer Hypothesis 4. Group 1 differed significantly in the 'Problem-Solving' strategy (Mdn = 12.00) than group 2 (Mdn = 14.00), U = 17.13.0, z = -2.959, $p < 0.05$, r = -0.25. However, significance was shown for 'Seeking Social Support' for Group 2 (Mdn = 18.00) than those in Group 1 (Mdn = 15.00), U = 1935.5, z = -2.018, $p < 0.05$, r

= -0.17. No significant differences were found between the other five factors. Confrontative Coping (U = 2163.5, z = -1.05, ns, r = -0.09), Distancing (U = 2139.5, z = -1.15, ns, r = -0.10), Self-Controlling (U = 2392.0, z = -0.85, ns, r = -0.001), Accepting Responsibility (U = 2070.5, z = -1.47, ns, r = -0.12), Escape-Avoidance (U = 2116.5, z = -1.25, ns, r = -0.11) and Positive Reappraisal (U = 2129.5, z = -1.20, ns, r = -0.10).

Linear and Multiple-Linear Regression

To explore whether staff coping strategies influence their attitude towards DSH (Hypothesis 5) and whether staff sex, age, job-role and LoE influenced attitudes, a linear regression was firstly tested between each univariations against total attitude (See **Table 3, (page 118**). Results shown there to be no statistical significance between the demographic variables of Gender, Age, Job-role and LoE between Total-Attitude, yet showing significance between each coping-strategy and total-attitude.

A Multiple-Linear Regression **(MLR)** was then conducted which excluded the demographic variables and which was bootstrapped, due to prior data being skewed. However, before analysis, assumptions were firstly tested (Field, 2009) which revealed that the Normality of Residuals was met, the independent errors were tenable **(Output 10.0)** and that the data was normally distributed across the variables.

The MLR revealed a significant effect between coping strategies and attitude ($F(8,130) = 4.647$, $p < .000$, with an R^2 of .222), which accounted for 22.2% variation. As shown in **Table 4, (Page 119),** results found Confrontative Coping to be the one significant, positive relationship towards DSH attitudes ($t(126) = 2.44$, $p < .05$), whereas the rest showed no significance.

The multicollinearity between each variable was analysed by which the average VIF was calculated **(Output 11.0).** This result showed that the value exceeded 1 which indicates collinearity (Field, 2009). Thereby causing either Regression-bias (Bowerman & O'Connell, 1990), or the outcome that, because each variable is significantly related to one another, no matter how staff cope after DSH (excluding Confrontative Coping), this does not impact upon attitude. However, from using Steins Formula, the results show no cross-validity, meaning that future research may show different effects (**Appendix 12.0).**

Discussion

Attitude

To the researcher's knowledge, this is the first study exploring nursing staff attitude and coping strategies towards patients who DSH and are diagnosed with ID or PD within UK MSUs. For both groups, overall attitude was mostly negative, thus supporting the first hypothesis that staff who work with either population will have negative attitude towards DSH. These negative attitudes could be explained by the stigmatisation and misunderstanding staff have towards patients with these diagnoses and DSH (Mesa & Tsakanikos, 2014) or towards their belief that DSH cannot be changed (Lay & Cheung, 1999). Therefore, those that project negative attitude may also have 'negative regard', meaning that they perceive those who DSH, commit to that behaviour for the same reasons (Dickinson & Hurley, 2011), despite research indicating multiple precipitating factors (Abidi, Zia and Waqas, 2010). In relation to patients situated within MSUs, this could be based on their diagnoses, which may lead staff to only view symptoms rather than the individual (Common-Teloar & Lewis, 2008). Nevertheless, this could be that staff view DSH lower priority compared to

other challenging behaviours, like aggression (Donner et al, 2010).

Previous research such as Deans & Menocevic (2006) and Bodner et al (2011), who found anger and frustration common feelings staff have when managing DSH in patients diagnosed with PD where partially supported. This is because negative attitude was similar, yet the specific emotions could not be determined such as frustration or feeling unprepared. Reversely, research that explored DSH in patients with ID (See Dick et al, 2010; James & Warner, 2005) indicated mostly positive attitudes towards DSH. However, negative attitudes were found, which were through stigmatisation staff had towards ID and recovery.

In relation to factors embedded within ADSHQ-DV, results supported Mesa & Tsakanikos's (2014) research who found staff reported less confidence in communicating with ID patients that DSH, due to lack of empathy and support from their service. The results showed no significance for both groups in Factor 1: 'Ability to effectively deal with DSH', Factor 3: 'Empathetic Approach', and Factor 4: 'Ability to cope effectively with hospital regulations towards DSH'. However, within Group 1 (ID), there was significance in Factor 2: 'Perceived confidence in assessment and referral of self-harm patients', whereas those in Group 2 (PD) showed no significance. This could be explained by patients with PD being not as vocal and expressive than those with ID (Bodner et al, 2015), which may continue staff to perceive the complexity of PD (Hauck et al, 2013). However, significance within Group 1, could be explained by previous training staff may have had prior participation. Nurses may have received management skills throughout their nursing which may influenced thoughts towards DSH. Furthermore, these results alongside overall negative attitude may support Wiener's Attribution Theory, in which attitude are influenced by whether staff

believe there is control (Wiener, 1985). Nevertheless, the second and third hypothesis, in which both groups show no differences in Factor 2 and Factor 3 were supported.

Coping

Results which explored how staff cope following DSH, from using the eight coping strategies showed that that coping strategies altered depending on diagnosis patients have. Nursing staff in Group 1 (ID), mainly used problem-solving strategies. This implies that staff manage stress through solving what factors may have lead DSH to occur and then solve the issue quickly. Hill & Dagnan (2002) argues that when using problem-solving approach after a perceived stressful event occurs, emotional exhaustion is reduced. Individuals feel better when they understand and manage the problem that is causing distress (Folkman & Lazarus 1988).

However, results shown that staff in Group 2 (PD) show no significance in problem-solving, yet they seek social-support. Whether the support is through obtaining information or managing emotions (Folkman & Lazarus, 1988) through their organisation or from colleagues, is unknown. Nevertheless, this result is therefore comparable to how staff cope within Hill & Dagnan (2002) and Fawzi-AbuAlRub (2004) research. Although, their research was not based upon DSH, staff suggested that using such strategy is necessity and effective during stressful encounters. Reversely, Commons-Teloar & Lewis (2008) research found that staff working with patients with PD coped through social-support. Staff wanted to understand from other colleagues' perspectives reasons behind such behaviours. This partly supports the current research by suggesting how problem-solving is used, but through social-support.

Upon reflection, these results appear contradictory. Staff report lack of empathy within their attitudes, yet they attempt to find solutions or support through understanding such behaviour. One explanation for this could be compassion fatigue overriding compassion satisfaction. (Kelly, Runge & Spencer,2015). Staff may try and become compassionate, yet they become exhausted through constant secondary traumatic stress, in this case dealing with DSH, that no empathy occurs (Kelly, Runge & Spencer,2015). Overall, both groups did not support previous research, (Chang et al, 2006; Hill & Dagnan, 2002), nor did they support the fourth hypothesis, which states how staff use escape-avoidance as means of coping with DSH.

Coping and Attitude

Lastly, results shown there to be no relation towards any demographic variables stated towards attitude. This conflicts with previous research that states how experiences (Conlon and O'Tuathail, 2012) or gender (Commons-Treloar & Lewis, 2008) impacts attitudes. Nevertheless, the results support Gibb et al (2010) who found no significance with these variables.

Results however, found significance between coping strategies and attitude, in which coping accounted for 22.2% attitude. Thereby, supporting our last hypothesis and Lazarus and Folkman (1984) model of stress. Confrontative Coping, where aggression is used to alter situations, was the only predictor that influenced attitude. Nevertheless, because each coping strategy shows significance towards one another, no matter what coping strategy staff may have (excluding Confrontative Coping), this will not affect attitude. Other variables appear to be more influential towards attitude however, because data showed collinearity, this may have enabled regression bias (Bowerman & O'Connell, 1990).

Strengths and Limitations

The findings from this study are novel and clinically important. They provide insight into how staff perceive and cope with managing DSH on adult inpatients diagnosed with ID or PD within MSUs. However, the online research design could be criticized, as with all online research, confounding variables may have occurred and influenced the results, subsequently altering the validity. For instance, the uncertainty as whether participants currently worked within MSUs, whether they reflected upon their experience working within MSU or whether they were influenced by another perception whilst completing the questionnaires. Additionally, whether they worked with patients diagnosed with ID or PD at the time of data collection cannot be assumed.

Asking staff to reflect on how they cope whilst managing DSH could be criticised. Some staff may not have encountered much DSH than others or may not be aware of what behaviours are classified as DSH. Furthermore, the retrospective self-report nature may also be problematic as memories can be misconstrued (Eysenck & Keane, 2010), therefore staff recall of coping mechanisms may not be accurate. Staff may have reflected on what strategies they had before managing DSH.

Additionally, attitude is often multifaceted which can be built prior to work. For instance, some participants may have had personal experiences with DSH outside of work. Such factors were not explored, which may have become confounding variable that influenced the bias within regression analysis.

The research assumed that coping with DSH is stressful for all participants, however those who are more exposed to DSH may have higher resilience. Some staff may not have been exposed to DSH as much as others. Exposure to DSH may influence attitude rather than experience. To explore this, further research could enquire how stressful participants perceive DSH to be compared with their coping

strategies' and how often they are exposed. In addition, the study could have explored perceptions as to whether they perceive DSH to be deliberate or not and how this impacts on their attitude. Exploration may further enhance support for Wieners Attribution theory (Weiner, 1985) that would help further understanding in staff attitude.

Furthermore, many staff that participated may have worked across both patient-groups. Therefore, their perceptions may have interlinked, which may explain why attitude from both groups were the same. Despite the nature of working across units within MSUs, this study attempted to control this variable by reminding participants throughout the study to refer to the patient-group they predominantly work with. Therefore, minimising interference of attitude from other client-groups that DSH. Future research needs to continue being aware of this extraneous factor and find possible ways of data to be collected where there is a chance that participants do not work with both patient-groups.

Implications

This study has developed an understanding towards DSH within both ID and PD patients and how nursing staff cope after managing DSH. Since the findings outlined that staff display negative attitude and the use of social-support or problem-solving as common coping strategies, training could be implemented within services to enhance or educate staff into understanding why patients with such diagnosis DSH (Bodner et al, 2011), and how staff could use their coping strategies effectively. The use of training may also help staff to develop empathy as this may strengthen staff-patient relationship (Patterson et al, 2007). Patients would become optimistic towards treatment (Dickenson & Hurley, 2011) because of staff showing 'positive-regard' (Commons-Treloar & Lewis, 2008).

Furthermore, training could explore why people may choose their coping strategies within that service, which may benefit other staff.

Future Research

Exploring and comparing attitude in different settings may help develop concrete understanding of DSH in both populations. Marzano, Adler & Ciclitira (2013) explored prison officers' experiences towards prisoners that DSH within prison service. Findings were comparable to research within secure-services in which staff felt frustrated and uneducated. This could be related towards the diagnosis prisoners may have. Therefore, exploring prison officers' attitude and coping strategies towards PD or ID and DSH within this setting may be advantageous.

Re-engaging with this study by adapting methods stated within limitations could provide more profound conclusion between attitude towards DSH within MSUs. With these adaptations and extraneous variables taken into consideration, future research could compare attitude and coping-strategies between several UK or international MSUs, or those with different security, towards patients diagnosed with either ID or PD.

Rather than focusing upon staff duration within their unit, studies could investigate whether the number of shifts per week influences how many times they witness DSH, which may correlate toward attitude, or whether attitude or coping towards DSH changes over time.

Additionally, research could explore whether other coping strategies are used through using open-ended questions and staff perceptions upon them. The types that were explained were broad, which mostly could refer within Escape-Avoidance strategy. According to Abel (2002), humour is effective at releasing stress and tension when facing stressful situations,

which may be beneficial when staff manage challenging behaviours like DSH.

Conclusion

The present study found several results that both contradicted and supported previous research. Majority of staff portrayed negative attitudes towards DSH, regardless of diagnosis. Apart from Factor 2: 'Perceived confidence in assessing and referring self-harm', both groups showed that within each factor of ADSHQ, there were no significance. Results further showed differences between staff coping-strategies after managing DSH within their patient-group. Staff who work alongside patients with ID tend to use problem-solving strategies, whereas staff who work alongside patients with PD seek social-support. Lastly, coping strategies influenced attitudes by 22.2%, suggesting that there are stronger variables that are more influential. Confrontative Coping was shown to be the strongest indicator that influences attitude positively. Having significance from the other variables may show that coping through any of them strategies would not majorly impact attitude. Like majority of research, this study provides limitations that need to be rectified if future research implicates such results. For instance, attending to the design and confounding variables. Nevertheless, the study provides strengths that enables the study to be novel, sound and valid.

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Appendices – Part 1

Appendix 1.0: Ethical Approval from the Ethics Committee

University of Nottingham
UK | CHINA | MALAYSIA

Email: FMHS-ResearchEthics@nottingham.ac.uk

Faculty of Medicine & Health Sciences
Research Ethics Committee
c/o Faculty PVC Office
School of Medicine Education Centre
B Floor, Medical School
Queen's Medical Centre Campus
Nottingham University Hospitals
Nottingham, NG7 2UH

5 April 2018

Mr J A Inger
MSc Student Forensic and Criminological Psychology
c/o Dr Shihning Chou
Associate Professor, Deputy Director
Centre for Forensic & Family Psychology
Psychiatry & Applied Psychology
Room B03, B Floor, YANG Fujia Building
University of Nottingham, Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Mr Inger

Ethics Reference No: 248-1802 – please always quote	
Study Title: Investigating Nursing Staff Attitudes on Deliberate Self-Injurious Behaviour in Personality Disorders and Intellectual Disability Populations and the Coping Strategies' Nursing Staff use after managing with Deliberate Self-Injurious behaviours.	
Chief Investigator/Supervisors: Dr Shihning Chou, Associate Professor, Deputy Director, Dr Lydia Bullock, Assistant Professor of Forensic Psychology Centre for Forensic & Family Psychology, Division of Psychiatry & Applied Psychology, School of Medicine.	
Lead Investigators/student: Mr James A. Inger, MSc Student	
Type of Study: MSc Forensic and Criminological Psychology questionnaire-based study: internet-mediated research	
Proposed Start Date: 01/03/2018	**Proposed End Date:** 30/07/2018 3 mths
No of Subjects: 112-130	**Age:** 18+years

Thank you for notifying the Committee of amendment no 1: 27.03.2018 In summary as follows:

- To extend recruitment using social media to participants who work in other medium forensic hospitals in addition to Calverton Hill as previously approved. This will improve and broaden the data collected.

These have been reviewed and are satisfactory and the study amendment no 1: 27.03.2018 is approved.

Approval is given on the understanding that:

1. The protocol agreed is followed and the Committee is informed of any changes using a notice of amendment form (please request a form).
2. The Chair is informed of any serious or unexpected event.
3. An End of Project Progress Report is completed and returned when the study has finished (Please request a form).

Yours sincerely

Professor Ravi Mahajan
Chair, Faculty of Medicine & Health Sciences Research Ethics Committee

Appendix 2.0: Participant Information Sheet

PARTICIPANT INFORMATION

Centre for Forensic & Family Psychology

Division of Psychiatry & Applied Psychology

School of Medicine, Faculty of Medicine & Health Sciences

Unique Personal Code: _____

The code can be any numerical or alphabetical figures as you would like but must contain 7 characters.

If you struggle with formulating a code, then having the **first three letters of the month** you were both, followed by the **last three letters of your phone number**, followed by **initial of last name** would be ideal. **Example Nov669I.**

Project Title:

Investigating Nursing Staff Attitude and Coping Strategies on Deliberate Self-Harm in Patients diagnosed with Personality Disorders or Intellectual Disabilities and who are situated within Medium-Secure Hospitals within the United Kingdom.

Ethics Reference Number: **248- 1802**

Researcher:	Supervisors:
James Alexander Inger (msxjai@exmail.nottingham.ac.uk)	Lydia Bullock (mszlrb@exmail.nottingham.ac.uk) Dr Shihning Chou (lwzsc1@exmail.nottingham.ac.uk)

You are invited to participate in a research study for a MSc Forensic and Criminological Psychology dissertation project for the University of Nottingham as you meet the requirements for participation. This study is conducted by James Alexander Inger who is supervised by Lydia Bullock and Dr Shihning Chou from the University of Nottingham.

The information we get from this study may help provide training programs designed for healthcare staff within secure settings to understand self-harm behaviors on these populations and how staff can cope after managing self-harm. If staff psychological wellbeing is improved or maintained than this can positively impact on patients' recovery.

What is the research code used for?

Having a research code allows researchers to recognize which data belongs to which participant, whilst enabling the data to remain anonymous. If you or any other participant would like to withdraw from the research, then the data can be recognized from the research codes on all the dataset provided and then removed.

If you want to withdraw your data, then simply contact one of the researchers with your unique code through postage to **James Inger, Room B Floor YANG Fujia Building (formerly International House), Jubilee Campus, Wollaton Road, Nottingham, NG8 1BB, UK** and your data will be then destroyed within 24 hours. Withdrawing through postage helps the data to remain anonymous. Your research code, that you provide will be on the information sheet, consent form and debrief sheet.

The code you provide will be asked to be put on the consent form, all questionnaires and debrief form. The code can be any numerical or alphabetical figures but must contain 7 characters. It is advisable to make your code easy to remember to yourself only.
If you struggle with formulating a code, then having the first three letters of the month you were both, followed by the last three letters of your

phone number, followed by initial of last name would be ideal. **Example Nov669I.**

What is the study about?

This study explores attitudes nursing staff have regarding deliberate self-harm by patients with intellectual disabilities' or personality disorders within forensic secure hospital. This study will also identify coping strategies staff use to manage stress associated with self-harm. Additionally, this study aims to identify any differences in attitudes or coping strategies staff use working with either individuals with intellectual disabilities or individuals with personality disorders.

What will I have to do?

You will be asked to complete a consent form, followed by three questionnaires which will take approximately 20 minutes to complete with a total of 100 short, simple questions. These questionnaires will relate to the patient group you stated you work with. This is either working with patients with Intellectual/Learning Disabilities or patients with Personality Disorders.

You will not be timed when completing the questionnaires and will not be judged. You do not have to answer all the questions provided but doing so will benefit the results. Your participation is voluntary, and you may decline to answer a question, and without giving a reason. You are free to

withdraw at any point before or during the study by closing the browser window. This will not affect you in anyway and you will still be allowed to take part in the prize draw. The data will only be uploaded on completion of the questionnaire by clicking the **SUBMIT** button. However, once you have submitted your answers you will have **two weeks** to withdraw your data.

Will the research be of any personal benefit to me?

For participating within the study, and to thank you further, you can be placed within a prize draw for an Amazon voucher of £25. To enter, email msxjai@nottingham.ac.uk the word **"PRIZEDRAW"**. Even if you do not complete the study or that you decide to withdraw then you can still be able to enter the prize draw. Not being able to complete the study or withdrawing your data from the research will direct you to the debrief form. More information on how the prize draw will be available on the debrief. Please note that the email address you send **will not be linked** with the research data you provide.

The information that the researcher gets from this study will provide data that will improve the knowledge and understanding of the effects and attitudes self-harm implements on staff members. The study could be utilised as data to impact on training for staff members within the future to increase or adapt their understanding of self-harm within these two populations

What will happen to the information I provide?

All the information you provide during the research will remain confidential and anonymous. Only your data from the questionnaires will be used when reporting the research findings. You will not be asked for your name or any other personal details, so it will not be possible for you to be linked with the data. The UK Data Protection Act 1998 will apply to all information gathered within the questionnaires.

We believe there are no immediate risks linked with this research study, however, some questions may be sensitive. You are not required to answer any questions you do not feel comfortable answering and are free to withdraw at any point. It is advisable that if you do become upset from the questions to seek support.

The data is for academic purposes only and will be stored on a secure computer that only the three researchers can access. As the research is based on personal opinions about the subject, any information given for the participation of the study will not be judged. Due to the University of Nottingham's code of research conduct, the information you provide, including your personal information will not be kept for longer than what is necessary. This includes email addresses for the prize draw and that research data must be kept for a minimum of 7 years.

What will you do with the data?

The data will contribute to the researcher James Inger dissertation. The results of the study may be published in scientific journals and presented at scientific conferences.

If you would like a summary of the results, then you can contact the researchers using the contact details above. If you have any questions or concerns, please don't hesitate to ask. We can be contacted before and after your participation at the above address.

THANK YOU FOR YOUR PARTICIPATION

Contact Address:	**Other Contacts:**
University of Nottingham Jubilee Campus Wollaton Road Nottingham NG8 1BB T: +44 (0) 115 9515151 **Postal Address for Withdrawal:** Room B Floor YANG Fujia Building (formerly International House) Jubilee Campus Wollaton Road Nottingham NG8 1BB UK	Your Line Manager Psychologist at your institution Social Worker at your institution Your Lead Nurse **Mind Charity:** T: 020 8519 2122 F: 020 85221725 E: supportservices@mind.org.uk **Self-Injury Support:** T: 0117 927 9600 E: infor@selfinjurysupport.org.uk

Appendix 3.0: Consent Form

PARTICIPANT CONSENT

Centre for Forensic & Family Psychology

Division of Psychiatry & Applied Psychology

School of Medicine, Faculty of Medicine & Health Sciences

Unique Personal Code: _____

The code can be any numerical or alphabetical figures as you would like but must contain 7 characters. If you struggle with formulating a code, then having the **first three letters of the month** you were both, followed by the **last three letters of your phone number**, followed by **initial of last name** would be ideal. **Example Nov669I.**

Project Title:

Investigating Nursing Staff Attitude and Coping Strategies on Deliberate Self-Harm in Patients diagnosed with Personality Disorders or Intellectual Disabilities and who are situated within Medium-Secure Hospitals within the United Kingdom.

Researcher:

James Alexander Inger (msxjai@exmail.nottingham.ac.uk)

Supervisors:

Lydia Bullock (mszlrb@exmail.nottingham.ac.uk)

Dr Shihning Chou (lwzsc1@exmail.nottingham.ac.uk)

Ethics Reference Number: **248- 1802**

Please **Tick** either **YES** or **NO** after reading each statement

1. have read and understood the Participant Information Form and what the study entails?

YES **NO**

2. I know how to contact the researcher(s) if I have questions or concerns about this study?

YES **NO**

3. I am aware that this study may be sensitive as the topic focuses on self-harm and that if completing this study affects me in any way I can withdraw without giving reason?

YES **NO**

4. I understand that my participation is voluntary, and I am free to withdraw at any time during the study and the two weeks after I have completed the study?

YES **NO**

5. I understand that to withdraw I can give the researcher(s) my personal unique code via post so that they can withdraw that data?

YES **NO**

6. I understand that the overall anonymised data from this study may be used by other researchers in the future for research and teaching purposes?

YES NO

7. I understand that data from this study might be used in academic research reports or publications?

YES NO

8. I am 18 or over and I am/had worked in forensic secure hospital with either patients with Intellectual Disabilities or Personality Disorders?

YES NO

9. I indicate my willingness to take part in the study voluntarily?

YES NO

Appendix 4.0: Questionnaires for the Study

Appendix 4.1: Demographic Questionnaire

Both these questions are the same in both groups yet depending on the patient-group staff work with is what they referred to. See Question 3. Those who work with ID, the below question of 'how long you worked with individuals diagnosed with PD at the place where you work', was not shown.

Please **tick** your answer.

1. What is your Gender?

o Male
o Female
o Other

2. Please state your age. _____

3. How long have you worked with Individuals diagnosed with **Intellectual disabilities' (Learning disabilities')** at the place where you work?

   OR

   How long have you worked with Individuals diagnosed with **Personality Disorders** at the place where you work?

o Below 3 months
o Between 3 – 6 months
o Between 7 – 9 months
o Between 9 months – 1 year
o Between 1 year – 3 years
o Above 3 years

4. What is your job role in the place where you work?

o Nurse
o Healthcare Assistant
o Occupational Therapist
o Other (Please State below):

<u>Appendix 4.2</u>: Dutch Version Attitudes towards Deliberate Self-Harm Questionnaire (ADSHQ-DV) Questions

(Both Groups Received Same Questions)

Like the Demographic Questionnaire, staff answered according to the patient-group they worked with. The "Intellectual Disabilities (Learning Disabilities) that self-harm" were replaced with "Personality Disorders that self-harm" for those in Group 2.

All Questions were answered using a 4-point scale **below EACH QUESTION:**

1= strongly disagree

2= Disagree

3= Agree

4= Strongly Agree

Coding: All score was coded and added periodically. Total Score were all these totals combined. Scores range 33 - 132. With score 85 plus, being high.

<u>Factor 1</u>: (Dealing Affectively with Self-Harm)

15, 1, 23, 26, 8, 5, 10.

<u>Factor 2:</u> ('Perceived confidence in assessment and referral of self-harm patients')

13, 20, 28, 12, 19, 30

Factor 3: '(Empathic approach')

18, 21, 11, 14, 4, 2.

Factor 4: (Ability to cope effectively with legal and hospital regulations that guide practice')

9, 16, 31, 6, 32, 33, 7.

This questionnaire constitutes of your own attitudes and perceptions of self-injury. Please answer the 33 items in relation to Individuals with **Intellectual Disabilities (Learning Disabilities) that self-harm** by ticking the correct box below each statement. Please complete all statements before proceeding to the next stage.

1. Overall, I am satisfied with the control I have in dealing with deliberate self-harm patients in my unit.
2. There is really no way I can help solve some of the problems the deliberate self-harm patient has.
3. Sometimes I feel that I am or may be used by deliberate self-harm patients
4. There is little I can do to help deliberate self-harm patient change many of the events that take place in their lives.
5. I often feel helpless in dealing with the problems of deliberate self-harm patients

Please answer the 33 items in relation to Individuals with **Learning Disabilities that self-harm** by ticking the correct box below each statement

6. Sometimes I feel that I am being used by the hospital system
7. What happens to me in this job mostly depends on me.
8. I feel useful when working with deliberate self-harm patients
9. The way the hospital systems works effectively encourages repetitions of deliberate self-harm behaviours.
10. I feel as though I have the appropriate knowledge in skills to help deliberate self-harm patients.

Please answer the 33 items in relation to Individuals with **Learning Disabilities that self-harm** by ticking the correct box below each statement

11. Self-harm patients just 'clog up' the systems.
12. Knowledge of referral sources is important when dealing with deliberate self-harm patients.
13. Assessing risk of future deliberate self-harm is an important skill for me to have.
14. Dealing with self-harm patients is a waste of the healthcare professional's time.
15. I can deal effectively with deliberate self-harm patients

Please answer the 33 items in relation to Individuals with **Learning Disabilities that self-harm** by ticking the correct box below each statement

16. The hospital system impedes my ability to work effectively with deliberate self-harm patients.
17. Patients who deliberately self-harm have been hurt and damaged in the past
18. When a patient presents again with deliberate self-harm, I actively use actions calculated to discourage her or him from coming back.
19. On-going education and training would be useful in helping me deal appropriately with deliberate self-0harm patients
20. Risk assessment is an important skill for me to have.

Please answer the 33 items in relation to Individuals with **Learning Disabilities that self-harm** by ticking the correct box below each statement

21. Patients who deliberately self-harm are just attention seekers.
22. Sometimes, when all other actions have failed, I feel the need to go to extremes when dealing with deliberate self-harm clients
23. I feel as though I have the appropriate knowledge in counselling skills to help deliberate self-harm patients

24. Referral of deliberate self-harm patients to external consultant services for further assessment or treatment is an effective course of action.

25. Self-harm patients are just using ineffective coping mechanisms.

Please answer the 33 items in relation to Individuals with **Learning Disabilities that self-harm** by ticking the correct box below each statement

26. I feel as though I have the appropriate knowledge in of communication skills to help deliberate self-harm patients

27. I feel sorry for patients who deliberately self-harm.

28. Providing patients with deliberate self-harm information about community support groups is a good idea.

29. Self-harm patients are victims of some other social problems

30. Patients who deliberately self-harm are in desperate need of help.

31. The legal system impedes my ability to work effectively with deliberate self-harm patients.

32. I feel that patients who self-harm are treated less seriously by the medical staff than patients with serious medical problems.

33. Sometimes people self-harm because their cultural beliefs condone this practice when they are dealing with traumatic issues.

Appendix 4.2.1: Cronbach Alpha for the ADSHQ-DV (Kool et al, 2015).

Through Kool et al (2015) and Rexrode, Petersen & O'Toole (2008) research, the ADSHQ-DV helped increase reliability and internal consistency through Cronbach Alpha by 0.20.

Negative words within the question-items **were not reversed,** as proposed in the original version. McAllister et al (2002) believed that this would reduce response bias, yet we agree with Kool et al (2015) that since many items could be classified negative and that items are sensitive to change.

The Cronbach Alpha in ADSHQ-DV shown scores to be 0.623, with scores of Factors 1; a = 0.809, Factor 2; 0.471, Factor 3: a = 0.617 and Factor 4: a – 0.665.

Whereas, the Cronbach Alpha in the ADSHQ (See McAllister et al, 2002) showed 0.42 for all the factors and Factor 1: α = 0.71; Factor 2: α = 0.73; Factor 3, α = 0.67 and factor 4, α = 0.57 for each factor (Kool et al, 2015).

Thereby, this study implemented the same coding techniques in the Dutch version. However, negative worded items, such as, 'dealing with self-harm is a waste of time' were not reversed scored in this study.

Appendix 4.3: Ways of Coping Questionnaire (WOCQ) Questions

All Questions were answered using a 4-point scale:

0 = Does not Apply to me / Not Used

1 = Used somewhat / Somewhat Applied

2 = Used quite a bit / Applied Quite a bit

3 = Used a Great Deal / Applied a Great Deal

Coding: All score was coded and added periodically. There were NO Total Score.

1. **Confrontive Coping** (Items 6, 7, 17, 28, 34, 46)
2. **Distancing** (Items 12, 13, 15, 21, 41, 44)
3. **Self-Controlling** (Items 10, 14, 35, 43, 54, 62, 63)
4. **Seeking Social Support** (Items 8, 18, 22, 31, 42, 45)
5. **Accepting Responsibility** (Items 9, 25, 29, 51)
6. **Escape-Avoidance** (Items 11, 16, 33, 40, 47, 50, 58, 59)
7. **Planful Problem Solving** (Items 1, 26, 39, 48, 49, 52)
8. **Positive Reappraisal** (Items 20, 23, 30, 36, 38, 56, 60).

This questionnaire consists of questions in relation to a stressful event that you have experienced.

Before responding to the statements, please think about a situation where you have dealt with self-harm within the patient group you work with.

Please answer the 66 items by **clicking on** correct box below each statement. If you can, please complete all statements before proceeding to the next stage.

If you would like to take a break from answering the questions than you may. There is no time limit on the questionnaires.

0 = Does not apply to me/ Not used 1 = Used somewhat/ somewhat applied 2= Used quite a bit/applied quite a bit 3 = Used a great deal/ applied a great deal.

1. I just concentrated on what I had to do next – the next step.	0	1	2	3
2. I tried to analyse the problem to understand it better	0	1	2	3
3. I turned to work or another activity to take my mind off things	0	1	2	3
4. I felt that time would have made a difference – the only thing was to wait.	0	1	2	3
5. I bargained or compromised to get something positive from the situation.	0	1	2	3
6. I did something that I didn't think would work, but at least I was doing something.	0	1	2	3
7. I tried to get the person responsible to change his or her mind.	0	1	2	3
8. I talked to someone to find out more about the situation.	0	1	2	3

Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.

0 = Does not apply to me 1 = Used somewhat a bit 3 = Used a great deal			2= Used quite	
9. I criticised or lectured myself.	0	1	2	3
10. I tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11. I hoped for a miracle	0	1	2	3
12. I went along with fate; sometimes I just have bad luck.	0	1	2	3
13. I went on as if nothing had happened.	0	1	2	3
14. I tried to keep my feelings to myself.	0	1	2	3
15. I looked for the silver lining, so to speak; I tried to look on the bright side of things.	0	1	2	3
16. I slept more than usual.	0	1	2	3
Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.				
0 = Does not apply to me 1 = Used somewhat a bit 3 = Used a great deal			2= Used quite	
17. I expressed anger to the person(s) who caused the problem.	0	1	2	3
18. I accepted sympathy and understanding from someone.	0	1	2	3
19. I told myself things that helped me feel better.	0	1	2	3
20. I was inspired to do something creative about the problem.	0	1	2	3
21. I tried to forget the whole thing.	0	1	2	3
22. I got professional help.	0	1	2	3

23. I changed or grew as a person.	0	1	2	3
24. I waited to see what would happen before doing anything.	0	1	2	3

Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.

0 = Does not apply to me 1 = Used somewhat 2= Used quite a bit 0 3 = Used a great deal

25. I apologised or did something to make up.	0	1	2	3
26. I made a plan of action.	0	1	2	3
27. I accepted the next best thing to what I wanted.	0	1	2	3
28. I let my feelings out somehow.	0	1	2	3
29. I realized that I had brought the problem on myself.	0	1	2	3
30. I came out of the experience better than when I went in.	0	1	2	3
31. I talked to someone who could do something concrete about the problem.	0	1	2	3
32. I tried to get away from it for a while by resting or taking a vacation.	0	1	2	3

Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.

0 = Does not apply to me 1 = Used somewhat 2= Used quite a bit 3 = Used a great deal

33. I tried to make myself feel better by eating, drinking, smoking, using drugs or medication, etc.	0	1	2	3
34. I took a big chance or did something very risky to solve the problem.	0	1	2	3
35. I tried not to act too hastily or follow my first hunch.	0	1	2	3
36. I found new faith.	0	1	2	3
37. I maintained my pride and kept a stiff upper lip.	0	1	2	3
38. I rediscovered what is important in life.	0	1	2	3
39. I changed something so things would turn out all right.	0	1	2	3
Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm. 0 = Does not apply to me 1 = Used somewhat 2= Used quite a bit 3 = Used a great deal				
40. I generally avoided being with people.	0	1	2	3
41. I didn't let it get to me; I refused to think too much about it.	0	1	2	3
42. I asked advice from a relative or friend I respected.	0	1	2	3
43. I kept others from knowing how bad things were.	0	1	2	3
44. I made light of the situation; I refused to get too serious about it.	0	1	2	3
45. I talked to someone about how I was feeling.	0	1	2	3

46. I stood my ground and fought for what I wanted.	0	1	2	3
47. I took it out on other people	0	1	2	3

Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.

0 = Does not apply to me 1 = Used somewhat 2= Used quite a bit 3 = Used a great deal

48. I drew on my past experiences; I was in a similar situation before.	0	1	2	3
49. I knew what had to be done, so I doubled my efforts to make 0things work.	0	1	2	3
50. I refused to believe that it had happened.	0	1	2	3
51. I promised myself that things would be different next time.	0	1	2	3
52. I came up with a couple of different solutions to the problem.	0	1	2	3
53. I accepted the situation, since nothing could be done.	0	1	2	3
54. I tried to keep my feeling about the problem from interfering with other things.	0	1	2	3
55. I wished that I could change what had happened or how I felt.	0	1	2	3

Please refer the items to the patients diagnosed with Intellectual/Learning Disabilities or Personality Disorder who self-harm.

0 = Does not apply to me 1 = Used somewhat 2= Used quite a bit 3 = Used a great deal				
56. I changed something about myself.	0	1	2	3
57. I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58. I wished that the situation would go away or somehow be over with.	0	1	2	3
59. I had fantasies or wishes about how things might turn out.	0	1	2	3
60. I prayed.	0	1	2	3
61. I prepared myself or the worst.	0	1	2	3
62. I went over in my mind what I would say or do.	0	1	2	3
63. I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64. I tried to see things from the other person's point of view.	0	1	2	3
65. I reminded myself how much worse things could be.	0	1	2	3
66. I jogged or exercised after.	0	1	2	3

Appendix 5.0: Debriefing sheet

PARTICIPANT DEBRIEF

University of Nottingham,

Centre for Forensic & Family Psychology

Division of Psychiatry & Applied Psychology

School of Medicine, Faculty of Medicine & Health Sciences

Unique Personal Code: _____

The code can be any numerical or alphabetical figures as you would like but must contain 7 characters.

If you struggle with formulating a code, then having the **first three letters of the month** you were both, followed by the **last three letters of your phone number**, followed by **initial of last name** would be ideal. **Example Nov669I.**

Date of taking part: _____

Last Date of Withdrawal: _____

Project Title:

Investigating Nursing Staff Attitude and Coping Strategies on Deliberate Self-Harm in Patients diagnosed with Personality Disorders or Intellectual Disabilities and who are situated within Medium-Secure Hospitals within the United Kingdom.

Researcher:	**Supervisors:**
James Alexander Inger (msxjai@exmail.nottingham.ac.uk)	Lydia Bullock (mszlrb@exmail.nottingham.ac.uk) Dr Shihning Chou (lwzsc1@exmail.nottingham.ac.uk)

I would firstly like to thank-you for your cooperation in completing the study. The aim was to explore nursing staff attitudes towards self-injurious behaviours of patients with either intellectual disabilities' or personality disorder(s) within a secure forensic hospital. We believe that exploring attitudes will aid training programmes that will increase staff understanding of self-harm, within both populations and to enable staff to develop positive staff-patient relationship with the patients, which may improve patients' recovery (Maben and Wilkinson, 2012). The study further explored coping strategies staff use after dealing with self-injurious behaviours within both populations. This could further guide training programmes for staff within secure settings to reduce the emotional impact dealing with self-harm may have on the staff.

Entering the Voucher Scheme Prize

We would like to thank you further for completing the study so, because of your participation, you are eligible for your name to be put into a prize draw of winning £25 Amazon Gift Voucher. To enter the draw, all we require you to do is to email **the word "PRIZEDRAW" NOT your unique code** to msxjai@nottingham.ac.uk. The winner will be emailed through the email address you sent and will be notified on the 30th August 2018, 17:00.

Withdrawing from the research

Just a reminder. You are eligible for your data to be withdrawn from the research without giving any justification during or after the research. The last day you can withdraw will be two weeks after the date you participated., however this can be flexible. The two-week period is a guideline so that researchers can analyse the data received.

If you would like to withdraw, then it is advised you to do this by either posting to the university your unique code (see above) or to give the code to your line manager who will then pass the code onwards.

Please note if you email the researchers your code, then your identification may be revealed through your email address you sent it from. If emails were to be received, your data will be destroyed.

If you are affected by the study

If you feel affected by any of the questions or content, then please do not hesitate to contact your line manager or any other forms of management such as hospital counselling or occupational health service within your hospital or help charities such as MIND. Suggestions are listed below.

Again, I would like to thank- you for your participation. If you would like result of the study, please feel free to contact any researcher listed below.

Researchers:

James Alexander Inger: (msxjai@exmail.nottingham.ac.uk)

Lydia Bullock (mszlrb@exmail.nottingham.ac.uk)

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Contact Address:	**Other Contacts:**
University of Nottingham Jubilee Campus Wollaton Road Nottingham NG8 1BB T: +44 (0) 115 9515151	Your Line Manager Psychologist at your institution Social Worker at your institution Your Lead Nurse
Postal Address for Withdrawal: Room B Floor YANG Fujia Building (formerly International House) Jubilee Campus Wollaton Road Nottingham NG8 1BB UK	**Mind Charity:** T: 020 8519 2122 F: 020 85221725 E: supportservices@mind.org.uk **Self-Injury Support:** T: 0117 927 9600 E: infor@selfinjurysupport.org.uk

Appendix 6.0: Tables

Appendix 6.1: Table 1

Table 1: Participant characteristics of staff working with patients with either ID or PD.

	Males	*Female*	*Mean Age*	*Nurses*	*Healthcare Workers*	*Occupational Therapist*	*Other*	*Total*
Intellectual Disabilities	9	63	33	45	25	0	2	72
Personality Disorders	8	59	31	36	27	2	2	67
Total	17	122	32	81	52	2	4	**139**

Appendix 6.2: Table 2

Table 2: Length of experiences for staff working with either patients with ID or PD.

	Below 3 Months	*Between 3-6 Months*	*Between 7-9 Months*	*Between 9 Months – 1 Year*	*Between 1-3 Years*	*Over 3 Years*	*Total*
Intellectual Disabilities	2	0	2	6	25	37	72
Personality Disorders	2	2	5	4	22	32	67
Total	4	2	7	10	47	69	139

Appendix 6.3: Table 3

Table 3: Univariations between each variable against total attitude.

Independent variables	*Unstandardized B Coefficient*	*Confidence Interval from Lower Bound to Upper Bound (2SF)*	*Significance*
Confrontative Coping	0.666	(0.41, 0.92)	P<0.01
Distancing	0.266	(0.40, 0.49)	P<0.05
Self-Controlling	0.380	(0.18, 0.58)	P<0.01
Seeking-Social Support	0.509	(0.27, 0.75)	P<0.01
Accepting Responsibility	0.362	(-.001, 0.73)	P=0.05
Escape-Avoidance	0.315	(0.15, 0.49)	P<0.01
Problem-Solving	0.305	(0.08,0.53)	P<0.05
Positive Re-Appraisal	0.336	(0.14, 0.54)	P<0.01
Gender	-2.304	(-4.77, 0.17)	P>0.05
Age	-0.040	(-0.12, 0.04)	P>0.05
Length of Experience	-5.16	(-1.22, 0.19)	P>0.05
Job-Role	0.518	(-0.70, 1.73)	P>0.05

Appendix 6.4: Table 4

Results can be found in the "Coefficients Table" within the CD (Page 79)

The reporting of Multiple Regression was guided from Field (2009, page 252), which is the APA Format.

Table 4: Multiple-Linear Regression outputs for each coping strategy against total-attitude

	B	*Std. Error B*	*Beta*
Constant	54.51	7.54	-
Confrontative Coping	0.49	0.18	0.30*
Distancing	0.01	0.13	0.01*
Self-Control	0.14	0.13	0.11*
Social Support	0.25	0.15	0.18*
Accepting Responsibility	-0.47	0.26	-0.21*
Escape Avoidance	0.16	0.14	0.16*
Problem-Solving	0.06	0.13	0.05*
Positive-Reappraisal	-0.05	0.14	-0.04*

Appendix 6.5: Table 5

Table 5: Descriptive Statistics Table for Participants Attitudes (2SF). **(SPSS Output can be found on CD)**

	Mean	*Variance*	*SD*	*Min*	*Max*
Factor 1 (ID)	20.54	6.82	2.61	12	28
Factor 1 (PD)	20.57	6.61	2.57	15	27
Factor 2 (ID)	20.13	4.59	2.14	16	24
Factor 2 (PD)	20.79	3.68	1.92	16	24
Factor 3 (ID)	12.19	5.71	2.39	7	19
Factor 3 (PD)	11.81	7.95	2.82	8	22
Factor 4 (ID)	12.01	7.08	2.66	5	18
Factor 4 (PD)	12.66	8.14	2.85	5	20
Total Attitude (ID)	64.88	20.70	4.55	57	76
Total Attitude (PD)	65.82	26.79	5.18	55	84

Table 6.6: Table 6

Table 6: Descriptive Statistics Table for Participants Attitudes (2SF).

	Mean	*Variance*	*SD*	*Min*	*Max*
		Confrontative Coping			
ID	11.78	7.92	2.81	7	20
PD	12.18	9.45	3.07	8	20
		Distancing			
ID	11.70	10.75	3.28	6	20
PD	12.48	14.80	3.85	6	21
		Self-Control			
ID	15.40	16.08	4.01	7	23
PD	15.42	15.82	3.98	7	25
		Social-Support			
ID	12.88	10.79	3.28	6	22
PD	13.94	9.82	3.13	9	23
		Accepting Responsibility			
ID	6.57	6.14	2.48	4	14
PD	5.90	3.28	1.81	4	10
		Escape - Avoidance			
ID	13.03	21.41	4.63	8	27
PD	12.27	21.47	4.63	8	26
		Problem – Solving			
ID	15.36	13.33	3.65	8	24
PD	17.07	11.53	3.39	7	24
		Positive – Reappraisal			
ID	13.58	14.87	3.86	7	26
PD	14.43	16.46	4.06	7	26

(SPSS Output can be found on CD)

Appendix 7.0: Assessing the Power Sample Size for the required number of participants for an effect to occur.

*G*Power 3.0.10*

My analysed used **Man-Whitney U test** which is the non-parametric version of the t-test

T-test entered for 2 Tailed, sample size reached 42 per group (ID and PD) which meant **84 participants overall were needed** for there to be a large effect 0.80 (Cohen, 1988), when alpha is 0.05 and power is 0.95.

MANOVA (Between Subjects) = 100

When alpha Is 0.05,

Power is 0.96,

0.25 as a large effect (Cohen, 1988).

Multiple Regression = 107

When alpha is 0.05,

Power is 0.95,

0.15 medium effect size (Cohen, 1988).

Although 107 was largest, we wanted to have around 130 participants, in case of missing data or withdrawals.

Appendix 8.0: Z-Scores to show whether datasets are skewed through Skewness or Kurtosis.

(The Skewness was further exploring using the Histograms that can be found in the CD).

Because each survey has a small sample, the threshold would be **1.96**. That is, above 1.96 is significant at p<.05. If values are **above 2.58** then they are significant at p<.01 **(Field, 2009).**

Appendix 8.1: Z-Scores from the Skewness and Kurtosis scores for Staff Attitudes

Skewness and Kurtosis raw data found in Descriptive Table, Page 8 within "SPSS Outputs" within the CD. Scores then followed the equation to show the ZScore:

$$\text{ZSkewness} = \frac{\text{Skewness Score} - 0}{\text{Standard Error of Skewness}}$$

$$\text{ZKurtosis} = \frac{\text{Kurtosis Score} - 0}{\text{Standard Error of Kurotosis}}$$

Scores are rounded to 2SF.

Intellectual Disabilities

Factors and Total	Skewness Z-Score	Kurtosis Z-Score
Factor 1	0.56	2.65
Factor 2	-0.59	-1.46

Factor 3	1.48	0.34
Factor 4	3.36	-0.45
Total Attitude	0.57	-1.35

Personality Disorders

Factors and Total	Skewness Z-Score	Kurtosis Z-Score
Factor 1	0.52	-0.30
Factor 2	-1.50	-1.10
Factor 3	3.23	2.47
Factor 4	-0.59	0.54
Total Attitude	2.40	2.47

Appendix 8.2: Z - Scores from the Skewness and Kurtosis of the Transformed data of ADSHQ-DV (For Attitudes)

(The Skewness was further exploring using the Histograms that can be found in the CD)

Skewness and Kurtosis raw data found in Descriptive Table, Page 20 within "SPSS Outputs" within the CD. Scores then followed the equation to show the ZScore:

$$\text{ZSkewness} = \frac{\text{Skewness Score} - 0}{\text{Standard Error of Skewness}}$$

$$\text{ZKurtosis} = \frac{\text{Kurtosis Score} - 0}{\text{Standard Error of Kurotosis}}$$

Scores are rounded to 2SF.

Intellectual Disabilities

Factors and Total	Skewness Z-Score	Kurtosis Z-Score
Log Factor 1	-2.13	5.50
Log Factor 2	-3.20	1.15
Log Factor 3	-0.59	0.25
Log Factor 4	-3.18	1.06
Log Total Attitude	0.13	-14.81

Personality Disorders

Factors and Total	Skewness Z-Score	Kurtosis Z-Score
Log Factor 1	-0.67	0.00
Log Factor 2	-3.19	0.57
Log Factor 3	1.00	-0.39
Log Factor 4	-6.83	13.10
Log Total Attitude	1.37	1.30

Appendix 8.3: Z-Scores from the Skewness and Kurtosis from the Combined Patient-Type Group of the Ways of Coping Strategy.

(The Skewness was further exploring using the Histograms that can be found in the CD)

Skewness and Kurtosis raw data found in Descriptive Table, Page 31 within "SPSS Outputs" within the CD. Scores then followed the equation to show the ZScore:

$$ZSkewness = \frac{\text{Skewness Score} - 0}{\text{Standard Error of Skewness}}$$

$$ZKurtosis = \frac{\text{Kurtosis Score} - 0}{\text{Standard Error of Kurotosis}}$$

Scores are rounded to 2SF.

Coping Strategy	Z-Score Skewness	Z-Score Kurtosis
Confrontative Coping	2.02	0.015
Distancing	1.59	0.96
Self-Controlling	0.50	-1.77
Seeking Social Support	1.85	0.02
Accepting Responsibility	5.81	2.72
Escape-Avoidance	5.62	1.90
Problem Solving	-0.84	-0.63
Positive Reappraisal	2.85	1.12

<u>Appendix 8.4</u>: Z-Scores from the Skewness and Kurtosis for EACH patient-type group and Coping Strategies

(The Skewness was further exploring using the Histograms that can be found in the CD)

Skewness and Kurtosis raw data found in Descriptive Table, Page 39 within "SPSS Outputs" within the CD. Scores then followed the equation to show the ZScore:

$$ZSkewness = \frac{\text{Skewness Score} - 0}{\text{Standard Error of Skewness}}$$

$$ZKurtosis = \frac{\text{Kurtosis Score} - 0}{\text{Standard Error of Kurotosis}}$$

Scores were rounded to 2SF.

Intellectual Disability

Coping Strategy	Z-Score Skewness	Z-Score Kurtosis
Confrontative Coping	2.49	0.76
Distancing	1.16	-0.49
Self-Controlling	-0.43	-1.35
Seeking Social Support	0.23	0.79
Accepting Responsibility	4.30	1.42
Escape-Avoidance	3.76	1.29
Problem Solving	0.47	-0.00
Positive Re-appraisal	2.18	1.31

Personality Disorder

Coping Strategy	Z-Score Skewness	Z-Score Kurtosis
Confrontative Coping	0.53	-0.28
Distancing	0.84	-0.95
Self-Controlling	0.63	-1.14
Seeking Social Support	1.05	-0.44
Accepting Responsibility	2.33	-1.30
Escape-Avoidance	-4.46	1.91
Problem Solving	-1.71	0.31
Positive Re-appraisal	1.90	0.56

<u>Appendix 8.5</u>: Z- Scores from the Skewness and Kurtosis of the Transformed data of WOCQ (Coping Strategies)

(The Skewness was further exploring using the Histograms that can be found in the CD)

Skewness and Kurtosis raw data found in Descriptive Table, Page 59 within "SPSS Outputs" within the CD. Scores then followed the equation to show the ZScore:

$$ZSkewness = \frac{\text{Skewness Score} - 0}{\text{Standard Error of Skewness}}$$

$$ZKurtosis = \frac{\text{Kurtosis Score} - 0}{\text{Standard Error of Kurotosis}}$$

Scores are rounded to 2SF.

Coping Strategy	Z-Score Skewness	Z-Score Kurtosis
Log Confrontative Coping	0.53	-0.28
Log Distancing	0.84	-0.95
Log Self-Controlling	0.63	-1.14
Log Seeking Social Support	1.05	-0.44
Log Accepting Responsibility	2.38	-1.30
Log Escape-Avoidance	4.46	1.91
Log Problem Solving	1.90	0.60
Log Positive Reappraisal	1.90	0.60

Appendix 9.0: MANOVA Assumptions

1) Independence – Observations statistically independent

2) Random Sampling – Measured at an Interval Level

3) Multivariate Normality

4) Homogeneity of Covariance Matrices

Appendix 10.0: Durbin-Watson Test

According to Field (2009), the assumption of independent errors is tenable. The statistic of **1.866** from Durbin-Watson, is close to 2.

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					
					R Square Change	F Change	df1	df2	Sig. F Change	Durbin-Watson
1	.472[a]	.222	.175	4.42182	.222	4.647	8	130	.000	1.866

a. Predictors: (Constant), Positive Reappraisal, Accepting Responsibility, Distancing, Problem Solving, Seeking Social Support, Self-Controlling, Confrontative Coping, Escape Avoidance

b. Dependent Variable: Total Attitude

Appendix 11.0: Assessing the Assumption of No Multicollinearity - Finding the Average VIF

Figures found in SPSS Outputs, **Coefficients Table**, Page 79 (See CD) (Highlighted in Yellow).

$$\overline{VIF} = \frac{\sum_{i=1}^{k} VIFi}{k}$$

$$\frac{(1.948 + 1.495 + 1.955 + 1.734 + 2.264 + 2.985 + 1.645 + 2.148)}{8}$$

$$= \mathbf{2.02175}$$

Average is higher than 1 which means that the regression may be biased (Bowerman & O'Connell, 1990).

Appendix 12.0: Steins Formula Equation

$$1 - \left(\frac{139-1}{139-8-1}\right)\left(\frac{139-2}{139-8-2}\right)\left(\frac{139+1}{139}\right) \text{x}(1-.222)$$

$$1 - \left(\frac{138}{130} \text{ x } \frac{137}{129} \text{ x } \frac{140}{139}\right) \text{x } (0.778)$$

$$1 - (1.062\text{x } 1.062 \text{ x } 1.007) \text{ x } 0.778$$

$$1 - (1.136 \text{ x } 0.778)$$

$$1 - 0.884$$

0.116 – Rounded 2SF = **0.12**

Appendix 13:Q: Effect Size Calculations

According to Field (2009) Small to Medium effect size = below 0.3 criterion. All these Effect sizes are small to medium.

Effect Sizes for each Factor and Total from Rosenthal (1991, page 19); cited in Field, (2009).

$$R = \frac{Z}{\sqrt{N}}$$

Z Scores can be found in the Test Statistic Box shown on the CD.

Factor 1 = -0.00

Factor 2 = -1.74

Factor 3 = -0.10

Factor 4 = -0.13

Total Attitude = -0.08

Effect Sizes for the Coping Strategies

Confrontative Coping = -0.09

Distancing = -0.10

Self-Controlling = -0.001

Seeking Social Support = -0.17

Accepting Responsibility = -0.12

Escape- Avoidance = -0.11

Problem Solving = -0.25

Positive Reappraisal = -0.10

Executive Summary

Target Audience: Nursing Staff

Introduction

Deliberate self-harm (**DSH**) has been recognised as a worldwide healthcare problem, that may lead to suicide (Hawton et al, 2012). DSH refers to intentional injury caused by oneself. Common methods include cutting, re-opening wounds and using items to tie around their neck (James et al, 2012).

In psychiatric hospitals, DSH has received less attention than other behaviours. This could be due to lack of money invested for treatment (Sarkar, 2011). This is concerning because research has shown that in secure-services, the amount of people DSH is higher than those within the community (Jeglic et al., 2005). Research estimates that 31% of all incidents in medium-secure hospital relate towards DSH (Uppal & McMurran, 2009).

Within the current literature, research involving interviews showed that staff have both positive and negative attitude on DSH within acute-services (See Shaw & Sandy, 2016; Gibb et al, 2010). However, these have not focused on the type of patients whom DSH.

Current research reports that individuals diagnosed with Personality Disorders (**PD**) or Intellectual Disabilities (Learning Disabilities; **ID**) often DSH (See Dick et al, 2010; Bodner et al, 2011). Reports show that on average those diagnosed with PD will DSH fifty times during their section (Bodner et al, 2011) whereas, within ID populations, prevalence varies 4.9% to 24% (Cooper et al, 2009).

Recent studies have indicated both positive (Dick et al, 2010; Hauck et al, 2013) and negative attitude (James & Warner, 2005; Bodner et al, 2011) in both

populations. These attitudes could be because of how they cope after managing DSH. Although there are currently no studies that looks at how staff cope after DSH, other research has provided results in how staff cope with stress. For example, Folkman et al (1986) found eight coping strategies people may use after encountering stressful situation.

Aims

This research investigated nursing staff attitudes of those working within UK medium-secure hospitals, on adults having either ID or PD. In addition, the researched looked at how nursing staff cope after managing self-harm within these populations. Five hypotheses were produced which involved looking at the coping strategies staff have, whether attitudes from staff are the same across both ID and PD populations; whether nursing staff have empathy towards patients with ID and PD that DSH, whether nursing staff feel that they can deal with DSH in both client-groups and whether coping strategies influenced attitudes.

Rationale

This is the first study that explores nursing staff attitudes and coping strategies towards DSH in patients diagnosed with LD or PD and whom are situated within medium-secure units. Investigating and comparing staff attitudes and coping strategies may help organisations apply training programmes designed to enhance or change staff current perceptions. These future training programmes

could reflect coping strategies current staff use, so that new staff are prepared in how best to cope with DSH.

If staff do not have efficient coping strategies, this could affect well-being. This may then affect their responses towards patients, which may impact patient-recovery (Weiner, 1985). Having an understanding in how staff cope can be start in helping organisations reflect on what they could further implement for staff, to help them find coping strategies beneficial to them, rather than training alone.

Data Collection

Participants needed to be part of a nursing team, who work within medium-secure hospital with patients diagnosed with ID or PD. Participants included Nurses, Healthcare Workers, Occupational Therapists or other staff members who have close connection with the patients. Medical professionals were excluded from the study.

Two surveys with three questionnaires were put online through the Bristol Online Survey and were sent through emails and appropriate media resources; such as pages for mental health nurses. Participants could only select one survey which depended on the type of patients they work with. Both surveys were the same but asked staff to relate to their patient-group. This was stated before they participated.

Analysis

Results was analysed through SPSS using four tests. These tests included two Man-Whitney tests which looked at exploring staff attitudes towards DSH and what coping strategies are prominent in both groups. Linear Regression was conducted to explore whether coping strategies, age, gender, job-role and length of experience influence their attitude. Multiple Regression was then used on all coping strategies to explore which coping strategy was predominant with attitude, despite the type of patient they worked with.

Key findings

Findings shown that all staff, despite what patient-group they worked with, displayed negative attitude, lack of empathy and difficulties in dealing with DSH. However, staff working with LD were able to assess their behaviours than those working with PD. Staff working with LDs, use problem-solving techniques, whereas those working with PDs seek social support after managing DSH.

Results shown that age, gender, job-role or length of experience does not impact attitude and that Confrontative Coping was shown to be the one positive indicator that influences attitude, when all coping strategies were explored together.

Implications

The results can be implicated towards several medium-secure facilities to help them understand and implement new and updated training on DSH in relation to the client-group and what coping strategies they could use that will benefit their

well-being. The results can further be used for future research to explore the impact this phenomenon has.

Recommendations

It is recommended that further research is needed within secure-services on attitude and how staff cope with DSH in both patient-groups. Future research may need to compare medium-secure hospitals attitude and the coping strategies their staff have after dealing with DSH. This could help each service to understand and construct methods that benefit their own staff through using educational training. However, it could be beneficial for research to look at the different security services provide and compare staff attitude.

Nevertheless, it is also recommended that research goes beyond secure-services and understand how other staff in other institutions, such as prisons cope with DSH with each of these patients-groups. This may than provide evidence in which the government can be aware of the impact DSH has upon services.

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Word Count: 1,000 Words

(Excluding References)

Reflective Report

This project enabled me to face unexpected dilemmas, which will improve my competencies, when facing similar situations when qualified. In this report, I will reflect on these difficulties, my supervision and experiences from other external professionals. I will discuss how I have felt, what I have done to resolve the issues, what I learnt and what I could have done better.

Conceptualisation of idea

Conceptualising the topic for my research was challenging largely due to practical considerations. This included, deciding on the topic before the deadline and ensuring that the project was original and under-researched. I firstly discussed this dilemma with external professionals who advised me to research two ideas of interest and think of the strengths and weakness of each topic. I took their advice, due to feeling stuck and found the approach helpful. From this, I acknowledged how taking on different approaches from other perspectives through communication helps decision-making and critical thinking competencies to develop, which is needed throughout the core roles as a Forensic Psychologist.

My final research idea became conceptualised around my workplace within secure-hospitals on staff attitude on DSH towards patients diagnosed with PD or LD. However, to decide whether this research relating to medium-secure services was needed, I asked staff members within my workplace their thoughts upon DSH. There was mixture of responses from several having no emotions to others finding the behaviour difficult. This led me to research staff coping strategies on DSH, which lead to no research within the literature. Therefore, I decided that coping strategies were needed to be explored alongside attitude.

From this, I learnt how querying experiences from other professionals could adapt previous ideas, which may lead to new ideas developing. Nevertheless, I ensured that the project would not be over-complicated by adding in other factors. I knew that my word count was small, and this would be difficult when coming to write-up.

Preparation

I set plans of when I wanted data-collection to be done. From previous experience, I expected this to be time-consuming. Therefore, two-month timeframe between March-June 2018 was opted for collecting participants. Thus, giving me time to analyse, write up and feedback. I set weekly deadlines to complete - this helped my anxiety and time-management. I learnt through this that being organised and prepared is vital when undertaking any project and that personal targets need to be met. I learned from this how methodological I am when preparing for complex tasks, which is a strength needed within research.

Proposal

After writing the proposal and making changes from the draft, I needed signatures from my supervisors. Originally, they both claimed I had more changes to make before they could sign the proposal. I made these changes, yet I became anxious that I was going to miss the ethics committee's deadline as they required these signatures. Following this, they were still reluctant to sign the proposal. I therefore arranged a meeting with them to resolve this dilemma. I explained to them that I needed these signatures so that I could get approval

from my workplace before submitting to ethics, which they then understood. I learnt through this that communication is vital when deadlines need to be made and that dynamics of relationships may change. However, I also realised that I need to manage my time more efficiently and that I could not expect others to surrender their time in short-period when they may have their own deadlines.

Design

I originally wanted to conduct an experimental research, however due to the course's time-frame, I felt that this was not feasible. Therefore, I felt obliged in doing online surveys. At first, this made me become wary as I knew that I would have no control on the types of participants doing the survey or whether they re-did the survey. I would have attempted to control this variable otherwise by enabling participants to complete surveys alone with hard-copies. Nevertheless, I realised that obtaining participants online would be useful at gathering larger samples of participants quickly, which would make me have sufficient time to analyse and write the data within the deadline.

Obtaining questionnaires was difficult than what I expected. I knew from previous experiences not to conduct my own questionnaires, as I would have to do pilot studies to test validity. From approaching the research methodologically, I knew that I did not have time. Therefore, I decided to find research that were short, easy-to-read and had no copyright violations. I started by examining measures used within previous research. This lead me to find ADSHQ-DV, which had excellent validity. I reflected how I approached the situation appropriately by being cautious, which is needed when gathering materials for any research

and that I should continue using this approach when finding my other questionnaire.

For the second questionnaire I struggled due to the lack of research. I found basic coping-questionnaire, which I planned to use. However, after examining the questionnaire I noticed that the scale did not measure what the study needed. I felt stuck but realised I had my supervisors who could guide me. After speaking to them I was advised that WOCS may be more suited. After researching the scale, I realised that this would be beneficial due to purpose and validity. From this, I learnt the value of open communication and collaboration with other professionals is a commodity. However, I wished I did a pilot study on whether the questionnaires were suitable, despite research indicating that they were. If I were to replicate the study, this would have been one of my changes.

External Approval

Gaining organisational approval from the hospital became an unexpected challenge. I started by asking several Forensic Psychologists within the company how they have had permission from their research. I followed their advice, which were to discuss the research with my line manager (lead nurse) and to get her approval. Although she approved, I was noted that policies had changed which altered research approvals. After researching the new policies, I found that second approvals were needed after completing "Passport-Form" **(See Appendix 15.0).** Although this change occurred, I remained confident as at the time. I felt that I had enough time to complete the form and wait for confirmation before data collection. However, after reading all the policies and filling out the 'Passport form' for company to approve, I realised that I could not

request for full approval until university approved of my research. This made me anxious. I was uncertain as whether ethics would approve. This meant that I would have short-period of gathering participants. Nevertheless, I reflected on how important ethics were and how this is part of the process within research. If changes were to be made they were so that my research would cause no harm which may be easily be resolved.

On the 14th March, the ethics committee approved my research (**See page 52**). By this time, I felt that I was ready to proceed to the next stage. This included gaining approval from hospital director **(X)** and medical director of the company **(Y).** After this, I could proceed gaining participants. X responded and confirmed **(See Appendix 16.0),** yet I continued to wait for Y's approval. Overall, I reflected on how vital this process is and how it would help me progress within the core-role "research" when becoming a forensic psychiatrist. I began to reflect on the importance of following company's procedures and abiding by their policies because I could cause unintentional harm, for which I may have been unaware of. I felt that I should have prepared myself by reading policies beforehand, rather than getting advice from others as these could change, which staff may be unaware of.

Changes to Original Proposal

After waiting several weeks, Y contacted me on 29th March **(See Appendix 14.0)** disapproving the research. This was not expected which overwhelmed my anxiety. I became fearful and angry that I would fail the course and that Y responded at an inappropriate time (Friday evening before Easter). I felt that Y needed to clarify on the phone, as my proposal may have been

miscommunicated. This was the case. I explained my intentions were not what he thought. I discussed confidentiality and that the research may progress onto my doctorate which may aid staff-training programme for DSH, which would be based within their hospital. Y then informed me that I'd need to adapt my research and to speak to other external professionals within the company to adapt my proposal for him to approve.

After the discussion, I reflected on whether continue gaining approval would be ideal due to the time I had left and whether there were other ways of data collection, rather than focusing upon one medium-secure hospital. I arranged supervision to discuss what my next option would be. This lead me to conclude that I need to adapt my proposal by obtaining participants from range of medium-secure hospitals, online. I knew that my validity of research would be affected but I felt like this was the only choice, again due to the course's time-frame. Without a time-frame, I would have proceeded with getting permission off the company. From this, I learnt that even with timeline in place, I had to be prepared that certain things may go wrong and that I can adjust accordingly. I felt that I did this competently, despite the struggle. Nevertheless, changes can also become benefits. This change lead me to gain larger sample size which may enhance my research findings. After I made the small change, I edited my proposal and sent to my ethics committee, who then approved.

Data Collection

My main worry was collecting enough participants within the time-frame I set myself (last week in May). However, I was surprised by how many people wanted to participate and all my data was completed within three weeks. I realised from this that there is a necessity for this research to be conducted in this area. The only dilemma I had was that of one participant wanting paper format. I felt that this was easily resolved, yet I was concerned with confidentiality of knowing their response. When explaining this to them, they were comfortable for this to proceed on paper. I learnt the importance of assuring confidentiality even when undertaking changes that may breach confidentiality.

Data Analysis

Since finishing my undergraduate degree in 2015, I knew that I would be unfamiliar with SPSS. I felt that I needed to re-cap over SPSS through re-reading previous lectures and from Fields (2009) book. Having re-engaged with the processes, I learnt how reflecting from previous work would help build competence in going forth with further research.

However, when analysing my data, I found that my data was not what I expected. I tried to resolve this by transforming my data as stated **in Field (2009).** Nevertheless, this did not go to plan which made me feel stuck. To resolve this, I began exploring other alternatives. This lead me to conduct my research through another analysis. I reflected on how change of plans has helped me build competence through statistics and that data can be analysed in different ways.

Writing up

I knew at the beginning that writing-up would be time-consuming. I decided to use my advantages at this point and prepared myself personal deadlines to get each section written within certain time-frames. However, after completing few sections, I was apprehensive within my writing style due to my dyslexia and whether I was on the right track. I spoke to my supervisors and stated my concerns. They offered that they could look briefly over my research to see whether I was on the right track. I felt nervous doing so. However, I felt more confident with my progress afterwards. One of my weaknesses is my confidence, however, I realised that I do have the ability to complete this project. I reflected on the importance of others views and how they can help progress my academic capabilities and noticing errors I may make which may become crucial for future-publishing.

Word Count: 2,000 Words

Appendices - Part 2.

Appendix 14.0: E-mail from Medical Regional Director

Dear James,

I'm sorry to inform you that I cannot agree for your research to be carried out at Priory sites in its current form.
I appreciate that in many ways it is well thought out, supervised from your academic institution & ethically approved.
I also acknowledge that the attitude &coping strategies of staff working with patients is something we need to understand.
My concerns though have similarities to those raised by Kate Jennings & I will make some additional comments.
My concern is around context.
Staff surveyed are only seen as working in isolation in a "Hospital system" or
There isn't consideration of therapeutic model, philosophy of care, treatment modality, psychological are, team work, training, staff support, supervision, reflective practice, institution.etc.
I hope these are all relevant to the care at Calverton & its sister units.
I'm concerned the research might misrepresent or do Calverton an injustice.
I appreciate it is not for me to tell you what to research or rewrite your project & that your supervisors have academic rigour behind them.
To change your project would also cause you delay & a return to ethics again.
If you wish to revise the proposal I'd respectfully ask if you have discussed with the Psychologists at site & if not consultant with them. Kate Jennings or Ann Simmonds may also offer a further view.

Regards

Appendix 15.0: Company's Passport Form for Approval (See Next Page)

Section A – For ALL Research Projects

PROJECT TITLE	**Investigating Nursing and Healthcare Staff Attitudes on Deliberate Self-Injurious Behaviour in Personality Disorders and Intellectual Disability Populations and Coping Strategies Healthcare Staff utilise after managing Deliberate Self-Injurious behaviours.**
Name of Principle Local Investigator (Priory Staff) completing this form	James Alexander Inger
Name of the Priory Unit where the principle local investigator works	Calverton Hill
Names of any other healthcare partners included in the study	Nursing staff at Calverton Hill
Type of research project (Tick or X one type)	Non-commercial research ☐ Priory Group Funded research ☐ Non-commercial Student research ☒ Commercial research ☐
Expected start date for the research project	01/04/2018
Expected completion date of the research project	01/08/2018

Approval to proceed from operational management		
Name of Unit Manager:	Ann Simmonds	
Signature of unit manager:		Date:
For Hospitals only:		
Name of Medical Director:	Santosh Mudholkar	
Signature of Medical Director:		Date:
Estimated costs of the Research to Priory Group. **Attach** spreadsheet if necessary.	N/A	
Approval obtained by clinical governance/quality committee and copy of this form appended to minutes (tick when done)		
Anticipated benefits to Priory Group:	Understanding attitudes nursing staff have towards self-harm within patients with personality disorders and intellectual disibilities. This could be implemented into training for the company for new and current members of staff.	
Agreement to the research has been obtained from Clinicians and other colleagues on site(s):	Tick or X YES ☒	
Name of Priory Group accountant managing the resource:		
Peer Review		
Type of peer review process: (Refer to paragraph 3.5 in CP10)	By the non-commercial grant awarding body ☐ By the academic institution and clinical supervisor for student research ☒ By relevant experts in the area to be researched external to Priory Group ☐	
Date of Peer review process approval:		
Ethical procedures		
Name of ethics committee:	Medicine and Health Sciences (FMHS) Ethics Committee **Attach** ethics committee approval certificate.	

Systems are in place to report any adverse events: (Refer to section 11 of GP20)	Tick or X	YES ☒
Systems are in place to ensure confidentiality and integrity of the data collected:	Tick or X	YES ☒
Anticipated form of disseminating the results (describe):		
Consent forms approved by the Ethics Committee (Copies of signed forms to be given to participants). (Refer to section 6 in GP20)	Tick or X	YES ☐ **Attach** an example
Systems are in place to send quarterly reports to the R&D Administrator. (Refer to paragraph 2.7 in GP20)	Tick or X	YES ☐
Arrangements are in place to feedback results to the participants: (Refer to paragraph 3.2 in GP20)	Tick or X	YES ☒
A written agreement is in place for the management of intellectual property rights (If not in place these will remain with Priory Group (Refer to section 13 of GP20)	Tick or X	YES ☒

Section B - For completion for Externally Sponsored research projects only (i.e. those with an academic partner)

Name of sponsoring organisation (the academic not the funding partner):		
The sponsoring organisation has arrangements in place to manage and monitor research: (Refer to paragraph 3.3 in GP20)	Tick or X	YES ☐
The chief investigator in the sponsor organisation will provide assistance with any enquiry, audit or investigation arising from the research activity: (Refer to paragraph 3.3 GP20)	Tick or X	YES ☐
Approval by representative of Sponsoring Organisation		
Name of chief investigator in the sponsor organisation:		
Signature of the chief investigator:		Date:

Section C - For completion for Externally Funded (both commercial and non-commercial) research projects only

Name of funding organisation:	
Total funding:	
Over how many years:	
Priory accounts manager responsible for managing funds:	
Attach funding contract with signature of agreement to provide funds	

Section D – For completion for Commercially Funded projects only

Name of funding organisation (e.g. pharmaceutical company):		
Arrangements are in place for all payments relating to this study's activities will be processed through Priory Group	Tick or X	YES ☐
Attach full description of the financial accounts of the study showing the costs, and overhead (surplus) accruing to Priory Group		

Section E - For completion for Student Research Project Only

Name of Higher Education Institution:	University of Nottingham
Name of supervisor:	Lydia Bullock and Shihning Chou

Name of degree being studied for:	MSc Forensic and Criminological Psychology (by research)
Was this degree sponsored by Priory Group?	No

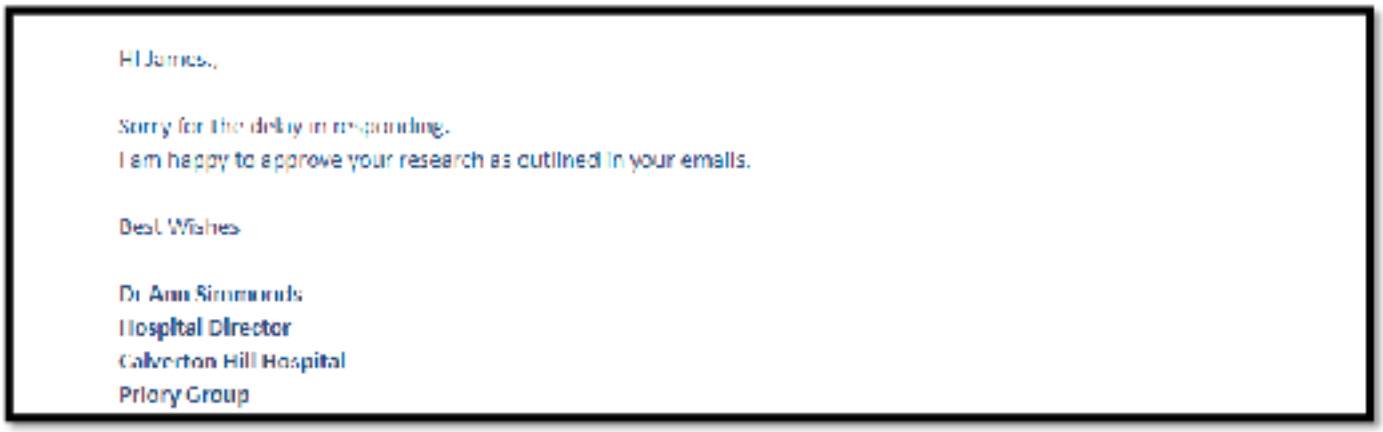
Declaration – To be completed by the Principal Local Investigator		
I confirm that all the statements made in this Project Passport are true and correct. ☒ **I** undertake to discharge my duties as laid down OP20 Research and Development ☒		
Signature of Principal Local Investigator:		Date:

Send this form to the R&D Administrator when Section A and any other relevant sections have been completed

For Office Use:

To be completed by the Executive Director for Research and Development		
Declaration: I confirm that this passport raises no ethical or commercial issues for Priory. All necessary items on the passport have been completed and all relevant agreements are in place.		
Research project approved and logged with Research and Development office:	Date logged:	
Written confirmation of Insurance and indemnity obtained	☐	
Honorary contracts in place for any investigators not employed by Priory	☐	
Date for first quarterly report:		
Approved by the Executive Director of Research and Development:		
Name:		
Signature:		Date:

Appendix 16.0: Confirmation from Hospital Director



Hi James,

Sorry for the delay in responding.
I am happy to approve your research as outlined in your emails.

Best Wishes

Dr Ann Simmonds
Hospital Director
Calverton Hill Hospital
Priory Group

Appendices 17.0: Link for 'Instructions for Author' (The International Journal of Forensic Mental Health).

https://www.tandfonline.com/action/authorSubmission?page=instructions&journalCode=ufmh20