

**An Examination of the Attitudes of Accident &
Emergency Clinicians toward Children who
Deliberately Self-harm.**

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Abstract

Recent years have seen an increase in self-harm behaviours amongst children and young people. In tandem, the amount of research on the phenomenon has also grown. However, despite the evident importance of care staff attitudes in the treatment of those who self-harm, an examination of the literature indicated a limited number of studies on how clinicians view such behaviour in the young. The aim of this thesis was to examine the attitudes of health care staff toward child self-harm. Within the study, it is argued that factors pertaining to both patients (age, gender and rate of admission) and care staff (role and clinical experience), will influence how an incidence of child self-harm is viewed. To answer the question, both quantitative and qualitative methods were employed. Within the former, a questionnaire was developed that contained hypothetical case vignettes of child self-harm. Once constructed, the instrument was distributed to the care staff of four Accident and Emergency departments, each of which treated self-harming children. Examination of the completed questionnaires ($n = 152$), showed significant differences in both staff and patient variables, confirming that attitudes toward child self-harm should not be viewed as a single entity but rather as constituent parts of a whole phenomena, each worthy of examination in its own right.

In order to explore these issues in more detail, a series of focus groups were undertaken amongst care staff. Use was made of a Foucauldian discourse analysis framework devised by Kendall and Wickham (1999). This revealed intrinsic differences in the way clinicians view self-harm in children and the constituent parts therein. Comparison of both experienced and inexperienced nurses and physicians

produced a raft of reasons why child self-harm elicited responses particular to each group, ranging from personal experiences to the use of medical jargon.

In conclusion, this thesis has explored a particular aspect of the self-harm spectrum, touching on topics that appear to have been neglected by the literature. The dissemination of its results to a wider audience, it is hoped, will generate debate around this sensitive topic and thus increase an understanding of the needs of those clinicians who deal with such vulnerable patients.

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Introduction

Introduction

The aim of this introduction is to provide a background to the research undertaken in this thesis. Issues of self-harm and child self-harm in particular are explored in brief before being examined in more detail in the following chapters. The researchers reasons for undertaking the current study are given alongside a brief overview of previous attitude studies. The introduction also includes a brief outline of each of the chapters contained within this thesis.

Reasons for Undertaking the Current Study.

As a registered mental nurse the researcher has come into contact with a number of self-harming patients. Initial experience took place as student nurse working in an Accident and Emergency (A & E) department. The busy nature of the clinical area meant a high turnover of patients, with a range of presenting conditions. Staff-patient interaction was excellent save for those patients who were viewed as time wasting. Whilst drug and alcohol cases were seen as unrewarding the most negative responses were reserved for those who had carried out acts of self-harm. Patients would be described as manipulative, showing little intent to end life and would be dealt with brusquely by those treating them. Such attitudes appeared universal amongst clinicians who felt unqualified to provide the best care for such patients. Indeed, the researcher received no formal training on the treatment of such patients whilst a student and found no education packages in place within his current post as a nurse educator, confirming the concerns of those he had spoken to.

It was whilst working as a staff nurse in child and adolescent mental health that the issue of self-harming patients again became an area of interest. A small minority of the children would display self-harming behaviours, in some cases on an almost daily

basis. These acts would range from 'minor cutting' through to severe self-destructive acts that would warrant transfer to a medical paediatric ward. Again, the researcher observed negative attitudes toward this patient group. Conversations with ward staff revealed a high number of self-harming young people who through a lack of specialist beds would find themselves placed on busy paediatric wards. Nursing staff would describe feeling unprepared to deal with such 'demanding patients' and saw those admitted on numerous occasions as a drain on scant resources. Often young patients would be left feeling isolated, adding to the often negative emotions that lead to the act in the first instance. Such feelings amongst paediatric clinicians were explored in more detail in a Masters degree study (Harrison, 1998) examination of whose results indicated that such attitudes were widespread amongst nursing staff.

Alongside no empirical study on attitudes toward child self-harm, examination of the literature showed a number of attitude studies on adult self-harm took place within A & E departments. As such units were often the first point of treatment for self-harm behaviours staff attitudes were seen as vital in gaining a positive outcome. This led the researcher to believe that an important part of health care research had been neglected and that if treatment outcomes were to be improved then an in-depth exploration of the phenomena must be made. The above, coupled with the experiences of the researcher lead to the successful application for a Department of Health research grant to undertake the current study.

Self-harm in Context.

Self-injurious behaviours have been identified within almost all cultures and periods of history (Warren, 1997) alongside numerous presentations and definitions that have been seen to alter according to a number of factors (World Health Organisation, 1986).

What can be acknowledged is that the rate of self-harm remains an increasing problem for the healthcare services of a number of countries (Diekstra, 1993). Within the United Kingdom, government concern for the levels of self harm have manifested themselves in a range of initiatives to reduce what has been seen by some as an increase in the phenomenon (McGaughey and Harrison, 1995). Numerous studies have noted that demographic factors have a major influence on the outcome of self-injurious behaviours. The most important in terms of this study lies in the difference in rates of attempted and completed suicides between males and females. Although the rate for actual suicide amongst males is higher per capita than females, the rates for self-harm of low lethality are higher amongst the female population a factor identified in a number of studies (Baume, 1988; Gelder et al., 1994). Therefore one of the important foci of the current study will be in the impact of patient gender on staff attitudes.

The impact of this dichotomy within the clinical environment has been well documented. Hawton et al. (1996) noted a high rate of self-harm of limited lethality but of high repetition amongst the females in their study. This high rate of repetitive self-injury has been noted by other studies (McGaughy et al., 1995; Hill, 1995) and will be discussed in greater detail within the next chapter.

The difference between attempt rates and eventual suicide is also identified by the literature that deals with child self-harm. DeRose and Page (1985) note that girls who engaged in acts of parasuicide were less likely to kill themselves than males of the same age, a theory supported by later studies (Kienhorst et al., 1987; Kerfoot, 1988).

Child Self-harm in Context.

Alongside the issues of gender, another important feature of self-harm is patient age. Epidemiological studies have noted that the age of the patient can have a profound impact on the potential lethality of their actions (Gothelf et al., 1998).

Rates of self-injury vary between studies and as indicated actual figures are difficult to calculate. Yet, there is an acceptance that acts of self-harm amongst the young are increasing. King (1999) suggests that since the 1950s the suicide rate amongst adolescents has more than tripled. Other studies do suggest that there is an epidemic of self-harm amongst the young (Li et al., 1997).

Further examination of the issue shows that there are characteristics of age and gender particular to self-harm in children. Studies have shown that young males have a propensity to use violent methods of self-injury (Crook, 2003).

As well as gender some methods of self-harm have been seen as age specific, with even the youngest children undertaking particular acts (Pfeffer, 1986). Other studies identify the age of the child influencing the reasons behind the act Gould (1990) suggested that younger children carry out acts of self-injury in the belief that they can influence their peer group standing through their own death. This lack of understanding of the finality of death has led some authors to believe that suicide contagion amongst the young is an issue of real concern (Lester, 1971).

Other research suggests that the perceived benefits of self-harm are more widespread and numbers of young people carry out self-destructive acts in order to ape well-known individuals whom they admire (Gould and Shaffer, 1986).

Consequently, the numbers of young people admitted to hospital for the treatment of self-harm behaviours has increased. As a result of this, the age of the self-harming

individual has been felt to influence the actions of those whom they come into contact with (Range & Goggin, 1990). Many young people have described negative reactions towards their injuries. Hospital staff have been noted to act critically toward young self-harm patients (Spandler, 1996) resulting in increased feelings of isolation and self-loathing. The importance of care staff attitudes towards this patient group has been acknowledged as an important topic, though one that has received limited examination (McLaughlin, 1994).

Attitude Studies in Context

The study of attitudes toward those who self-harm has been acknowledged as scant (McLaughlin, 1994). However, studies that examine the phenomenon, note that those who self-harm elicit a range of responses from others. Huband and Tantam (2000) observed that patients who self-harm evoke powerful emotions amongst care staff, a sentiment echoed in other studies (McAllister et al., 2002). Those patients who self-harm are seen as unrewarding and difficult to treat, resulting in a lack of empathy (Bent-Kelly, 1992).

Within attitude studies, a number of clinical areas have been identified as vital in the treatment of self-harming patients amongst them the Accident and Emergency departments. The importance of A & E departments and thus the attitudes of those working there in dealing with those who self-harm is acknowledged by a number of studies that examine attitudes toward the phenomenon (Ghodse, 1978; Anderson, 1997).

As noted, negative attitudes toward self-harming children were felt to increase feelings of anxiety. This supports earlier research (Dunleavey, 1992) in which some patients described their treatment within A & E as an extension of their act of self-injury. The importance placed on negative staff attitudes is such that some authors

believe that it could compromise the quality of treatment that patients receive (Touslon, 1996; Riley, 1996).

However, examination of the literature has identified a limited number of studies that examine care staff attitudes toward children who self-harm (Anderson et al., 2000; Anderson et al., 2003). Within these studies the importance of further research is acknowledged. Negative attitudes and staff frustrations are again seen as hindering interactions between the two groups. These attitudes are felt to manifest themselves in avoidance and limited interventions and culminate in a reduction in possible suicide prevention. Anderson et al. (2003) suggest that further research should explore these issues in detail. Hence, the aim of this study is to provide an in-depth examination of these issues.

Chapter Summaries

The following is a brief outline of the chapters contained within this thesis. **Chapter One** provides a review of the literature that surrounds the phenomenon. This shall include historical as well as current theories of self-harm causation. Sociological and psychological theories of self-destructive behaviour are explored alongside contemporary medical explanation of the condition. These are followed by an examination of current legislation and policy issues designed to alleviate what is seen as a growing problem within healthcare. The chapter concludes with a statement of the aims and objectives of the first phase of the research.

Chapter Two deals with the methodological and ethical considerations within the first phase of data collection. Primarily, the issues surrounding the development of the data collection instrument are explored in detail and the justification for variable selection given. Issues surrounding the sample population, their recruitment and

safeguarding are then examined. Finally the pilot work undertaken on the instrument is discussed, leading on to the first phase of data collection.

Chapter Three contains phase one data collection and analysis. Sample population demographics are followed by a discussion of the analysis process. The above provide a backdrop to the results obtained in this phase. The results themselves are presented in conjunction with the aims and objectives set out at the end of the previous chapter.

Chapter Four explores the methodological considerations of the second phase of data collection and analysis. Alongside the chapter questions issues of method and the utility of qualitative research are discussed. The use of focus group research in attitude measurement is followed by respondent selection criteria and the safeguards put in place for their protection. The chapter concludes with a discussion of the theoretical framework used as a means of data analysis.

Chapter Five deals with phase two data collection and analysis. Each focus group is examined in turn and the results obtained from the data given. Cross-group analysis is also provided and the overall patterns of responses in terms of the research questions discussed.

The thesis concludes with **Chapter Six**, discussion and recommendations. The results obtained from each phase of the study are reviewed in the light of the literature examined and current policy examined in Chapter One. Overall strengths and weaknesses are discussed and the contribution made by this thesis to the existing body of knowledge acknowledged. Recommendations for further research are given and the chapter concludes with the potential educational and clinical impact the results of the study could engender.

Chapter One

Literature Review

1.1 Introduction

This thesis examines the attitudes of Accident and Emergency clinicians toward children who self-harm. The aim of this chapter is to outline the alteration in attitudes toward self-destructive behaviour within human society. An historical perspective will establish how important self-harm has been within human society and how views of the phenomena differ throughout the changes of history.

Prior to this exploration, a definition of self-harm will be given and the current government legislation to reduce the rate of self-destructive behaviour examined. This will set the scene not only for the retrospective content of this chapter but also the clinical environment in which this study is set.

Alongside sociological perspectives the conflicting theories of Psychological and Medicine will be investigated. As well as the theories themselves, the factors that lead to their development will be explored. A wide-ranging exploration of these issues will benefit the study in a number of ways.

An examination of various theories of self-harm causation will indicate the breadth of attitudes toward this emotive topic. These issues coupled with the examination of the historical perspectives of self-harm causation will provide the background to this exploration of different attitudes.

1.2 Definition of Self-harm

Whilst this thesis explores attitudes toward self-harm, a good deal of this chapter deals with perceptions of suicide. The reason for this dichotomy lays in the way all aspects of self-destructive behaviour is viewed. The close association between self-harm and eventual suicide has been identified by a number of authors (Babiker, 1997; Taylor and Stansfeld 1984). This

close relationship between self-harm and suicide has been identified amongst young people. Babiker (1997) identified the same factors that would lead to suicide influencing self-mutilation in children, a concept shared by a number of authors (Martuten et al., 1998; Maris, 1981).

Such a close correlation between self-harm and suicide has resulted in a raft of definitions for such behaviours leading to what Burrow (1992) described as ‘semantic paella’.

Consequently, there is a range of possible definitions to explain the phenomenon (Norris, 1997). This thesis supports the suggestion that there is a close association between all forms of self-destructive behaviour.

‘It now seems more appropriate to see suicidal behaviour in terms of continuum with self-injurious behaviour and suicide at the two poles.’ (O’Connor, 1997, p43)

Therefore, the definition of self-harm used within this thesis is based on the acknowledgement that the term encompasses a range of behaviours. Therefore whilst a definition is given below, it is acknowledged that a raft of explanations exist that would have sufficed for this thesis:

‘Habitual behaviours such as self-poisoning which usually do not have suicidal intent, although there is a risk of accidental death.’ (Mind, 2003)

In this thesis therefore, the examination of attitudes toward causation in terms of suicidal behaviour (rather than actual suicides) deals with views of self-harm in the broadest context. This close association between all forms of self-destructive behaviour is evident in the epidemiological figures available.

1.3 Prevalence

Whilst difficulties surround a definitive explanation of self-harm similar problems occur in terms of an actual rate for such behaviours. Incidences of self-harm identified through the rate

of clinical intervention is felt to be a fraction of the actual number of self-destructive acts, with many not coming into contact with medical services (Samaritans, 2005).

Given the above, it is a cause for concern that the United Kingdom has one of the highest rates for self-harm in Europe. Horrocks (2002) estimates the current rate at 400 per 100, 000 of the population. Of greater interest to this thesis is the high rate of such behaviours amongst the young. Hawton and James (2005) suggest that 7% -14% of young people will self-harm at some point with 45% of older adolescents admitting to suicidal thoughts. Within such behaviour a number of salient features arise, the most important of which is the high rate of repeated behaviours. Research undertaken by Zahl and Hawton (2004) show that between 15 and 25% of people will repeat a self-harm act within a year. Studies that examine self-harm rates amongst the young show rates far higher than this. Kelly et al. (2002) noted that 33% of patients committed more than one act in a year and 24% within six months.

The correlation between acts of self-injury and eventual suicide has been well documented (Department of Health, 2002) with an estimated 1,180 deaths per year. As a consequence of this efforts have been made to reduce rates of self-destructive behaviour and therefore suicide. These initiatives have come from a number of sources and provide the current clinical picture in which this study is set.

1.4 Policy Issues Regarding Child Self-harm

Examination of current self-harm literature shows that there are a raft of initiatives currently underway to reduce the rate of suicide and self-harm within the United Kingdom. The first ‘modern’ effort to reduce the number of admissions for such behaviours began with the ‘Health of the Nation (Department of Health, 1992) and have continued with the recent clinical guidelines on treating self-harm patients within the clinical environment (National Institute for Clinical Excellence, 2004).

Examination of these initiatives can be divided into two areas', those contained within a general healthcare framework and those that deal with children.

One of the earliest responses to the Health of the Nation document came from the Royal College of Psychiatrists. Amongst a range of publications on the subject, guidelines were provided in 1998 on managing self-harm behaviours amongst the young. Within this document a number of clinical and educational recommendations are made. The first was an acknowledgement that all acts of self-harm by the young should be taken seriously and that the particular needs of self-harming young people should be acknowledged when developing patterns of care. These issues would be addressed through the formation of specialised units and an improvement in staff education. This requirement for improved staff training was repeated a year later in the Department of Health document 'Saving Lives: Our Healthier Nation (1999). Emphasis was again placed on a reduction in rates of suicide amongst the general population although certain at risk groups such as young males were singled out as causes of concern. Amongst the methods highlighted to achieve this goal were the establishment of good practice guidelines for those treating self-harming patients. Through a number of clinical initiatives and staff awareness training the primary care environment would be improved for the patient. Issues such as assessment of self-harm assessment and patterns of care were addressed in an effort to improve overall rates.

More recently the National Suicide Prevention Strategy for England (Department of Health, 2002) identified 6 goals to aid in the reduction of self-injurious behaviours. Amongst these was the identification of the need for an anti-stigma campaign to help improve the general mental health of young people and other at risk groups whilst again highlighting the need for greater awareness amongst care staff of the main features of self-harming behaviours.

Efforts to improve the general psychological well being of the young are a feature of other initiatives. Within the National Service Framework for Children, Young People and Maternity Services (Department of Health, 2001) Standard Nine dealt specifically with mental health issues. Within the document the needs of self-harming young people were acknowledged. Treatment outcomes for this patient group would be improved through a process of care mapping between services and an overall rising of care staff knowledge on subjects such as availability of method. The 2004 Children Act (HMSO) and the subsequent document 'Every Child Matters: Change for Children in Health Services (Department of Health, 2004) highlighted a number of past failings in the treatment of young people with mental health problems. Strategic Health authorities and Primary Care Trusts were required to show improvements in treatment outcomes. Lead professionals would be responsible for the treatment of self-harming young people, ensuring greater assimilation of care agencies and again dealing with staff education on issues of child mental health.

However, despite this raft of Government lead initiatives the issue of self-harm particularly amongst the young remains a cause for concern. Targets for reducing rates of self-destructive behaviour have been seen as unrealistic even by those involved in their drafting (Hawton, 1998). As a result, self-injurious acts amongst certain groups have been felt to have greatly increased despite efforts at intervention (Slim et al., 2001).

Yet why do these current policies appear to fail? One argument is based on the lack of data available that truly reflects the clinical picture (Leo, 2002). Given the wide spectrum of self-destructive behaviours the over use of data collection methods such as the psychological autopsy of successful suicides results in severe methodological limitations (Eagles et al., 2003). This in turn leads to a lack of accuracy in identifying those most at risk and the

implementation of successful treatment policies, particularly for those whose acts of self-injury eventually lead to suicide.

‘Suicide prevention remains essentially a land of hopes and promises but not certainties.’ (Leo, 2002, p373).

When concrete recommendations are made, research seems to suggest that there is no universal process of implementation (Hawton, 1998). Research undertaken by Slinn et al. (2001) showed that services for treating deliberate self-harm fall far below existing guidelines. Whilst the Royal College of Psychiatrists (1998) called for an established policy of care within each hospital, it was found that 40% of the hospitals within the study did not have such a scheme implemented. However, the greatest concern lay within the lack of specialist environments and staff education, two factors that lead to the current study being undertaken. 31% of trusts within the study did not have a designated ward for the treatment of self-harm patients. Whilst the Department of Health (1999) has called for an increase in staff awareness of self-harm issues, Slinn et al. (2001) feel that current educational provision falls way below national guidelines.

Such difficulties would seem to confirm the views of Hurry and Storey (2000) who feel there is a general failing on the part of health care agencies toward patients who self-harm. The importance of improving staff knowledge as a means of reducing the overall rate of self-harm has been established in a number of studies (Crawford et al., 1997). As the subsequent chapter will show, a lack of understanding of self-destructive behaviour can lead to a raft of negative attitudes. The perceived need to improve staff attitudes within legislation is mirrored in the literature review and reveals two important facts. Firstly, societies’ will best attempt to explain and deal with self-harming behaviours within the context of their own understanding.

Secondly, that the alteration of these views mean that education could have a positive effect on the way this patient group is viewed.

1.5 Historical Perspective

An exploration of the perceived causes of suicide is best commenced with a historical perspective. This will provide a background to the theories of suicide causation and will indicate the emphasis society places on suicide.

Investigation of the earliest societies, described what Fedden (1938) calls suicide horror.

Those who have committed suicide along with those who had been murdered, the unnaturally dead, were viewed with fear. Peoples such as the Australian Aboriginal Iora tribe felt that the soul of a suicide had been snatched from life and would attempt to control and placate the spirit (Hughes, 1988). This appeasement would take numerous forms from the offering of food to the punishment of those who were felt to have offended the suicide in life. Such behaviour explains the fear felt by early man towards suicide. Given the supernatural explanations awarded to everyday events acts such as suicide, violent in nature, were causes of great terror.

Other views of suicide were identified as human society altered. Again cultural and religious beliefs heavily influence suicide perception. Altruistic suicide, in which the individual commits suicide for the benefit of society, was a feature of developing civilisations, (Herodotus, 1992). Leaders both spiritual and temporal had powerful positions within the social system. When one of these leaders died, common practice dictated that those in their service followed them into death by taking their own lives. Within the religious process, suicide was sanctioned, the cause a sense of duty towards leaders who were often endowed with religious significance. However, these perceived acts of loyalty should be questioned.

While there is little evidence of coercion within the early literature, this was often produced by religious leaders who used such ceremonies to maintain their authority.

The culturally sanctioned suicide, with accepted causes of duty and honour continued within the Greco-Roman period. Suicide after defeat in battle or to avoid imprisonment was viewed as an act of noble intentions. Perceptions of suicide already identified had little credence within classical cultures. Attempted suicide carried out during military service was perceived as desertion and punished as such. However, those whose suicidal behaviour was due to mental illness were exempt from such consequences. Despite such concessions, the classical period was one in which a stoical attitude to suicide prevailed. Evidence of this can be found in legislation for the suicidal act. In Roman society those who wished to commit suicide were given permission to do so by the Senate if they could justify a cause (Morgan, 1979).

Acceptable causes of suicide continued in the embryonic Christian Church. The early Church like modern day sects based their virtue on the number of martyrs it had. These martyrs were active in seeking their own death, their sacrifice a guarantee of eternal life (Morgan, 1979).

The use of personal injury as a means of spiritual advancement, continued with the actions of the ascetics. Their self-inflicted privations, often fatal, had the same aims as those who sought death at the hands of the authorities for their religious beliefs (Menninger, 1966).

However, later Christian dogma altered attitudes towards the suicidal act. St Augustine (1984) condemned self-harm as sinful. Eternal damnation was promised to those who ended their lives to avoid divinely ordained suffering. While this could be seen as an extension of the self inflicted wounds of the ascetics, the initiative had been removed. While early Christian martyrs were lauded for their actions, suffering became the remit of the Divine. Actions to frustrate this (through the act of suicide) were therefore viewed as influenced by the Devil.

The Council of Arles in 452, declared suicide as diabolical in cause and a crime against God. The literature of the period, described the eternal torment that awaited suicides (Dante, 1998).

Civil legislation of the period echoed the repressive attitudes of the Church. The property of the suicide was confiscated and those who may have assisted in the suicide convicted of murder. Even in death, the body was subject to the rigours of the law. The corpse would be dragged face down through the streets prior to burial in unconsecrated ground (Morgan, 1979). While the first action can be seen as an exercise in deterrence, the burial practice is an indication of the perceived link between the causes of suicide and the supernatural (Dante, 1988).

Although such practices continued into the Nineteenth century (Fedden, 1938), a number of works attempted to reflect contemporary perceptions of suicide. Seabourne and Seabourne (2001) differentiated between suicides, with those 'sick of mind' exempt from eternal punishment.

Methods of prevention were identified, with friends of the suicide advised to keep the individual away from bridges and weapons. Despite such works, the general and judicial attitude continued to view suicide as an act against God.

However, with the onset of the more liberal views and the reduction in Church power in the Nineteenth century, public attitudes toward suicides altered. Suicidal causes again entered the realm of the individual; enlightenment such as philosophers such as Voltaire (1974) reduced the emphasis of the supernatural and saw the drives of the individual as a cause of suicide.

These changes in attitudes, evident in the practice within the Napoleonic Army, suicides were felt to have deserted and buried without ceremony, provides a direct link to the attitudes of the Roman Army toward suicide (Fedden, 1938).

These changes in perception took time to be established. Although supernatural causes held less credence, society still attached great stigma to self-destruction.

Whilst suicides were no longer buried at crossroads, cemeteries contained a suicide corner, with nighttime burials. Suicide was felt to bring shame on the family and communities would attempt to hide suicides because of this stigma, a factor that would influence later studies of the phenomenon (Fedden, 1938).

It can be seen therefore that attitudes toward suicide have altered over the years. This change of perception is caused by the alteration of the society in which that perception was formed.

This is identified within an examination of how factors that this thesis identifies as influential to perception differ in periods of history.

1.5 (1) Gender.

How suicide between the sexes is perceived in a historical context, is to examine gender difference in early societies. Wives, who committed suicide due to the loss of a husband, carried out socially sanctioned acts within Greco - Roman society. In contrast, within the same societies, accepted suicides for men were those carried out for higher ideals of honour (Fedden, 1938). However, it should be noted that such suicides tended to be exclusive to upper echelons of society, as noted by contemporary authors such as Herodotus (1992) writing in the 3rd century B.C. This lack of reported suicide amongst the working classes may be caused by a lack of interest on the part of historian rather than actual rates.

Within the early Christian Church, those women who chose suicide to maintain their chastity were viewed as martyrs. However, as the position of the Church altered, perceptions of such women changed. When the Church became an integral part of the state, it developed as already noted a negative attitude towards suicide.

1.5 (2) Age

Given the reduced life expectancy within early societies such as the Greek and Roman, age as an influence on society would have less importance than modern society. However, Fedden (1938) described examples where elderly suicides were sanctioned (particularly in times of famine). Given the aim of the thesis to examine perceptions towards children an examination of historical perceptions should take place.

As with gender, the perception of child suicide is a product of that period. Child suicide receives no distinct examination within the literature and this may be caused by the position of children within early societies. For instance, children in Greek society were seen as a resource (both in terms of potential labour and as a political tool). As a result their position in society is reflected in this lack of identified child suicides (Herodotus, 1992).

Perceptions towards child suicide can be seen to emerge, as childhood becomes a distinct phase within human culture. By the Eighteenth century, efforts were made to prevent suicide amongst the young in imitation of popular fictional characters. Books such as Goethe's 'The Sorrows of Young Werther' in 1774 (1973) were banned to reduce the suicide rate amongst those influenced by its glorification of self-destruction (Morgan, 1979). The Victorian period saw the development of a sentimental view of childhood, reflected in the mawkish descriptions of child suicide within contemporary literature (Hughes, 1988).

1.6 Sociological Perspectives on Suicide

1.6 (1) Introduction

As already noted a number of disciplines have put forward explanations of the causes of suicide. Amongst these are theories propounded by sociologists, themselves divided on the causative factors of suicide. Differences within sociological theory range from methods employed to examine suicide to the position of suicide within society.

The methodologies employed and the theories that support them will be examined within this section. More importantly, the underlying factors that generated these theories will be investigated. The purpose of this thesis is to explore perceptions towards children who self harm. If attitudes take place within a social interface, then the exploration of the perceived position of suicide within society is necessary.

1.6 (2) Durkheim's Sociological Theory of Suicide

Day (1987), suggested Durkheim should always be the starting point for a sociological study of suicide. Even those who are seen as critics of Durkheim accept that his work on suicide remains pivotal (Pope, 1976). Before the publication of 'Le Suicide' (1897) the issue of suicide had been discussed in a number of scholarly works. However, it is felt that Durkheim's was the first and to a degree the only complete theoretical discourse on suicide (Douglas, 1967). It is this importance placed on 'Le Suicide' and the causes Durkheim attributed to its cause that warrant such a detailed examination within this thesis.

1.6 (3) 'Le Suicide'

Durkheim first published 'Le Suicide' in 1897, close behind 'The Rules of Sociological Method' (1895), in which he outlined his theories of the 'new science of sociology. For a number of scholars, Durkheim's work not so much examines suicide as explains the importance of social factors and hence sociology within self destruction. (Parkin, 1992). In its most basic form 'Le Suicide', outlines the influence society and social factors have on the individual. It is in this 'illustrated guide to scientific method' that Durkheim describes what he perceives as the causes of suicide.

According to Durkheim, society constrains individuals in two ways:

- 1/ It integrates them by binding them to the values and norms of social groups.
- 2/ It regulates their potentially limitless desires and aspirations by defining specific goals and means of attaining them.

Without integration and regulation life would be in chaos. The act of suicide occurs because of the over and under integration and the over and under regulation of the individual. The equilibrium needed to prevent suicide is unbalanced and the suicidal individual is at increased risk. Durkheim saw these four factors as interrelated, in that both their cause and prevention are social. Egoistic suicide is caused by the reduction of the ties that bind the individual to society. When the individual is removed from the values and expectations of their social group, they are at risk of an excess of individualism and thus vulnerable to suicide. Durkheim used religious differences to explain this phenomenon. By the use of suicide statistics, Durkheim showed that Catholic countries had lower suicide rates than their Protestant counterparts.

Opposite to egoistic, altruistic suicide is caused by the over integration of the individual into their society. The ego is too weak to resist the demands of society and this could result in the suicide of the individual. Identity has become dissolved into the social group and altruistic suicide is the result of society's expectations on the individual to end their own life. Durkheim felt that altruistic suicide was confined to primitive societies and existed in the modern age only in tight knit communities such as the military.

Anomic suicide is caused by the lack of regulation by society on the individual. Again, Durkheim made use of suicide statistics to support his theory. During times of economic change, the suicide rate increases, due to the social and individual instability brought about by this change. However, the threat of suicide and then further suicidal acts to achieve a perceived need could provide a sociological explanation for repeated self-harm, an area of importance in this thesis.

As with egoistic and altruistic suicide, fatalistic suicide is the opposite of anomic. In this case, it results from the over regulation of the individual. Durkheim described fatalistic suicide as one in which the individual (due to excessive regulation) perceives the future blocked by excessive discipline. Durkheim stated that there was little evidence of fatalistic suicide within western society. Slaves and prisoners were seen as examples of those at risk of this form of self-destruction.

1.6 (4.)Summary

In 'Le Suicide'(1897), Durkheim presented a pivotal work on the development of suicide theory. His use of the suicide statistics of the time to explain social causes of suicide rates, lead to the development of four causes of suicide. However, along with social explanations of suicide, the early part of 'Le Suicide', was spent in the elimination of other possible 'non social' factors.

Again, with the use of suicide and other statistics, Durkheim discounted such previously accepted causes as heredity and environment. While he accepted that mental illness was the cause of a number of suicides, Durkheim suggested that the majority of suicides were carried out for real motives, as opposed to the meaningless suicide of the mentally ill. Therefore, the suicide rate is not affected by mental illness.

This process of explanation by elimination, has drawn a number of critical examinations of the study. Given the importance of Durkheim's work and the radical standpoint that he took in terms of suicide research, the analysis of 'Le Suicide' has been widespread. This analysis, as well as an exploration of Durkheim's motives for the writing of 'Le Suicide' is examined below.

1.7 Criticisms of 'Le Suicide'

Day (1987) suggests that modern sociologists view 'Le Suicide' as limited in value. However, critics of the work accept its importance and influence (Lester, 1995; Youseff, 1990; Douglas, 1967).

One of the aspects of 'Le Suicide' that differentiates it from earlier studies of suicide was its use of mortality statistics. The use made of these statistics provides one of the main criticisms of Durkheim's work. Day (1987) suggests that the data used to support Durkheim's theories are flawed. Factors such as religion and the stigma associated with self-destructive behaviour in Catholic societies would result in actual suicide rates being concealed, a theory supported by Parkin (1992). Pearce (1989) feels that even though the statistical evidence is limited Durkheim had already preconceived ideas of suicide causation utilised to establish his theories.

Indeed, Durkheim has been seen by some authors as less than scientific in his quest to establish the sociology of suicide. Jones (1986) accused Durkheim of the use of scientific phraseology to 'confuse and mislead'.

However, it should be noted that Durkheim's theory of anomie is still examined within current research. Rossow and Lavitzen (1999) hypothesised that the perceived alienation on the part of young drug addicts leads to acts of anomic suicide. This is despite the fact that Durkheim himself gives limited attention to young people within his work. Children appear as a means of suicide prevention rather than an individual group with their own suicide risks (Pope, 1976).

Consideration should be made however to the period in which Durkheim wrote and that society's attitudes toward children (Pickering, 1994). The late nineteenth century was one in which children were viewed with sentimentality. As a consequence, Durkheim may have seen the gift of children in a similar manner, the exploration of their self-harm could therefore be a subject of bad taste. Societal factors may have also influenced the gender issues discussed in the study. The self-destructive acts carried out by women are explained within the social mores of the time. It was suggested that women carry out acts of suicide less often than men because they are less involved in society and its ills.

'Fundamentally traditionalist in nature (women) govern conduct by

fixed beliefs and have no great intellectual needs.' (Durkheim, 1897 p166)

However, the greatest criticism is based on the premise that *Le Suicide* was written simply to establish Sociology as an academic discipline. A number of authors have viewed Durkheim as attempting to replace the established religions with his own 'cult of sociology' to the degree that he has been labelled the 'Secular Pope.' (Pickering, 1994; Berros and Mohanna, 1990).

Despite these criticisms Durkheim's work remains well established within the discipline

(Giddens, 1971) and it was not for many years that alternative theories of suicide were put forward.

1.8 Alternative Sociological Theories

Although it has been accepted that Durkheim established a more scientific approach to investigation, alternative methods have been developed within sociology. These alternatives use different sources of data and draw different conclusions as to the causes of suicide.

Douglas (1967) developed an 'interpretative' approach to suicide research. The understanding of suicide needed to be based on the careful study of the micro social contexts of the suicidal act. This methodological change was designed towards an understanding of the variety of meanings attached to suicide within specific contexts (Taylor, 1982). Data collection would take the form of interpretative sources such as suicide notes and case histories. The aim of this approach was to get as close as possible to the 'inner world of the suicide' (Douglas, 1967).

Sociologists were seen as exploring the real world of suicidal experiences, opposite to the traditional macro theories that surrounded the phenomenon. One area in which this new approach differed from the traditional and in particular Durkheimian studies, is the concentration on non-fatal acts within the suicide continuum (Robins et al. 1971).

The social situation in which the suicide took place, has been closely examined by interpretative sociology. Taylor (1982) stated that sociology should concentrate on the individual's concept of suicide, a concept supported by Stengal:

'We must also try to understand in every individual case, the hidden message of the act of self-injury.' (1973, p381).

The act of suicide is not seen as an end, but a strategy or means of communication (Taylor, 1982). This theory was developed by Douglas (1967), who identified appeal suicides, which are carried out in the hope of a response from others.

Societal reaction, the response of others, was seen as a key motivation in a number of suicidal acts. Douglas (1967) saw common meanings to suicide of revenge, escape and repentance, all based on the interactive nature of the suicidal act. Suicide, is seen as an instrument for change, with the suicidal aware that there are social consequences for their actions. For Douglas (1967) the response that the suicidal individual receives, will be dictated by the attitude of the society in which they live. This influence of group attitude on the suicidal individuals behaviour is further explored by Firth (1961) and Stengal (1973).

An exploration of the Tikopia people of the Southern Pacific (Firth, 1961) outlined a society in which suicidal behaviour had culturally sanctioned guidelines. Methods of suicide followed gender specific lines, female suicides swam into the surrounding shark infested waters; males tended to sail out into the vast expanse of ocean to die of exposure. However, of greater importance was the reaction of the society to the suicidal attempt. Firth (1961) outlined the society wide search for the individual and the complete reintegration of the attempter. Suicide and in particular attempted suicide was an accepted form of social problem solving.

This use of suicide within the social process in Western society, was dealt with in the work of Stengal (1973). Those that surround the suicide, show concern and attempt to prevent the suicidal individual from killing him or herself, the suicide receives attention and their social situation is changed for the better. For Stengal, (1973) the reaction of others and the exploitation of the environment are important aspects of suicide research.

The development of the interpretative strand of sociology, has taken the study away from macro social cases identified by Durkheim (1897). However, the causes proposed remain within the realms of the social. The factors listed by the interpretative sociologists are based more on the methodologies they employed. The differences between the causes cited by Durkheim (1897) and those of Douglas (1967) have no basis in psychological and biological

theory. Douglas (1967) felt that these differences were methodological and have more to do with ongoing issues within Sociology.

As with historical and Durkheimian concepts of suicide, interpretative sociologists include both age and gender in their perceptions of the phenomenon.

1.9 Gender

It is within self-harm rather than suicide that interpretative sociologists perceive gender as an influence. Authors such as Taylor (1982) observe that while fatal acts are predominantly male the reverse is true for acts of self-harm. Acts of self-harm are caused by the confused ambivalent intentions of young women.

This connection between self-harm and women was taken further by Stephens (1985). Within a series of interviews with 50 female self-harmers, she found that acts of self-harm were based around relationship rather than individual traits. The women often had dysfunctional violent relationships, in which self-harm was an expression of their perceived worthlessness and despair.

1.10 Age

As with gender, age is seen by interpretative sociologists as a social factor that impinges on the individual. Catanzaro (1981) notes that suicide in childhood is rare and provides a number of reasons why. Social isolation, leads the individual to perceive him or herself as of little value and thus suicidal thoughts occur. However, this is not relevant to children because of their position in society.

Adults, usually parents protect young children from social adversity. In the few cases where children commit suicide dysfunctional parenting is perceived as the main factor.

The concept of childhood trauma as an indicator of suicidal behaviour is explored by Douglas (1967). Events within childhood particularly the loss of a parent are seen as factors that could

lead to suicide. The child may have fantasies of reunion, in what are perceived as often compulsive acts of self-destruction. The escape theme (in this instance escape from grief), is an important component of suicide in childhood, caused by the lack of understanding of the finality of death on the part of children.

Therefore, it can be seen that both age and gender are perceived by interpretative sociologists as factors that can lead to specific acts of self-harm. This is an important issue within the hypothesis of this thesis in that both may shape attitudes.

However, within sociology, there have been studies that have introduced elements of psychological and biological theory within the sociological study of suicide.

Catanzaro (1981) attempted to examine the theories within 'Le Suicide' (1897) in biological terms.

Factors such as altruistic suicide, were seen in terms of natural selection. This sociobiological approach perceived Durkheimian causes of suicide such as widowhood as based on a reduction in reproductive potential. Overall, Durkheim is accused of not considering the evolutionary causation of suicide. Yet, such works can be seen only as a link between sociological theories of causation and those based on other disciplines. An examination of these other disciplines, will provide alternative causes to those outlined above.

1.11 Psychological Perspectives of Suicide

Psychological theories of suicide appeared almost in tandem with the development of sociological studies of the phenomenon. As with sociology, psychological theories of suicide cover a wide range of factors such as suicidal causation and prevention.

As with sociology, the time framework of psychology will be examined. Factors that shaped such theories as psychoanalysis and behaviourism shall be taken into consideration. The section will also include current psychological theories of causation, which will be of

importance given their possible affect on the study population. The study of the psychology of child and adolescent self-harm will also be examined, thus leading to a greater understanding of those factors that may influence staff perceptions.

1.12 Psychoanalytic Theory

Berman and Jobes (1991) suggest that any theoretical discourse on the nature of suicide must begin with the work of Sigmund Freud. This can be seen as a direct comparison to Durkheim and his impact on sociology. However, the above and other scholars accept that within his numerous works, he did not produce one that dealt specifically with suicide and self-destruction.

As will be shown, Freudian theories of suicide developed within the framework of his other writings and were influenced by events that occurred throughout his life (Bloom, 1985). Freud saw suicide as hostility directed towards the love object that is then internalised against the self, described by Schneidman et al. (1970) as murder in the 180th degree.

Within this description, Freud suggests that suicide along with murder and war are all part of mans innate aggression. However, there are factors both internal and external (family, society) that prevent this aggression from being directed outwards.

As a consequence, the aggression is turned inward against the self and suicide takes place. The individual reproaches themselves for such emotions though Freud suggests that self-harm could be carried out as an act of revenge. This hypothesis is supported by Paulson et al. (1978) who found an association between violent fantasies against family members and acts of self-harm amongst young children. Later studies also noted that some suicides are carried out in order to punish family members (Baumeister, 1990).

These theories were discussed in detail within 'Beyond The Pleasure Principle' (1961). The basis for this discussion was the development of the 'death instinct', a primary force within

every member of society, though suppressed within the majority. Society prevents the death instinct from coming to the fore, pressure from the family and wider instruments of social control keep the majority of people from self-destruction and murder. In tandem with this attempt by society to control the death instinct is its opposite, the life instinct. Freud attempts to develop a biological argument to support these theories. Every organism has the death instinct as its driving force and the life instinct is used throughout its existence to pull the organism back from the brink. This is not because of an innate desire for life but rather to end its life on its own terms:

‘The organism wishes to die only in its own fashion.’

(Freud, 1961, p33).

However, as already noted the amount of work produced by Freud on the subject of suicide is limited in comparison to the breadth of his other work. Yet, there are a number of authors who have criticised even this small amount of work. Berman and Jobes (1991) described Freud’s work on suicide as simply an indirect and contextual discussion of the subject. This theory is echoed by Schneidman et al. (1970) who felt that the theories developed by Freud were ‘ambiguous and redundant.’ Schneidman et al., (1970, p580). Indeed Freud’s discourse on suicide can at best be described as limited (Leenaars and Balance, 1994). Even within his own sphere, he offered little on the subject. When the issue of child suicide was debated in a meeting of the Psychoanalytical Society, Freud chose to remain silent (Pedder, 1992). As a consequence of this, modern commentators on Freud feel that he has little to offer within the process of suicidology. Schneidman et al. (1970) felt that Freud viewed death as an abstract concept within the development of his major theories. However, an exploration of Freud’s life indicates that death played an important part in the formulation of Freud’s theory of suicide.

1. 13 The Origins of Freudian Theory

Within his biography of Freud, Jones (1961) stated that death played an important part in Freud's adult life and strongly influenced his writing. Freud's experience of suicide itself was widespread both as a doctor and in his private life. Indeed, it has been hinted that he made a tentative suicide threat in early adulthood (Jones, 1961). However, despite this action Freud had a pronounced and well-publicised fear of his own death. The deaths of those around him were also influential, evident within his depression after the death of his father and his comments on the death of his grandson Heinz:

‘He experienced each death as a loss of a part of himself.’

(Jones, 1961, p19).

The above could to some extent explain why Freud wrote comparatively so little on the subject of death and suicide in particular. The knowledge that he had once threatened to kill himself coupled with his death fear and experiences may have prevented him from producing more. He accepted himself that his own theoretical explanations were incomplete for such a major clinical phenomenon (Schneidman et al. 1970). However, the psychological exploration of suicide did not end with Freud, but was extended by those who followed him.

1.14 Menninger's Theory of Suicide

Menninger's study of suicide, ‘Man Against Himself’ (1966) has been described as one of the most important theoretical examinations of the topic (Berman and Jobes, 1991).

He is seen as taking Freud's brief discourse on the phenomenon further with the development of his own theories of suicidal behaviour. Menninger (1966) divided his own work between causes and presentations. Of importance to this study is the inclusion of a theory on the causes of non-suicidal self-harm behaviour. These causes are outlined below.

1.14(1) The wish to kill

The urge to be destructive is inherent even in the youngest of children. All have the primitive instinct to act aggressively, but the majority of people are able to control them. However, there are individuals who are unable to control their murderous impulses. Society prevents the majority of these impulses from being acted upon and as a consequence these thoughts are turned towards the self. For Menninger (1966) once these murderous impulses have been released and thwarted it is turned on the self as a replacement object, therefore for some, suicide is displaced murder.

1.14(2) The wish to be killed

Being killed is described as an extreme form of submission. The enjoyment of this submission, the pain and even the death is for Menninger the essence of masochism. These individuals achieve satisfaction through punishment. This is seen as a passive search for suicide, the more violent, and the greater the degree of sexual preoccupation. Menninger describes what he sees as the sexual enjoyment experienced during their deaths by the early Christian martyrs. This is seen as the optimum example of the push to be killed as a cause of suicide. However, Menninger made use of a more developmental than psychoanalytical framework to explain his third cause of suicide.

1.14(3) The wish to die

Despite the inclusion of this third cause of suicidal behaviour, Menninger (1966) felt that the wish to die was hypothetical in comparison to the demonstrable facets of the first two causes. He described the wish for death as present in the suicidal acts of children. For the child the act of death is not final, rather it is a temporary means of going away from an unhappy environment. This concept that the death wish is not fully understood by children indicates that few people actively seek the finality of death. Menninger (1966) states that the wish to die

is absent from a large number of suicidal acts. The individual who has their suicidal attempts thwarted may actually wish to be found and will orchestrate their attempt to ensure this happens. The actual wish to die the death instinct of Freud, is only evident in the behaviour of those who expose themselves to danger.

What Menninger describes as:

‘The ultimate gratification of the death instinct.’

(Menninger, 1966, p69).

Alongside his theories of suicidal causation, Menninger (1966) described two forms of suicidal behaviour: chronic and focal, although one of these forms, focal deals with self-harm (an area discussed at the end of this chapter).

1.14(4) Chronic

Chronic suicide describes a long drawn out process of self-destruction. Menninger cites asceticism as the prime example of this form of suicidal behaviour. The individual would bring about their death by the prolonged exposure to hardships such as fasting and poor living environments. The religious aspect of such behaviour is explained as a fear of punishment for perceived bad behaviour. The individuals punish themselves in order to show God that they are sincere in their repentance. The greater the privations the greater the sense of guilt and thus an increased need to be relieved of such emotions.

Menninger (1966) also cited alcoholism as another method of chronic suicide. Again the individual committed acts of self-harm in an effort to avert a greater destruction. They are aware of feelings of aggression and consequently develop a sense of guilt. The use of alcohol allows both aggression and guilt to be masked. What the sufferer uses to ease his pain will eventually destroy him. Yet, while Menninger’s other method of self-destructive behaviour has its foundations in guilt, its results are less fatal.

1.14 (5) Focal Suicide

Menninger described focal suicide as 'localised self destruction' (1966, p201). As already noted, acts of self-harm will be examined in depth at the end of this chapter though Menninger's theory will be examined here.

Focal suicide covered a whole range of behaviours; from the biting of fingernails through to severe mutilation. Menninger (1966) felt that the method of self-harm would be dictated by the severity of the mental illness suffered by the victim. Neurotics would attempt to hide their self-injury. For this group self-injury was a means of punishment that they needed to keep secret because of the shame of their actions. Religious acts of self-harm were cited to reinforce the concept of self-harm as punishment, Menninger describing the actions of the early Christian martyrs. Although this would appear to be at odds with the concept of secrecy, as many martyrs suffered a public death

Psychotic acts were the opposite to the secretive behaviour of the neurotic. Self harm often had great symbolism, associated with the particular disorder the individual had, the mutilation of eyes for visual hallucinations, ears for auditory and so on.

The above, although similar in theory to the writing of Freud, is obviously a development on the earlier work. Menninger appears to have none of Freud's difficulties around the subject of death although he has critics. Roazen (1990) accused Menninger of carrying out his modifications of Freud's theory in an effort to establish psychoanalysis as a political instrument within Western society.

Although the psychoanalytical branch of psychology has been credited with the early exploration of suicide, it has left a number of key issues uninvestigated. The main issue in terms of this thesis, is the neglect by the psychoanalysts of child and adolescent self-harm.

However, this issue is rectified by other theories within the discipline. Given the nature of this thesis, and the abundance of child related studies within both familial and developmental psychology, it is possible to focus on child self harm in the next two phases of this chapter.

1.15 Familial Factors

An exploration of the 'psychology of suicide', indicates that there are a number of theories that attempt to explain the phenomenon. Whilst these viewpoints are not as oppositional as those within sociology, they do offer alternatives to the 'Freudian' stance on child self harm. Amongst these theorists are those psychologists who identify the family as an influential factor in suicide causation. Within this theoretical framework, a number of sub causes can be identified, an exploration of which will provide an indication of how these authors perceive child self harm,

1.16 Poor Family Communication

The communicative aspect of self-harm has been emphasised within a number of studies that examine perceptions towards the phenomenon (McLaughlin, 1994; Anderson, 1997). Those who carry out acts of self-injury are seen as adapting the act as a medium in which they outline their needs. However, such works fail to provide a full explanation for this behaviour. If such actions are a means of communication, then the processes that lead to its use should be examined.

Richman (1986) in an exploration of the backgrounds of suicide identified poor family communication as a possible contributing factor. Family members avoid direct verbal communication with each other and would walk away from intra-family confrontation. Of greater interest is the identification that within such environments there was an overemphasis on the use of gestures to express emotions. This hypothesis is supported by Pfeffer (1986) and

Henry et al. (1993) who note, that although such families discourage members from expressing emotions, despite the high degree of hostility that they feel.

The connection between poor family communication and hostility within the families of suicides was further explored by Wagner (1997). Within the family environment members use violence as medium of communication as well as a method of control and containment.

Research suggests that such violent family interactions increase the risk of suicidal behaviour amongst children (Brent et al., 1993). However, it is the use of such behaviour within the family as means of communication that is of greater relevance to this study. The family environment has been identified as the first stage of social development within childhood (Jenks, 1996). Children will imitate parental role models in order to develop behaviour sanctioned within their culture. The micro culture of the family is one in which emotions are communicated through violence then self-reproach could be manifested in self-harming behaviours. Thus the child who feels the need to punish themselves (for whatever reason), may find it hard to verbalise their distress to care staff that have been socialised by different means. A barrier between staff and patient is created before any intervention has taken place. Despite the above, a number of issues arise around the research of this phenomenon. Wagner (1997) felt that there was only modest evidence that poor family communication was a risk factor for suicide. Yet it is the methods of data collection that cause the greatest concern. Most evidence of poor family communication has been collected via self completed questionnaires. given that these were often given to the families of completed suicides questions of possible bias within the answers should arise. Whilst these methodological issues cause concern the possible causes of self-reproach within the family have been identified by a number of authors.

1.17 Scapegoating the Child

Whilst violence as a means of communication within the family is a cause of self-harm, the violence itself has an influence on self-destructive behaviour. Poor parental relationships have been identified as a factor that could increase acts of self-harm. Taylor and Stansfield (1984) within a cohort study of adolescents found those who attempted suicide had a greater percentage of disturbed parental relationships than non-suicidal controls. However, few studies have considered the impact on the child of being an unwanted part of the family (Wagner, 1997).

The rejection of the child could be caused by a number of factors such as unplanned pregnancy or remarriage. Whatever the reason its psychological impact upon the child has been well documented (Edwall et al., 1989). That poor parent child relationships have a link to suicide, is evident within the literature. Wagner (1997) identified differences in suicidal behaviour between siblings. Those children who had poor relationships with their parents had greater suicidal ideation than their brothers and sisters. As a consequence of this rejection, the child perceives themselves as a burden to their family and this results in feelings of self-loathing that could manifest itself in self-destructive actions:

‘Your family would be better off without you.’

(Wagner, 1997, p259).

The issue of scapegoating the child as a psychological cause of suicidal behaviour also includes the issue of child abuse (Deykin et al., 1985). Whilst he identified a number of studies that examined the relationship between abuse and suicidal behaviour, Wagner (1997) noted a number of difficulties. Firstly, the studies themselves did not specify which form of abuse they examined and who carried out the act. The other difficulty is that the studies are retrospective and thus restrictive in their benefit to a complete exploration of the issue.

Despite this a number of studies identified a higher rate of suicide amongst children who had been abused compared to similar aged controls (Shafii et al. 1985; Brent et al. 1993). Other studies explore the subject in greater depth noting that the higher suicide rates amongst abused adolescents occurred when the abuser was a family member (Edwall et al., 1989). While the above provides an indication that there is a link between abuse in childhood and suicidal behaviour a number of questions arise. Firstly, it is difficult to quantify abuse, the issue of the act may mean differing things to different people. As noted, few studies discussed the results of which form of abuse they examined. The form of abuse could be reflected within the method of self-destructive behaviour. Deykin and Buka (1997) noted that there is a closer link with suicide in male victims than females. However, within the study the issue of social stigma is neglected. Given the socialisation of males within our society, abuse may have a greater affect on that group. This could have particular ramifications within the clinical area investigated within this study. The adolescent male who presents for treatment may find the physical examination an intrusive act and respond in a violent manner. Coupled with this difficulty, is the possibility that care staff may fail to recognise abuse specific methods of self-harm. Favazza (1987) outlined specific forms of self-harm that relate to events such as sexual abuse. The care needs of the sexually abused child will differ greatly from that of the child who self-harms for other reasons. Failure on the part of staff to identify the cause could lead to greater distress for the child and cause hospital treatment to be another aspect of a traumatic experience. Therefore an important aspect of the literature has been neglected. Despite these difficulties, other familial causes of child suicide can be identified within the literature.

1. 18 Change in Parent Child Relationship

The concept of separation as an influence on child suicide was developed by Bowlby (1980). Although it is of interest that Shaffer (1974) had noted that although child suicide was rare, those who completed the act often experienced parental divorce by the age of 15. This is supported by authors who examined the characteristics of adolescent suicides and found that few lived with both biological parents (Shafii et al., 1985; Brent, 1994). However, a number of similar cohort studies observed that the death of a parent did not produce the same rate of self-destruction (Slap et al., 1982; Kienhorst et al., 1990). A possible cause could lie in the communicative aspects outlined above. If self-harm is used as a means of communication, then the act of self-harm could be the means by which the child can express their distress at parental separation. The act may be an attempt on the part of the child at parental reconciliation.

This could explain why there is no significant link between suicidal behaviour and parental death. As death is irreversible, suicidal gestures as a means of manipulation is useless.

Kienhorst et al. (1987) noted that a number of childhood suicide attempts occurred when another member of the family was ill. A possible attempt on the part of the child to cajole the person out of their illness. If suicidal behaviour was purely an attempt to communicate distress then the loss of the parent, an irretrievable loss, would generate the greatest anguish and therefore the highest rate of suicidal behaviour, however, this is not the case.

As already noted, the family is the earliest agent of socialisation for the child. A number of authors have suggested that dysfunction within the family itself may lead to suicidal behaviour in children and adolescents.

1.19 Parental Psychopathology

Within this psychological theory of suicidal causation, it is the exposure of the child to conflict within the family that poses the greatest threat. Chief amongst these is the presence of mental illness and suicidal behaviour in other family members. Shafii et al. (1985) found evidence of self-destructive behaviour amongst the relatives of child suicides. Both Brent (1997) and Pfeffer (1986) found evidence of mental illness within the first-degree relatives of children who self-harmed.

In particular the incidence of major depressive and bipolar disorder, both of which have a close association with suicide (Berman and Jobes, 1994). The possibility that the above behaviour is copied by the child cannot be discounted (this is discussed later in the chapter).

Another possible area of influence is the disturbances that occur in such families. Wagner (1997) observed that family tensions and stresses are often a precursor to attempted suicide in children. He went on to state that some children who are exposed to family arguments could later develop suicidal behaviour. However, Wagner (1997) accepts that such theories fail to take a number of factors into consideration. He states that many of the studies fail to consider the severity of the symptoms to which the child is exposed. The intensity of reaction on the part of the child was not included, children may have different levels of tolerance towards parental behaviour and this is a factor that the studies failed to include. It would appear that a number of issues have been neglected by this aspect of the literature. However, the developmental theories of child suicide go some way to addressing them.

1. 20 Development Theory

Within the development theory of psychology, adolescence is a period of traumatic change in which issues of identity provide a crisis of confidence. As the individual progresses from childhood to adulthood, the adolescent is caught between what is right and what is wrong , what is acceptable age appropriate behaviour and what is not. Overholser et al. (1995) described adolescence as a period of self-examination. Within this exploration, the individual may find qualities within themselves that are unacceptable. This self reproach could develop into self-destructive behaviour, research has indicated a link between low self-esteem and repeated acts of self-harm (Wetzler et al., 1996). Whilst all adolescents suffer episodes of low self-esteem, evidence indicates that those who carry out self-destructive acts are most likely to have suffered traumatic events in childhood. de Wilde et al. (1992) in a study of suicidal adolescents found that childhood problems often resurfaced due to the stressful nature of the teenage years:

‘Presence of stressful life events..... seems to have important implications for understanding suicide attempts in children and adolescents.’

(de Wilde et al., 1992, p45).

As a consequence, a negative cycle may develop, negative events within adolescence result in emotional distress, which in turn lead to further negative events (Spirito et al., 1989). This phenomenon could go some way to explain the high rate of repetition, identified as a feature of adolescent self-harm (Hawton et al., 1996). Therefore, whilst studies of staff perception indicate connection between repetition and perceived manipulation, the reality could be an individual for whom the act of self-harm is a means of coping with repeated low self-image. This theory is supported by those studies that identify the link between low self-esteem and

gender. Esteem has been identified as different for each sex. Males base self-esteem on the attainment of specific goals, whilst female adolescents place emphasis on social relationships (Overholser et al., 1995). As adolescence is a period of fluctuation within personal relationships, this could explain the high ratio of repeated self-harm amongst young women.

‘Research on self esteem, depression and suicidal tendencies
must take into account the relative impact of gender.’

(Overholser et al., 1995, p921)

The adolescent who may have a lowered self-esteem may find the disappointment of a lost friendship a major stressor that could lead to the onset of suicidal behaviour (de Wilde et al., 1992). However, there are theories that conflict with the above and offer alternative developmental causes for child suicide such as Baumeister’s Escape theory.

1.21 Escape Theory

Baumeister (1990), agrees with authors such as deWilde (1992) that low self-esteem and self-blame are features of adolescent suicide. However, the concept that suicide is caused by stressful or disappointing events is rejected. For Baumeister, the suicidal act is seen as a need to escape from adverse emotions, on a basic level, the suicidal individuals are escaping from themselves. Within the theory, the suicide sets too high standards of themselves and others. Evidence that the suicide rate is highest within those nations with a high standard of living is an indication of this theory. Individuals within these societies have high expectations and react poorly when these are not met (Lester, 1995). Baumeister provides the example of the tandem increase in social position and rate of self-harm amongst young women. As a consequence of

this societal change, the needs of young women alter, when these needs are unfulfilled the individual becomes frustrated and suicidal thought occur. The potential suicide is not the introverted that Baumeister feels is portrayed in other studies such as de Wilde et al. (1992) but rather someone with strong evidence of desires.

This period of change is also evident within adolescence, Baumeister (1990) suggests that change could induce negative views of the self. The individual must then get away from that (themselves) which they perceive as the cause of such negative emotions. Suicide allows the individual to get away from a low social position or rejection from a peer group.

However, Baumeister's theory differs from other developmental theories in that he suggests that the person escapes from negative affect by avoiding meaningful thought. During the suicidal act cognition is affected, the suicide has a limited sense of the future awareness, there is a need for immediate gratification and cognitive deconstruction takes place. This deconstructed state leads to irrational fantasies in which the possibility of a future is denied.

A difficulty with this hypothesis is its failure to take planning into consideration. If cognitive deconstruction does take place then how are those suicides which are meticulously planned explained. It also rules out the possibility of the act of self-harm as a means of communication. However, Baumeister (1990) rejects the idea of communication within suicide as such motives appear to oppose the wish to die:

‘Strictly speaking, the cry for help theory is not an explanation of suicidal motivation at all.’

(Baumeister, 1990, p106).

For Baumeister, the difference between life and death includes ambivalent factors such as luck, competence with lethal means and the strength of the competing will to live. There are a number of difficulties with Baumeister's theory, namely that it is based on the premise that individuals and in particular adolescents have the strength of personality to establish personal goals and to react so strongly when they are not achieved. However, there are authors who suggest that adolescents carry out acts of self-harm not through strength of individual personality but because of a need to belong.

1.22 Imitation Theory

As with escape theory, those authors who examine imitation as a cause of suicide suggest that cognitive distortion takes place (Spirito et al., 1989). Suicidal youth are perceived as impulsive, with poor problem solving skills and high levels of acting out behaviour. A possible consequence of such behaviour is rejection by the peer group. A feature of adolescent self-harm identified in the literature is the social isolation of the individual. Hodgeman and McAnarney (1992) noted that those adolescents who attempted self-destructive acts tended to have poor peer group relationships, this rejection with childhood a factor for those who attempt suicide in later life (Spirito et al., 1989) many of the attempts are seen as responses to arguments with this rejecting peer group (Leenaars, 1989).

That social relationships and peer group acceptance is important within adolescence has already been identified. However, imitation theory suggests that this need to 'fit in' could lead vulnerable adolescents to attempt suicide. Gould and Shaffer (1986) suggest that those adolescents who have low self esteem may wish to adopt what they see as admirable in others. A role model could emerge, whom the adolescent would imitate in order to be more acceptable to the peer group. If this role model commits an act of self-harm, then the

adolescent could imitate the behaviour in an attempt to achieve the same popularity. Gould et al. (1994) noted that if the role model was highly popular or as a consequence of their actions obtains a high degree of public sympathy then a suicide cluster could occur. A number of adolescents would imitate the act, in order to achieve a similar sense of belonging.

The idea that a role model could influence adolescent suicide has been taken further by Gould (1990). She suggested that the suicide of a popular figure in the media could be copied by young fans. Again the emphasis is on the adolescent who perceives desirable qualities on the part of the celebrity. Gould and Shaffer (1986) suggest that if the suicide is well publicised, there could be a number of suicides.

However, there are questions about the above hypothesis. Firstly, if the character is fictional, the idea that the adolescent is aware of this should be considered. Secondly, that the suicidal adolescent actually saw the film / television programme. Despite such queries, the theory does provide an age appropriate explanation of adolescent suicidal behaviour. Although, the issue of gender is not fully discussed, do female role models lead to greater acts of self-harm, do male role models use more violent methods? Also, the issue of age has been overlooked younger children may not comprehend the finality of their idols death, a factor that could lead to higher rates amongst that sub group.

1.23 Cognitive Theory

The explorations of psychological theories of suicide identify a range of academic philosophies. If the psychology of the phenomenon does begin with Freud, then it ends with cognitive theories of suicide seen as the dominant theory in current exploration of the condition (Temple, 1997).

Cognitive psychology as a separate aspect of the discipline was initially developed within the 1930s although, it is only within recent decades that it has achieved dominance (Dunn, 1996). Within the cognition of suicidal behaviour, risk is determined by the extent of cognitive distortions. These distortions are seen by Leung and Wong (1978) as the processes of biased interpretations of outside events. Within these distortions, are those that could lead to acts of self-destruction:

1.24 Hopelessness

A key variable within the cognitive exploration of suicide, hopelessness is for Brent (1997) a negative view of the future. Suicidal adolescents view their happiness linked to others, a possible explanation of the high correlation between suicidal behaviour and disruptive relationships (Hill, 1995). Brent and Perper (1995) identified a tendency amongst suicidal adolescents towards an external locus of control and negative self-opinion. This link between hopelessness and suicide is identified within the literature (White 1992; Lewis and Sloggett, 1998). In response, cognitive therapy is seen as effective in the reduction of the negative views of the self and therefore suicide (Rush et al., 1982).

1.25 Impulsivity

The impulsive nature of the majority of suicide attempts amongst children and adolescents is well documented (Hawton et al., 1982). Brent and Perper (1995) suggest that this impulsiveness could be caused by cognitive distortion. The suicidal adolescent, has poor problem solving techniques in which impulsivity is a symptom. As a result of this the lethality of the act is dictated by the lethality of the methods available to them at the time of the crisis. This use of available method, a possible explanation of the high rate of firearm suicides amongst American adolescents (Shaffer, 1993).

1.26 Rigidity of Thought

Even before the suicidal act, cognitive psychology suggests that the suicidal adolescent is at risk. These individuals are seen as more rigid in their approach to tasks and as a consequence generate fewer alternatives in problem than other adolescents (Rush et al., 1982). The suicidal adolescent is unable to develop beyond this rigidity and because of this inability to change they use other channels to voice their distress:

‘Suicide attempters tend to use suicidal behaviour as their means of communication as they lack the availability to be assertive.’

(Brent, 1997, p 283).

This provides an indication of the current psychological theories of suicidal behaviour. However, as a science, psychological thought is fluid and cognitive theory of suicidal behaviour has begun to attract its critics (Roberts et al., 1998). The explanation of the above as well as other issues within psychology will provide an explanation of how these theories were formulated.

1.27 Age

As already noted, age is hypothesised as an influence on attitude toward self-harm within this thesis. Its importance within the psychology of suicide is evident in the examination of the theories outlined above. While a number of these age related theories have already been explained, their inclusion in a separate section underlines their importance within this work.

Age as an influential factor in suicide causation has been neglected by the psychoanalysts. Freud's fear of death has already been noted, although it would appear that age and his own old age in particular were not acceptable topics for discussion (Jones, 1961). Therefore, the

concept of age as an influence on death (suicide) was not a factor that Freud would have dwelt on at any great length.

Within familial psychology the emphasis is obviously on factors within the family as the main causes of suicidal behaviour (Murray et al., 1996). However, Shaffer et al. (1996) expounded the theory that dysfunctional family environments will have greater effect on young children. This hypothesis is supported by Wagner (1997) who found that exposure to family difficulties in early childhood could reappear as suicidal behaviour in adolescence. While this would appear to be a limited exploration of a pivotal factor for this thesis, age is explored in greater detail within developmental theories of suicide.

The greatest evidence of age as a factor in suicide causation occurs in those studies that examine adolescents. Both Baumeister (1990) and deWilde (1992) emphasise the teenage years as ones of great upheaval in which societal roles under go rapid transformation. This period of change causes the adolescent to constantly evaluate him or herself (White, 1995).

If the evaluation is self-critical, then the possibility of suicide arises. Given the age range of the patient group within this study, the above is of great importance. The conflict and turmoil of adolescence that leads to acts of self destruction could be transported into the casualty department, leading to conflict with care staff, a factor that could lead to negative attitudes amongst those who deal with this vulnerable patient group.

1.28 Gender

Those studies that identified age as an influential in self-harm causation cited gender as another factor (Williams, 1997; Bettridge and Favreau; 1995; Kolita, 1989) again an important issue within the hypotheses of this thesis.

As with age, psychoanalytical theorists placed little importance on gender as a causative factor. Rather, gender was an issue only in certain methods of self-harm. Menninger (1966) described certain forms of self-wounding associated with the guilt of female masturbation. Guilt and the need for self-punishment were also identified within the castration ceremonies of religious cults. However, this link with gender as a causative factor in suicide is tenuous. Other forms of psychological theory were needed to identify the importance of gender within suicide and adolescent suicide in particular.

Baumeister (1990) identified the change in young women's role within society as the cause of increased self-harm amongst this group. If change in societal role does increase suicide rates, it could explain the increase amongst young men in postindustrial societies. Gender has also been identified as a factor within teenage suicide rates. Overholser et al. (1995), described the importance of low self-esteem within adolescent suicidal behaviour. Self-esteem was seen as gender orientated with teenage girls placing greater emphasis on friendships. Adolescence has been identified as a period of shifting friendships, thus the basis for self-esteem is fluid, an explanation for the high rate of self-harm behaviours amongst this group (Leenaars, 1989; Overholser et al., 1995).

If self-harm is a product of disrupted friendships, care staff may perceive female acts of self harm as lacking in suicidal intent. However, there are factors that pertain to the staff themselves that could influence their perceptions and these are identified in the next section of this chapter. Yet, the issues that influenced the production of the above psychological theories should also be examined, in order to understand how these ideas were formulated.

1.29 Causes of Psychological Theory

Brennan (1995) suggests that the academic attitude of psychology is not fixed but alters with the society it examines. The prevalent attitudes of the society will dictate the stance taken within academia, shaping the accepted thoughts within disciplines such as psychology.

Thus as with sociology, psychology, or rather the position it offers is influenced by the zeitgeist that surrounds it. Individual factors that shaped Freud's view of suicide have already been identified. However, the period in which these views were formulated should be considered. As with his contemporary, Durkheim, Freud developed his theories amid a period of medical dominance. Coupled with this factor, is the issue of Freud's education and employment as a physician. Within this period, any medical care above the most basic was private. Thus, for Freud the introduction of radical methods of treatment would require patients with the money as well as the time to receive these new processes. Freud practised in Vienna, at the heart of the Hapsburg Empire, which received all the benefits of such a position (Appignanesi and Zarate, 1992). As a consequence, Freud had a surfeit of individuals who had the means to support the development of his theories (Jones, 1961).

As Psychology progressed, so those who took part in this progression put forward their own theories. Behavioural theories of suicidal causation have been identified within this chapter, yet the development of behaviourism within Psychology is seen as the ambition of psychologists who support its theories. Leahey (1994) saw behavioural psychologists such as Watson, champion their particular theories as the means to establish psychology as an independent science.

However, other psychologists offered alternative theories. Richards (1996), described the 'cognitive revolution' as breaking behaviourism's hold on the discipline. This new theory of

psychology was supported by the period in which it was developed. Alongside the great social changes that took place in the 1960s cognitive psychology made use of the development in technical knowledge to advance its own theories (Matlin, 1989).

However, as cognitive theories replaced behaviourism, it became the established method of psychological thought (Leung and Wong, 1998). This strengthening of the discipline was seen to spread into other aspects of society, with greater clinical emphasis on cognitive methods of diagnosis and treatment (Goodwin, 1999). Indeed, it is suggested that the position of the cognitive school has become too strong (Benjafield, 1996).

Therefore, as with behaviourist theories, cognitive psychology has come under increased criticism within recent years. Dunn (1996) suggests that whilst cognitive psychology does provide valuable insights into the human condition, there is still a great deal of work needed. Coupled with this need for greater exploration of cognitive theories, is the belief that it is wrong to reject other areas of psychological thought. A view shared by Goodwin (1999) who describes the lack of unity within the discipline.

Therefore, the causes for the psychological theories of suicide causation echo those of sociology. As a society alters, so do the pertinent theories of psychology. At present, cognitive psychology is viewed as the dominant theory. This dominance extends to the clinical area and as such cognitive theories of child and adolescent behaviour are important within this study. Yet, of greater importance, is the fact that attitudes within psychology as with other aspects of suicide theory are influenced by the environment in which they operate. Theories of suicide causation, presentation and treatment have altered accordingly. The understanding of this is pivotal if an exploration of care staff perceptions is to take place.

However, an examination of the theories of suicide causation within the disciplines to which the care staff belong is needed if the above hypothesis is to be justified.

1.30 Medical Perspectives of Suicide

The aim of this chapter was to outline the alteration of perceptions of suicide within human society. The examinations of historical, sociological and psychological theories of suicide causation have provided an indication of how these perceptions are formulated. However, of greater interest to this study, is the explanation of suicide causation within medical theory. This thesis examines the perceptions of care staff towards children who self harm. Therefore, the way self-destructive behaviour is discussed within the medical literature will provide the background to the exploration of these perceptions. As with other sections of this chapter, the causes of suicidal behaviour will be examined. However, given the importance to this study of medical perceptions, this exploration will include an examination of treatments for self-destructive behaviour outlined in the relevant literature. The issue of self-wounding will also be examined within the chapter and an exploration of its perceived causes made.

1.30 (1) Medical Theories of Suicide Causation

As with other aspects of medical theory, exploration of suicide causation is based in the first instance on biological phenomena. Although there is no need within this thesis for an in-depth exploration of these factors, they are outlined below to provide a basis for other aspects of medical theory.

1.31 Biological Theories of Suicide Causation

In direct opposition to the psychological and sociological theories, which suggest external factors, medical theories of suicide causation, see phenomena within the individual as the

cause of suicidal behaviour (Ghanshyam et al., 1999). Within medical research, there are numerous neurochemical studies that deal with suicidal behaviour. In such studies, reduced serotonin levels have been explored and a correlation between diminished levels of noradrenaline (5 HT, a hormone related to adrenaline, realised as a neurotransmitter) and impulsive suicidal behaviour (Biver et al., 1997). In response to this chemical imbalance, antidepressants are introduced to increase serotonin levels, such as imipramine, which acts on noradrenaline (Morgan and Butler, 1993). This biological basis for suicide behaviour has been further explored by Partonen et al. (1999) who noted low rates of serum total cholesterol and suicidal behaviour. This biological aspect of suicidal behaviour has also been identified in adolescent self-destruction. As already noted, these neurological issues will not be discussed in depth. However, it is the emphasis medicine places on the link between mental illness and self-destructive behaviour that is of interest within this thesis.

1.32 Mental Illness as a cause of suicidal behaviour.

The ownership of suicide within the sphere of mental illness is evident in such texts such as D.S.M.III (American Psychiatric Association, 1987) and the development of organisations like The National Confidential Inquiry into Suicide and Homicide. Bodies developed and run by members of the medical profession (Evans et al., 1996; Appleby et al., 1997). Through these organisations, medical personnel, prophet mental illnesses as the main cause of suicidal behaviour and offer numerous examples to support their theories (Gunnell et al., 1995; Feighner and Boyer, 1991).

In an extensive exploration of completed suicides, by means of psychological autopsy, Harris and Barraclough (1997) showed that 90% of suicide victims had one or more psychiatric illnesses at the time of their death. With depression being the most prevalent of these

conditions. Amongst those studies that deal with suicidal behaviour amongst the young a clear correlation between depressive illness and self-destructive behaviours is identified (Besseghini, 1997).

The imbalance in neurological function outlined above has been identified as a direct link to depressive illness and eventual suicide (Foster et al., 1997). Even amongst low risk social groups such as postnatal mothers, those who suffered from post partum depression often made suicide attempts (Appleby et al., 1998). Harris and Barraclough (1997), noted that the majority of suicide victims suffered from clinical depression, yet identified other psychiatric conditions such as eating disorders as possible causes of suicidal behaviour, a theory supported by other medical research:

‘Suicide is a complex act and although its association with depressive illness is robust, other factors appear to influence its frequency.’

(Kelly and Rafferty, 1999, p485).

Indeed within the medical literature, there is disagreement as to the degree depression is associated with suicide (Brent et al., 1993). It is suggested that those studies that do highlight the relationship between depression and suicide tend to base their studies on psychiatric in-patient populations. This would mean the examination of the most severe depressive cases and therefore not typical of the majority of individuals with the illness (Appleby 1998). Coupled with this are difficulties in how this data is collected. Abed (1996) notes there is no standard procedure to collect the demographic details of those who commit suicide. In response, other medical theorists suggest that there are other factors that lead to suicidal behaviour (Jacobson et al., 1996). Bostock and Williams (1974) accuse some patients of using suicidal behaviour as a means of manipulation, a hypothesis echoed by Kreitman and Casey (1998):

‘To the clinician, parasuicide always presents a crisis.’

(Krietman and Casey, 1988, p792).

However, in contrast, other authors suggest that those who carry out repeated acts of self-harm, do so because of enduring mental illness (Brent, 1997; Granboulan et al., 1997). Yet, whatever the perceived cause of suicidal behaviour, there is a consensus of opinion in terms of treatment.

1.33 The Treatment of suicidal behaviour.

Kapour and Hourue (1998) suggest that the best way to reduce the suicide rate is to develop suitable pharmacological treatments. This hypothesis is supported by Scorer et al. (1999) and Kelly and Rafferty (1999) who propose that rates of pharmaceutical treatment should match the degree of suicidal behaviour. However, amongst the later it is accepted that there is no evidence that an increase in the amount of antidepressants prescribed has reduced the suicide rate. Even those who explore the treatment of suicidal behaviour in children, suggest that pharmaceutical interventions should be considered (Black and Cotterell, 1993).

However, Cranmer (1998) suggests that there are other factors that will influence the treatments received by suicidal patients from medical staff, namely, staff opinions. Dorer (1998) states that the basis for admission was the method of self-harm used. Patients who carried out self destructive acts that involved alcohol or drugs, were found to be the least likely to be admitted. This is of interest to this study, given the high correlation between suicidal behaviour and alcohol ingestion amongst adolescents (Aldridge and St John, 1991). This concept is supported by Bostock and Williams (1974) who suggest that individuals who repeat acts of self-harm do so to manipulate others. Consequently, staff may reinforce such behaviour by displays of concern. Treatment should consist of the withdrawal of this attention

and a refusal to respond to this perceived manipulative behaviour (Bostock & Williams, 1974). In terms of child suicide, this aspect of perceived manipulation is also evident in the treatment process:

‘The evaluation of suicidal intent is the keystone in the assessment of an adolescent overdose.’

(Kingsbury, 1993, p518).

Alongside this theory that care staff should be aware of the manipulative nature of some suicidal behaviour, is the belief that those medics (psychiatrists) who specialise in the mentally ill are needed to provide the correct treatment of the suicidal. Michel and Valach (1992) suggest that outside psychiatry, medics have little insight into the issues of suicide and so need further training. Greater training for non-psychiatrists is supported by Scorer et al. (1999) and Boer et al. (1996), if only to ensure that the correct doses of antidepressants are prescribed.

Although the above indicates the position of psychiatry within medicine, it is only of limited importance to this study. This thesis is set in A & E departments, staffed by doctors, whom the medical literature sees as lacking in appropriate knowledge of the suicidal act. This lack of knowledge, is a possible issue in the formation of their perceptions of self-injurious behaviour. This perceived lack of knowledge on the part of non- psychiatrists is also evident in treatment theories within the nursing literature.

1.34 Nursing Staff

Within this research, a large percentage of the sample population will be nurses. Therefore, the causes attributed to suicidal behaviour within the relevant literature should be examined.

In contrast to medical theories, Bunclark and Adcock (1996) considered more psychological causes of suicidal behaviour, such as the consequences of emotional and physical abuse. However, they do suggest that in the absence of these factors mental illness should be considered. This need to follow medical theories is supported by Sebree and Popkess - Vawter (1991) and Allen et al. (1997) who also perceive a manipulative cause to some suicidal acts:

‘Nurses should be aware of the addictive and rewarding nature of self harm
to the patient.’

(Allen et al., 1997, p37).

As a consequence of this perceived manipulation, nurses are advised to limit their contact with patients and to limit the period the individual stays in hospital. This lack of interaction between nurses and patients who self-harm, is evident in terms of child suicidal behaviour and is to a degree based on a lack of awareness on the part of the nursing staff (Harrison, 1998). However, the medical literature does provide an explanation for self-destructive behaviour in the young.

1.35 Age

‘The relationship between psychiatric disorder and adolescent suicide
is now well established.’

(Brent et al., 1997, p37).

As with general theories of suicide causation, within child and adolescent self-injury, the emphasis is on psychiatric illness (Nelson and Crawford, 1990; McKenry et al., 1982). Evidence suggests that although there is a high incidence of depression amongst adolescents, it is often transient in nature (Kerfoot and Huxley, 1995). However, authors such as Brent et

al. (1997) suggest that the best way to reduce suicide rates amongst adolescents is to identify their main mental illness and progress on a suitable treatment regime. This is seen as particularly relevant in those older children and adolescents who are involved in substance misuse.

Indeed, amongst the over 12-age group, the influence of drug and alcohol use has been identified as a factor that could influence the treatment received by medical staff. Dicker et al. (1997) note that the aggressive behaviour associated with alcohol related adolescent suicide attempts could possibly be a factor that would influence treatment. An important issue within this thesis.

Despite the above, treatment for suicidal behaviour in children and adolescents mirrors that of adults. McKenry et al. (1982) observe that within paediatrics, child suicide is not seen as an overriding issue and as a result, there is a need for input from psychiatric services. this input, in the form of greater understanding of psychopharmacology (Brent, 1997). Although it should be noted, that Brent (1997) as well as advocating the need for the greater exploration of antidepressants in paediatrics, suggests that alternative treatments such as therapeutic environments should not be discounted.

1.36 Gender

As with previous sections within this chapter, gender can be identified as a defining issue within suicidal causation. Studies of suicide demographics continue to be divided along gender lines (McClure, 2000; Schwartz et al., 1989) the causes of which can be seen in issues such as rate, lethality and method, issues pivotal within this thesis.

Brent (1987) in a cohort study of self-harming adolescents observed that males showed a greater rate of suicidal intent. This is related, he thought, to higher incidences of depression. In comparison, female adolescents were seen to make suicidal acts of low lethality. Similar studies by Shaffer et al. (1996) noted a high incidence of mood disorder amongst adolescent males, who accounted for the majority of completed suicides. In contrast, female patients tended to make attempts of low lethality (Krietman & Casey, 1988; Dicker et al. 1997). However, the number of attempts amongst females has been identified as greater than their male peers:

‘Self-poisoning represents the commonest reason for the acute medical admission of females to hospital.’

(Dorer, 1998, p156).

The causes for such behaviour, is again identified as mental illness. Davis & Ames (1998), observed that factors such as conduct disorder were prevalent amongst female adolescents who carried out acts of low lethality. Older female patients often had their acts of low lethality diagnosed as a consequence of personality disorder (Lyttle, 1986).

The above examination of medical theories of suicide causation provides this study with an indication of how the phenomenon is observed within the professions that form the study population. The factors that lead to these observations will give this indication depth and these are examined below.

1.37 Self-Wounding

Self-wounding is not a new phenomena, as already noted, there are a number of examples of self-injury that is culturally sanctioned (Timber, 1998) and those that result in censure

(Morgan, 1979). As with suicidal behaviour, these perceptions of self-wounding alter over time:

‘Views regarding what would be seen as disturbed or dysfunctional behaviour change over time and depend on which group views are sought.’

(Norris, 1997, p2).

Self-wounding is included within this thesis, for a number of reasons. Firstly, acts of self-injury are often identified as precursors to suicidal behaviour and eventual suicide (Hill, 1995; Owens et al., 1994). The inclusion of self-wounding, within the medical and psychological literature that deals with suicide suggests that there is a perception amongst these groups that both actions are linked (Maris 1981; Hawton et al., 1982).

As with suicidal behaviour, there is a wide range of definitions, which are often used inconsistently (Burrow, 1992). Instead of definition, Tantam and Whittaker (1992) suggest that internal damage is typical of suicidal behaviour while external damage is representative of self-wounding. Cutting, being the most common of these external injuries.

Within psychological theory, Freud (1961), described self-wounding as sadism turned against the self. This hypothesis was expanded by Menninger (1966) who saw self-harm as a response to internal difficulties.

This is developed by more recent examinations of psychodynamic theory. Self-wounding confirms the reality of the damaged self and expresses this damage to others (Hartman, 1996). Particular acts of self-wounding have symbolic meanings in which the individual may attempt to deal with difficult experiences (Walsh and Rosen, 1988).

Within cognitive theories of self-wounding, the act is seen as a combination of factors that lead to a cycle of self-harming behaviour (Feldman, 1988; Kahan and Pattison, 1984). Poor problem solving skills linked with low self esteem (often caused by factors such as abuse), may lead the individual to view the act as a coping mechanism (Spandler, 1996).

The act of self-wounding forms part of a coping mechanism (Viet and Schwarz, 1989).

Favazza (1987) described the benefits that self-wounding holds for those who carry out the act. Feelings of anger and self-loathing are reduced and those who self wound experience a release of tension and an escape from unacceptable emotions. As a consequence of this, the behaviour becomes addictive with the individual self-wounding to deal with any emotional problems (Schwartz et al., 1989). Self-wounding can therefore become a long-term behaviour, in which some individuals attempt to keep their acts hidden from others (Hill, 1995).

Within medical theories of self-wounding, there is again an initial emphasis on neurological factors. Simeon et al. (1992) observed that difficulties in serotonin levels often lead to impulsive anxious behaviour. This follows work by Favazza (1987) who noted that individuals with normal serotonin levels are able to deal with problems and express their irritability outwardly. However, for those with low serotonin function, irritability is turned inward, the result of which is self-damaging behaviour.

As a result, mental illness is identified amongst medics as the cause of self-wounding behaviour. Pao (1969) differentiated between neurotic and psychotic cutters. The psychotic 'coarse cutter' carried out acts of high lethality, often acts of mutilation based around their psychotic delusion. In contrast, the 'delicate cutter' (Pao, 1969), carried out acts of low lethality, such as light superficial lacerations, these actions often carried out in an attempt to influence others (Feldman, 1988; Tantam and Whittaker, 1992). Personality disorder is the

psychiatric condition associated with such behaviour (Gunderson and Kolb, 1978). Personality disorder is described within the medical literature as :

‘A deeply ingrained and maladaptive pattern of behaviour.’

(Concise Medical Dictionary, 1990).

Yet within the medical literature it is accepted that the label of personality disorder often stigmatises the patient and results in the withdrawal of treatment, because of perceived manipulative behaviour (Kendell and Zealley, 1993). This theory is supported by Feldman (1988) who suggests that psychiatrists tend to use a label of anti-social personality disorder in order to explain self-wounding behaviour.

‘The diagnoses emphasised in the literature may say more about the doctor than the patient.’

(Feldman, 1988, p254).

Though of greater interest within this thesis is the belief that there are specific age and gender related factors that influence self-wounding. In terms of age, medical theorists suggest that self-harm behaviour is at its most prevalent within adolescence (Guoha et al.,1997). Within the psychological literature, self-wounding is perceived as a response to the development issues within adolescence (Woods, 1988).

In terms of gender, there is a strong emphasis on self-wounding amongst female adolescents.

Within a cohort study, Favazza and Conterio (1989) found that 97% of self-wounding respondents were female. As a result, they described the typical self wounded as female, educated, in their teens with an abused background. However, in contrast, Gardner and Gardner (1975) suggest such descriptions could be applicable to a whole range of non-

psychotic female psychiatric patients. Those who self wound often commit acts of low lethality, which are often repeated over a number of years (Sakinofsky and Roberts 1990; Lycaki et al. 1979).

Yet, as already noted the diagnosis of self-wounding may be a greater indication of the personality of the medical practitioner than the patient. Therefore as with suicidal behaviours, its impact upon a group of professionals can only be measured if the issues that influence that group are taken into consideration.

1.38 Causes of Medical Attitudes

As with sociological and psychological perceptions, medical theories of suicide causation have a number of causes. Given that the population within this study are members of the medical profession and allied disciplines, these factors could be central to the exploration of attitudes towards children who self-harm within this thesis.

In comparison with the 'social science' theories already examined, medical theories of suicide are based on biological factors rather than wider issues within the family or society. As a result, the problem and therefore any treatment, is based in these physical sciences.

This allows medical staff to perceive a process that follows a set pattern of causation, presentation and treatment, typical of the natural sciences. This allows those who understand this process (the physician), to have possession of the cure. In comparison, causes identified within Psychology and in particular Sociology are beyond the scope of the individual and can only be altered by changes within the wider environment. Within those psychological theories that pinpoint causes such as child abuse, the alleviation of suicidal behaviour is dependent on a long-term process and the co-operation of a number of individuals including the victim. This

is not so in medical theories, the cause is neurological and the treatment is neurochemical.

There is no need for any action on the part of the individual except compliance with medical instruction. This leaves the medic with an unassailable position because of the of the specialist knowledge they have of the suicidal process. However, these positions of control, or rather the reasons behind the need to establish this position are the factors behind the development of a medical model of suicide.

Thomas Szasz (1972), himself a psychiatrist, saw the psychiatric profession playing a pivotal role in what he described as the medical game. Within the game, society rewards the healthy and punishes the sick. Those who are ill are seen as bad and they need to be made better in order to conform to the wishes of society. By the rules of the game, the patient should attempt to get better. If they are unable or unwilling to be treated, they forfeit the right to have the doctor and others behave kindly toward them.

Szasz (1972) took his perceptions of mental ill health beyond the confines of the medical processes. He saw psychiatric illness as a bogus concept and psychiatry as a metaphor based on physical medicine. Mental illness presented the medical profession with a good deal of power, in that they are responsible for the control of society's values. Mental illness as a concept is needed to keep the medical profession in a position of dominance.

However, Szasz (1972) should be seen in the context of the period in which he was writing. Shorter (1997) described Szasz as being part of an anti-psychiatry movement, typical of the wider social issues at the time. Writing in the America of the 1960s' the anti authoritarian stand taken by Szasz found credence with the youth culture of the period. Indeed, Shorter (1997) saw Szasz write a number of works that denigrated the medical profession and psychiatry in particular.

Szasz's views were obviously considered with distrust by the medical profession, he was accused of neglecting the mentally ill for the sake of literary popularity (Leahy, 1994).

However, even this criticism is tempered by the acceptance that Szasz was part of a disruptive period in American society (Shorter, 1997). Though, the degree to which these issues affected British Psychiatry is open to debate.

Despite the efforts of writers such as Szasz, suicide causation and treatment are still seen as the realm of the medical profession. The doctor, as the medical expert is still seen as the best person to act on behalf of the patient (Scambler, 1991).

Yet, why does this position exist? If mental illness is the cause of suicidal behaviour, then the medical profession can maintain its position of dominance. Alternative causes and treatments can be rejected and ridiculed because they lack medicines grounding within the physical sciences (Gair, 2001).

This position of authority is supported from both within the healthcare system and in the wider context of society (Soothill et al., 1995). Castledine (1997) stated the medical profession maintained its position because they are seen as the holders of a great deal of moral strength. Therefore those that question the judgement of doctors are acting against this morality (Keddy et al., 1986). Patients are expected to accept the treatment that the doctor offers. Those who reject this offer, the long terms sick and in particular patients who make themselves unwell (by repeated acts of self-harm) are viewed as deviant. Within the framework of mental illness, this deviancy is diagnosed as personality disorder. Not only does this diagnosis bracket the individual, it labels them as difficult to treat (Kendall and Zeally, 1993). Thus repeated admission for self-harm is seen as the fault of the patient. The position of the doctor, as the carer, of those who wish to be cured, is maintained.

Within medical training, there is an emphasis on the socialisation of the medical student into the values of the profession. As well as this induction into positions of dominance (Robins et al., 1998), would-be doctors learn to differentiate between patients. Scambler (1991) noted that medical students learn to view patients as either rewarding to treat or those who are less so.

Medical views of suicide are therefore seen to reinforce the position of the profession. The basis of this reinforcement is the biological factors that justify the medical model of suicide. Whilst other theories of suicidal causation were developed in order to support the development of a particular discipline, medical theories help support the position of a profession. Even when medical staff are seen as lacking in knowledge, the task of their education falls to other medics, thus ensuring that dominance remains within the profession. Only medics have the ability to instruct other medical professionals, no other group has the knowledge or status. However, medical staff form only one part of the care staff within the population sample, nurses forming the majority of care staff within A & E departments.

The factors behind nurse attitudes toward suicide causation are evident in a number of publications. As already noted, the nurse theorists that examine factors behind causation tend to support the medical model. Those that do offer alternative causes, do so tentatively.

The reason for this support of the medical theories of suicide causation is found within the nursing profession itself. That there is an established medical dominance within healthcare has already been noted. However, it is the position of nurses within this hierarchy that will explain the stance taken by the nursing literature.

A number of authors have noted that historically the position of nursing staff was subservient to that of the medic (MacKay, 1993; Kalisch and Kalisch, 1977). Subservience, that starts

with the involvement of doctors within nurse education (Radcliffe, 2000). Medical staff were able to instil their value systems upon the embryonic nursing staff, who soon learned that progression came through the obedience of the doctors wishes (Porter, 1991; Sweet & Norman, 1995). Therefore the adherence to the medical model of suicide can be explained to some degree. Those nurses who attempted to question medical theory would find themselves isolated and belittled (Keddy et al., 1986). This is a possible explanation of the limited alternatives offered by the nursing literature.

However, those nurse theorists that do offer more 'holistic' causes of suicidal behaviour may be seen as products of the emergence of nursing within higher education (Walby and Greenwell, 1994). This alteration in nurse education has been seen to produce better-educated nurses who are able to question the dominance of the medical profession. However, despite this development others suggest that despite the alteration within nurse education, the medical profession is still in a position of dominance (Melhuish et al., 1993).

The above will have a direct impact on the results of this thesis. If the neurobiological theories are dominant with the sample areas, then the perceptions of the care staff will be so influenced. Issues of lethality and repetition will be perceived within the medical model and children who self-harm will be viewed accordingly. However, if the current advances of nursing theories are influential amongst that staff group then alternative perceptions may arise. If the nurses do take a more 'holistic' approach to the causes of suicide, then both staff groups will have different perceptions of children who self-harm.

1.39 Aims & Objectives Phase One

Following this exploration of the literature, it was possible to identify the aims and objectives of the first phase of the thesis. These are based on two factors. Firstly, the exploratory nature of the study, given the limited number of published works on attitudes toward self-harm in children. Secondly, on the premise that there are certain factors pertaining to both staff and patients that hypothetically could influence care staff attitude the examination of which form the initial aims of this thesis:

- 1: To examine if care staff attitude may be influenced by clinical experience.**
- 2: To examine if care staff attitude may be influenced by clinical role.**
- 3: To examine if care staff attitude may be influenced by the gender of the patient**
- 4: To examine if care staff attitude may be influenced by the age of the patient.**
- 5: To examine if care staff attitude may be influenced by the number of previous admissions a patient has for self-harm behaviour.**

Chapter 2

Methodological and Ethical Considerations

2.0 Introduction

An examination of the literature found a limited number of works that dealt with staff attitudes toward child self harm in any detail.

The primary aim of this chapter is to develop and utilise an instrument that is capable of eliciting attitudes. The background to the development of the instrument forms the first part of the chapter. This is followed by the justification of both the patient and staff variables that are examined in this thesis. The pilot and main study will then be explored. This will include issues of population, data analysis and results. The chapter concludes with a brief discussion of results and the possible need for further study.

2.1 Attitude Formation

The concept of attitude has an intrinsic position in social research (Rosenberg and Howlands, 1960). However, the definition of attitude remains open to debate and such is the range of both attitude definition and management that a brief overview of the main theories is given below.

Whilst the range of theories provide conflicting causes of attitude, Triandis (1971) identified a workable definition evident in most works. The common theme evident in most texts is that attitude is 'the ability to respond to a situation'. Attitudes are seen to help the individual understand the world around them. They allow the person to adjust to particular events and environments.

Triandis (1971) saw attitude as made up of three components:

- 1/ The idea – a process undertaken whilst thinking.
- 2/ The affective component – an emotion that affects the idea.
- 3/ The behavioural component – the predisposition to a certain action.

The above is based on the three-component model developed by Rosenberg and Howlands (1960). Within this theory, attitude sits between stimulus and response. This provides the link between emotion and the resulting action. Attitude is a predisposition that causes the individual to act in a particular manner to a given situation. Responses to the stimulus are divided into three areas. Cognitive responses are based on opinion toward the object (e.g. that those who self harm do so to gain attention). Behavioural responses, that can be subdivided into actual overt actions as a consequence of the stimulus and verbal statements of intent and belief. Finally, affective responses, these are based on issues of like and dislike. Once an attitude has been formed it will become associated with either positive or negative experiences. Therefore, how the individual perceives the 'attitude object' is in response to previous experience (Triandis, 1971).

In contrast, Fishbein and Ajzen (1975) argue that there is a difference between an attitude toward an object and the attitude toward the action to be undertaken in response to it. Within this expectancy value model the process of attitude is based on probability. Certain features are associated with the attitude object and the individual will respond accordingly. Within this process of reasoned action, an individual will view an item as good or bad because of the beliefs that they hold. Behaviour toward the object will be based on intention. Intention itself is based on attitude and what is termed the subjective norm. This is the process by which our acts are governed by how we wish to be viewed by others.

However, a problem with this theory lies in the issue of specific individual belief. Whilst an individual may hold attitudes and thus act according to the subjective norm, they may be influenced by previous exposure to the stimulus. Eiser and van der Pligt (1988) suggest that an individual may respond to a given object according to their

action toward it. This process of self-serving bias takes place in order to legitimise our actions and see the self in a favourable light. Thus, the identification of attitude formation could be seen as limited.

The difficulty in attitude measurement is acknowledged within the literature. It is the very abstract nature of attitude that is the crux of the problem (Henerson et al., 1987). When measuring attitude, it is only possible to infer their construction and thus impact. There is a tendency within attitude research not to measure the attitude of the individual but rather the group (Eiser and van der Pligt, 1988). Thus the singular factors affecting one person's attitude are neglected. Despite this, the process of attitude measurement is well established in the research literature. Whilst results may be based on inference, a process of systematic exploration can allow for the identification of even the most emotive attitudes (Glaser, 2003). The next section of this chapter examines the process to be undertaken within this research.

2.2 Questionnaires in Attitude Measurement.

Questionnaires have long been established as a means of eliciting attitudes (Aiken, 1997). Indeed, one of the perceived benefits in using questionnaires as a means of data collection lies in the respondent groups familiarity with them (Hek et al., 1996). Whilst this can be seen as a positive indication of their use within this research, the over exposure of clinicians to requests to complete questionnaires has been cited as a problem. De Vaus (2002) sees apathy in questionnaire completion as a serious threat to that methods utility in attitude measurement.

Other factors that may limit the use of questionnaires are well documented by the literature. Sapsford and Jupp (1996) argue that there is limited control over the individual who completes the questionnaire. They suggest that within postal questionnaires, the researcher is uncertain as to who actually completes the instrument

itself. Less fundamental issues surround the nature of the process itself. Because of their rigid structure, questionnaires can be seen as divorcing the individual from their surroundings, a process of atomism. Consequentially, the data collected fails to reflect the respondent's actual experiences of their world (Pole & Lampard, 2002).

However, despite these criticisms the evidence for using questionnaires within this study is manifold. One of the main benefits cited in the literature is the number and range of respondents that can be reached. Clough and Nutbrown (2002) see questionnaires offering a broad view of both situations and attitudes. As already indicated, there is little in-depth research on attitudes toward child self-harm (Harrison, 1998). If a thorough understanding of the phenomenon is to be made as wide a sample as possible should be utilised. Given their wide use within healthcare research, respondents would be used to completing questionnaires, therefore ensuring a higher response rate, this is an important factor in ensuring that the data obtained is representative of the subject under examination.

Another benefit lies in relation to the topic under investigation. The issue of child self-harm is an emotive one. Questionnaires provide greater levels of anonymity than methods such as interviews (Pole and Lampard, 2002). By allowing respondents to complete the instrument alone, the issue of interviewer bias is also removed (Jupp, 1999). Respondents would also be under less pressure for an immediate response, allowing them to think about their attitudes toward this sensitive topic.

Questionnaire use in attitude studies of adult self-harm is well established. An examination of the literature identifies their widespread use. Early studies such as those of Ghodse (1978) used postal questionnaires to elicit attitudes of A & E staff. Domino et al. (1982) developed the Suicide Opinion Questionnaire, an instrument utilised in later studies (McLaughlin, 1994) and readapted by Domino in a more

recent work (Domino et al., 2000). Indeed, a recent study of care staff perception toward self-harm in young people made use of this questionnaire to measure attitudes (Anderson et al., 2003).

Extensive use has been made of survey data collection methods in assessing attitudes toward self-harm and suicide. Yet, there is clearly an emphasis on the use of previously validated instruments. Given that this study deals with attitudes toward child self-harm, the development of a questionnaire that encapsulates the main aspects of the phenomenon is required.

2.3 Development of the Instrument

Pole and Lampard (2002) describe questionnaires as a beneficial means of data collection on the condition that they are valid measures of a phenomenon. The development of an instrument that deals with the particular issues of child self-harm is therefore essential. A good questionnaire is seen as one that is based on theoretical reflection. It is therefore important that extensive use of the literature is made within the instrument's construction. Given the particular aspects of child self-harm such an instrument may differ greatly from one that deals with issues of adult self-injury. A factor supported by Wisker (2001), who cites a correctly structured instrument as vital if the research questions are to be answered sufficiently.

Prior to any data collection a questionnaire will be developed that is specific in the measurement of attitudes toward child self-harm. The process of development is outlined in the next chapter. Yet, in order to ensure that the instrument itself is effective a number of criteria must be met.

2.4 Reliability

If a questionnaire is effectively to elicit attitudes toward child self-harm it must be both reliable and valid. The reliability of the instrument is seen as one of the key features of a questionnaire (Clough and Nutbrown, 2002). Reliability is identified as the extent to which a tool is consistent in its measurement (Hek et al., 1996).

Oppenheim (1992) saw reliability as the area upon which researchers should concentrate, it being a precondition of validity. The instruments reliability is achieved when the range of items used are correlated. The structured approaches of questionnaires are felt to have greater reliability due to their transferability to other environments. Within this study, the questionnaire's construction must ensure that the process is considered as a whole rather than a set of disparate questions (Pole & Lampard, 2002). However, there are processes that ensure that the reliability of the instrument has been achieved.

Test –retest reliability has been identified as one of the oldest methods of showing consistency of measurement (Henerson et al., 1987). The premise of this process involves the comparison of the results obtained from one administration of the instrument with another, using the same sample population. Scoring the results obtained and their comparison provides a test-retest correlation. A reliable instrument will produce scores that correlate. However, the logistics of ensuring group availability on two separate occasions can prove problematic (Judd et al., 1991).

Split half reliability is felt to measure consistency within a single administration. Dividing the instrument into two equal halves and treating them as two separate

administrations achieve this. The correlation of the two half tests results provides an estimation of reliability.

It should be acknowledged that other problems with reliability lie in a lack of clarity on the part of the instrument. This could result in misunderstanding and errors on the part of the respondents. The instrument must undergo a structured process of development including pilot testing and the analysis of scores against the existing literature (Sandelowski, 1986). Not only should the questionnaire cover all aspects of child self-harm but be structured in such a way that the intended population is able to understand how to complete it.

2.5 Validity

Within the context of survey research, a valid instrument is one that measures what it intends to measure (De Vaus, 2002) in this instance the attitudes of care staff toward children who deliberately self-harm. The extent of validity within the instrument can be gauged in the following ways:

2.5(1) Criterion Validity: deals with the comparison of the results obtained with those of previously validated instruments. Given the extent of questionnaire use in attitude studies toward adult self-harm, this should not prove difficult. However, the differences in child self-harm should be acknowledged throughout.

2.5(2) Content Validity: deals with the instrument's ability to deal with the full extent of the phenomenon (Robson, 2002). Again, the development of an instrument that deals specifically with child self-harm is necessary in order to meet this assessment. As previously indicated, research on the topic is scant. Examination of the literature failed to find an instrument designed specifically to examine attitudes toward child self-harm. Therefore, any instrument created must ensure that it includes the main features of the phenomenon in order to claim validity. In this instance issues

of the child's age, gender and number of previous self-harm episodes should be included; each of these factors will be discussed later in this chapter.

2.5(3) Concurrent Validity: is defined as the process in which the variables contained within the instrument can be assessed (Judd et al., 1991). Thus, the developed instrument must ensure that it measures those variables at the heart of the research question. However, this measure of how meaningful an instrument is can be difficult to assess (Litwin, 1995).

2.5(4) Face Validity: is by contrast seen as the weakest form of validity. It deals with how well the instrument appears to measure what it intends to measure. Yet, in order to engender interest from the respondents it is important that the instrument is clear in its intentions. If the sample population do not feel that the questionnaire covers the issue of self-harm in childhood they may be reluctant to complete and return it.

2.6 Additional Design Considerations

Alongside the development of a suitable instrument to elicit staff attitudes there are other methodological considerations. These are outlined below but are considered in detail within the relevant chapters of the study.

2.7 Sample Population

This study examines care staff attitudes toward children who self-harm. Previous attitude studies have utilised a range of healthcare environments. Goldney and Bottrill (1980) examined the attitudes of a number of clinicians including consultant psychiatrists and student nurses. However, exploration of the literature shows a high proportion of attitude studies are based within Accident and Emergency (A & E) departments.

Early attitude studies such as Ghodse (1978) made use of both A & E and ambulance staff, later research concentrated on nurses working in the department (McLaughlin, 1994). Whilst this will allow for a comparison of results, it is the causes behind these studies that influence sample choice in this research project.

A & E has been identified as the first place many self-harming patients receive healthcare. Therefore, the attitudes of care staff within the environment could have major implications for the outcome of any treatment. This factor is acknowledged by Dunleavey (1992) who examined the experiences of self-harming patients in A & E departments, describing the harmful impact of negative attitudes on patient's willingness to receive further treatment.

Issues of sample size must also be considered. Crano and Brewer(2002) and Cioyne (1993) saw too small a sample as unable to detect differences in variables. However, a large sample would need to take factors such as regionalism into consideration in terms of the results obtained. Other factors such as staff variables, once selected would allow these issues to be dealt with. These are considered in the development of the instrument.

2.8 Qualitative Study of the Phenomenon

The examination of care staff attitudes toward child self harm in young people has been identified as an area that requires further exploration (Anderson et al., 2003). Therefore, the main necessity lies in the identification of what factors shape views toward the issue. As indicated, within this study exploration takes the form of a questionnaire designed to deal exclusively with issues of child self-harm. However, in order to glean the underlying factors behind the results obtained, further analysis may prove necessary.

The use of more than one means of data collection and analysis to examine a topic has been well documented (Robson, 2002). This process of triangulation within research has been identified as dealing with the weaknesses of both quantitative and qualitative methods of data collection and analysis (Wisker, 2001) ensuring that a fuller understanding of the topic is achieved. The use of a second phase, which deals with the factors that shape attitude, has a twofold benefit. Firstly, it strengthens the validity of the results obtained from the questionnaire. Secondly, it provides the background to these results, enabling a fuller picture of phenomenon.

2.9 Ethical Considerations

‘Research which duplicates other work unnecessarily or which is not of sufficient quality to contribute something useful to existing knowledge is in itself unethical.’ (Department of Health, 2001).

Whilst the above has been addressed by the factors already discussed, there are other issues within research ethics that must be acknowledged. Ethics have been defined as ‘The systematic study of value concepts. And the general principles that justify applying these concepts (Siber, 1992, p3). Within the process of social research this applies to a basic tenet that the respondent population should incur no harm. This sentiment is supported by Allmark (2002) who suggest that no participant should be exposed to any risk from the research process if it is not outweighed by a chance of benefit. In essence, an ethical research project is one in which the respondent is placed at no greater risk than in everyday life.

Oliver (2003) suggests that it is important to consider ethics from the early stages of the research process. In order to ensure that this philosophy is adhered to, two main areas of ethical research are dealt with: consent and confidentiality.

2.9 (1) Consent

Allmark (2002) saw consent as divided into three areas. Firstly, consent would be given by someone competent to do so. Secondly, that the individual in question has been adequately informed as to the nature of the research. Thirdly, that any consent is given voluntarily. This process of voluntarily informed consent has been well documented within the literature (Diener and Grundall, 1978; Homan, 1991).

Within this study, these issues have been addressed in the following ways. As to competence, each respondent is a clinician, therefore it can be expected that they possess the cognition to understand the ramifications of consent. A full explanation as to the nature of the study and the process of questionnaire completion is provided with the instrument (see appendix 3). The use of a self-completion questionnaire also covers the issue of voluntary participation. The very nature of the data collection process allows for the use of free will to be addressed. Evidently there is no pressure on the respondent to complete the instrument if they do not wish to.

This process was aided by the use of respondent anonymity followed throughout the research. Oliver (2003) argues that if possible respondents should have their identity hidden at all times. Using codes and not requiring individual respondent details assured this process. Anonymity is of increased importance within this study given the emotive nature of child self harm. While respondents may hold negative attitudes they may not wish to publicly acknowledge them. Anonymity is seen as an important component of the other feature of research ethics confidentiality.

2.9(2) Confidentiality

The process of confidentiality should be transparent throughout the research process.

Data generated from the study should only be used for the purpose for which respondent consent was given a factor that should be made clear to those taking part.

It is the responsibility of the researcher to inform their sample that all information will

be treated in the strictest confidence and destroyed following completion (Sieber, 1992).

Other processes are undertaken to ensure ethical research. Oliver (2003) suggests that if approval of a University Ethics Committee is given then the studies ethical position is assured. Before any empirical work was undertaken, the appropriate ethics committee was approached and written approval obtained (see appendix 1).

Once ethical approval had been obtained, it was necessary to develop an instrument that would ensure that each of the issues highlighted above were addressed in detail.

2.10 Background to the Instrument

Recent years have seen an increase in official interest in suicide and self-harm, initially with the resolution to reduce suicide rates in the document the Health of the Nation (Department of Health, 1992) continuing with 'Saving Lives, Our Healthier Nation' (Department of Health, 1999) which again aimed to reduce the number of fatalities caused by self injury More recently, further guideline have been produced to help clinicians deal with self harming patients (National Institute of Clinical Excellence, 2004). Alongside this official interest, is the growth in academic studies. Such work includes examination of the needs of suicide survivors (Van Dongen, 1990) and the fluctuating rates of self-harm amongst young people (Hawton et al., 1982).

The attitudes of care staff toward thee patients have been examined in numerous studies (Hawton et al., 1981; McKie, 1994). However, examination of these texts shows that the trend is to focus on variables associated with staff rather than those of the patient. Such as Sidley and Renton's (1996) study of general nurses attitudes toward self-harming patients. Within such studies, role and environment are felt to affect attitude. Other works identified staff age and gender as influential (McLaughlin, 1994). However, factors such as gender have been discounted in later studies (Huband and Tantam, 2000). Those studies that examine patient variables do not do so in isolation, but use them in relation to established variables (Ramon et al., 1975).

Within both types of study, assumptions proliferate. In some works, it is suggested that staff would have the same level of awareness of such issues as the lethality of the self-harm act. Other factors such as patient age and gender are often not considered and when they are never in combination (Ramon et al., 1975). As already indicated this study deals with the affect both staff and patient variables have on attitudes amongst clinicians toward child self-harm.

2.11 The Development of the Instrument (The use of vignettes)

As discussed in the previous chapter, this thesis intended to make use of a questionnaire as a means of data collection. In keeping with previous studies (Ramon et al., 1975; Samuelsson et al., 1997) a series of clinical vignettes were developed to aid this process.

However, a number of difficulties in the use of vignettes have been observed. In their examination of the general public's attitudes toward mental illness Barry and Greene (1992) note issues of question and response format are as important as vignette content. Despite such reservations, they used seven hypothetical vignettes of case descriptions of what they described as a 'range of behaviours' (Barry and Greene, 1992, p144). It should be noted, that they concede that few empirical studies into the use of such methodologies have been made. Also that they concentrated on lay perceptions of adult illness, thus limiting the utility of their study to this research.

However, there are those studies that did concentrate on issues of self-harm. Ramon et al. (1975) used vignettes in their investigation of A & E (Accident & Emergency) staffs' attitudes, whilst Samuelsson et al. (1997) focused on those of psychiatric staff. Within both studies, vignettes were used in tandem with other data collection techniques, namely questionnaires and structured interviews. Yet, the vignettes in both studies present with similar features. Of interest to this study, is the small number of vignettes used by both sides. 'Four short descriptions.' (Ramon et al., 1975). Further difficulty can be identified in the lack of justification for the vignettes employed. There are no formal selection criteria in either study. If rigour is to be applied to this research then it is important that a more stringent procedure is employed in vignette development.

If an in-depth examination of staff attitudes toward self-harm is to take place it is important that patient variables are taken into consideration. To ensure that this examination is systematic a framework shall be adopted. This should enable the salient aspects of child self-harm to be incorporated; it will also provide the opportunity to examine the staff variables of the above works in terms of child self harm. The identification and justification for these variables and the framework that encompasses them are given below.

2.12 Variable Identification

Examination of the relevant literature provided an insight into those factors particular to child self harm. The vignettes themselves would be constructed of these variables, each of which is discussed below. It should be remembered that the aim of the vignette is to elicit staff attitudes. If the study is to provide a close picture of how child self-harm is viewed in the clinical area then the patient variables should reflect those issues faced by the respondents.

2.12 (1) Age

Studies that examine staff attitudes toward adult self-harm place emphasis on staff rather than patient age (McLaughlin, 1994). Those works that do indicate the patient's age provide no significant association between their age and staff attitudes. A recent study by Anderson et al. (2003) does identify the age of the patient as an issue. However, they do not differentiate in terms of age. The individual is seen simply as a young person. There is no consideration given to the effect an act of self-harm by a young child could have on attitude. However, within child self-harm age has been identified as an important factor (Guoha et al., 1997). Within this study, age will be divided into two areas: under 12 years and 12 years and over for the following reasons.

Kienhorst et al. (1987) noted the limited number of self-harm episodes committed by children less than 12 years, with a sharp increase in older children. A factor echoed by a number of other studies (Hawton et al., 1982; McClure, 2000; Levy et al., 1995). In another study, a subgroup of self-harming children under 12 was identified.

Opinions expressed within the literature also justify the selected age division. Spirito et al. (1989) also identified a lack of studies that examined age differences amongst self-harming young people and stated that such works were greatly needed. However, the literature itself could provide an explanation.

Greene (1994) described the lack of willingness on the part of health professionals to accept that young children would wish to harm themselves. This is manifested in the 'clinical belief' described by Goldney and Bottrill (1980) that young people make suicide attempts of limited lethality. In the same study, gender was also perceived as an influence on fatality, a matter addressed within another of the independent variables.

2.12 (2) Gender

Gender differences abound within the literature that examines child self harm (Gould et al., 1988). Of particular interest is the difference in suicide and parasuicide rates amongst male and female patients. Although the rate for actual suicide amongst men is higher than women, the rate of attempted suicide is greater in the latter (Baume, 1988; Gelder et al., 1994). This differences between rate of attempt and eventual fatality is identified by other aspects of the literature. DeRose and Page (1985) noted that females who engaged in self harm were less likely to kill themselves than males of the same age. This is an argument echoed by other studies (Kienhorst et al., 1987, Kerfoot, 1988; Dicker et al., 1997; Hawton et al., 1993).

Research that deals with self-wounding identifies the majority of non-fatal acts of self-harm being committed by young women (Pao, 1969).

This high repetition rate amongst young females was noted earlier by Hawton et al. (1996), who conceded that this could put pressure on already overstretched services, this is a possible cause of negative perceptions amongst staff. If it is accepted amongst care staff that young female self-harmers are less likely to commit an act of high lethality, then gender should be included as a variable. Attitude studies that examine patient gender found that females who self-harm were viewed as more manipulative (Ramon et al., 1975). However, readmission is itself a factor that warrants inclusion within the study as a separate variable.

2.12 (3) Admission Rate

The high rate of readmission for self-harm has been identified above. A number of authors have noted that a large percentage of adolescents repeat self-harm behaviours in a short period of time (Lowe et al., 1999; McGaughy and Harrison, 1995; Hill, 1995), 10% will repeat the act within a year (Hawton et al., 1982). In terms of staff attitude toward this client group, it will be of interest to discover if a high repetition rate does affect how an individual's act is viewed. Studies that examine staff attitudes towards patients who self harm have noted a greater empathy for those who were perceived as genuinely suicidal (Samuelsson et al., 1997). Those patients who have had a number of previous admissions could thus be viewed as more manipulative in their motives than the child who self-harms for the first time. The format developed by Krietman and Casey (1988) formed the basis of this third independent variable. Within this variable three categories of patient were identified:

First Ever (no previous treatment for self-harm)

Minor Repeaters (less than 5 previous admissions)

Major Repeaters (5 or more admissions for self-harm).

The use of such a categorisation is a departure from the formats used in previous suicide attitude studies (Samuelsson et al., 1997). However, it does acknowledge the issue of repetitive self-harm as an important aspect of the phenomenon and thus a potential influence on staff attitudes. Whilst this may be seen as a simplification of the phenomenon, it does allow for ease of analysis.

2.12 (4) Method

Whilst the following is not under examination, if a thorough exploration of the phenomenon is to be undertaken then these methods of self-harm should be acknowledged. If the literature that pertains to child self-harm is examined then two methods of self-injury predominate, ingestion and self-wounding (laceration). However, whilst their inclusion is important, there is little consensus as to what constitutes these two acts and the debate on classification has little uniformity (McLaughlin et al., 1996).

2.12 (5) Ingestion

There has been an established correlation between ingestion as method of self-harm and children (White, 1974; Boergers et al., 1998). Examination of the literature has identified a range of substances used within the act of ingestion (Shugg and Menahem, 1992; Appleby et al., 1997). However, the literature does suggest that the most common method employed is paracetamol ingestion. Indeed, the use of the drug is so widespread that a number of studies have been instituted to explain its popularity (Gazzard et al., 1976; Hawton et al., 1995). The main reason cited for its endemic use amongst children is availability (Hawton et al., 1996). Other factors include its use within media portrayals of suicide. Studies have noted that young people have a limited knowledge of the protracted death associated with paracetamol (Gilbertson et al., 1996).

2.12 (6) Self-Wounding

Hill (1995) in what she described as the 'suicide spectrum', discusses the confusion that exists around self-wounding. For some self-injury is a release of tension, rather than an attempt to end life (Tantam and Whittaker, 1992).

This hypothesis is supported by other aspects of the literature, which divide the act into two categories. These categories being based around the actual act of self-wounding. Pao (1969) and Favazza (1987) describe patients who carry out self-destructive acts such as marking themselves for the same reasons as those identified by Hill (1995). Pao defines this group as delicate cutters and their behaviour is seen as a way of coping with stressful situations.

A theory supported by Feldman (1988) who defined self-wounding as:

‘An individual intentionally damaging a part of his or her own body apparently without a conscious intent to die (Feldman, 1988, p254)

Of particular importance is the association between such behaviours and attention seeking in young people (Suyemoto and MacDonald, 1995). Given the extent of both behaviours in child self-harm, they warrant inclusion within the development of the instrument and this will ensure a more realistic picture of the issues faced by clinicians.

Each of these categories will form the framework of a vignette that will be used to elicit staff perception. Each vignette will examine a variation of the independent variables. The level of staff perception will be examined by means of outcome variables outlined below.

2.13 Outcome Variables

The above suggests that certain factors (in this case, the independent variables; age, method, gender and rate of admission) will influence care staff perceptions. In order to regulate the measurement of these perceptions, staff will be asked how they perceive the child in terms of

a number of variables. As with patient variables, these will be based on the relevant literature. An examination of each variable will provide a justification of their inclusion within this study.

2.13 (1) Communication

Method of self-harm can be interpreted by staff in a number of ways. Feldman (1988) noted that patients self harm in certain areas such as arms and legs to elicit certain responses from others. This is a factor further identified by Bunclark and Adcock (1996) who described the efforts made by patients to either reveal or hide their injuries. Within these studies, the authors perceive self-harm as a means of communication. Patients express their distress through physical injury. As a consequence of this need to communicate emotions through physical actions, an individual may carry out repeated acts of self-harm. A patient may have numerous admissions for self-harm behaviour, a possible cause of negative staff attitudes (Samuelsson et al., 1997).

A number of studies differentiate between patients in terms of the 'incentive' behind their self-harm (Elliot et al., 1996; Anderson, 1997). Those who were seen as manipulative in terms of their behaviour were seen as less acceptable to staff than the 'genuine' suicide attempt. Staff may view a method of self-harm such as the ingestion of paracetamol in front of others as communicative and thus of lower priority than one who harms in a covert non-communicative manner.

2.13 (2) Intent

Another outcome variable closely linked to method is intent. Its importance is evident within the development of suicide intent scales, in which the amount of care a patient requires is equated to the perceived seriousness of their intent (Beck et al., 1974). The link between staff attitudes and the suicidal intent of the patient has been noted by a number of studies (Ramon

et al., 1975; Samuelsson et al., 1997). Within these studies, staff felt greater incentives to care for those who had high suicidal intent. Those patients who carried out acts of limited intent were perceived as less acceptable.

As already noted, there are a number of works that identify a lack of willingness on the part of care staff to accept that younger children would wish to self-harm (Greene, 1994; Spandler, 1996). In terms of this study, a direct association may be found between the age of the patient and their perceived intent. Although, it will be of interest to note if there is a link between perceived intent and the other independent variables. One of the main factors that determine the perceived level of suicidal intent is the lethality of the act, which forms the third dependant variable within the study.

2.13 (3) Lethality

The perceived lethality of the self-harm act has been identified as an important factor within numerous attitude studies (Patel, 1975; Sidley and Renton, 1996). Patients whose act of lethality was high were viewed as more genuine in their suicide attempts by staff. The lethality of the act, as perceived by staff could possibly be influenced by all of the independent factors. Given the repetition rates for self-harm behaviour in children the number of admissions for self-harm could influence the staff perception of the act.

It is possible that a child with a large number of admissions for self-harm could have each attempt viewed as less lethal than one who self harms for the first time. Research by Anderson et al. (2003) has shown that the young person who self-harms can often frustrate clinical staff. It is possible repeated acts of self-injury could result in negative attitudes on the part of staff. However, it could be suggested that only those staff with extensive experience of self harming children would be influenced by this variable, a factor that will be addressed in the identification of the independent staff variables.

2.14 Independent Staff Variables.

This study in part followed a format similar in terms of staff variables to those studies that dealt with attitudes toward adult self-harm:

Role (Physician / Nurse).

In keeping with other attitude studies, this study chose to divide staff according to role (Patel et al., 1975; Anderson et al., 2000). In this case staff were divided between physician and trained nurse. This justification for this selection was as follows. Firstly, both groups make up the majority of those employed within A & E departments. Secondly, the difference in role means that their interaction with children who self-harm will be different and this could affect attitude. The use of trained rather than auxiliary nursing staff provides a base line in terms of training, which allows the introduction of experience as the other staff variable

Clinical Experience (Less than a years experience / a year plus).

Staff groups were divided in terms of clinical experience, in this instance based on one years clinical experience in an A & E department, the choice of such a cut off point is based on the following. The literature indicates that A & E departments are often at the forefront of treating acts of self-harm (McKenry et al., 1982; McManus et al., 1997). Therefore, within a year a clinician could be expected to come into contact with numerous examples of the phenomenon. The use of A & E department experience also ensures that experience in other departments is not included. It is possible that a clinician could work in another area for several years and have not worked with self-harming children. It should be noted that certain staff variables have not been used in this thesis. Previous attitude studies have divided staff in terms of gender (Morrison, 1991; Valente et al., 1994). However, as indicated Huband & Tantam (2000) suggest staff gender can be discounted within attitude studies.

Regarding staff age, it should be remembered that those works that include this as a variable deal with adult patients (McLaughlin, 1994; Samuelsson et al., 1997). In terms of child self-harm, it possible that the age of the patient will have the greatest impact on attitude, a factor hinted at by Greene (1994).

2.15 Means of Data Collection.

As indicated, a score obtained from the respondents provided the dependant variable.

Therefore, it is important that the developed instrument encompasses all of the above factors.

As already noted, this thesis makes use of a questionnaire and vignettes as a means of data collection. The development of this instrument is outlined below.

2.16 Questionnaire Development

Peterson (2000) feels that the starting point of any questionnaire should be a consideration of what type of questions should be asked. Given that this thesis examines the attitudes of care staff toward child self-harm it is essential that the main elements of the phenomenon be incorporated into the method of data collection. As indicated, the questionnaire is based on a number of hypothetical vignettes of child self-harm. Issues of age, gender and rate of admission are all incorporated within the instrument and are identified in the literature already discussed. Each act of self-injury within the vignettes was based around factors that the literature has identified as predisposing a child to self-harm, including issues of grief, school anxiety and bullying.

The use of suitable topics within questionnaires development is seen as vital if the instrument is to measure what it was constructed for (Oppenheim, 1992). The instrument must portray as realistic a picture as possible the actual acts of self-harm confronting the respondents within their own clinical environments. To this end, an item pool of 36 vignettes (3 for each patient type) was developed from the relevant literature and distributed to a group of psychiatrists.

Each of the group had achieved college membership and had experience in the treatment of young people who self-harm. The psychiatrists were then asked to identify which vignettes (of each category) they felt most mirrored actual cases of child self-harm. From the initial list, the most realistic 24 were selected and from this a second round produced the 12 used in this thesis.

Litwin (1995) states that this process of expert review helps ensure the content validity of the instrument. Whilst this is not a scientific measure of validity it can be seen as a strong indicator of vignette relevance, with face validity also assured by this process. If the psychiatrists were able to identify the vignettes as accurately depicting acts of child self-harm is reasonable to assume that the sample population will do the same an important issue if the study was to achieve a high return rate.

The psychiatrists were recruited as the expert group for a number of reasons. Firstly, they were a convenience sample, the researcher having access to a group of psychiatrists in the Liverpool area. Secondly, as experienced health professionals all had extensive experience working with the subject group and importantly this experience had been accrued for the most part within the A & E environment. It is accepted that they do not fully mirror the sample population and that there could be variations in response as a consequence. However, this is balanced by the knowledge that contamination of the sample populations would not take place.

The use of clinicians also ensured the degree of 'relative understanding' (Peterson, 2000) within the sample population would be high. The administration of a questionnaire that was incomprehensible to the respondents would obviously result in a low return rate. Indeed, there were a number of inherent issues within the instrument that could influence levels of response. The first issues to consider is the time needed to complete the questionnaire. Given the nature

of the clinical environments under examination it is intended to use a mailed approach to data collection. Whilst this is seen by some as limiting return rate (Aiken, 1997) in general a mailed questionnaire should take no more than 30 minutes to complete important given the limited time available to busy clinicians. Therefore within the pilot study, the time taken to complete the instrument will be of real significance. In order to reduce completion time Aiken (1997) feels that instructions on how to complete the questionnaire should be made as clear as possible at the beginning, with responses identifiable to the questions to which they refer, a format adopted in the current study (see appendix 3).

The use of closed questions within the instrument is also seen as beneficial given the emotive topic under investigation. Open-ended responses may result in the sample population giving what they see as the correct answer. By limiting the range of potential responses, it is hoped that a truer picture of the phenomenon is uncovered. The possibility of 'ballot effect' (Peterson, 2000) in which busy respondents simply complete the questions in the quickest time is another factor in selecting closed questions. Yet, whatever format is selected the utility of the instrument can only be confirmed through the piloting process.

2.17 Pilot Study

The importance of pilot work within the research process has been highlighted by numerous authors, Oppenheim (1992) saw the pilot study stage as a process for the revision, refinement and adaptation of the data collection instrument, this is supported by Mitchell and Jolly (1996) who see pilot work as a confirmation that the instrument measures the potential range of scores for which it was developed.

Even when a previously validated instrument is used, pilot work is still seen as a necessary phase of the research process. Given this study's use of a newly developed questionnaire, issues of layout and instrument reliability are of increased importance. Based on this premise,

the purpose of the pilot phase in this study is to ensure that the questionnaire is capable of eliciting the attitudes of care staff toward child self-harm.

2.17 (1) Pilot Study Population

The pilot study population should in theory mirror that of the main study as much as possible.

It is intended that the main study population will consist of the trained medical and nursing staff of local Accident & Emergency (A & E) departments. Therefore, the pilot should be carried out in a similar unit. However, time constraints dictated that another study sample be used. The use of another A & E department would have meant the identification of another hospital, with a unit similar to those of the main study, which would limit the number of respondents available to the main study.

As a result of the above, a convenience sample of nursing students within the University was selected. In order to have as close a match as possible, the respondents were trained nurses with at least one year's clinical experience. Although the main study population will include medical staff, it was felt that the use of one of the independent staff variables would be sufficient. The process of the pilot being to ensure that the instrument measures what it is intended to measure rather than begin a process of analysis and comparison. The use of the University as the environment to complete the pilot study is beneficial for a number of reasons. Firstly, the researcher could be present to answer any questions posed by the respondents. The chance to have both researcher and a large number of respondents who had just completed the questionnaire together would be limited in a busy A & E department. Secondly, the length of time it takes to complete the instrument could also be measured, important if the sample is to be made up of busy clinicians.

2.17 (2) Process

Two tutorial groups of post registration nurses on a research methods course were selected. Each group had a range of clinical experiences and respondents of both genders one group would complete the questionnaire that contained case studies of paracetamol ingestion, the other cases of wounding.

The researcher asked if any of the respondents were employed in the intended A & E departments to ensure that contamination of the main study populations did not take place. Whilst there is debate regarding this process (Edwards and Talbot, 1999) it was felt best to curtail any discussion of the topic within the chosen data collection areas. The purpose of the study was outlined and the respondents asked if they had any objections to taking part. The questionnaire was distributed to the students who were timed by the researcher as they completed it. Once the questionnaires were collected it was possible to commence with data analysis.

2.17 (3) Data Analysis

Duxbury (2003) suggests that the piloting of a questionnaire can help establish its validity and reliability. The process of establishing reliability can be undertaken by measuring the internal consistency of the instrument (MacInnes, 2003). If an instrument is to measure an underlying theme (in this case attitudes toward child self-harm), then the items that make it up should have a strong relationship with each other. Internal consistency exists if the items correlate highly. The higher the internal consistency of an instrument, the lower the chance of error and the greater its reliability (Oppenheim, 1992).

Examination of the literature suggests the use of Cronbach's Alpha as the most suitable means of measuring internal consistency and thus reliability.

Lewis-Beck (1994) saw Cronbach’s Alpha as similar to the split half method of measurement but without that methods limitation in estimating reliability. Another benefit of using Cronbach’s within this study lies in the test’s suitability in measuring an instrument that does not have binary scores (Black, 1999).

An alpha score of 0.7 is considered an accepted level of internal consistency by MacInnes (2003) whilst Bland and Altman (1997) suggest that a coefficient of 0.75 or greater is needed to confirm reliability. If this latter score is taken as the benchmark within this study, then any score greater than the above will indicate the instruments suitability for use in this study.

A total of 25 respondents completed the questionnaire, 8 completed the instrument that dealt with paracetamol ingestion, 17 with self-wounding. The data of all 25 questionnaires was encoded with the use of the SPSS statistical package. The answers for all questions from each respondent given the following values:

(Low) Communicative = 0.00	(High) Communicative = 1.00
Intent = 0:00	Intent = 1:00
Lethality = 0.00	Lethality = 1.00

From this, the percentage response for each vignette could be assessed. The calculation of these ‘scores’ allowed the internal consistency of the instrument to be measured. Each group response was initially measured then both combined and the overall alpha score obtained.

Table 2.1 Reliability Coefficient of Ingestion Questionnaire

N of Cases = 8	No of Items = 22
Alpha = 0.93	

Table 2.2 Reliability Coefficient of Wounding Questionnaire

N of Cases = 17	No of Items = 22
Alpha = 0.86	

Table 2.3 Reliability Coefficient of Pilot Study Questionnaire

N of Cases = 25	No of Items = 22
Alpha = 0.89	

The scores obtained above indicate a high level of internal consistency and thus reliability within the questionnaire. However, the establishment of reliability was not the only issue within the pilot study process.

2.17 (4) Completion Time

As previously discussed, the time taken to complete the questionnaire may be of great importance given the intended subject population and their place of work. Both pilot groups were timed, with questionnaires completed in a 10minute period.

2.17 (5) Comments

Respondents had the chance to make comments about the instrument. The majority of these were around the subject area. Three of the respondents expressed confusion around the term 'communication'. However, all three completed the questionnaire within the 10-minute period.

Some respondents felt that they would benefit from a 'practice' vignette in order to enable them to understand the format of questionnaire, as a result it was felt prudent to include two 'test vignettes to aid familiarity with the instrument.

2.17 (6) Discussion

The short time period needed to complete the questionnaire indicates that busy A & E staff would be willing to take part. Given the processes undertaken in its development it was felt that the instrument was now ready for use in the main study.

Chapter Three

Phase One Data Collection and Analysis

3.1 The Main Study

This section comprises the process of data collection and analysis for the main part of the study. The selection and recruitment of the sample population is given alongside their demographic details. Methods of data collection and analysis are also discussed and conclude with the presentation of the data itself.

3.2 Sample Population and Recruitment

Oppenheim (1992) defines a sample as a smaller group within a population and that if it is to be representative of the population then it must share similar characteristics. This thesis examined the attitudes of A & E clinicians toward child self harm. Thus, if the results obtained were to be representative then the process of sampling must be undertaken (Kumar, 1996). However, Oppenheim (1992) acknowledges that there must be some compromise between theoretical sampling and the practical limitations of research. Moseley and Mead (2004) support such a theory, seeing factors such as access, time and logistics as issues within sampling. Such opportunity sampling because of its non-probability allows for poor generalisation. However, such methods of sampling are often employed in attitude studies (Morrison, 1991) and the data obtained does allow for observations to be made.

As already noted, the use of A & E department staff is based on a multitude of factors. Not only is the A & E department of the first point of contact for self harming patients (NICE, 2004) its use in previous attitude studies allows for comparison. In keeping with earlier attitude studies (Norris, 1997; Anderson et al., 2003) this thesis made use of a number of clinical areas. The sample population consisted of the medical and nursing staff of four A & E departments.

The four departments were selected because they all shared similar characteristics. Firstly, in terms of geography, they were all situated close to a large paediatric hospital with its own A &

E department and could thus be expected to refer complex cases there. Secondly, each department served a similar socio-economic population. All were based in satellite towns, with high rate of unemployment and substance misuse amongst young people. As drug and alcohol abuse are linked to self-injurious behaviour (Kerfoot et al., 1995) it was felt that the clinicians could expect to treat a similar range of cases. It is acknowledged that the departments are not equal in terms of staff size or staff ratio. Selecting hospitals on the basis of size could have been undertaken, yet, this would result in finding A & E departments in other areas. Using a wide spread population would result in issues of regionalism, which has been acknowledged as a factor in self-harm from the earliest (Durkheim, 1897).

In keeping with the ethical issues outlined in the previous chapter, the researcher approached the ethics committees of four hospitals. The background to the study and the methods of data collection were presented and ethical approval gained. The researcher then approached the head clinicians of each department and outlined the research process to them. Once consent had been given, it was possible to approach the sample population.

3.3 Process

The clinical staff of each department were presented with the questionnaires and vignettes, that examined either investigation or self-wounding. Along with the vignettes a written explanation of the study and instructions for completion were included (see appendix 3). Each respondent completed the questionnaire in the same way as those in the pilot study. Each questionnaire was contained within a self-sealing envelope that ensured anonymity. Responses were then placed in a sealed box provided by the researcher. Contact was maintained with senior clinicians and reminders sent to staff two weeks after distribution and one week before collection.

3.4 Demographic Tables

The researcher collected the boxes containing completed questionnaires. This allowed the demographic make up of each department to be identified and the response rate to be calculated

Hospital A

78 medical and nursing staff worked in the A & E department. 54 questionnaires were returned, a response rate of 69%.

Table 3.1 Demographic details within Hospital A

CATEGORY	NO	%
Medical Staff	11	20.3
Nursing Staff	43	79.9
<1 Years Experience	10	18.5
>1 Years Experience	44	81.4

Hospital B

81 medical and nursing staff were employed within the unit during the data collection process. 54 questionnaires were returned, a response rate of 65%

Table 3.2 The Demographic details within Hospital B

CATEGORY	NO	%
Medical Staff	10	18.8
Nursing Staff	44	81.2
<1 Years Experience	11	20.7
>1 Years Experience	43	79.2

Hospital C

18 medical and nursing staff worked in the A & E department during the data collection period. 10 questionnaires were returned a response rate of 56%

Table 3.3 The Demographic details within Hospital C

CATEGORY	NO	%
Medical Staff	1	10
Nursing Staff	9	90
<1 Years Experience	0	0
>1 Years Experience	10	100

Hospital D

Table 3.4 The Demographic Details within Hospital D

During the collection period 69 medical and nursing staff worked in the A & E department. 35 questionnaires were returned a response rate of 50%

CATEGORY	NO	%
Medical Staff	6	17
Nursing Staff	29	82
<1 Years Experience	12	34
>1 Years Experience	23	65

3.5 Data Analysis

This chapter examines the results obtained from the first phase of data analysis. Each section deals with a particular research question posed at the start of the research process. As already noted, variables were divided between staff and patient. Each of these is examined in turn with a corresponding table to provide evidence of the statistical information obtained.

Initial analysis deals with those questions that pertain to clinical staff. This is followed by an examination of the patient variables that make up the self-harm vignettes. Each section is concluded with a brief discussion of the analysis. The chapter ends with a general summary, which draws on each of the research questions and draws a number of conclusions from the results obtained.

Methods of Analysis

The methods of analysis within this first phase fall into two distinct patterns, one dealing with staff variables and the second with patients. The method of analysis used to examine patient variables is discussed later in this chapter and the section below corresponds with the staff variables explored overleaf.

Use was made of inferential statistics, in this case the t test. In its simplest form the t test is used to determine if there is a significant difference between the mean scores of two groups (in this case groups based on role and clinical experience and the scoring method outlined in the previous chapter) (Burns, 2000). Within this study means are obtained from a scoring method to assess the content of each questionnaire. If a respondent felt that an act was high in lethality then it would be given a score of one with the same scores obtained for intent and communication. Acts of low lethality, intent and communication would be scored as nought.

The use of t tests are seen as acceptable if the following provisions are in place:

1/ The data are quantitative.

2/ The distribution of the differences (not original data) is plausibly normal.

3/ The differences are independent of each other (Swinscow, 1996).

Given that analysis is based on the comparison of two independently sampled groups, independent t test were used and the level of probability set at $P = <0.5$ in keeping with the accepted levels (Crichton, 2001). In order to establish equal variance the Levene Test was employed in order to verify assumption. When equal variance was not significant it was deemed acceptable to proceed with the use of the t test.

Table3: 5 Staff Role as an influence on attitude

Variable	Role	Mean	Std Error	Sig (2 tailed)
Female Lethality	RN	3.12	0.17	0.05
	DR	2.32	0.39	
Male Lethality	RN	2.21	0.39	0.01
	DR	3.48	0.16	
Female Intent	RN	2.04	0.12	0.21
	DR	1.68	0.25	
Male Intent	RN	2.60	1.13	0.03
	DR	1.96	0.24	
Female Communication	RN	3.97	0.16	0.57
	DR	4.18	0.30	
Male Communication	RN	3.81	0.17	0.58
	DR	4.04	0.36	
U12 Lethality	RN	3.13	0.18	0.02
	DR	2.04	0.40	
P12 Lethality	RN	3.46	0.16	0.01
	DR	2.54	0.39	
U12 Intent	RN	2.00	0.13	0.03
	DR	1.36	0.25	
P12 Intent	RN	2.63	0.14	0.33
	DR	2.32	0.28	
U12 Communication	RN	4.00	0.17	0.31
	DR	4.39	0.33	
P12 Communication	RN	3.77	0.17	0.76
	DR	3.89	0.33	
First Lethality	RN	1.95	0.13	0.18
	DR	1.54	0.27	
U5 Lethality	RN	2.37	0.13	0.03
	DR	1.71	0.30	
P5 Lethality	RN	2.29	0.14	0.01
	DR	1.36	0.30	
First Intent	RN	1.18	0.10	0.99
	DR	1.18	0.20	
U5 Intent	RN	2.00	0.10	0.06
	DR	1.54	0.21	
P5 Intent	RN	1.40	0.11	0.04
	DR	0.89	0.19	
First Communication	RN	2.45	0.12	0.01
	DR	3.18	0.21	
U5 Communication	RN	2.55	0.12	0.67
	DR	2.34	0.24	
P5 Communication	RN	2.68	0.13	0.99
	DR	2.68	0.26	

*Within the study there were 124 nurses and 28 physicians

3.6 Staff Role

3.6 (1) Introduction

Within this study, it is suggested that staff role will influence attitudes toward child self harm. As with earlier studies (Anderson et al., 2000) the study population was divided between physicians and nursing staff, who were exposed to the same set of

patient vignettes. This section will examine the perceptions of each of these groups toward the variables contained in the patient vignettes. Each group will be examined in turn and results described. Comparison of the two groups will be made and both significant and non-significant differences examined.

3.6 (2) Nurse Perception

Nurse perception was influenced by patient gender. Whilst greater lethality was seen amongst female patients than male the latter were felt to have greater intent of self-harm. Nurses also saw greater evidence of communication amongst female patients than male. Nurse response varied according to patient age, with higher levels of lethality and intent perceived amongst older children. This trend was reversed for patient communication, marked as higher amongst younger patients. Rate of admission also altered nurse response. Mean scores rose and then decrease in tandem with the number of previous self-harm episodes. In comparison, levels of perceived communication were greater with each admission with the highest mean mark amongst those vignettes that described five or more admissions.

3.6 (3) Physician Perception

Doctors saw a correlation between lethality and intent. Male patients were perceived to have committed acts of higher lethality and with greater intent. In contrast female patients were felt to have carried out acts of greater communication. This pattern was again identifiable in perceptions of patient age. For the physicians, older patients carried out acts of lower communication but high intent and lethality. However, as with nursing staff a different pattern emerged for rate of admission. As can be seen in, the highest mean score for lethality was given to those patients with between 1 and 5 admissions. Physicians also perceived this group to have the highest levels of suicidal

intent. However, communication was felt to be greatest among children who self harmed for the first time.

The development of these patterns indicates that there is some aspect of the physicians training or role that produces the results obtained. This may be the length of medical education that last two years longer than nursing. This extended period of learning that includes further examination may expose the physician to a range of possible explanations for the phenomenon and thus result in a different response to the patient vignettes (Sinclair, 1997).

3.6 (4) Group Comparison

Examination of the data produced patterns of both significant and non-significant variations in the mean score between the two groups.

The aim of this section is to examine differences in the response of doctors and nurses to the vignette description variables. Non-significant results are of equal importance because they describe the patterns of perception elicited by the phenomenon.

3.6 (5) Significant Differences

There were significant differences in mean response for nurse and physician perception of lethality in both male and female patients (physicians saw a higher level amongst males). Statistical significance was also evident for intent amongst male patients with the greater mean 'score' amongst nurses. (RN = 2.04; Dr = 1.68)

As with gender, there were significant differences in the perceived lethality of patient acts. In both cases, nursing staff saw greater levels of seriousness within the vignettes. This pattern continued in the examination of admission rates. Both significant differences saw a higher mean score amongst nursing staff. Again, for perceived intent

in two of the three variables nurses saw significantly higher levels in the vignettes than medical staff. In contrast, the only significant difference in perceived communication dealt with no previous admissions. Medical staff perceived higher levels of communication than did nurses.

Whilst these results indicate a number of important differences in patterns of response by nurses and physicians, the lack of significant differences is also of interest.

3.6 (6) Non Significant Differences

It is evident from the table that there are a number of similarities in sub-group response. These cover all patient as well as outcome variables, suggestive of a similar perception toward the phenomenon. However, closer examination of the results does show an interesting pattern. Of the 11 non-significant differences only one deal with patient lethality. Patient intent is evident in four equal responses. The remainder deals with patient communication. Indeed, there is only one significant difference in staff response toward perceived communication. This deals with children who have self-harmed for the first time: (RN = 2.45; Dr = 3.18, $P = 0.007$).

Evidently there is some aspect of patient communication that is held in common view. Yet, it may be that it is the communicative aspect of child self harm that is the greatest influence on staff perception. As the table shows mean scores for these variables are consistently high. Whatever the reason, this is the strongest shared response amongst the respondents.

That there are other variables that engender similar perceptions is also an indication that there are some shared attitudes toward the phenomenon.

3.6 (7) Discussion

Examination of the data identified a number of important patterns of response. As indicated there are a number of issues in which both groups have similar attitudes. None more evident in the high mean scores gained by both sets of respondents seeing little suicidal intent (RN = 1.18; Dr = 1.18 P = 0.996)

It is within the examination of patient lethality that the greatest significance occurs. Of the variable combinations that deal with lethality of act, statistically significant differences occur within six. Evidently there is some aspect of each group's perception that leads to this difference. This is confirmed by examination of the table. In all but one test of perception, nursing staff scored higher than physicians. It can be summarised that this aspect of child self harm is viewed according to clinical role. The above indicates that there are aspects of patient variables that affect attitudes. Similarities in response may be due to a lack of sensitivity on the part of the instrument. Yet, it may also indicate shared view toward some aspects of the phenomenon. These similarities and differences suggest the need for further investigation as to how such issues are formulated within the nursing and medical professions.

Table 3:6 Clinical Experience as an influence on attitudes

Variable	Role	Mean	Std Error	Sig (2 tailed)
Female Lethality	M	2.91	0.18	0.43
	L	3.21	0.34	
Male Lethality	M	3.22	0.17	0.73
	L	3.36	0.38	
Female Intent	M	1.99	0.13	0.76
	L	1.91	0.22	
Male Intent	M	2.55	0.13	0.27
	L	2.24	0.24	
Female Communication	M	3.92	0.17	0.23
	L	4.33	0.26	
Male Communication	M	3.75	0.18	0.19
	L	4.24	0.31	
U12 Lethality	M	3.27	0.17	0.80
	L	3.36	0.35	
P12 Lethality	M	2.85	0.19	0.37
	L	3.21	0.38	
U12 Intent	M	1.91	0.13	0.67
	L	1.79	0.24	
P12 Intent	M	2.62	0.14	0.30
	L	2.39	0.26	
U12 Communication	M	3.99	0.17	0.09
	L	4.36	0.27	
P12 Communication	M	3.66	0.17	0.09
	L	4.27	0.27	
First Lethality	M	1.78	0.13	0.13
	L	2.21	0.25	
U5 Lethality	M	2.22	0.13	0.61
	L	2.36	0.25	
P5 Lethality	M	2.12	0.14	0.99
	L	2.12	0.28	
First Intent	M	1.18	0.10	0.98
	L	1.18	0.20	
U5 Intent	M	1.92	0.11	0.97
	L	1.91	0.20	
P5 Intent	M	1.40	0.11	0.06
	L	0.97	0.19	
First Communication	M	2.48	0.12	0.05
	L	2.97	0.20	
U5 Communication	M	2.49	0.12	0.49
	L	2.67	0.23	
P5 Communication	M	2.64	0.13	0.52
	L	2.82	0.21	

*There was 119 experienced and 33 inexperienced staff in the study.

3.7 Clinical Experience

Clinical experience has been seen as a factor that influences staff attitude

(McLaughlin, 1994). Within this study, the sample population was divided on the

basis of one year A & E experience. of the 152 respondents 33 had less than one year in the field.

As with staff role, analysis was based on initial examination of each staff sub group and then comparison. This produced one significant and a number of non-significant variations in mean score.

3.7(1) Less-experienced Staff

Initial examination of inexperienced staff response yielded a number of patterns.

Firstly, there is evidently a limited perception of patient intent. Mean scores for this variable were consistently low; suggestive that child self harm is perceived to be of little concern. By comparison mean scores for communication were high. Across all patient variables children were felt to use self-harm to communicate, an indication that for inexperienced staff this is a central element of the phenomenon.

Lethality was scored between these two variables. As shown in the table, the mean score remained almost equal across the patient variables.

3.7 (2) Experienced Staff

As indicated by the table, the responses of experienced staff follow a similar pattern to those above. Low mean scores are given for patient intent. A greater mean is achieved for perceived lethality. However, the greatest score is for patient communication. This variable was viewed as high across all patient sub groups.

3.7 (3) Group Comparisons

As with staff role, this section examines differences in the response between experienced and inexperienced staff. Again, non-significant results are equally important.

3.7 (4) Significant Differences

Compared to staff role, the number of significant differences between the two groups is limited. Indeed, analysis of response produced only one statistically significant result. This dealt with patient communication and noted a greater mean score from less experienced staff toward children admitted for the first time ($M = 2.48$; $L = 2.97$; $P = 0.056$)

3.7 (5) Non significant Differences

As already noted, there are great similarities between the two groups of respondents in their perception of child self-harm. The highest mean marks are for perceived communication, the lowest scores are given regardless of experience to patient intent. That these patterns of response are evident throughout the table is an indication of a consensus of opinion toward self-harm behaviour in children.

3.7 (6) Discussion

What is most evident is the comparison of response in this staff variable to that of clinical role. The lack of statistical significance between sub groups is in sharp contrast to the results shown in table 3.5. While this is of interest itself, there are other aspects of the analysis of equal importance.

Firstly, the differences in mean scores between patient variables. While lethality is perceived as high it does not achieve the same response as communication. This aspect of child self harm is consistently viewed as high by both groups of respondents. In direct contrast not one vignette is felt to contain evidence of high suicidal intent. It can be accepted therefore that for the clinician, there are certain factors particular to

child self-harm. While their actions may be lethal, the young person who self-harms does so to communicate with limited intent of self-destruction. That both sets perceive the phenomenon in this way is of interest. It is possible that the results obtained reflect a lack of sensitivity on the part of the instrument though other aspects of the analysis point toward another explanation.

A second factor identified is that the above patterns of response are not exclusive. There is not one patient type that engenders these particular staff attitudes. Age, gender and rate of admission do not appear to affect staff attitudes. It would seem that it is not patient variables that affect response between these two sub groups. Rather, there is a universal perception toward child self-harm. That the patient has any of the variables identified seems irrelevant. For experienced and inexperienced clinicians alike, there are set responses to the subject.

However, this does not explain the differences in perception according to role. It should be remembered that staff were divided according to length of A & E experience, all are qualified practitioners. While these may be relatively new to this particular environment they may have dealt with child self-harm in other clinical areas, this is a factor that warrants further investigation.

Table 3:7 Roles as an influence on inexperienced staff attitudes

Variable	Role	Mean	Std Error	Sig (2 tailed)
Female Lethality	RN	3.70	0.44	0.08
	DR	2.46	0.55	
Male Lethality	RN	4.15	0.44	0.01
	DR	2.15	0.56	
Female Intent	RN	1.75	0.26	0.37
	DR	2.15	0.39	
Male Intent	RN	2.30	0.28	0.77
	DR	2.15	0.44	
Female Comm	RN	4.25	0.36	0.70
	DR	4.46	0.39	
Male Comm	RN	3.90	0.42	0.17
	DR	4.77	0.44	
U12 Lethality	RN	3.80	0.50	0.05
	DR	2.31	0.50	
P12 Lethality	RN	4.00	0.40	0.02
	DR	2.38	0.56	
U12 Intent	RN	1.80	0.30	0.95
	DR	1.77	0.39	
P12 Intent	RN	2.25	0.32	0.50
	DR	2.62	0.46	
U12 Comm	RN	4.10	0.33	0.22
	DR	4.77	0.43	
P12 Comm	RN	4.05	0.39	0.31
	DR	4.62	0.35	
First Lethality	RN	2.60	0.37	0.08
	DR	1.62	0.38	
U5 Lethality	RN	2.80	0.28	0.03
	DR	1.69	0.43	
P5 Lethality	RN	2.55	0.34	0.06
	DR	1.46	0.45	
First Intent	RN	1.05	0.26	0.42
	DR	1.38	0.33	
U5 Intent	RN	1.90	0.24	0.84
	DR	1.92	0.35	
P5 Intent	RN	1.00	0.22	0.84
	DR	0.92	0.35	
First Comm	RN	2.65	0.28	0.05
	DR	3.46	0.22	
U5 Comm	RN	2.60	0.29	0.72
	DR	2.77	0.38	
P5 Comm	RN	2.60	1.27	0.19
	DR	3.15	0.99	

3. 8 Inexperienced Respondents

Given the results obtained from role and clinical experience it can be expected that the perceptions of inexperienced physicians and nurses will be similar toward patient variables. Respondents were divided in terms of clinical role. Of the 33 inexperienced clinicians 20 were nurses and 13 physicians.

3.8 (1) Analysis

Examination of the table indicated a number of significant and non-significant variations in mean score between the two groups. The aim of this phase of the study is to examine the response of inexperienced doctors and nurses to the vignette description variables. Each group will be examined in turn and results described. Both significant and non-significant differences will then be examined.

3.8 (2) Inexperienced Nurses

Patient gender was perceived as an important factor amongst the inexperienced nurses. As shown in the table, male patients were seen to commit acts of greater lethality and intent. In comparison, female patients had higher mean scores for communication. This pattern linking levels of intent and lethality is also evident in the perception of patient gender. Greater mean scores for both variables were attained by older children. Higher levels of communication were seen amongst the younger patients.

It is of interest to note that rate of admission also produced a similar pattern. The highest mean scores for lethality and intent were found amongst patients with less than five admissions. However, as shown in the table, they did not have the highest mean for communication.

3.8 (3) Inexperienced Physicians

Unlike the inexperienced nurses, the physicians did not develop the same patterns of response to all three patient variables. In terms of patient gender, no set pattern emerges. Table 3.7 indicates that there is no link between levels of perceived lethality

and intent. However, a theme is discernible for patient age. Again, there is a link between all three of the outcome variables. Older patients were perceived to carry out acts of greater lethality and intent though less communicative than the younger children. This pattern continues with the rate of admission. The highest mean scores for lethality and intent were given to those with less than five admissions. This patient group were also perceived to have the lowest levels of communication, a factor that can be identified in the perceptions of inexperienced nurses.

3.8 (4) Non-significant Differences

As indicated above, there are similarities between the attitudes of both groups. However, there are a number of differences. Examination of the table shows that in every exploration of perceived communication the mean score was greater amongst the physicians. Although this was statistically significant in only one case it is an evident theme within the analysis. Yet, as the table shows in each of the patient variables both groups are in agreement as to which 'patient type' had committed the acts of greater communication. It is possible that while both sets of respondents perceive patient communication in the same way there is an aspect of the physicians' role that heightens this attitude.

With the exception of the examination of lethality according to gender this pattern continued throughout the analysis. Whilst both groups were in agreement as to which patient groups were most at risk, one continually obtained the higher mean score. In a reversal of perceived communication nurses saw greater evidence of lethality and intent, evident in the significant differences between the two groups.

3.8 (5) Significant Differences

As the table shows significant differences in mean score occurred throughout the analysis, most evident in terms of patient gender. Although there is only one significant difference it represents a break in the pattern identified above. Whilst the physicians saw greater evidence of lethality amongst female patients the nursing staff felt the reverse (Male Lethality RN = 4.15, DR = 2.15).

Lethality engendered differences in perception within the other patient variables. Although this occurred only once within the examination of admission rates patient age produced different results. In both sets of patient variables nurses saw far greater evidence of lethality than the inexperienced physicians.

As already shown an evident difference between the two groups occurred in terms of perceived communication. This occurred in the examination of those who had self-harmed for the first time. However, it should be noted that in this instance both mean scores were the highest from both sub groups.

3.8 (6) Discussion

The most evident aspect of this analysis is the pattern of response that differentiated the two groups. With the exception of communication nursing staff continually had higher mean scores. Such a difference is evidently at the heart of staff perception toward child self harm. While the respondents had limited A & E experience, it should be remembered that all are qualified clinicians. Therefore, it is probable that they would have had some contact with self-harm behaviour. The differences in perception may be based on the clinical roles particular to each group. What is of

interest is the fact that medical staff see greater evidence of communication than intent and lethality. Given the demographic details of child self harm, physician response is suggestive of some knowledge of the phenomenon.

However, as noted there was only one instance in which the two sub groups differed in terms of which patient had the most lethal act. It could be suggested that the nurses share the same knowledge. Yet, this does not explain why there are significant differences between the two groups. It is possible that whilst all the physicians are aware of the issues within child self-harm this is shared by only a number of the nurses. The length of medical training is a possible answer though there is not enough information to draw this possibility to a conclusion.

Of equal interest is the link between high levels of communication and reduced levels of lethality and intent. That this theme is more frequent within the nursing respondents is of interest, especially given the overall means of the two groups. However, it should be noted that this pattern of response has been evident in other phases of this analysis. It is possible that this is an integral part of the clinical perception of child self harm. Yet, it does not explain why it was not as equally evident amongst the inexperienced physicians.

Table 3:8 Role as an influence on experienced Staff attitudes

Variable	Role	Mean	Std Error	Sig (2 tailed)
Female Lethality	RN	3.01	0.19	0.13
	DR	2.20	0.59	
Male Lethality	RN	3.36	0.17	0.03
	DR	2.27	0.56	
Female Intent	RN	2.10	0.14	0.03
	DR	1.27	0.28	
Male Intent	RN	2.65	0.14	0.02
	DR	1.80	0.24	
Female Comm	RN	3.91	0.18	0.96
	DR	3.93	0.46	
Male Comm	RN	3.80	0.19	0.46
	DR	3.40	0.51	
U12 Lethality	RN	3.00	0.19	0.03
	DR	1.80	0.61	
P12 Lethality	RN	3.36	0.18	0.18
	DR	2.67	0.56	
U12 Intent	RN	2.04	0.14	0.01
	DR	1.00	0.29	
P12 Intent	RN	2.70	0.15	0.12
	DR	2.07	0.33	
U12 Comm	RN	3.98	0.19	0.87
	DR	4.07	0.50	
P12 Comm	RN	3.72	0.18	0.38
	DR	3.27	0.50	
First Lethality	RN	1.83	0.14	0.40
	DR	1.47	0.44	
U5 Lethality	RN	2.29	0.14	0.17
	DR	1.73	0.44	
P5 Lethality	RN	2.24	0.15	0.02
	DR	1.27	0.41	
First Intent	RN	1.20	0.11	0.50
	DR	1.00	0.24	
U5 Intent	RN	2.02	0.12	0.01
	DR	1.20	0.22	
P5 Intent	RN	1.48	0.12	0.02
	DR	0.87	0.22	
First Comm	RN	2.41	0.13	0.15
	DR	2.93	0.34	
U5 Comm	RN	2.54	0.13	0.27
	DR	2.13	0.31	
P5 Comm	RN	2.69	0.14	0.29
	DR	2.27	0.40	

3.9 Experienced Staff

Given the central themes of role and experience, it can be expected that there will be differences between the two staff groups. Within the sample population, there were 104 experienced nurses and 15 physicians. In the overall aim of the research, the hypothesis can be identified as the expected differences in attitude toward child self-harm between experienced nurses and physicians.

3.9 (1) Analysis

As with earlier sub group analysis, each of the respondent groups is examined in turn. This will allow for the identification of any patterns of response toward the patient variables. Comparison between the groups shall deal with both significant and non-significant differences. A discussion of these will allow for an in-depth examination

3.9 (2) Experienced Nurses

Initial examination of the table shows that patient gender is important in the formation of experienced nurse perception. Greater levels of lethality and intent were seen amongst male patients with female children more communicative. This link between low levels of lethality and intent can also be observed for patient age. The table indicates that the experienced nurses perceive younger children as more communicative. Though their acts were less lethal and of lower intent when compared to older patients. Admission rates are however viewed differently. As shown in the table, lethality and intent are felt to increase with the number of previous self-harm episodes. Yet, as the admissions increase perceived severity declines. It is patients with between 1 and 5 admissions who are felt to carry out the most dangerous acts. In comparison least concern was shown toward those whom had self-harmed for the first time. Unlike earlier patient variables the pattern that linked levels of intent, lethality and communication is absent. Levels of communication were felt to increase with the number of self-harm episodes.

3.9 (3) Experienced Physicians

Patient gender is an influential factor in physician perception. As with the experienced nurses a pattern of response can be identified. Male patients are felt to commit acts of greater lethality and intent while greater communication was seen amongst females. This pattern was repeated in perceptions toward patient age. Those over 12 were felt to carry out acts of greater lethality and intent. Yet, as shown in the table, it is the younger patients who carried out self-harm episodes of higher communication. In terms of rate of admission, the vignettes provided the same response for lethality and intent. Those children with one to five admissions were felt to commit acts of lethality and intent greater than other patients. Those who had self-harmed on at least five occasions were perceived to be of least concern. However, it was those who had self-harmed for the first time that were perceived to carry out acts of greater communication.

3.9 (4) Group Comparisons

An examination of the differences between the two groups provided both significant and non-significant differences as well as a number of similarities.

3.9 (5) Significant Differences

As shown in the table, there are a number of significant differences between the two sub-groups. These covered all patient and outcome variables except communication. Patient gender produced a number of differences. In terms of male lethality, the nurses saw greater evidence than their medical peers did. However, patient gender produced the greatest difference when both groups examined intent. Both male and female

patients were perceived by nursing staff to have greater intent compared to the views of the physicians (Male Intent: RN = 2.65, DR = 1.80; Female Intent: RN = 2.10, DR = 1.27).

Examination of other patient variables was not as clear-cut as the above. Patient age engendered two major differences between respondent groups. The nurses and physicians perceived the lethality and intent of children under 12 very differently. In both cases, nursing staff saw patient actions as more serious. Indeed the greatest difference between the two groups occurred in their examination of patient intent (RN = 2.04, DR = 1.00) As with patient gender, the theme is one of physicians perceiving patient acts as less serious. Rate of admission also engendered a number of significant differences between respondents. Again lethality and intent were the catalysts. Greater mean scores were found in perception toward those with at least one previous admission. Those who self-harmed for the first time did not elicit major differences in staff attitude.

3.9(6) Non-Significant Differences.

As indicated above, the attitudes of both groups followed a similar pattern toward a number of vignettes. That both sets of respondents saw a link between high levels of intent and lethality is of interest.

However, the identifiable difference is that for nearly all the measurements of perception the higher mean score was obtained by nursing staff. Indeed examination of the table shows that there is no incidence of perceived lethality and intent in which physicians 'obtained' a higher mean.

Perceived communication provided the reverse to this trend. In both examinations of admission rate and patient age, physicians saw greater evidence of communication.

However, this was not the case in all variables. Nurses saw higher levels of communication in male patients; those over 12 and those with more than one admission. Given the monopoly in terms of intent and lethality, this spread of mean scores suggests that communication is an important aspect of child self-harm for both groups.

3.9 (7) Discussion

It is evident that there is a difference in how experienced nurses and physicians perceive child self-harm. While the number of significant differences is of interest it is the overall trend they represent that is of importance. Nurses view patient actions as more serious than physicians. That this is most evident amongst the experienced respondents is a strong indication that there are factors within the clinical role of both groups that help shape perception. Yet, the levels of perceived communication varied between the two groups. It is possible that this aspect of the phenomenon impacts on each group differently according to the 'patient type' they are dealing with. This is an indication that clinical role does shape staff attitudes; it is also an indication that those patient variables are influential. However, the degree to which this is true cannot be answered at this stage.

What can be identified are the patterns of response both groups provide toward the outcome variables. For physicians as well as nurses, there is a link between low levels of lethality and intent and highly communicative behaviour. The high levels of repetition within child self-harm have been identified within the literature. This is echoed by the response of the experienced clinicians. The low level of fatality amongst younger children is also acknowledged in the mean scores given to those patients under 12. Evidently both sets of respondents have an awareness of the issues

that surround the phenomenon. That this is greater amongst the physicians (evident in the lower mean given) is of interest. The fact that the statistically significant differences between the two groups occurred around these variables reinforces this suggestion.

However, the above, while of interest does not explain the basis of these differences. The exploration of the patient variables themselves is needed in order to gain a fuller understanding of the issues in question.

3.10 Patient Variables

Alongside the staff variables examined above, it is hypothesised within this thesis that patient characteristics will also influence staff attitudes. As already indicated, the majority of attitude studies deal with staff variables (Ghodse et al., 1978). Indeed, an exploration of those studies that examine attitudes toward child self-harm found no evidence of patient variables being explored in their own right (Anderson et al., 2003). However, the study does indirectly show that the age of young self-harmers has an influence on how they are viewed. Within the same work, staff expressed a range of emotions toward the child patients amongst them the issue of patient age:

‘They are young and have so much to live for.’

(Anderson et al., 2003, p592).

Alongside such comments, there is also evidence suggesting the influence of patient gender, ‘...there will always be a couple of girls at the end of the ward.’ (p590). Rate of admission is also evidenced within care staff statements. Therefore, whilst there is no empirical research against which to measure these results, it is evident that the variables under investigation in this thesis are pertinent to the phenomenon.

3.11 Method of Analysis

Use was made of a non-parametrical statistical test, the McNemars Chi square. The use of chi-square allows for observation of a distribution of frequencies (in this case rates of response) in order to establish if that distribution has occurred by chance (Salkind, 2000). McNemars test, whilst often used for nominal data can be seen as a variable of Chi square (Swinscow, 1996).

As with staff variables, significance was set at $P < 0.05$, with the intention of conducting a test for each patient variable. Thus, patients would be examined according to age, gender and rate of admission.

Repeated use of the same test must raise the issue of type *I* error. According to Perneger (1998) if a null hypothesis is true (e.g. perceived lethality does not differ according to gender), a significant difference will occur once in twenty tests. In some cases, it is suggested that a more stringent criteria be applied. Swinscow (1996) feels that one answer is the reduction in the number of confirmatory hypotheses.

Alternatively, the researcher may implement a Bonferroni correction. The correction suggests that if significance for one test is set at $P < 0.05$, then two independent hypotheses would have a significance level of $P < 0.025$. However, Perneger, states that the use of a Bonferroni correction will increase the likelihood of type *II* error and best practice is to simply describe the statistical process. This thesis intends to follow the above, yet it accepts Swinscow's (1996) suggestion that within multiple comparisons, *P* values should be seen as guidelines until confirmed by other studies.

3.12 Patient Age

One of the most striking issues within child self-harm is the age of the young person themselves. Studies have shown that there are a number of presumptions around the self-harming behaviours of the young (Greene, 1994) the majority around an apparent unwillingness to acknowledge that someone so young would wish to harm themselves.

As already discussed earlier in this chapter, patient age is divided into two areas; those under 12 and those aged 12 and over. Again, outcome variables of lethality, intent and communication are used, each will be examined in turn and the results described and

significant and non-significant differences examined. Each vignette contained particular variables such as rate of admission, gender and age will be measured against its direct opposite in order to ensure that the other patient variables employed do not mask the results obtained e.g. Male <12 1st admission will be compared to Male >12 1st admission.

3. 12 (1) Lethality

The research aim was to discover if age would have influence on perceived lethality. Examination of the McNemars Test results suggests that it is not possible to reject the null hypothesis in this instance. Comparison of male patients showed that age did influence attitudes to a degree. Statistically significance occurred in only one of the three comparisons (see appendix). The use of frequency tables indicated that the impact of age altered with the rate of admission. In the case of those admitted for the first time male patients under the age of 12 were felt to have committed a greater number of highly lethal acts ($P = 0.01$). As the number of treatment admissions increased the position of the two patient groups, with acts of the older children seen as the more lethal ($P = 0.21$; $P = 0.41$) although not in sufficient numbers to provide significance.

Examination of the female patients produced a different range of responses. Again, rate of admission appears to affect the way patient age is perceived by care staff. First time admissions and those with between two and four previous episodes produced significant differences in terms of staff response ($P = 0.01$; $P = 0.01$). In each case, female patients over the age of 12 were felt to have committed a greater number of lethal acts. However, amongst female patients with over five admissions, age did not produce significant differences in staff response ($P = 0.90$), it was noted from the

measurement of frequencies that the range of response was almost equal, with female patients over 12 committing the lower number of high lethality acts.

3.12 (2) Intent

The research aim was to discover if patient age will influence perceived intent.

Examination of the McNemars test results suggests that it can be rejected. Yet, as with perceived lethality, age, when combined with the number of self-harm admissions produced a range of results.

There was no significant difference in terms of male patient age in both first and two to four admissions ($P = 0.41$; $P = 1.00$). Indeed, an examination of the frequency tables shows that in the case of patients with between two and four admissions responses were almost equal, evidenced in the P value obtained.

Significant differences occurred only with male patients with five or more admissions ($P=0.03$), with a greater score obtained by those aged under 12.

Examination of the age differences amongst female patients produced another range of results. Each of the three McNemars tests undertaken with this patient group showed statistically significant differences in staff response. However, as with lethality, staff attitudes seem to alter according to the rate of admission. Intent was felt to be greater amongst older patients with between one and two and four admissions ($P = 0.01$; $P = 0.01$). Five or more admissions saw a reverse in attitudes with younger girls viewed carrying out the greater number of acts of high intent ($P = 0.01$).

3.12 (3) Communication

As the tables indicate (see appendix 4), of the six tests dealing with age and communication, statistical significance occurred in only one instance. Amongst male

patients, age had no influence on the levels of communication perceived in their actions. As the P values for each test show ($P = 0.88$; $P = 0.23$; $P = 0.85$), respondents saw high levels of communication in both younger and older patient groups. Amongst female patients the impact of age on perceived communication was marginally greater. Of the three measurements taken only one provided a significant difference in staff attitudes ($P = 0.01$) and dealt with girls admitted for the first time indicating a greater level of communication amongst the younger patients. No significant differences were found for those with between two and four and five or more admissions ($P = 0.10$; $P = 1.00$).

3.12 (4) Discussion.

Examination of the above has identified a number of important responses toward the phenomenon. Within this thesis all results, both significant and non-significant are worthy of note.

What does emerge from this initial observation is the influence of the rate of admission on how patient age is viewed. That levels of significance change within the same variable with rate of admission the only alteration is suggestive of its importance. However, the analysis also indicates that age itself does influence staff perception, in terms of both lethality and intent the numbers of significant differences across patients of both genders means that patient age will affect how that individual is viewed. The relative lack of differences in terms of perceived communication may signify that there are aspects of child self-harm that are viewed as universal by care staff and that the age of child is irrelevant. If this is the case, then it would appear that there are issues within care staff perception that run contrary to the accepted knowledge on the causes of self-harm in young people (Hill, 1995).

3.13 Patient Gender

The issue of patient gender within child self-harm has been discussed in depth within the development of the instrument. As shown, a number of studies have highlighted differences between male and female patients including methods of self-injury and rate of morbidity and mortality (Kienhorst et al., 1987; Hawton et al., 1999).

313 (1) Lethality

The research aim was to discover if patient gender would have an influence on perceived lethality. In order to aid the explanation of the analysis patients were divided in terms of age as well as gender.

Statistical significance occurred in each case for patients under the age of 12 ($P = 0.01$; $P = 0.03$; $P = 0.01$). Among the younger patients, males were felt to commit the more lethal acts. Of interest in this case was the lack of difference made on the frequencies by rate of admission. Whilst frequencies obviously fluctuate, the levels of significance all pointed to boys being viewed as the group most likely to commit a highly lethal act.

Examination of the test results for older children would seem to confirm this. Whilst first time admission saw girls gaining the higher score ($P = 0.01$), the situation changed as admission rate increased. For those with two to four and five plus admissions it was males who perceived to carry out the more lethal acts ($P = 0.02$; $P = 0.01$). It would seem therefore that overall, the respondents' view gender as an indicator of potential lethality.

3.13 (2) Intent

Significant differences occurred within the examination of perceived intent.

Examination of the McNemars Test showed that it was possible to acknowledge the impact of gender on this particular aspect of the phenomenon, that statistical significance occurred in each case suggests that there is a degree of correlation between the gender of the young person and the perceived reason for their actions.

Boys under 12 were felt to carry out acts of greater intent if admitted between two and four times ($P = 0.01$) or on five or more occasions ($P = 0.01$). If the younger patient was admitted for the first time then the view changed to girls ($P = 0.02$).

Examination of the test scores for older patients saw a similar pattern. Amongst first time admissions intent was more often perceived amongst female patients ($P = 0.01$), this was repeated for those with two to four admissions ($P = 0.01$). The final McNemars test again significant, frequency showing a greater level of perceived intent amongst male patients ($P = 0.01$).

3.13 (3) Communication

Unlike the previous outcome variables analysis of perceived communication showed that there was limited impact on attitudes (see appendix 4). Of the six test undertaken, only one proved any significant difference in the way the patients were viewed by the respondents. Amongst children under 12 on their first admission, female patients were felt to commit the greater number of communicative acts ($P = 0.04$). That the remaining analysis failed to note any differences suggests that gender does not impact on perceived communication to the degree of the other two outcomes. Although an examination of the frequencies of response for each category show some differences

between the patient groups they are viewed in some instances as almost similar evidenced in the P values obtained for the McNemars Tests ($P = 1.00$; $P = 0.30$).

The situation was repeated for older patients with no discernable difference in the way communication was perceived ($P = 0.35$; $P = 0.68$; $P = 0.07$).

Evidently there is some aspect of child self-harm that produced an almost universal response in terms of how the communicative aspects of the act are viewed by care staff. Of course the one case of significance should not be ignored but questions as to the sensitivity of the methods of data collection and analysis should be considered.

3.13 (4) Discussion

The impact of gender on care staff attitude is clear from the above analysis. The differences in perceived lethality and intent show that the gender of the young person was obviously impacting on the way the way clinicians view them. Again, rate of admission causes frequency rates to fluctuate but the overall pattern is one in which male patients are felt to carry out the most serious self-harm acts. Of equal interest is the comparative lack of difference between the genders in terms of communication. As with age, this lack of overall significance may lie in the way child self-harm is viewed universally and regardless of gender the fact that the patient is a young person may prompt the respondent to see each act in the same manner.

3.14 Rate of Admission.

Whilst age and gender are variables contained within all patient groups, rate of admission and readmission in particular is an issue that almost seems almost unique to self-harming young people. Authors such as Hill (1995) have noted a high rate of repeated admission amongst children and young people a factor echoed in government

legislation, designed to reduce what is seen as an increasing problem (National Institute of Clinical Excellence, 2004). Rates of admission amongst adult self-harm patients have been noted to influence staff attitudes, Samuelsson et al. (1997) noted that those with numerous admissions were seen as manipulative by care staff. Given the combination of the above, it can be expected that rate of admission will influence staff attitudes.

As indicated earlier in this thesis, patient admission as a variable is divided into the three categories devised by Krietman and Casey (1988), of first timers; minor (less than five) and major (five or more) repeaters. The outcome variables used to examine patient age and gender are again utilised here.

3.14(1) Lethality

The research aim was to examine the rate of admission as an influence on perceived lethality. To aid analysis, patients were divided in terms of age and gender. Initial examination of the younger male patients suggests that the null hypothesis can be tentatively rejected. Of the three McNemars Tests undertaken, statistical significance occurred in two cases. It would appear that rate of admission increases in influence in tandem with the number of self-harm episodes. Examination of those admitted for the first time and minor repeaters showed no significant differences in staff response ($P = 0.90$). However, as the number of self-harm admissions increased so did the perceived differences in lethality. Those patients seen as major repeaters were felt to commit the most serious acts in comparison to those admitted for the first time ($P = 0.01$) and those seen as minor repeaters ($P = 0.01$).

In comparison, examination of the younger female patients showed a differing pattern of response. Again, patients with five or more admissions were seen as committing

the highest number of lethal acts. However, there was only one significant difference in staff attitudes, occurring between the major repeaters and those admitted for the first time ($P = 0.01$). The comparison with minor repeaters ($P = 0.30$) and that group and first time admissions ($P = 0.60$), showed a closer 'score' between patient variables.

Older patients appeared to elicit a different response from care staff. Of interest is the fact that amongst older male patients, it is those with between two to four admissions that care staff saw as carrying out the greater number of highly lethal acts. Yet, only one of these comparisons saw a significant difference in response, against those admitted for the first time ($P = 0.01$). The lethality of the act rose initially with admission and then fell slightly when the patient was admitted for the fifth time or more (see appendix 4).

Older female patients produced a different response from the A & E staff. Whilst minor repeaters carried out the greater number of lethal acts, the lowest response was awarded to those admitted five or more times. As a consequence, significant differences were found amongst two of the three Chi squared tests undertaken (see appendix 4), amongst major repeaters and first admissions ($P = 0.01$) and against minor repeaters ($p = 0.01$).

3.14 (2) Intent

Amongst males under the age of 12, the highest levels of intent were felt to be among those with five or more admissions, although significant differences occurred between those admitted for the first time and minor ($P = 0.01$) as well as major repeaters ($P = 0.01$). The same differences occurred amongst female patients, though in this instance, the greatest 'score' for intent occurred amongst patients with two to four admissions.

Amongst the older male patients, it was also minor repeaters who were felt to have committed the greatest number of intentional acts. Again, significant differences occurred in the perceived intent of first-timers and those classified as minor ($P = 0.01$) and major repeaters ($P=0.01$), with no significant difference between the later ($P = 0.24$).

A similar pattern appeared within the examination of the older female patients with the minor repeaters seen as carrying out the most acts of high intent. Yet, within this patient group significant differences occurred each test (see appendix 4).

Given the above it would seem that rate of admission had a direct bearing on the way staff view the self-harm intent of a young person. However, examination of perceived communication would seem to contradict this.

3.14 (3) Communication

The research aim was to explore the impact of rate of admission on the perceived communication within the self-harm act. Amongst the younger male patients, no one group gained a significantly different response. In terms of frequency, minor repeaters were felt to be the most communicative, with first-timers the lowest, though the differences in response rate between the two groups was small ($P = 0.66$).

Among female patients aged 12 and above, the highest levels of communication were seen amongst those admitted for the first time and the lowest amongst the minor repeaters. Yet, once again there was no significant difference in the way the two groups were viewed ($P = 0.75$) or in the other comparisons undertaken ($P = 0.25$; $P = 0.46$).

This lack of significant difference in response was again evident in the examination of the older male patients. In this instance an equal measure of communication was given to those admitted for the first time and those seen as major repeaters ($P = 1.00$), though the other test undertaken also showed a similarity of response ($P = 0.68$; $P = 0.67$).

However, amongst the older female patients, admission clearly affected perceived communication. As with their male counterparts, an equal level of response was given to those admitted for the first and two to four occasions ($P = 1.00$). Yet, a significant difference was detected between these two groups and the major repeaters ($P = 0.02$; $P = 0.01$).

3.14 (4) Discussion

Evidently, there some correlation between older female patients of numerous admissions and high levels of communication in the eyes of care staff. Though given the range of result obtained, it would be prudent to treat such statements with caution. What is evident however, is the impact of the other patient variables within the study. That the levels of perceived lethality fluctuated according to age and gender suggests that it is probably wiser to see all three patient variables acting in tandem to produce an overall picture. The equal scores given in some cases is suggestive of the limited impact rate of admission may have in some cases, though overall there is clearly some aspect of the phenomenon that will influence the way care staff view an act of self-harm.

3.15 Chapter Summary.

What is evident from the analysis is patient and staff variables do influence attitudes toward child self-harm. Interest lies not only in the fact that patient age, gender and rate of admission affect the way a self-harming child is viewed but rather that it

fluctuates according to the combination of the three variables involved. This suggests a number of things. Firstly, that the instrument itself does reflect the main features of the phenomenon. Secondly, it has established empirically the importance of not seeing patient or staff variables in isolation but rather as part of a myriad combination of factors that will shape attitude within the clinical environment. Thirdly, that any future research should acknowledge this complexity and not attempt to see either staff or patient variables as the sole contributory factors in any attitude study but attempt an holistic approach to understanding the phenomena.

This complexity is particularly evident in the examination of perceived communication. Care staff may see the communicative aspects of child self-harm as an almost universal component to the act, which fluctuates only marginally with each case. It is only when the patient presents with a large number of previous admissions, in this study five or more, that communication is felt to be more of a motivating factor. That this is one of the occasions in which there is a degree of agreement amongst the staff groups is also indicative of the impact staff variables have on the study although the limited differences in terms of staff role should be acknowledged. Indeed, given the exploratory nature of the study any findings should only be confirmed after further research.

Whilst this phase has contributed to the understanding of attitudes toward self-harm in children it fails to identify the underlying factors that shape the responses obtained.

We are able to identify patient variables of age and gender as influential but are unable to say why. The complexity acknowledged above requires further exploration not only to further understand the phenomenon but also confirm to some degree that

the results obtained so far are a true reflection of the way A & E clinicians view child self-harm.

Chapter Four

Phase Two Methodological Considerations

4.1 Introduction

Phase one identified the attitudes of A & E staff toward children who self-harm. However, it did not explain the factors that underpin them. Indeed as noted, the majority of works that examined attitudes toward suicide fail to deal with these underlying factors (Sidely and Renton, 1996; Samuelsson et al., 1997; McLaughlin, 1997).

Given the limited research into attitudes toward child self-harm, it is important that the phenomenon is explored to its fullest extent. In order to do this a process of data collection needs to be employed that provides an in-depth examination of what shapes staff attitude. As shall be seen, the method used provides an ideal means of understanding the issues that influence the way child self-harm is viewed. An ethos of exploration that shapes this chapter's questions

4.2 Aims and Objectives Phase Two.

To explore the possible factors that shape the attitudes of A & E staff toward children who self-harm with particular reference to the following:

A/ That these factors will differ according to clinical staff role.

B/ That these factors will differ according to clinical experience.

It should be remembered that these specific phase objectives are contained within the rubric of the overall aims on page 69.

4.3 Method

The method of data collection within this phase is shaped by a number of factors. Firstly, it should help answer the research questions already given. Secondly, it should provide a link to the first phase Finally, to ensure validity it should mirror the environment within the A & E department as much as possible. The examination of

each of these issues in turn will help provide a justification for the methods employed within this phase.

4.4 Previous examinations of care staff attitude

As already indicated the majority of previous studies into attitudes toward self-harm concentrate on either patient or staff variables. These have ranged from patient type (Ghodse, 1978) to length of staff clinical experience (McLaughlin, 1994). Yet this limits the depth of knowledge around the topic. Therefore, it is important that the present research overcomes this.

Examination of the literature identifies a number of methods used to obtain the factors behind attitude. Care staff attitudes have been obtained through participant observation (Johnson and Webb, 1995), as well as traditional interviews (Norris, 1997). Yet, whatever method is employed, the paradigm is consistently qualitative.

4.5 Qualitative Research.

As discussed earlier in the thesis, qualitative research provides the researcher with the opportunity to understand the issues behind phenomena (Silverman, 2000; Ashworth, 1997). What is at question here is the type of qualitative research method to be employed. It is acknowledged that there is a range of qualitative approaches available (Weinberg, 2002). Importantly, a quantitative phase has already been undertaken.

While some authors suggest that both paradigms are mutually exclusive (Michell, 2003) others suggest that there is benefit to be gained from the employment of the two within the same research (Schuman and Presser, 1996).

This concept is explored in greater depth by Miles and Huberman (1994) who feel that the use of qualitative analysis provides a 'rich depiction and strategic comparison across cases' (p41). They also suggest that a prior quantitative phase provide structure

to non-positivist research. The prior use of a questionnaire that contained clinical vignettes is evidently a factor in the selection of a suitable method of data collection. The development of the vignettes is based on empirical evidence of child self harm. Their use within the second phase will thus ensure that the phenomenon is at the heart of any data collection. As well as the content of the instrument, the sample population within phase one should also influence methodological considerations (Silverman, 2000).

This research examines the underlying attitudes of A & E staff toward child self harm. Therefore, any method of data collection should reflect the idioms of that clinical environment (Weinberry, 2002). The particular natures of A & E departments have already been acknowledged in the development of phase one. Re-examination of these issues will help frame the method employed here.

By their nature, A & E departments are busy environments. The quick turnover of patients and the unknown element of primary care ensure that there is limited patient contact in comparison to other aspects of healthcare. Therefore, the method employed should reflect the limited time available to A & E to formulate perceptions. The use of in-depth interviews would fail to acknowledge this. The informant would have greater time to consider aspects of the phenomenon. Wren (2001) sees interviews as a way of gaining access to the informant's experiences. By not placing the informant in an environment that mirrors these experiences the interview could isolate them from situational norms that shape attitude.

Another factor is the communal nature of A & E work. Care staff do not work in isolation. The smallest departments employ staff in shifts. Therefore, the staff have continual access to peers, who could prove influential in the development of attitude.

If a method of data collection is to provide a plausible account of staff experiences it should acknowledge this.

One possible method of data collection is observation. This would allow the researcher to place the results obtained within phase one into the context of respondent's actions. The comments made by respondents toward the phenomenon could be seen within the context of their own working environments (Weinberg, 2002). However, there are a number of factors that negate this method within the second phase. Observational techniques do not provide the meaning behind actions. Unless a respondent actually provides their opinion toward a particular aspect of the phenomenon we could only infer attitude (Wolcott, 2001).

This research examines attitude, therefore it is vital that it explores the factors behind actions rather than their physical manifestation. Another issue is the influence of phase one. As noted, the use of case vignettes provided the research with the chance to explore a number of factors within child self-harm such as patient age and rate of admission. It would be impossible to ensure that all of these variables would be found in the department during the observational period, limiting comparisons between the two phases. Phase one divided staff along lines of clinical experience and role. More experienced senior members of staff may influence the behaviour of more junior colleagues. Therefore a method of data collection must be employed that takes these factors into consideration. The use of focus groups within phase two will provide a solution to all of the above whilst ensuring an in-depth examination of staff attitude

4.6 Focus Group Research

Focus groups have been selected as the method of data collection within this phase. The following provides a definition and justification for the use of this method.

Examination of the literature provides a range of definitions. Greenbaum (2000) views the process as simply a group of individuals engaged in conversation. Others see focus groups as more complex, with set rules and procedures (Silverman, 2000). A combination of the two is provided by Barbour and Kitzinger (1999)

‘Focus groups are group discussions exploring a specific set of issues.’ (p4).

Yet why select this particular method? It has been noted that there are a number of difficulties with the use of other qualitative methods within this study. It is possible to identify similar problems within the use of focus groups. Examination of these issues in turn provides a justification for the choice of data collection technique.

As with most methods of data collection, there is the possibility that the researcher will influence the dynamic of the group. As a result, the data is less naturalistic in comparison to the information obtained from observational techniques. However, it should be remembered that this research examines attitudes, an issue not best explored through observation.

Another factor to consider is the group process itself. Morgan (1997) suggests that the group may influence the responses of the individuals taking part, affecting the validity of the data collected. Yet, this should be seen as a strength of the method. Interaction is at the heart of the focus group (Krueger, 1998, 1994). Respondents compare attitudes and responses with other members of the group. This provides an insight into the motivations behind actions and comments, a vital component of this research, this is taken further by Barbour and Kitzinger (1999) who see focus groups as operating within the social networks that formulate attitude. Also, the clinicians involved in this research do not work in isolation they are involved in a work environment that is based on the multidisciplinary process. Therefore, the use of a focus group will to some extent allow the clinical environment to be reproduced.

Alongside the above, is the language used within focus groups. A problem cited with one to one interviews is the respondent couching their answers in a manner they feel is expected of them (Silverman, 2000). Within a focus group the language used is that of the respondents social network. The researcher simply facilitates the group so the dynamic belongs to the respondents themselves (Bloor et al., 2001).

That the group converses in its everyday parlance may place respondents at ease.

Morgan (1997) suggests that focus groups allow for greater discussion of more sensitive topics. Individual interviews may engender reluctance to express opinions on emotive issues the group may provide support and make the individual feel able to express their views (deAlmedia, 1980).

Another factor in the selection of focus groups as a methodology lies in its suitability to follow other forms of research. A number of authors see the use of focus groups as an excellent follow up to survey research. Morgan (1997) perceives focus groups providing insight into results obtained from earlier quantitative phases. This is supported by Fern (2001) who sees the method as ideal in the analysis of survey results. No other method of data collection is felt to uncover core meanings to such an extent. Particularly of controversial topics such as perceptions of child self harm. Focus groups have been employed to uncover attitudes toward a range of issues, from attitudes toward sexuality (Knodel et al., 1996) and prostitution (Van Landingham et al., 1998). By their nature, the group process provides the environment to support perception as well as limiting interviewer bias.

‘Potentially, therefore, focus groups offer a more critical or reflexive framework for research on the very nature of attitudes.’

Barbour & Kitzinger (1999, p129)

In conclusion, the use of focus groups will provide this research with a framework to examine attitudes. By using groups, it will be possible to elicit the factors that shaped the results obtained in the first phase. The logistical issues of this phase are outlined below.

4.7 Method

In order to develop the process used within the second phase a number of questions arose. The answers to these questions provide the framework to the data collection undertaken.

4.8 Selection of Participants

As this phase was undertaken to explain the results obtained from the use of the questionnaire, participant selection was in the main predetermined. The composition of the groups would mirror staff variables from phase one:

Experienced Physicians;

Experienced Nurses;

Inexperienced Physicians;

Inexperienced Nurses.

While this is linked to the first phase it is also good focus group practice. By ensuring that the groups are based on role and experience, their views are not too disparate, which may result in a lack of depth of information (Bloor et al., 2001). Dividing the groups along such lines ensures that the value orientation of each sub set is not compromised (Fern, 2001). It will be possible to examine the attitudes of each staff group in turn, so aiding comparison.

The above appears contrary to any effort to eliminate selection bias. Yet, focus group sampling within this thesis is driven by theoretical motivation rather than issues of random recruitment. Another issue is the awareness of the respondents to the research

itself. In order to reduce issues of respondent bias, group members will not be drawn from those clinicians that took part in the first phase.

4.9 Group Size

The issue of focus group size is an area of contention within the literature, the main issue is that of productivity over practicality. Large groups require a high level of moderator participation and as such are difficult for the novice to undertake (Morgan, 1997). However, by their nature smaller groups result in limited data. Therefore, it is best to find a mid range. Most authors suggest a range of between five and ten respondents per group (Barbour and Kitzinger, 1999). Given this, it is suggested that the researcher would aim for a maximum ten respondents and conduct the group with five or more.

The number of groups for each staff sub-group, is directed by the issue of saturation (Morgan, 1997). This is the process by which the information obtained by the researcher will not be altered by the inclusion of more groups. Most texts suggest between three and four groups (Greenbaum, 2000). However, these guidelines can be reduced when there is more structure to the group process and homogeneity amongst the respondents. It is suggested that two groups per variable are conducted and if discussions differ then further groups will be undertaken.

4.10 Vignettes

It is intended that the self-harm vignettes used in phase one be utilised. As already indicated, they will provide a link to phase one, allowing for greater ease of comparison. The vignettes will also act as stimuli for the group process and reduce the need for involvement on the part of the researcher. Their use will also ensure uniformity in the way each group is conducted again aiding analysis. It is suggested that the use of vignettes or other methods of group stimuli will reduce spontaneity of

response. This theory is countered by Greenbaum (2000) who describes them as an ideal means of moderation. Problems may occur if the information given is long and complex. As the vignettes were designed to be quickly digested by busy clinicians this issue is negated. Once the method was established it was important to ensure that it could be implemented and a pilot of the data collection process was undertaken.

4.11 Pilot Study

The pilot phase, would allow the researcher to develop his moderation skills. Krueger (1998) suggests that in order to glean as much information as possible from a focus group, good moderation is essential. Although the researcher has extensive experience of group leadership, it would be vital to master such issues as audio tape recording. Also, the actual data collection process can be examined and potential difficulties highlighted. A convenience sample of post registration nurses on a course within the University was selected to form the pilot phase population.

4.11 (1) Process

The researcher approached the students and briefly outlined the purpose of the study. A date was confirmed for the group to take place and the researcher arranged the venue. Given the use of professionals within the study, no formal approval was needed. The confidential nature of the group was explained to the respondents and their attendance taken as an indication of consent. A total of seven trained nurses formed the group. Although from a variety of clinical backgrounds, all worked within the field of child health and had experience of children who self-harmed.

The respondents were seated around a table on which recording equipment had been placed. The need for a tape recorder and microphone were explained to the group who expressed no conflict with their presence. The respondents were introduced to an assistant moderator who would take shorthand minutes of the process. The use of

multiple methods of data collection within focus group research has been recommended by a number of authors (Morgan, 1997; Barbour & Kitzinger, 2001). Within this study, the use of hand written notes augmenting the audiotape process would ensure that all aspects of the group had been covered.

The researcher explained the process of the group and outlined group rules. Respondents were then shown a series of acetates that contained hypothetical case vignettes of child self-harm. They were then invited to express opinions of the case. The group was an open forum with the absence of a set pattern of response. After they had read the vignette, the respondents were able to comment as they wished.

However, in line with good focus group practice, the researcher asked direct questions of the more withdrawn respondents from the group. This was based on an interview schedule, that Morgan (1997) deemed necessary within structured groups (see appendix 5). This would ensure that all group members had the chance to express their views and thus produce an in-depth picture of how child self-harm is perceived. A total of 13 case vignettes were presented to the group. As with phase one, the first two vignettes were designed to allow the respondents to become acquainted with the case format and thus increase the richness of the data.

Once all the vignettes had been examined by the respondents, the researcher brought the group to a close. The group was thanked for their input and questions as to the purpose of the research answered. With these final questions the group had lasted a total of one hour and fifty-three minutes.

The assistant moderator typed the shorthand notes, which produced an abridged transcript of the group dialogue. Transcripts were then examined by the researcher who compared its contents to those of the audiotape and added any relevant comments that had been neglected. The completed scripts were then returned to the

assistant moderator who again examined the contents. This process of multiple method data collection prior to analysis is recognised within focus group literature as a method that ensures accurate reporting of the group process (Casey, 1998).

4.11 (2) Safeguarding Participants

Given the chosen method of data collection within phase two a number of ethical issues arise. One of the identified benefits of postal questionnaires is the anonymity afforded to the respondents. The face to face nature of the focus group means that this anonymity is to a degree removed. Compounded by the sensitive nature of the topic under investigation respondent confidentiality was an important consideration within this thesis.

Lee (1993) suggests the use of a range of methods to ensure the safety of respondents, a number of which have been acknowledged in this thesis. The first lies within the research topic itself. It is accepted that child self-harm is an emotive topic and there is a possibility that the nature of the topic may lead to anxiety on the part of the respondents. Lee suggests that a method be employed that allows research participants to distance themselves from the topic. One method suggested is the use of hypothetical vignettes to elicit response. The vignettes are seen as less intrusive than direct questions, the respondents are able to offer their own response to the situation avoiding potential distress. That the thesis has already made use of hypothetical vignettes allows for the easy implementation of this safeguard.

The other issue to consider is one of confidentiality, not only of the respondents but also of the data. In terms of those taking part in the focus groups the answer lies in the allocation of the numerical designations. These numbers are contained within the transcript codes, with each member of each group identified by a code number (See appendix 6). Each of the focus groups were assured of the confidential nature of the

research and that data would only be seen by the research team and once the study was finished all data would be destroyed. During the running of the focus groups the researcher and assistant moderator used first names only for group members increasing the degree of anonymity required in this thesis.

4.11 (3) Analysis

Given the aim of the second phase of the research project is to answer the 'why' of the result of phase one, the analysis framework is based on the variables examined within the initial stage. This results in the division of the analysis process into defined subsections. Although, one aspect of the study is the comparison of different staff groups, the make up of the pilot population prohibits this. Thus, analysis concentrated on the independent patient variables:

Age,

Gender,

Rate of admission.

As the group had examined the vignettes in turn, it was possible to analyse the comments as they pertained to each case. Initial analysis consisted of the identification of statements that covered the outcome variables of lethality, intent and communication.

Within focus groups, the use of coding is seen as beneficial to the analysis process. Not only does it allow for the identification of variables within the text, coded transcripts can easily be compared to each other. This is of importance within this study given the number of variables to be examined. These variables formed the basis of the coding system within the pilot study. Staff perceived acts as either low or high in: intent; lethality or communication. However, given the depth of data available. other codes were developed to aid analysis. A process carried out by hand using coloured markers and a cut and paste system.

Once these variables had been noted, the researcher examined each patient group in turn for the emergence of relevant themes. Comparisons were made between each group and initial conclusions drawn. The transcript and audiotapes were re-examined to ensure that no

significant data had been neglected. This also allowed for the identification of quotes that would illustrate the various codes made within the text.

However, given the nature of the data collection process other themes emerged from the group. These would provide a more in-depth picture of how focus group members viewed the issue of child self harm.

Findings 4.11 (4)

A summary of the categories that have emerged from the pilot group is given in the table below.

Table 4.1 Summary of Pilot Group Study

Patient variables	(1) Patient Age (2) Patient gender (3) Rate of Admission
General Issues	(1) Clinical experience (2) General Comments (3) Focus Groups

The accounts given in each of these main areas have been drawn from all the vignettes presented. Therefore the comments are not mutually exclusive but have been identified through analysis as best describing how that variable was perceived by the focus group. Extracts that support these items are emboldened.

4.11 (5) Patient Variables

The use of case vignettes allowed comparisons to be made between patient groups. As already noted, the coding system used within the report is based on outcome variables used in phase 1. However, given the depth of data available when positive and negative themes occurred they were included within the analysis.

Patient Age

Examination of the data, via the three outcome variables produced differences between the two patient age groups. Within the general context of the discussion, the patient's age was

seen as an important issue. The majority of the comments made centred on the age of the child in relation to the size of the paracetamol overdose they had taken.

‘Age will make a difference.’ (PLE)

It was felt that the amounts taken by the children (between 10 and 15 paracetamol) was of greater significance if the child was younger. The belief being that young children have difficulty in the ingestion of tablets, therefore in comparison, the lethality of their actions is greater than that of older patients.

Intent

However, despite the influence of age on perceived lethality, the reverse occurred in terms of perceived intent. Within those vignettes that dealt with children over the age of 12, there was a range of comments. Some cases were seen as high in suicidal intent, while other patients were perceived to have carried out their act with a limited desire to end life. Another feature of this patient variable was the level of disagreement that occurred within the focus group. Whilst some respondents felt that older children were intent on killing themselves there were also examples of perceived low intent.

‘If it was more serious, don’t you think he would have gone for more than 15 paracetamol.’ (PLD)

In contrast, there was universal agreement amongst the respondents that younger patients had carried out acts of limited intent. In some cases the act was viewed as a ‘knee-jerk’ reaction.

‘She (may) feel that she is losing control of the situation and must do something to stop it.’ . (PLE)

The younger patients were felt to have committed acts of limited seriousness. When this question was put directly to the group, the response to the negative was given quite strongly. The reason given for this lay in the belief that a child under the age of 12 would not comprehend the consequences of their actions. In one case it was suggested that a child may not have been aware of what was ingested.

Lethality

Within the coding system, a difference was observed between the two patient groups. Not only in terms of the rate of perceived lethality, but in how it was constituted. Amongst the younger patients the greater threat was seen in a lack of understanding on the part of the child. Linked with the lack of perceived intent, the concern lay in the possibility of the child ending its life due to naivety.

'He doesn't realise the danger.' (PLB)

As a result, the majority of cases amongst the younger patient group were seen as lethal due to this perceived innocence. In contrast, older children were felt to commit acts of high lethality if they attempted to hide their actions.

'He told his parents, if he had wanted to do it he wouldn't have told anybody.'

(PLD)

This decision on the part of the child to hide or conceal their actions was felt to be the pivotal factor.

'It's those that don't get found.... those that go and do it, they just want to get away from it. It's the ones (patients) who tell you that are seeking the help.' (PLG)

As a consequence, as perceived lethality was based on the exposure of the act, it is linked to the other outcome variable of communication.

Communication

The majority of the younger patients were felt by the respondents to have carried out highly communicative acts of self-harm. It was felt that they had not understood their actions and when insight occurred, the act was carried out to alert others to the child's distress.

'I think its attention seeking as well because he informs his mother, he commits the act to be admitted.' (PLA)

'She has just decided to take this paracetamol to try and get this attention.'

(PLE)

In contrast attitudes differed towards older children in terms of communication. These differences were based on the factors the respondents perceived as the cause of the self-harm act. Consequently, some patients were seen to be less manipulative in their actions than others.

'It's more than a cry for help.' (PLB)

'She just wants her own way.' (PLE)

Differences in how the older patient group was perceived was often based on their gender.

Patient Gender

The main difference between patients in terms of age was the potential ability on the part of the child to understand the consequence of their actions. Between male and female patients social factors tended to induce a difference in positive and negative staff comments.

Intent

One of the main factors that differentiated the two patient groups was the perceived intent of the act. Female patients were felt to have carried out their self-harm with limited suicidal intent but in order to gain within the social environment.

‘She needs a firm hand so she doesn’t do it again, anytime there’s anything happening with the family, I’ll take paracetamol and I’ll get my own way.’ (PLE)

‘She felt that she couldn’t do anything else, one way of alerting others to her feelings.’ (PLD)

In contrast, while some male patients were seen to have limited intent in their actions others were seen as serious about ending their own life. Even when the intent behind the act was disputed within the group, the majority felt favourable towards male patients. Their acts were felt to be understandable, which resulted in greater sympathy from the respondents.

‘He needs lots of cuddles.’ (PLE)

Female patients often produced negative comments from the group. Their vignettes were often discussed in a lighthearted manner with the majority of cases viewed as not too serious. A factor evident in the perceived lethality of female patients.

Lethality

Acts of perceived high lethality were spread more evenly amongst the two patient sub groups. Some male patients were felt to commit standard adolescent acts of self-harm that engender off-hand comments from group members

‘This happens a lot...I’d give him a slap.’.(PLE)

However, these negative comments were given in a jocular manner. This was reversed for female patients, who would still be viewed in a negative light even if the act was seen as highly lethal.

‘I think it was very serious, but I think it was a cop out really.’ (PLB)

Even when the act was seen as serious within the group, a female patient would be seen as a means to remove unwanted pressure or to gain attention. This attention seeking on the part of the female patients evident in how their acts were perceived as highly communicative.

Communication

Given the majority of female patients were felt to have limited suicidal intent, it can be accepted that this is equalled by views of high communication within their acts of self harm. Within the group this was evident in the factors that would make them repeat the act.

‘I think she’ll self harm, but not dangerously, enough to get her own way.’.

(PLG)

This theme of self-harm as a means of communication is evident in all but one of the female cases presented.

‘I feel that she would probably try to do it again, not to kill herself but for attention seeking.’ (PLE)

It was felt that female patients would attempt to control future situations through self harm and if left unchecked it would become a simple means of communication, because they would be unable to develop less maladaptive coping mechanisms.

‘She would self harm again, enough to get attention, if she doesn’t get her own way.’ (PLA)

‘Not very bright,’ (PLE)

Whilst some male patients were felt to use self-harm as a means of communication, based on fear rather than manipulation.

As he told his Mum, he may have done it on the spare of the moment and regretted it straight away.’ (PLD)

The situations for male patients were seen as intolerable and if they used self-harm to communicate they did so to find help. This need to seek support is one of the main themes identified in the examination of the other outcome variable of admission.

Rate of Admission

The number of times a child had been admitted for the treatment of self-harm behaviours influenced how they were perceived by the group. Again, analysis followed the pattern already established.

Intent

Amongst those patients who had carried out an act of self-harm for the first time, the majority of cases were seen as limited in their intent often seen as harming on impulse to a particular situation. This was seen to translate as learnt behaviour amongst those patients who had five

or more admissions. In contrast, patients with between one and four admissions were felt to have less manipulative causes for their behaviour.

'I think he is very disturbed to try it three times.' (PLG)

Lethality

The differences between the patient groups continued in terms of perceived lethality. Those patients with less than five admissions were felt to be attempting to increase the amount of paracetamol ingested. Important given the perceived link between dose and lethality.

'He could do it again and succeed.' (PLD)

The respondents' felt that this patient group had a limited prognosis and would need the greatest input in order to prevent them from eventually committing a fatal act.

Communication

Those patients with five or more admissions were felt to base their behaviour on attention seeking. For the respondents a large number of admissions were seen as an indicator of such. In some cases it was seen as a 'typical teenage scenario'. As already noted, the first time act was seen as a reaction, in which treatment should be based on explaining the dangers of such behaviour. In contrast, those with less than five admissions were felt to have been failed by the system. This failure a common feature of how the group viewed child self harm in general.

4. 11 (6) Clinical Experience

One of the emergent themes from the group was the emphasis placed by the respondents on their own clinical experience. The use of paracetamol as a means of self-harm was viewed with some concern. The antidote to paracetamol ingestion (parvalax), can only be administered on a limited number of occasions. Consequentially, those patients with several admissions for ingestion were felt to be at particular risk.

Another area in which the respondents made use of clinical knowledge was in the provision of actual cases as examples that they felt mirrored the vignette under discussion. This theme was continued within the general discussion of child self harm, particularly around the services available to this patient group.

‘That’s my experience, I know these kids aren’t helped.’ (PLG)

4. 11 (7) General Comments

The most striking feature of the group was the emphasis placed on the scenarios contained within the vignettes. Explanations would be developed and the cases expanded to explain the self-harm act. For the respondents the causes behind the self-harm were of greater importance than the dosage taken or the number of previous admissions.

‘ I know on (name of ward), we used to call it Saturday Night Fever. The amount of kids that came in with four paracetamol and half a bottle of vodka, because somebody else had a Berghaus jacket and I didn’t and that type of thing.’ (PLE)

However, in general it was felt that the system had failed to support those children who carried out acts of self-harm with high suicidal intent.

‘In between all these kids who are just swines’, there was one who had serious problems, but they all seem to be treated the same.’ (PLG)

Some of the respondents felt this lack of support for what were felt to be ‘genuine’ attempts at self-harm, was based on their own lack of clinical knowledge about the subject. This lack of knowledge was alluded to on a number of occasions.

We only look at our view, in our training years ago, we didn’t have this sort of thing. You think you don’t hardly know anything.’ (PLD)

‘I am becoming quite disillusioned. The amount that we really know about these children. How much research. What care. How we cope with these situations, how little we actually know about these children.’(PLA)

Whilst this view was common amongst the group, it was accepted that child self harm had increased in recent years. Again a number of causes were put forward, the main theme, that of the pressures faced by children today. The respondents felt that their own childhoods were very different from those of the patients. As a result, they had difficulty in understanding children who they felt were not children in the sense that they knew.

‘They don’t have that childhood any more.....they grow up more the pressures there.’ (PLG)

4.11 (8) Focus Groups

In response to questions to questions from the moderator, the group expressed no difficulties in terms of the group itself. They described the group as informative, which was reflected in the number of questions they asked about the research and child self harm in general. A number of respondents were more forthcoming during the discussion phase, but this can be felt to be a reflection of the actual clinical environment.

4. 11 (9) Conclusion

In summary, the pilot produced large quantities of valuable data. Although this was the first time the moderator had run a focus group, the respondents offered lively discussion around the individual vignettes and the subject of child self-harm in general. Of particular interest was the emphasis placed by the respondents on vignette scenarios. This would suggest that such factors play an important part in the development of staff perceptions. Another important

factor was the use of previous clinical experience of self-harm to highlight particular cases and explain value judgements.

The comparison of this group of experienced nurses to other staff groups is needed to examine if these factors are group particular. Despite such problems the group proved a highly useful exercise and could prove a benchmark for other groups.

4. 12 Theory

Given the success of the above, the use of focus groups as a means of data collection was established. In terms of both logistics and depth of data, they will provide a useful means of collecting staff perceptions toward the phenomenon. However, the issue of why such attitudes occur remains. While the method of analysis employed within the pilot indicates that analysis is possible, it is essential that a theoretical link with previous analysis be maintained.

According to Silverman (2000) research issues are theoretically driven. This is supported by Wolcott (2001) who acknowledges that theoretical implications should be an important issue within the analysis process. As this thesis is examining care staff attitudes in detail, it is important that the theoretical framework of the study is established.

4.13 Theory Acquisition

In order to provide an analytic framework for this research it is important that a theoretical standpoint is established. Within Phase One, a range of attitudes toward self-harm were identified. However, the issues behind these views remain unanswered. Indeed, what constitutes perception itself is unexplored. An examination of these factors will provide a justification for the theoretical position taken within this thesis. It is important to discuss alternative theories, not only to offer balance but also to add credence to the choice made. The combination of this with factors identified within Chapter One will provide the structure around which the rest of the rest of the research will be built.

4.14 Alternative Theories of Attitude

Before a suitable theory of attitude is examined, it is important to identify what attitude is. What should be noted is the range of definitions available. Fishbein and Ajzen (1972) reported 500 different operational definitions. These differences are inherent within attitude theories themselves. Brief overviews of two attitude conceptualisations are presented below. These are the three component models of Rosenberg and Howland (1960) and Petty and Cacioppo's Unidimensional view (1981).

According to the three component models, an attitude is a hypothetical construct that intervenes between observable stimuli and subsequent behaviour. An attitude is defined as the predisposition of response to a certain class of stimuli. The classes of response are divided into three groups:

Affective responses (evaluative feelings);

Cognitive responses (related to ideas, opinions and beliefs);

Behavioural responses (behavioural intentions).

The Unidimensional model, in contrast emphasises the evaluative component as the sole factor in attitudes. Attitude is regarded as an enduring feeling (positive or negative), about an individual issue or factor (Petty and Cacioppo, 1981).

Both of the above models are grounded within the psychological paradigm. Chapter One identified the psychological viewpoint of self-destructive behaviours. This has included the initial exploration of the phenomenon by Freud (1961) to more recent studies by psychologists such as Menninger (1966) and Spirito (1989). The purpose of this process was to indicate the shifting pattern of attitudes within psychology. Yet, to explain this process, there is a need to examine a psychological framework of attitude.

4.15 Expectancy Value Model

Ajzen (1988) saw attitude as a hypothetical construct, that being inaccessible to direct observation must be inferred from a measurable response. Whilst this has direct implications for the method of data collection used within this thesis, it asks the question of how these constructs were developed.

One possible solution lies with the expectancy value model developed by Fishbein (1967). A unidimensional model, it contains evaluative aspects of attitude formation. An attitude toward an object is based on the 'expectancy' that certain values are associated with that object. The 'value' of these factors, is the importance placed upon them. The measure of an attitude toward an object is obtained by the multiplication of the value and the expectancy components and summing these products.

For Fishbein (1967) an individual attitude toward any object is learned through mediation and conditioning. Beliefs about an object and the attitude toward it are in a continuous dynamic relationship. Once an attitude concept has been learned new beliefs may be acquired, with the original standpoint weakened or strengthened. As shown within Chapter One attitudes are not static, but alter over time.

Attitudes are learned initially as part of concept formation, a theory supported by Ajzen (1988).

‘People carry within them the accumulated experiences of previous generations as well as their own unique life histories.’ (1988, p146)

The views of the focus group respondents toward children who self-harm could well be influenced by factors outside their clinical experiences, issues such as the social environment in which they were raised and the general views of self-harm within their wider communities should therefore be considered. Within the framework of this model, the expectancy placed on the patient and their consequent value could have its basis within early socialisation of the respondent both in their training and their initial clinical employment. For Fishbein, this is the important factor within attitude studies. By the assessment of attitudes, we attempt to unveil the hidden factors that as a result of past events lead to certain actions. To understand the unique combination of factors that lead up to the behaviour is to provide a possible explanation of how the attitude object is perceived.

As indicated, there are factors that will influence and alter the attitudes of an individual. O’Brien and Bierman (1988) felt that peer groups would influence attitude. If an individual hears a particular comment from a sufficient number of peers they will adopt these comments as a perceived trait (value) of the response object. This is particularly the case if the new comments reinforce the values already held. The acceptance of information from others is a major form of attitude acquisition (Fishbein, 1967).

In elaboration of the above, Fishbein felt that there were a number of instances in which attitude could alter:

1/ When new beliefs are learned;

2/ The strength of already held beliefs alters (this is influenced by)

(a) The strength of the initial attitude,

(b) The strength of the new evaluative aspects (value) of the object.

In theory, the way in which children who self harm are perceived may be radically altered by a particular event. This could explain to a degree the importance placed on clinical events within the pilot study group.

In contrast, Fishbein discusses the issue of object association. If an object is linked to others, then how is it viewed, its expectancy will be the same. This is particularly the case if the associations are strong e.g. young children have a limited concept of the consequences of self-harm behaviour.

While the above provides the chance to examine the data from a psychological perspective, it neglects another of the main themes explored in Chapter One namely Sociology.

4.16 Sociological Theories of Attitude

It is suggested that a sociological theory be adopted as the framework of analysis within this thesis. The main body of this research deals with social institutions (A & E departments) and the influence of factors such as education and clinical environment on care staff perceptions. The first chapters of this thesis have explored the influence on society of sociological issues such as the political environment and the zeitgeist within the institutions of education, medicine and nursing. The use of a sociological theory, as well as underpinning the analysis process will provide the link between these observations and the results obtained from the data collection process. Before the selected theory is introduced, it is important that other theories are identified and the cause of their rejection highlighted.

Firstly, there is the breadth and quality of work undertaken by Goffman (1968).

‘Even the critics of Goffman agree, he is an extremely sensitive and acute observer of human interaction.’ (Ditton, 1980, p81)

The basis of Goffman’s theory is impression management. As individuals, we have a need to discover the facts as best we can. Our impression of others is based on clues, hints and other predictive devices. As a consequence, impressions are constantly amended in the light of changed situations. Over this entire interaction, there is a code that governs behaviour. The code is broken by social deviants, including the mentally ill and those who commit acts of self-harm. Society has a fear of deviancy. There is a need for continuity within society and deviant acts disrupt this. A rule is visibly broken, judgement is passed on whoever is deemed responsible and penalty is then exacted by society (Ditton, 1980).

This supports the theories put forward by Szasz (1961) who suggests that psychiatric conditions are not a manifestation of physical aberration. Instead mental illness provides a handy label for those who fail to abide by the established rules of interaction. Goffman suggests that the psychiatric hospital was an environment in which deviants were contained (1968). Individuals are expected to accept their role within society. This acceptance was also expected by patients within the hospital environment. The patient is seen to have a moral career, which begins with the initial diagnostic label and alters according to the patients’ actions. The patient is expected to adhere to the process placed upon him through the doctor patient relationship. Medical and nursing staff act in the way that society expects of them and the patient is meant to do the same. A deviant patient such as one who self harms threatens the position of the doctor. Such patients are treated in a particular way, to ensure minimum threat to the status quo. The response to the offender and the sanctions they receive are based on a number of conditions:

1/ Were they aware of the rule breaking?

2/ Were they aware of the consequences?

3/ What was the purpose of the act?

(Goffman, 1968)

It would appear that these variables would influence how the patient is perceived in terms of the variables given above. Previous studies on attitudes towards adults, who self harm, have highlighted factors such as perceived manipulation as the cause of negative emotions (Patel, 1974). The examination of the pilot study data has also indicated that certain patients such as younger children are felt to have limited knowledge of their actions and thus are viewed sympathetically.

It should be remembered that Goffman has attracted a number of criticisms. He has been accused of producing work for the sake of performance and of adaptation of his theory to suit his audience (Layder, 1994). Of particular importance is the accusation that Goffman concentrates on the episodic and situational rather than the historical circumstances in which they occur.

4.17 Alternative Attitude Theories

It should be remembered that there are alternatives to the theories outlined above. Harris (1997) deals with the value of others as central to the consideration of moral action amongst health professionals. Other sociologists such as Roth (1972) have developed the term 'moral evaluation' to describe certain types of labelling. Although it should be noted that such theories have been described as not completely satisfactory in the understanding of staff perceptions (Johnson and Webb, 1995). However, there are issues that limit the utility of Goffman's theories within this thesis. As already indicated, there are a number of criticisms of Goffman, particularly his emphasis on the episodic rather than the historical (Smith, 1999). This is important

given the historical context of the literature review in chapter one. A theory that limits comparisons between the results obtained in phase two and the earlier chapters will prevent a full exploration of the phenomenon. Yet, the main barrier to the use of Goffman within this study, is his emphasis on the individual. Although he does identify institutions it is the person within that holds the majority of his attention. This thesis is concerned with the issue of staff attitudes toward child self-harm. As such it is important to identify a theory that will examine these factors as well as provide a framework for data analysis.

The difference between a suitable theory and those already mentioned lies within the use of attitude itself, any theoretical standpoint requires an acknowledgement of the above. It should not be based on issues of like and dislike but rather on concepts of awareness and knowledge.

4.18 Foucauldian Theories of Discourse

A large percentage of qualitative data is based on language. There are researchers who have specific interest in language itself (discourse analysis). However, there is limited agreement as to what the term actually covers. Some researchers see language within its social context (Coulthard and Montgomery, 1981). Others focus on the variations within language between various groups and situations (Milroy, 1980).

Conversational analysis may go some way to identify attitudes toward self-harm.

However, this has been answered by Phase One. It is necessary to employ a method that unearths the background to these views. Foucauldian philosophy is based around the issues that shape attitude supported by a social exploration of historical events.

Foucault has attempted to move away from the traditional view of history. The common theory of events is one of gradual change and evolution. In contrast Foucault sees history as fragmented into epochs and discourses that have their own birth

development and thresholds. Archaeology in the Foucauldian sense allows for the exploration of the archives of discourse. Therefore discourses have a pivotal place in history. They can plot the historical change of institutions such as the medical profession. This has a direct link to one of the central issues of this thesis. Chapter Two identified that views of self-harm and suicide alter as the society in which they are held changes. This will allow for the possible differences in attitude of the various staff sub groups under consideration.

The above is central to Foucauldian theory. Knowledge is a matter of social, historical and political conditions. There is a link between historically specific relations between bodies of knowledge and forms of social control. Knowledge is collected into discourses that surround disciplines. Through the 'Birth of the Clinic' (1973), Foucault plots the historical transformation of medicine. The dominance of the physician within healthcare is established through a process, which according to Foucault is entrenched within two domains, the hospital and teaching. These provide the physician with a unique position. They are able to adapt their teaching structure to the clinical, providing them with power over other individuals within the environment.

'The clinical gaze has the paradoxical ability to hear a language as soon as it perceives a spectacle.' (Foucault, 1973, p108)

The concept of power is for Foucault closely linked with discourse. This lies in the production of knowledge, 'the capacity for the production of truths'. Within our current society, knowledge is based on the scientific. In this instance the scientific is the medical model. The accepted truth within the clinical environment. Herein then is the dominant feature for all perceptions of child self harm. Yet, it should be established that scientific truths are based historical conditions. As with the

sociological and psychological theories of suicide, they are shaped and influenced by the society in which they evolve. Time has its influence, the discourse develops and ends. Of particular importance are the beliefs that are specific to a particular period. What is seen as scientific fact, is seen by later generations as mere superstition. The treatment of suicides in the Middle Ages to prevent witchcraft obviously would not be countenanced today. Truths are then open to adaptation and therefore this constant flux could explain differences in attitude within medical discourse. However, it is important to consider what is meant by discourse in this instance.

4.19 Discourse

‘Foucault thinks of discourse in terms of bodies of knowledge.

His use of the concept moves it away from something to do with

Language.’ (McHoul and Green, 1993, p26)

Although there have been a number of theories developed around the concept of discourse, the Foucauldian aspect is somewhat different. For Foucault, discourse is not just about language. Discourse is about what cannot be said as well as the sayable. They are limited practical domains that have their own rules of formation. The basic unit of discourse is the statement. These join other statements and establish a context. Discursive processes are defined as much by what exists outside of them than what is within. A discourse can be identified by what it doesn’t contain.

‘Every discourse is part of a discursive complex, it is locked in an

intricate web of practices... by definition both discursive and material

(Kendall and Wickham, 1999, p91)

The discourse sets the parameters of the imagination, (the limits of truth). They represent every facet of the condition. What can be said as well as thought this is seen

in terms of 'the body' in which the main aspect of medical discourse is the identification of a condition and its treatment.

Therefore, statements are best approached not individually, but in terms of the organisation of which they form a part. The comments made by the respondents toward patient vignettes are thus examined from the plural rather than the singular, the medical model for the physician and so forth. Foucault states that discourses are structured with their own rules and knowledge. The respondent would therefore have a limited range of perceptions based on the discursive rules. Again, this allows for the expected differences between the groups examined. This is based on the Foucauldian belief that discourses is knowledge, collected into disciplines such as medicine and nursing. These result in the totality of the discourse and its effects not just on the sayable but also on practice.

Foucault argues that individuals occupy cultural and social environments. Within these are rules and procedures that regulate its members. This results in the development of hierarchies. Within the discourse these roles have existed before the individual occupied them.

Within the discursive process, the main issue is that of knowledge.

'Knowledge is that which can speak in a discursive practice and which is specified by that fact....knowledge is also the space in which the subject may take up a position and speak of the objects with which he deals in his discourse.' (Foucault, 1972, p 182)

However, it should be noted that there are criticisms not only of Foucault's theory but its adaptability within other areas of the social sciences. Moss (1998) suggests that Foucault's concept of discourse is uncertain within itself. This supports earlier criticism from Cousins and Hussain (1984) who feel that Foucault has elusiveness

within his writing that confuses the reader. As a consequence, the adaptation of Foucault to other areas is fraught with difficulty. Yet, even those who suggest that the use of these theories is difficult, acknowledge that the use of a philosophical theory provides greater understanding of phenomena such as discourse.

It should be accepted that as with other theorists, Foucault has attracted a range of criticisms (Racevskis, 1999). However, there is an equally lengthy list of counter critics. Danaker et al. (2000) suggests that those who offer negative comments fail to understand Foucault's concept of human society.

4.20 The use of a five-stage method of discourse analysis

Within their discussion of Foucauldian theory, Kendall and Wickham (1999) developed a five-stage process, which could be adapted for use within qualitative research. This process is easily transferable to the analysis of the focus group phase of this thesis. Not only because it provides an easily outlined procedure but also in keeping with other aspects of Foucauldian theory, it supports the theoretical standpoint taken by this thesis. Indeed, the first of these stages is enshrined within Foucauldian theory.

4.21 (1) Stage One

Step one requires the recognition of a discourse as a body of statements that are regular and systematic. This has been outlined above, particularly in terms of the medical profession. The process of diagnosis and treatment.

4.21 (2) Stage Two

The second of these steps, the identification of the rules of the production of statements is also closely linked to the theory outlined in this chapter. As noted Foucault's work 'The Birth of the Clinic' (1973) has gone some way to explain this phenomena. This stage deals with the identification of factors such as socialisation

and education within the discourse. This stage is absent from the initial data analysis. Yet, it will provide the link between each sub group and the results obtained from this phase and the first part of the thesis.

4.21 (3) Stage Three

The third and fourth steps in this process are closely related. The identification of rules that delimit the sayable and the identification of rules which create spaces in which new statements can be made. By those rules that provide statements within the discursive process, attention is drawn to those rules that limit what can be said. The staff subgroups under examination can be expected to base their perceptions toward child self harm within a particular frame of reference. The analysis of the focus group texts will highlight these rules and indicate their influence on attitude. They will identify those issues that limit what the respondents discuss in terms of those attitudes. This could be in the form of socialisation into a particular profession or clinical environment.

4.21 (4) Stage Four

The fourth stage the identification of rules by which a new statement can be made, is, as indicated, closely linked to the third. This stage is designed to deal with the creation of forms of identification. Within the analysis process, this is interpreted as the method by which respondents give their initial perceptions of the case vignettes.

4.21 (5) Stage Five

The final step within the process rules that ensure that a practice is material as well as discursive. For Foucault, thought and action are inseparable. For instance, the attitudes of care staff have an impact on the readmission rates of self-harm patients. Thus, the discursive is not limited to thoughts about a topic but has physical

consequences for those who come within its sphere. This will take the form of the impact physical factors have on the analysis process.

4.22 Conclusion

As indicated, there are a number of factors that identify Foucault's method of discourse analysis as suitable for this study. His perception of history supports the one taken in the earlier chapters of this research. The mutations of discourse follow a similar pattern to the changes of attitudes that take place as societies alter. The identification of knowledge as a social, historical entity is closely related to the factors that shaped the theories of suicide discussed in the literature review. The issues within 'The Birth of the Clinic' describe the development of the medical profession. As these form half the study population the link is evident.

The use of Foucauldian discourse analysis allows the issues to be explored within the framework of the second phase. The use of a theoretical framework within the data analysis process will provide the structure needed within the thesis, evident in the data presented below.

Chapter Five

Phase Two Data Collection and Analysis

5.1 Chapter Introduction

This chapter will provide the details of the focus groups undertaken within the second phase of this thesis. Each of the staff groups will be examined in turn using the Foucauldian framework identified in the previous chapter. The overall aim of the chapter is to answer the questions posed at the beginning of chapter five, given the limited research into attitudes toward child self-harm it is hoped that the chapter will provide an original insight into the phenomenon.

5.2 Trained Nurse Focus Groups Introduction.

Two groups of A & E nurses participated in this phase of the data collection process. Both groups were students on post registration courses within higher education and had a range of A & E experience from 18 months to several years. A total of thirteen nurses took part, with one group consisting of eight respondents. Despite the differences in size, the results obtained from both sets of respondents followed a similar pattern.

The data collection and analysis process followed that outlined at the start of the chapter.

Analysis will be informed by the use of a Foucauldian model. This process will allow the discursive process of the group to be identified and examined. The use of case vignettes to stimulate the group's discourse allowed greater access to attitudes of the respondents toward child self-harm.

In order to understand this process in great detail, it is divided into two parts. The first examines each of the patient variables contained within the vignettes and how they are perceived within the discursive process. The second identifies the salient features of the discourse itself. Based on a Foucauldian framework, the various sub themes within this stage

provided an in - depth picture of the phenomenon. This will provide an explanation of what shapes the attitudes of staff nurse toward children who self-harm.

5.2 (2) Patient Vignettes

Both groups were presented with a number of case vignettes that mirrored those used within the first phase. It should be noted that in one group only 11 of the intended 12 cases were presented. However, this did not prevent a complete analysis of the discursive process.

5.2 (3) Ambiguity

Whilst it is possible to calculate the perception of the group toward that particular patient variable. However, the results obtained come directly from the discursive.

Ambiguous statements proliferate throughout both groups. To a degree an indication of some of the difficulties expressed by the respondents around the topic. A breakdown of these statements however shows that the discourse followed a pattern. Within one group, the number of ambiguities increased as the process continued and this would appear to mirror the initial hesitancy of the respondents. Whilst the second group seemed more at ease, it is of interest to note that the largest number of ambiguous statements occurred in the later stages of the group. It could be suggested that initial levels of ambiguity do not accurately reflect the true nature of the group discourse. That an aspect of the staff nurses attitude toward child self-harm is a degree of uncertainty. Initial comments may have been guarded given the presence of the researcher. In terms of Foucauldian theory, knowledge is dominated by the discursive. If the staff nurses discourse is based in some part on ambiguity, it may explain why the staff nurses express a lack of understanding of child self-harm.

**‘I feel very anxious if they are little. It’s very hard
to relate to child even my own, it’s difficult.’ (TN2D).**

Despite this high level of ambiguity within the discursive process, the group members provided sufficient comment to elucidate how variables such as patient age and gender were interpreted within the group. An examination of these variables in turn will provide a greater insight into the group discourse.

5.2 (4) Patient Age

Examination of the group discourse of both sets of respondents indicated a difference in terms of patient age.

Respondents in both groups expressed difficulty in terms of patient age, particularly if the child was under 12. Use was made of the respondent's own childhoods in some cases. They would express an inability to contemplate such actions when they were of a similar age. As a result there was a number of confessions, with respondents unable to comprehend the patients actions.

'It's hard to imagine an 8 year old wanting to kill himself.' (TN1H)

Although such comments did not occur throughout the discursive process, they did appear with sufficient frequency to be identified as an integral part of the discourse. For Foucault, those things that exist outside the discourse have no conception amongst its members. Thus for the respondents active self-destruction in young children is outside their sphere of reference. While some younger patients were seen to have carried out acts of high intent the majority were perceived to have limited suicidal desire.

Within the discursive processes of both groups age was closely linked to intent. When older patients were examined within the groups, their age was utilised as an indicator of intent.

However, amongst these patients age would be used to reinforce the dominant discourses of the group. If the respondents perceived a patient as limited in their desire to kill themselves they would cite their age as proof that they were aware of the limited lethality of their actions.

Given the emphasis placed on patient age within the discursive process it is evident that it is an integral part of the staff nurse discourse.

This emphasis on age within the discursive process is also evident in terms of perceived lethality. As with intent, younger patients were felt to have carried out a smaller number of high lethality acts.

However, in some cases the age of some younger patients was felt to be an indication of potential fatality. Within the discursive process this was often used to underline the respondents overall perception of the case. Such expressions often met with the agreement of other respondents. This would thus reinforce the overall view of the discourse toward the case. Use was made of other aspects of the discursive process, such as clinical experience to bolster and justify such comments.

‘I think it was a serious attempt. But then lads at that age do silly things all the time.’ (TN1A)

The above statements also provide evidence of the other aspect of the discursive process. Younger patients who carried out acts of high lethality did so more by accident than design. Again this indicates that factors outside the discursive framework of the respondents are beyond their understanding. The perceived inability of younger to actively seek self-destruction is further evident within the examination of perceived communication. Younger patients were more likely to be perceived as communicative in their actions. Again these results are rooted within the discursive process.

‘At age 11, there is no concept of consequences of actions and can be more manipulative. Don’t consider other peoples feelings, just respond to what gets them attention.’ (TN1H).

This is evident that for the respondents age is a significant factor in terms of attitude. It is also evident that the discourse of the group heavily influences these attitudes. Examination of how other patient variables were viewed will also provide an indication of the strength of the discursive process.

5.2 (5) Patient Gender

The topic of patient gender did not occur throughout the discursive process. Indeed examination of the text from both groups shows some respondents gave no comment on a patient's gender. However, when a statement was made it was often linked with another aspect of the vignette under examination. This would include factors such as the rate of admission or more often a clinical event experienced by the speaker. As a consequence of this, the patient would be imbued with the same qualities as those previously encountered. Consequentially the lethality, intent and level of communication would be similarly 'scored'. As we shall see, when use was made of previous experience it would not be questioned. If such comments occurred at the start of each vignette, it would therefore shape the comments of others. However, this process did not occur an entire vignette could be examined without reference to the patient's gender.

The lack of distinct gender issues within the discursive process is reflected within the scores obtained. Intent was almost equally divided between both genders. Indeed, within both focus groups there was only one comment that linked gender to intent. that the examination of twenty-three vignettes produced such limited comment indicates the discourse of these respondents lies in other areas.

Although there were few statements that dealt with patient gender and lethality differences did occur in the frequency of statements. Examination of the text indicated that views of female patients were more often of low lethality. It should be noted that within Foucauldian theory,

discourse is a reconstruction of material aspects of thought and knowledge. It could therefore be suggested that the numerous comments of low lethality that pertain to female patients is a direct result of the discursive process. This is lent credence by the differences in communication between patient genders. Respondents in both groups perceived higher levels of communication amongst female patients. This provided a direct link to the levels of lethality discussed within the group. For the respondents, there was a strong link between manipulative behaviour and limited lethality. The majority of these comments were attached to female patients. When evidence of communicative behaviour was perceived in male patients these were often excused.

‘All his usual coping mechanisms have been taken away from him. Because he is so young he doesn’t know of another way of getting attention. But not in a bad way.’ (TN2D).

A pattern can therefore be identified that provides an insight into the discourse of the A & E nurses in terms of child self-harm. Even when not expressed directly, the undercurrent of group hegemony is evident throughout. Few comments would be questioned by others, particularly is supported by an example from clinical practice, a part of the discursive process particularly evident when the issue of admission rates arose.

5.2 (6) Rate of Admission

Within the discursive process of both groups, the importance of rate of admission is evident throughout. In comparison to other patient variables of age and gender, there are obvious differences in how patients are perceived. These perception reflect the discourse of the respondents who placed great emphasis on the number of times a patient had been admitted for self-harm behaviour.

Along with other aspects of the discursive process, the issue of admission rate would be interlinked with other factors. As already noted, use had been made of clinical experiences. Yet, it is within the perception of admission rate that this is used in almost every case. Examination of the texts indicates that views of outcome variables differed greatly when the respondents examined cases of first time admission.

Within all three of the outcome variables, those who had no previous admissions committed acts of the lowest lethality and intent and highest communication. The respondents often justified their comments by use of other variables. Younger patients who self harmed for the first time were felt to have limited understanding of the consequence of their actions. Female cases were seen as manipulative. When such comments would be made they were often supported by examples from the respondents A & E experience.

‘You can go over the top when dealing with it.

Too much reinforcement, too much attention

would be dangerous.’ (Agreement) (TN1C).

Yet, it is within the examination of patients with several admissions that extensive use is made of clinical events. Whilst levels of lethality and intent increased with initial admissions this declined as the patient became a more regular attendee. For the respondents, patients with numerous admissions presented as untreatable and manipulative. Examples of patients who had caused difficulties with the department were utilised. Often these would be far more severe than the cases presented within the vignettes. This would seem to authenticate the discursive process as well as acting as a reinforcement of the speakers position within the group process.

‘ 5 or 6 admissions is not a lot. Talk about 35 or 36 then

that’s a lot. But the older they are the less you can help them.

I've seen some cases with about 80 admissions.' (Agreement) (TN1C).

The above goes some way to prove that for the respondents patient variables do not influence attitude by themselves. Rather, there are the various elements of the group discourse that react with the contents of the vignettes. The use of the analysis process based on Foucaultian theory identifies each of these aspects in turn.

5.2 (7) the first stage of Foucauldian analysis

Within the process outlined by Kendall and Wickham (1999) the first stage is the identification of a body of statements that are regular and systematic. It can be expected that a theme would emerge particular to each group. The discursive process would then be unique to the group member's views of the self-harm vignettes. For Foucault the analysis of discourse has more to do with the institution of which the individual is a part rather than the person themselves.

5.2 (8) Technical Phraseology

Within the twenty-three vignettes examined by the A & E nurses, the use of technical phrases to explain patient behaviour was identified in 19 cases. These were used to help staff identify patient motive and differentiate between those patients who self-harmed due to factors outside of their control and individuals perceived as influencing their environment.

' It will become a coping mechanism for stress, the slightest bit of stress and that's it.' (TN2B)

'Does he see the illness as a positive factor, is he sitting there thinking I want this? Is he giving an injury to get attention?' (TN1D).

This use of technical terminology to describe patients is evident throughout the group process. All 13 respondents made use of these terms. It would seem that amongst these clinicians, patients who self harmed could only be discussed within these parameters. This indicates a group attitude based in part on the professional training they have received reinforced by the statements that accompanied these terms. The A & E nurses displayed hesitancy in the offering of final judgements toward the vignette actors.

Throughout the group process the need to explore each scenario in greater detail was expressed by each of the respondents. This would appear to be the process carried out within the clinical environment with A &E staff anxious to cover all possible eventualities

‘The positive or negative reinforcement of attendees is difficult.

**If you’re too much to the positive then you are reinforcing the
behaviour.’ (TN2B).**

Within a number of cases, the nurses discussed the need to involve specialists such as child psychologists and psychiatrists. Throughout the text there is a hesitancy that suggests the respondents defer within the treatment process. Whilst other factors influence staff attitude toward children who self-harm, this cautious approach can be identified as a feature of this groups interaction with self-harm patients.

5.2 (9) Rules that create spaces in which statements can be made

As with nurses examined in the pilot group, the respondents within the A & E group made ample use of their own clinical experiences. Again, these were introduced within the first discussion and the other respondents did not question the use of previous event. Indeed, as indicated previously, all 13 respondents made use of their experiences within the discursive process. However, the use of clinical experience between the two groups differs. Whilst seen as part of a tacit knowledge experience was used to reinforce themes that emerged within the

group discussion. Issues such as repeated admissions have already been identified within the analysis process as integral parts of the discursive process.

‘Sometimes there is a reason that they are regular attendees

But they just dismiss them as not you again.’ (TN1G).

Staff could hold a particular perception of a patient as valid because of their ability to cite similar cases from their working environment. Respondents concentrated more on the themes associated with the vignettes rather than the vignette actors themselves.

It could be suggested that such statements are used to establish authority. However, within Foucauldian theory for statements to be made they must be based within the discourse. Thus, for the A & E nurses, the experience of the clinical environment is paramount within the development of the discursive process. Respondents speak within the realms of their discourse. If it is to be accepted that the discourse shapes attitude then this is one of its central features.

Another aspect of the discursive process is the citing of other nurses’ attitudes. Whilst they did not describe their own attitudes in detail, they did comment on others. A number of nurses described negative views amongst their colleagues. These were often the more experienced staff, who it was felt had been overexposed to the stresses of treating self-harm patients. It is this theme of stressful work environments that forms the forth phase of the Foucauldian analysis process.

5.2 (10) The identification of rules that ensure that a practice is material and discursive

Busy Departments

Examinations of the focus group texts have indicated a number of threads that form the group’s discourse. These have been drawn from a number of factors within the respondent’s experience.

However, there is another practical phase of the discursive process. Whilst there is evidence of competent caring clinicians, examination of the focus group text highlights another influential factor. Spread throughout the group discussion, there is repeated evidence of an over taxed workforce and the negative impact of child self-harm upon it. Amongst the 13 respondents 8 described work environments in which there was little time to deal fully with the needs of self-harming patients. Within an A & E department, the emphasis is placed on the seriousness of the presenting condition. As a consequence, the respondents are within a task-orientated environment that they feel prevents them from fully supporting self-harm patients.

‘I love to sit to talk to them, but when the department is busy, there is no time for this. The only time you get to talk to them is when you stitch their arm.’ (TN1A).

However, within the discursive process, there is evidence that despite the structured system within which they work, there are factors particular to self harm that influence attitude. As already noted, the majority of the respondents cited the effect of repeated admissions for self harm behaviour on staff moral. This is of interest given the high incidence of readmission amongst children who self-harm.

‘You reach saturation point in A & E. We get 3 to 4 a day at least. you think Jesus Christ, especially if they are regular attendees. You feel you are getting nowhere with them, I would imagine after twenty years.’ (TN2E).

Coupled with the strains placed on over stretched services by multiple admissions, self-harm patients were perceived as disruptive. In busy A & E departments, it was felt that the demands made by self-harm patients effected the smooth operation of the unit. The respondents described the reception given to the patient as dependent on a number of factors. These

included the time of admission (i.e. early morning), which accompanied them and the amount of none self-harm patients already to be treated. One respondent suggested some self-harm patients brought the conflicts that caused the incident into the department.

‘If mum and daughter were arguing, this would anger staff.

‘For Gods sake, shut up. I am stressed out myself.’ You could have things to deal with like R.T.A.s and you have these two arguing.’ (TN1C).

Whilst this provides an insight into one respondent’s attitude it is indicative of the discourse as a whole, with the demands of the clinical environment a causative factor in how child self-harm is viewed.

5.2 (11) Discourse Summary

The use of a Foucauldian method of data analysis has provided a number of insights into the attitudes of A & E nurses. The identification of the discursive process pinpoints each of these influential factors. With the breakdown of this analysis into two distinct yet interrelated phases it is possible to identify each of them in turn.

The first stage of the analysis process concentrated on the way the group’s discourse acted upon the stimulus of the case vignettes. In the discursive process, the respondents saw differences between patients in terms of their intent and communication as well as the lethality of their actions. Yet, it was the way in which these attitudes were formed and voiced that provides the base for the analytical process. The use of technical phraseologies and previous clinical experiences formed the basis of the discursive. This suggests that it is their life as a nurse that is the main aspect of the respondents discourse. Not only does this affect perception it is the medium by which they converse with each other, an integral aspect of Foucaultian theory. Therefore the factors that shape attitude are evident. This is confirmed by the emphasis

placed on the hectic nature of A & E departments. A direct explanation of the attitudes toward patients who had numerous admissions. Again, the reinforcement of nurse experience as the pivotal aspect of the discourse.

However, this does not fully explain the attitudes of the respondents toward those patients with no previous self-harm attempts. Indeed, one of the outstanding features of the discourse was the level ambiguity and uncertainty displayed by the respondents. Two main elements of the A & E groups can be identified, their experiences as nurse and their uncertainty within some clinical situations.

In order to establish the importance of this discourse within the analysis process comparisons will need to be made. Not only should this incorporate the other groups examined in the second phase but the results of the questionnaire stage. Only with this will it be possible to identify fully those factors that shape the perceptions of care staff toward self-harming children.

5.3 (1) Trained Medical Staff Focus Groups Introduction

Two groups of physicians took part in the second phase of the research process. Each group comprised of a number of senior house officers (S. H. Os), who were working within the rotation scheme of the local medical deanery. The level of clinical experience amongst both groups differed greatly. Some of the respondents had several years work in other countries, whilst others had left medical school within the last three years. Despite this range of experience, all the respondents held the same position within the clinical environment and a number had close professional involvement with children who self harmed.

A total of fourteen medical practitioners took part in the focus groups. Both groups were of a similar size of six and eight. The set process for data collection within phase two was implemented. A total of twenty-four vignettes were examined by the respondents, one group ingestion the other wounding. Although the methods of self-harm were different, examination of the group texts identified a number of common themes. In keeping with the analysis of phase two, the discourse of both groups were identified and explored.

Again, this process is divided into two parts. The first deals with patient variables within the vignettes. The next explores the dominant aspects of the discourse itself.

5.3 (2) Ambiguity

Examination of the discourses within both groups of physicians followed a similar pattern. In comparison to the trained nurses, the number of ambiguous comments were kept to a minimum. Indeed, the discursive process left little room for ambiguity.

However, some ambiguous statements were made. As with the nurses these tended to be greater toward the latter part of the group process. Yet, this cannot be based on any initial shyness on the part of the respondents. Rather, these tended to be based around what the

physicians saw as less serious cases. Light-hearted comments would be made and would often be met with laughter from other group members.

‘This is what 16 to 19 year old girls do.’ (Laughter) (PH1D)

Other ambiguities would be made around the response of the others toward the details contained within the vignettes. When there was a need to offer a detailed comment toward the case the respondents would for the most part be precise. Comment was based on the facts contained within the vignettes. When any deviation from this took place, this would be quickly stopped by other group members. Respondents would be reminded that there was a set process within the examination of each case.

‘I don’t think you can possibly jump to that conclusion without more information.’ (PH1A)

Within both groups, such deviations tended to be limited to only one or two respondents. Once they had been admonished they would conform to the discourse. Thus levels of ambiguity can be seen as a reflection of the discursive process. This low level an indication of how the issue of child self-harm is viewed by the physicians. A factor borne out by an examination of the rest of the group discourse.

5.3 (3) Patient Age

Patient age was introduced throughout the discursive process of both groups. It should be noted that the age of the child was not mentioned at every stage of the group discussion. However, it did occur with sufficient frequency to be identified as a part of the discursive. When patient age was introduced, it was often as a part of a wider discussion based around the technical issues introduced by the respondents. The speaker would cite the age of the child with authority validating their initial comments. By examination of the discursive process it is

possible to divide these comments into two groups. Those that use the patient's age to reinforce a diagnosis of mental illness and those that deal with issues of cognition.

As already noted, within the discursive process, comments were made with authority. Such authority appeared to be based on the individual's medical knowledge. The information contained within the vignettes would be used by the respondents to formulate a diagnosis that would often be supported by the rest of the group as a result patient age is utilised to reinforce a dominant theme within the discursive process. Such comments were not particular to one of the patient age groups but would be used to explain diagnoses.

In contrast, the age of some of the patients was addressed directly. For some of the respondents, the cognitive abilities of the child were an issue that merited comment. Younger children were felt to have limited understanding of their actions. For some physicians the younger the child the lower the intent. However, the muted levels of awareness could also lead to greater risk of fatality.

'He could kill himself by chance, he's only 8.' (PH1A).

Such comments would again be based on a process of examination and diagnosis. Although some of the physicians felt younger patients had little suicidal intent, this was based on what was for them established fact. This contrasts with the experienced nurses whose lack of perceived intent in younger patients was based on their inability to accept such behaviours. Confessions of limited understanding had little place in the physician's discourse. However, patient age was used in a similar fashion when the actions of older patients were examined. As noted, the experienced nurses made use of their clinical work to explain attitudes. The physicians also used such tactics. Some vignettes were met with derision by the respondents who would then describe a similar incident of their own experience. The discursive process would therefore seem to allow such patients to be viewed negatively by the respondents. Such

cases were approached as difficult to treat and as such seemed of little interest to the physician.

‘13, 14, 15 year old, typical, always conflict between parents

and child. Yet, it’s the poor S.H.O. who has to do the bloods.’ (PH2H)

It is evident that patient age is a factor within the medical staff discourse. However, it is used as an aid within the wider discursive process.

5.3 (4) Patient Gender

The topic of patient gender was not a continuous issue within the discursive process. Again, as with patient age the issue of patient gender is tied up with the dominant themes of the discourse. As noted, the use of medical knowledge was a major theme of both groups.

Therefore patient gender would be incorporated into comments that reflected the education of the speaker. A number of comments around older male patients acknowledged that they were a high-risk group. Again, such comments would be made with certainty and would not be questioned by the other respondents. That they occurred in both groups on more than one occasion suggests that ‘statistical knowledge’ of the physicians is an important factor in their attitudes toward child self-harm.

In contrast, when female patients were mentioned within the group discussion, respondents tended to rely on their clinical experiences. As shown above, the respondents viewed some of the cases of female self-harm in a jocular frame of mind, which would be taken up by the other group members.

However, some of the female vignettes would be described as serious. The factors behind their actions would be analysed and the respondents would judge their acts of self-harm as dangerous.

**'This is a reaction to any stress. She will self-harm
again based on the information I have in front of me...**

This is an anxiety illness.' (PH1E)

Such differences in attitude toward female patients are evident. One female patient received eleven comments of low intent. However, eight female vignettes were felt to contain acts of high suicidal intent. The gender of the respondents could be a significant factor in these scores. One of the focus groups was made up entirely of female physicians. They may have seen the actions of the female patients as ones that they too could consider under similar circumstances. However, it is the content of the discourse itself, with its emphasis on medical and clinical knowledge that must be the main influence on the perceptions of the group.

5.3 (5) Rate of Admission

Within the discursive process of both groups, the issue of patient admission reflects the main aspects of the physician's discourse.

Foucault sees the discourse as all encompassing, with its members only able to communicate within their own terms of reference. The comments made by the physicians around admission rates would appear to support this theory.

As already noted, examination of the text of both groups shows the importance of technical knowledge amongst the respondents. This is reflected in the information proffered within the discursive process. The number of previous admissions produced a number of responses.

Some physicians felt that more information was needed about the methods used in previous attempts. A number suggested that the levels of lethality increased with attempt then there would be a strong possibility of eventual fatality. This was coupled with other comments, which acknowledged that previous acts of self-harm were an indication of severe psychological difficulties, particularly amongst younger children.

The need for greater input from services to prevent further acts of self-harm was suggested by a number of respondents. Indeed, in some cases a lack of suitable services was seen as a possible cause of repeated acts.

‘The previous acts are important. Intervention needs to be in place.’ (PH1E)

Another aspect of the physician’s discourse is their clinical experience and this is identifiable in how patients with several admissions are viewed. In particular comments toward female patients with over five admissions. A number of the respondents described how such patients would be treated when they would be admitted into A & E departments.

‘Not a very good response in A & E, this would not be taken seriously.’

She has already been in six times, obviously less serious.’ (PH1D)

In direct comparison to the treatments suggested for other patients, those patients with over five admissions were suspected of failing to take up the treatment offered to them.

It can be seen that the issue of patient admission rate is an important aspect of the physician’s discourse. Yet it is the other aspects of the discursive process that have shaped their attitudes of children who self-harm.

5.3 (6) Foucauldian Analysis

The procedure used within this part of the analysis follows that established at the start of this chapter. Thus, not all of the stages devised to utilise Foucauldian theories of discourse are presented here. As with the trained nurse group, these will be implemented later to provide greater structure to cross group analysis.

5.3 (7) The first stage of Foucauldian analysis.

Within the Foucauldian analysis process outlined by Kendall and Wickham (1999). The first stage is the identification of a body of statements that are regular and systematic. Thus, it can

be expected that a theme will emerge that is particular to the group examined. As already noted, for Foucault the analysis of a discourse has more to do with the institution of which the individual is a part rather than the individuals themselves.

Examination of the focus group texts amongst the physicians identified a discourse that contained a high incidence of medical orientated phraseology. Such use of technical terminology was carried out by each of the respondents. Comments would be made in response to other statements as well as the contents of the vignettes.

**‘I think the fact that he is an older child is important
because of the powers of cognition.’ (PH2A).**

Comments would be made that indicated the speaker’s knowledge of the topic. For Foucault, the position of the physician within the hospital hierarchy is based on the specific knowledge’s of illness that the profession maintains within itself. Examination of the comments made by the physicians would appear to reinforce this. The lack of ambiguity toward the case vignettes shows that the discursive is grounded in such knowledge. A discourse can only speak to itself of the things within its knowledge. For the physicians the issues within the vignettes could only be examined and explained within the framework of their medical knowledge’s the factors contained within the vignettes were used as diagnostic tools rather than factors that alter attitude.

**‘Bear in mind adolescent male suicide rates especially
in connection with drugs and alcohol.’ (PH1B)**

That the physicians conversed with each other in such technical terms is a further indication of a central feature of the discursive process. Indeed its importance is evident throughout the other areas of the analysis.

5.3 (8) Rules that create spaces in which statements can be made

Given the importance of the medical phraseology amongst the respondents, it can be expected that this will impact on the content of the discursive process. Consequentially, heavy use was made of the diagnostic statement.

From the first vignette, the initial comment offered by the respondents was a diagnosis. This process was not confined to a handful of speakers, but one in which all the physicians took part. When discussion occurred within the group it would be around this initial diagnosis.

Alternatives would be given with the identification of factors within the vignettes to support them. It has been identified that an important aspect of the physicians' discourse is the indicated knowledge of the speaker. Therefore, within the discursive process the use of a diagnosis within the group provides the opportunity for further comment. Amongst the physicians such an action shows the speakers knowledge of child self-harm and is therefore a prerequisite to further elaboration of the case. Once the diagnosis had been given, this would then be supported by information contained within the vignette. Such information would be used to add credence to the initial comment.

'It seems to be a grief reaction in this case. Possibly the mother has suffered a grief reaction and was probably depressed. Anna may have felt a double bereavement, the father physically and the mother emotionally.' (PH2C).

Such comments can be seen to have a twofold effect. Firstly they are an indication that the speaker is versed within the rules of the discourse and examines objects (case vignettes) by means of the discursive process. Secondly, the use of further diagnosis to support the first,

acts as a reinforcement of the elements that make up the discursive process, both factors seen as central in the Foucauldian concept of group interaction and attitude.

The most important aspect of the physicians' attitudes toward child self-harm can be seen as the identification of a diagnosis. This is highlighted by the emphasis placed on the collection of a 'full history' of each case. Within both groups even those cases, which were perceived to be of little concern, would be treated in the same way.

'More details are required after a full assessment of the case.

Possibly refer on to a psychiatrist....This should happen in every case, even though this looks superficial.' (PH1A)

The importance of examination into each background variable was expressed by all respondents. Factors such as patient age were seen purely as indicators that certain forms of exploration should take place. Indeed, so ingrained was the process within both groups that when this procedure was neglected by one of the respondents, they were quickly reminded of its importance.

'This sounds like overprotective parents.' (PH1B).

'I don't think you can possibly jump to that conclusion without more information.' (PH1A)

Whilst the use of diagnoses provides the opportunity for the discursive process to explain the self-harm behaviours within the vignette, it would also act as a reinforcement of the discourse.

5.3 (9) The identification of rules that ensure that a practice is material and discursive.

Another feature of the discourse is the treatment programmes suggested by the respondents. Within the twenty-four vignettes examined a treatment process was outlined in nineteen.

'The previous acts are important. Intervention needs to take place.' (PH1E)

In terms of Foucauldian analysis, this process can be seen as the physical manifestation of the discursive process. The physicians' discourse appears to be based on their medical knowledge of child self-harm. Therefore, it can be expected that the outcome will be medical in its structure. The respondents have a limited range of responses. These must be based on the medical processes to which they have been trained. Evident in the methods of treatment suggested.

Can she go to the GP if she is depressed? There may be a need to use anti-depressants.' (PH2F)

The importance of the physicians' medical knowledge within the treatment of self-harm is again evident. Whilst issues such as the patient's age and gender evidently influence the act itself, it is the actions of the physician that ends them. The treatment is the end product of a set process in which the respondents have a central and controlling role. From the first stage of identification of symptoms and initial diagnosis, it is the physician who has the ability to observe and classify. However, it is the process of treatment that allows the medical practitioner to control the patient's act of self-destruction. If there is conflict with this procedure, as with patients with several admissions, the fault is felt to lie with the individual rather than the medically dominated system.

'all under 16s' get assessed at the hospital..... However, attendance at follow up is voluntary. So this tends to be a very poor situation.' (PH2D)

Such comments met with approval from the rest of the respondents, who often added their own opinions of non-attendee's.

5.3 (10) Discourse Summary

Examination of the discursive process using Foucauldian theory provides an indication of how physicians view children who self-harm. The division of the analysis into two associated phases allows an in-depth identification of the factor that produces these attitudes.

First within the patient variables. In particular the importance placed on admission rates. That perceived lethality and intent were felt to increase and decrease with the number of self-harm episodes is a pivotal factor. Whilst the other variables of age and gender did not produce so striking a range of scores, there was sufficient difference to indicate their importance.

Whilst of interest in themselves, the results obtained above can only be examined in terms of the discursive process. The continual use of medical phraseology to describe the vignettes is an indication of the structure of the physicians' discourse. For Foucault, the members of a discourse can only think and communicate within the discursive framework. Examination of the focus group texts confirms this. All stages of the analysis process are controlled by the medical knowledge of the respondents, so their attitudes toward child self-harm will be similarly influenced. The use of diagnosis and treatment are further proof that the physician perceives the child who self harms as a medical problem to be examined, identified and treated accordingly.

5.4 (1) Student Nurse Focus Groups Introduction.

Two groups of undergraduate nurses participated in this phase of the data collection. Both groups were at the same stage of their training, with a number of clinical placements completed. A total of 14 students took part in the focus groups. One consisted of nine respondents, with a much smaller group made up of the remainder. Although there was a sizeable difference in numbers, the discursive process within both groups followed a similar pattern.

As with the other staff groups, analysis is carried out by use of a Foucauldian theory of discourse. The analysis process will be divided into two phases; the first deals with the variables contained within the case vignettes and how they stimulated the discursive process. The next stage deals with the discourse itself and uses the analysis procedure devised by Kendall and Wickham (1999) outlined at the start of the chapter.

5.4 (2) Ambiguity

Levels of ambiguity differ in both groups. Within the smaller group of students, there was a greater incidence of ambiguity toward perceived intent. In the first group, more ambiguous statements occurred around perceived lethality. A number of possible causes can be given. That the difference in size between the two groups could explain greater levels of ambiguity can be discounted by the differences in 'score' for perceived intent. Instead, explanation can be found within the discursive process itself. Further examination of the transcripts show that the lowest amounts of ambiguity for both groups were based around the potential lethality of the act. It can be argued that this is due to the methods of self-harm used. However, it should be remembered that the vignette shown to the groups

differed in the means of self-harm used. It is only through the examination of the discursive process that the reasons for such marks can be explained in any detail.

Despite the levels of ambiguity shown, the respondents did comment sufficiently on patient variables of age gender and rate of admission to explain how each was seen within the discursive process.

5.4 (3) Patient Age

Within the focus group process, the issue of patient age was frequently commented upon. These comments acting as an insight into the student nurse discourse.

Both groups used patient age as a means to show their anxieties and problems understanding the phenomenon. This was particularly evident if the child was under the age of 12. When such cases were introduced the group would often meet them with comments of disbelief. Such statements would often be the first reaction to the vignette. The majority of these were expressions of anxiety and bewilderment. The students felt unable to comprehend why children would wish to harm themselves. Particularly when the child was young.

‘I cannot imagine a child doing this. How would the

Family feel if their 11-year-old had taken an overdose?

That he is so young is very important.’ (SN1G).

These confessions were not limited to a number of respondents, with the majority of the students appeared to feel the same way. When such statements were made, the other members of the group would meet them with support. When some attempt would be made to explain self harm in young children they would be tentative. Some of the students felt that the patient was acting without full knowledge of their actions. Younger children were

felt to copy self-harm behaviour, either from those close to them or from television. Such speculation again reinforces the lack of knowledge the respondents openly expressed toward the phenomenon.

However, despite such limited understanding, the majority of respondents would describe feeling sympathetic toward the younger children.

‘I have a lot of sympathy for an 11 year old but, if she was a young adult tolerance levels would be lower.’ (SN1B).

However, the discursive process could alter, with some younger children seen as ‘brats’, whose self-harm was seen as attention seeking. Yet, these statements would be made in isolation and were limited to one of the groups.

In both groups, the discursive process concentrated more on cause amongst the older children. Examinations of the texts indicate that the student nurses divided the older patients into two groups. Those who were seen as manipulative and those for whom they expressed sympathy.

For the first group, age was seen as a justification for a negative label. These patients were felt to be in control of their actions. Because age linked with awareness, the methods of self-harm employed were seen as deliberate limited in their lethality. In contrast, the second group engendered a lot of sympathy. The students describe the difficulties encountered by adolescents. These problems ranged from exam issues to teenage relationships.

‘This is the first big romance. Hormones running wild. At

16 they think they are in love and there is nobody else in

life for them.’ (SN2D)

These expressions of sympathy were often supported by experiences from the students' lives. Relationship and education difficulties would be related to the group in order to reinforce initial expressions of sympathy. It should be noted that the majority of the group were or had just been teenagers. Therefore the problems of adolescence were still fresh in the mind of these 19-year-olds. A factor that may explain this aspect of the discursive process.

5.4 (4) Patient Gender

Examination of the focus group texts show that the issue of patient gender received little attention from the group. Indeed for the majority of the discursive process, the subject of patient gender did not arise. In both focus groups, comment around the topic was limited to two vignettes. This is of interest in that they were both concerned males over 12.

However the comments that surrounded these cases mirrored the main aspects of the students discourse. The first statement about patient gender was one of incredulity. A theme ran throughout each aspect of the discursive process.

'It surprised me for a boy of that age to do this to be perfectly honest. I would be less surprised if it was a girl they tend to be more emotional.' (SN1F).

Some of the respondents felt that the issue of male self-harm was so emotive that they themselves would be affected.

'I feel quite upset seeing men and boys crying. I feel like crying myself. If he came into A & E., I would be upset.' (SN1A)

In comparison, females were expected to show their emotions. To the extent that one student would be concerned if a girl in a similar situation didn't show her distress. For Foucault, the developing discourse is drawn from a number of factors. These factors include personal experience. Given that the majority of the respondents are young women, it could be suggested that they been exposed to their own anxieties and those of their friends and thus these become commonplace and unworthy of comment. However, they may have limited contact with such behaviour in young men.

When such actions were discussed, the respondents attempted to explain them. For some of the students, boys were expected to withhold their emotions and thus bottle up negative feelings that are brought to the surface as self-harm. In another example of the discursive process, one of the two male respondents described an episode from his own childhood that gave credence to this theory. A difficult situation was described in which the respondent was expected to hide his feelings because it was the manly thing to do, this was supported by others who described similar events from their own experience. Even though the issue of gender received little direct attention from the respondents, these provided insights into the discursive process.

5.4 (5) Rate of Admission

Examination of the focus group texts show that rate of admission provides access to the discursive process of the student nurses. Whilst the same could be said of age and gender a number of differences do arise.

Firstly, there is the response made to the number of self-harm episodes. Unlike the other two patient variables, the rate of admission is the first factor commented upon. This occurs in both groups, from the initial vignette.

Another difference was the use of the acts themselves within the discursive process. Whilst the student discourse for other factors is 'passive' in its perception of the patient variables, this alters with admission rate. For the first time the students make direct assumptions about outcome variables based on the information contained within the vignettes. In comparison to the tentative speculation evident around other variables some of the students provide statements that suggest the perceptions are fixed. However, a number of differences do exist within this apparent establishment of expertise.

Differences arise within the focus groups in terms of how admission rates are interpreted. For some of the respondents the numbers of previous acts were an indication of the seriousness of the patient's condition. To carry out another act of self-injury suggested the condition of the child was a cause for concern.

'Being so upset as to do it twice.' (SN2E)

These actions were seen as a strong indication of eventual fatality. It was suggested that there had been a failure on the part of the clinical services. More acts had been carried out because proper treatment had not been made available. One student offered the belief that the acts would contain and increase in their potential lethality until the correct intervention was made.

In direct contrast to the above, were those patients whose repeated acts were seen as proof of limited lethality and intent. It was felt that those patients were aware of the effects of their actions on themselves and those around them. For the students, repeated acts of self-harm were an indication that the child had no real intention to kill themselves. Instead, as the acts increased the level of suicidal intent fell accordingly.

‘Not serious suicide risk because she has done it five times before. If she really wanted to she would have managed it by now.’ (SN1G)

However, what is of interest is that both conflicting attitudes could exist within the same discursive process. Once a suggestion of either cause had been made, it would not be questioned. It should be remembered that not all of the respondents made such comments yet; the same respondent could use admission in these separate contexts within the space of two vignettes. Therefore, it would suggest that there are other aspects of the students’ discourse that leads to such contradictions. Some of the respondents saw numerous acts of self-harm as hard to understand. Although they saw a failure on the part of the clinical environment to prevent repeated admissions they would offer no solutions. It is only through an in-depth exploration of the discursive process that such comments can be fully understood.

5.4 (6) Foucauldian Analysis.

Given the close relationship between the two phases of the analysis process, it can be expected that they are interrelated. Whilst the first examined patient variables, this was carried out with a backdrop of the discursive process. Therefore, it is of little surprise to note that the first phase of the Foucauldian analysis mirrors the findings of the initial stage.

5.4 (7) Theme Identification

The theme identified as continuous within the focus group text is closely related to other aspects of the discursive process. For Foucault, the various elements of the discourse are inter-linked. Therefore, it can be expected that the main aspect of the students’ discourse is

reflected in the other elements. As already noted, the number of previous acts of self-harm were perceived as indicators of patient intent. However, within the discursive process these would be interpreted according to how the patient was viewed.

Throughout both groups, there was a factor that was used systematically. That within both self-disclosure by the patient was felt to indicate limited intent. Those who informed others were seen as at best drawing attention to their distress and in the worst cases simply manipulative.

**‘He told his mum. Realised what he had done. You know
took a lot of tablets then, hang on this is dangerous.’ (SN2D)**

Within this theme, those patients who attempted to hide their acts of self-harm were felt to have made concerted attempts to end their own life.

‘She did mean to do it because she gave it a good go.

Early in the morning and then her mother found her.’ (SN2D)

Not all the students made such comments. However, they did occur with sufficient frequency to be observed. When such comments were given, they would not be questioned by the other respondents. Instead there would often be supportive comments from the other students. They would not be limited to a particular patient group and took place throughout the discursive process.

In both groups there was no technical qualification for such suggestions. This was an identified feature of the students’ discourse. This is an indicator that for the respondents, attitudes toward self-harm is based on a more universal attitude of self-injury than any real knowledge of the phenomenon. That the students made comments with assurance suggests that for them these are universal truths. Foucault states that discourses adapt and change.

The student nurses have had limited clinical contact with children who self-harm.

Therefore, their discourse is drawn and adapted from other experiences. If their attitudes of child self harm are drawn from non-clinical knowledge then they must have their basis within the pre nursing environments of the family and media.

However, as already stated, the range from which the main theme is drawn can be identified throughout the discursive process. As can be expected, the other phases within the analysis can be identified via this main factor. Examination of the group texts allows for the identification of these variables and provides a greater insight into student nurses attitudes toward child self-harm.

5.4 (8) Rules that create spaces in which statements can be made.

The use of events witnessed by the respondents to support their attitudes has been identified in other groups in this analysis process. Of the fourteen student nurses within the two groups, all but two introduced events they had experienced to reinforce comments made toward vignette actors. Some of the respondents drew on a range of personal experiences in a number of vignettes. As with the other groups, the introduction of a personal experience was not questioned by the other respondents. It allowed the student who related the story to continue with their comments. It also enabled others who had similar experiences to introduce them. In nine of the twenty-four vignettes examined, a personal experience related by the respondent was followed by another supporting the initial statement.

**‘My lad was 17 when he finished with a girl and he moped
around the house for weeks. Awful. Plenty more fish in the sea.’
‘When I was 16, I thought I was in love and then it ended.
I was crying and people said ‘You’ll get over it, but I couldn’t
listen.’ (SN1G).**

The use of personal experiences appears to have lent credibility to the speaker. The prolific use of such methods, an indication of the level of credence it contained within the students’ discourse. It could also be suggested that the use of previous experiences helped reinforce the dominant values within the group. That no one questioned these processes would seem to confirm this. The use of past events to support specific theories evident in those experiences that described negative treatment of the self-harm patients at the hands of ‘less enlightened nurses’. This ties in with the positive attitude towards children who

self-harm. identified as a desirable feature of the group, which some qualified nurses were felt not to possess.

‘ I have been to A & E, with someone who tried to commit suicide...

**The attitude of the staff toward them was awful. How that person
felt, I don’t know.’ (SN2E)**

This confirms the role previous experience has within the discursive process both as a means of gaining kudos in the eyes of peers and as a factor that shapes attitude toward children who self harm. The idea of commentary as a means of status establishment can also be identified in the sanctions respondents placed on themselves. Although these were used as a means of self-censure, they did indicate another aspect of the discursive process. One in which comments expressed provided another indication of the group’s discourse

In the majority of cases, the respondents provided an initial comment towards the vignette actor that would be negative in nature. They would then retract the statement or chastise themselves for their observation.

‘But these people don’t think like normal people

That’s awful isn’t it?’ (SN1A).

These comments occurred throughout the group and covered all the vignette sub-groups of age, gender and previous admission. Examination of the text indicated that even perceived manipulative reasons would be tempered with this self-reproach. In contrast positive statements would be supported by other members of the group, who would then offer further positive explanations of why the act took place.

This self-regulation was justified within the group, who gave a number of explanations for this behavior. Positive expressions towards patients were seen as an indication of good nursing practice. The group saw such issues as empathy as qualities they should strive to achieve. It should be noted that all members of the group did not make these comments. They did however receive support within the group process. It was felt that the need for sympathy was greater in this instance due to the perceived vulnerability of children who committed acts of self-harm. Respondents cited a lack of empathy as a feature of outdated nursing practice, which it was felt would increase the suffering of those who had been admitted for treatment.

‘Some nurses have no inter-personal skills, the older ones, longer qualified ones. I won’t act like them when I am qualified.’ (SN2A).

Therefore a pattern of self-policing emerged within the groups. No respondent reproached another for a negative comment. That the respondents checked themselves (often in mid sentence), indicates the strength of the discourse.

Although these comments did occur within all of the vignettes, they did arise to an extent and with such intensity. Indeed, the lack of an unchecked negative comment appears to confirm this.

It should be asked as to what degree clinical experience would influence the group. If outside factors shape the students’ attitudes, then once in the clinical environment, comments made by more experienced nurses could have a greater impact. This is a theory supported by the results obtained through the final stage of the analysis.

5.4 (9) The identification of rules that ensure a practice is material and discursive

Within this phase of the analysis, emphasis is placed on the physical impact the discourse has on its members. In this case, what the students believed lay at the roots of their attitudes toward child self-harm. A belief that also determined how they thought this would transform itself into the reality of dealing with this patient group.

The student nurses expressed a lack of knowledge around the issue of child self-harm. Eleven of the fourteen respondents cited this difficulty when dealing with the contents of the case vignettes. That these problems occurred throughout the group process is an indication that the issue was not particular to isolated individuals. Examination of the text identified a number of possible causes for this apparent lack of knowledge.

One factor identified within the discursive process was the perceived lack of formal educational input. It was felt that within the curriculum, the issue of self-harm and child self-harm in particular was not addressed. The students believed that as general nursing students they had been neglected and saw the chance to learn about such issues denied to them.

‘I agree, we don’t get enough input, we get so little on this

Will we ever be taught anymore?’ (SN2E)

Given that the nurse population within the majority of A & E departments is general trained nurses, a perceived lack of educational input could have a profound impact on attitudes. Throughout the text, students stated that they failed to know the correct procedures to deal with the situations presented within the vignettes.

A lack of knowledge of self-harm issues is identified in the fears expressed by the respondents. Some were anxious that they would be too distressed to deal with self-harm patients. Others were more concerned that their lack of knowledge could compound the patient's distress. Respondents' thought that they may say the wrong thing and this would increase the possibility of further self-harm acts. Specialists should be contacted to deal with these problem patients. In general, it was felt that it would be best to keep a distance from the vignette actors.

**'I don't think I would communicate. I would keep away
from the child for quite a while, to try and take your own life
is serious...I would be too frightened to give advice.'** (SN1G)

However, a number of other respondents cited another cause for their lack of awareness towards self-harm issues. An inability to comprehend suicidal behavior in children. Some respondents related to their own child-hoods in which issues of child self-harm did not arise. Others drew upon family life to explain their failure to understand how a child would wish to harm itself.

**'I can't think how the thought of taking an overdose gets into
their heads? This is beyond me, and this is me speaking as a
parent.'** (SN1G)

Others, who voiced anxieties with their own children, took up this theme. The idea that a child of theirs could wish to harm themselves induced fears of family shame and accusations of poor parenting. One respondent expressed a risk to her own mental health is she discovered that one of her children had committed an act of self-destruction.

Therefore, although based on a number of causes, the lack of knowledge amongst the student nurses is evident. That clinical experience will improve this knowledge is open to debate. Both the pilot study population and the A & E staff expressed difficulties with self-harm patients.

5.4 (10) Discourse Summary

Analysis of the student nurse focus groups has produced number significant results. Use of both Foucauldian theory and the patient variables has identified the discursive processes of the student nurses toward children who self harm. As discussed, the five stages of Foucauldian analysis will be utilised to identify differences between the four staff groups as well as providing comparison between the results obtained and the literature reviews. However, within the stages used, a number of issues emerged. Firstly, the use of previous self-harm acts as an indication of intent, supports the results obtained from previous attitudes studies. The use of personal experience has also been identified as a factor that influences attitude. The influence of the discursive process within the practical realm had also been noted. The expressed apprehension and inability on the part of the students to engage in conversation with the vignette actors is an important part factor. As the literature has shown, for many self-harm patients, the lack of contact with care staff increases feelings of isolation and self-loathing (Dunleavey, 1992).

The combination of this process with the use of the patient variables provides a more in-depth picture of what influences student attitude. The identification of individual patient variables has allowed the extent of their importance to be recognised. That data obtained from this process is similar to that obtained from phase one. This shows not only that the methods were successful but also that patient characteristics are influential in the

development of views of self-harm. This process employed across all staff sub- groups will provide an insight into how this phenomenon is shaped.

5.5 (1) Medical Student Focus Groups Introduction

Two groups of medical students took part in the second phase of data collection. Both sets of students were in the same stage of their undergraduate programme and had completed a number of clinical placements. A total of fifteen students took part with two thirds of the respondents in one group. Despite these differences, examination of the group texts show the discourse of both sets followed a similar pattern.

The data collection process and analysis followed the established pattern. The use of Foucauldian theory allowed for the identification of the discursive process. The first deals with how each patient variable was viewed within the discursive process. The second with the discourse itself, providing an in-depth picture of the group dynamic.

5.5 (2) Patient Vignettes

Each group examined the twelve vignettes of child self-harm. One set dealt with ingestion, the other with self-wounding.

5.5 (3) Ambiguity

Ambiguity proliferated throughout both groups. A feature reflected in the content of the transcripts produced. These levels of ambiguous statements provide an insight into the discursive process. They also indicate the degree to which the issue of child self harm induced uncertainty amongst the respondents. As with the earlier sub groups the 'themes' obtained provided an insight into the main themes of the group discourse.

Ambiguous statements were made by each of the respondents. Levels of which fluctuated between vignettes. Indeed in some vignettes there no such statements. Whilst these cases differed in terms of patient variables, they tended to be those that were perceived as high in lethality and intent.

It is possible that the students were hesitant in their initial comments. Given the high levels of examination within medical training, accordingly the students may have felt unable to give their true views of the case and commented in a way that they thought was acceptable.

That the medical students had difficulty comprehending the contents of some of the vignettes is evident. Thus levels of ambiguity provide a direct link to the discourse itself.

‘Where do young children get their ideas from. To inflict

Self harm on themselves, this needs to be looked into.’ (MS1D)

Statements such as the above allow both phases of the discourse analysis to be identified. The need for greater understanding expressed by the students and the way patient age was perceived in the group process.

5.5 (4) Patient Age

Patient age was an identifiable feature of the medical students discourse. Within both groups the issue of age proliferated from the first vignette to the last. Each of the students made a comment toward the age of the patient. For some respondents this was the main aspect of their contribution to the discourse process. For these students the main issue was an inability to understand the motivation behind the self-harm act.

‘It is interesting to consider, where did this little boy get

the idea of self harm.’ (MS1G).

Such statements would find support amongst the other respondents who would also express their failure to understand how young children could commit acts of self-harm. Examination of the focus group texts show that such statements occurred in those vignettes that dealt with children under twelve. The students needed to understand how these behaviours manifested in such young children. There was a universal need for more information about these patients; features of the students discourse in general.

This need for more information may have been based on the concern of the students toward these children.

‘The boy is only 8 years old, he can’t think of suicide’ (MS2D)

Older patients were perceived to be more likely to carry out self-harm behaviours. For the respondents, there was a greater understanding of the factor that could lead to these actions. One respondent saw similar factors in a friend who had made a suicide attempt. Issues of examination pressure and relationship difficulties were discussed within the group. The fear of failure, particularly amongst one vignette drew a large number of comments from the respondents. It is possible that the exam pressure described by the vignette had been experienced by the medical students, who remembered an adolescence dominated by schoolwork.

‘From personal experience, one can relate to her emotions

But, when one has come through many more exams one tends

to forget the stress of the first exam.’ (MS1A)

Older patients were felt to have a greater understanding of the results of their actions. Consequentially, dependent on the case levels of intent would fluctuate between the very high and the low. Some of these older children were perceived to have very strong suicidal ideation and it was felt that the outcome would eventually be fatal. In contrast others were aware of the lethality of their actions and would ensure that they would be found, another theme within the discursive process such actions were perceived as missing amongst the younger children. When the act was seen as high in lethality its cause would be accidental. In one case it was suggested that the act of harm was not self-inflicted.

**‘Possibly Munchausens by Proxy. Are we sure it is Ryan taking
the pills and not some one giving them to him?’ (MS2E)**

However, such statements could be related to the difficulties the students had with younger children. Given the high incidence of patient age within the discursive process it is possible that the students would make such statements in an attempt to explain these behaviours.

Whilst such issues were prevalent throughout both focus groups the reverse occurred in terms of patient gender.

5.5 (5) Patient Gender

Within the text of both groups, no direct comment of patient gender was made. Both of these statements drew heavily upon the patient variables of age and rate of admission. There was no response or follow up statements and no further comment was offered.

Whilst this is of interest in itself, it is in comparison with the other groups in the second phase that a clearer understanding of the phenomenon can be made. Examination of the focus group make up showed that one group consisted entirely of males. Whilst this could explain the lack of gender interest it does not account for the other in which the sexes were equally matched.

As already noted, one aspect of the medical students discourse was their need for more information about each vignette. This could be interpreted as a lack of knowledge of self-harm behaviours. They would not be aware of gender issues within the phenomenon.

However, the student nurses who did make use of patient gender within their discourse expressed such difficulties. It may be that only through cross group comparison that the lack of patient gender within the medical students discourse can be identified.

5.5 (6) Rate of Admission

The way in which admission rate was perceived by the respondents is reflective of the whole discursive process. Not only do they request greater information about each case, they fluctuate in their interpretations of each factor and express anxieties toward them.

Some of the respondents stated a need to know about each previous admission. Others who would examine the wording of the vignettes in an attempt to glean further information would support such requests. Previous acts of self-harm would be interpreted as vital if an understanding of the patient was to be made. However, it should be noted that rate of admission would be interpreted differently throughout the discursive process. Indeed within the same vignette. That such behaviour would take place and without disagreement from the other respondents is perhaps symptomatic of the discursive process itself. For some of the respondents, the number of previous admissions was an indication of limited intent. For them, the patient had become aware of the results of their action and would thus manage the act accordingly. Such statements occurred throughout the discursive process but appeared to be concentrated amongst those children who had more than five admissions.

‘ I mean if she has done it five times before, she will know that fifteen paracetamol won’t kill her.’ (MS1F)

However, for others the high admission rate was symptomatic of a lack of proper input on the part of healthcare services. Five admissions were perceived as proof of a chronic condition. Although all the respondents did not make statements they did occur frequently enough to be identified as an important act of the discourse.

However, in some cases it was felt that there were patients who carried out more than one act of self-harm were perceived by some students to be accelerating the lethality of their actions.

‘He’s done it twice before....I mean it sounds like he has more of An intention to kill himself than the previous cases.’ (MS1J).

As with the other staff groups, the discourse toward each patient variable was based on the elements of the discourse itself. The comments toward patients with several admissions can be seen to hold each of these main themes.

5.5 (7) Foucauldian Analysis

In keeping with the other groups, in the second phase, a Foucauldian analysis was used to identify the main themes within the discursive process. As can be expected, their are elements of the discourse particular to the medical students. The identification of these variables will provide an indication of how child self-harm is perceived amongst the respondents.

5.5 (8) Theme Identification

In both groups, the respondents were particularly interested in the physical ramifications of each act of self-harm. When the medical consequences were brought into the discursive process the group would spend a period of time discussing the possibilities. These would include the method of self-harm employed and the dosage taken. For the students it was these physical aspects of the act that were indicators of lethality and more importantly intent. Within the group that examined cases of ingestion, this was heightened by suggestions that some of the older patients could have chosen more lethal methods, a factor that found support from the other students.

‘Yeah, if you really want to kill yourself you just dig out the rat poison.’ (MS1A).

Such comments were found throughout the group texts. For the students medical lethality was the only true indication of intent. Their views of child self-harm were thus heavily influenced by the physical manifestations of the act. Without this potential lethality, there could little evidence of suicidal ideation. In the discursive process there would be a direct correlation between the possibility of fatality and the highest intent. Students would use the methods employed to show the extent of the actual suicidal behaviour. They also made use of other aspect of the vignettes to reinforce their attitudes. The disclosure of the act by the patient was

proof that there was limited intent to end life. That these comments were made by most of the respondents indicates their importance in the discursive process. Even amongst those patients who appeared to receive sympathetic comments were felt to have had at least a change of heart.

‘He realises he is doing something wrong and so tells his

Mum immediately after doing it.’ (MS2B)

It can be seen that the issue of physical condition dominated the students’ discourse. This emphasis on the medical consequences of the act and the need to have the facts at hand play an important part in the other phases of the discourse process.

5.5 (9) Rules that create spaces in which statements can be made.

As with the need for more information, the issue of compassion is evident throughout the discursive process. Within one group, the first comment made was one of understanding toward the patient. This set a pattern in which a statement of sympathy would allow for further comment. This could be made by the speaker or by another respondent. Whoever made the statement it would provide the chance to comment on the difficulties in detail. With evidence taken from the vignette contents. Compassion would therefore be based on the plight of younger patients and the perceived traumas of those who had carried out multiple acts of self-harm. Whatever the variables examined the overall statements would be around the need to ensure that help was made available. It is of interest to note that whilst there were repeated requests for treatment not actual interventions were suggested.

The members of each group who either made a request for clinical intervention or would offer their agreement made these comments.

On the occasion that a negative statement was made, the respondent was instantly stopped.

I don’t like this girl;. I definitely don’t like her. Manipulative.’ (MS1A)

When you say you don't like this girl she has taken fifteen paracetamol on a regular basis and she needs our help.' (MS1H).

As a result compassion can be identified as an important aspect within the students discourse. It is expected that they should show concern for the patients who come into their care and to suggest otherwise deviates from a dominant aspect of the discourse.

This is reinforced by the way in which qualified medical staff were felt to act toward child self-harm. It was suggested by a number of the students that medical staff could be influenced by the variables contained within the case vignettes. Patients who had over five admissions were felt to engender negative emotions amongst experienced medical staff. These were emotions that a number of students felt were unacceptable and unlikely to be expressed by themselves.

'No, we should be more compassionate towards them, they are not showing normal behaviour.' (MS1H).

5.5 (10) The identification of rules that ensure that a practice is material and discursive

A theme that proliferated throughout the discursive process of both groups was the need for more information about the case vignettes. Of the twenty-four vignettes examined such a request was made in nineteen. The majority of the students made the comments with some making the demand repeatedly. These pleas would be general as well as specific. Some would be based around the need for greater information on self-harm behaviour. Factors such as patient age and rate of admission would be introduced in order to reinforce the need for information. This was particularly evident when the vignettes dealt with younger patients. As noted, for some the issue of younger children self-harming was a difficult concept to understand. Evident in the request for more details after such admissions

‘Where do they get the idea from, what makes young children inflict this harm upon themselves? We need more information, this needs to be looked into.’ (MS2A).

Such questions would be mixed with more specific requests, not only about the patient but other items within the vignette. These would often be about parents. A number of students would suggest the need for mental state examinations of those who cared for the children. These requests would be asked with a certain amount of authority. This demonstrates the need for more information was an established aspect of the medical students’ discourse. That the need for grater evidence was not particular to issues of self-harm. Rather, given the occupation of the respondents it could be suggested that it is an integral part of their discourse. These requests would be made to other students, often after initial statements had been made. When an attempt to interpret the information within the vignettes the group would reinforce this aspect of the discourse by citing the need for more details.

‘Well personally I get the impression that there is a slight bit more intent here...Again, I can’t tell from the information here.’ (MS1J)

Within Foucauldian theory, the position of medicine in the healthcare system is based on the acquisition of such knowledge. The role of the medical student is to develop a complete nosology of all conditions. The need to ask questions is central to the students discourse and is the physical manifestation of their perception of child self-harm. it is possible that the student believe that they are expected to ask questions. Indeed, the texts indicate that the majority of requests were in the first vignettes. However, as noted these statements of need continued throughout the discursive process. Therefore the material aspect of the discourse is continuos throughout.

5.5 (11) Discourse Summary.

Examination of the discursive process of the medical students produced a number of interesting results.

Firstly within the examination of the patient variables a number of factors arose. Indeed, the way patient age and rate of admission were viewed highlighted the central dichotomy of the students discourse. Rate of admission was a clinical indication that meant different things dependent upon vignette and speaker. Lack of agreement without argument may be suggestive of a basic lack of knowledge on the part of the group. While it was acceptable to make a diagnosis based on the vignette contents none of the students felt able to offer a line of questions that would require in-depth elaboration from the speaker. This uncertainty became manifest in the expressions of disbelief toward the actions of the younger patients. That examples of self-injurious behaviour in children under 12 produced such comments indicates that child self-harm have a limited place within the students discourse hierarchy, highlighted in the lack of comment around patient gender.

Yet, these differences in the way the respondents approached the phenomena is evident throughout their discourse. They appear certain that there are physical aspects of each case that indicate levels of intent and lethality. They reinforce such beliefs throughout the discursive process and approach the topic with apparent certainty. This is compounded by their expressions of compassion toward those children who they feel are at greatest risk of eventual fatality. Alongside the apparent failure of the clinical environment to provide acceptable treatments.

However, the material aspect of their discourse is the need for more information about each case. Possible proof of their limited knowledge of the topic. Also the importance within the

discourse of such nosologies in order to establish a position from which their statements will have an unassailable credence.

Yet, it would be impossible to examine the medical students discourse in isolation.

Examination of this and other staff subgroups suggest that there are factors particulars to each group as well as more common themes that will provide an understanding of the phenomenon.

5.6 (1) Cross Group Analysis

Introduction

Comparison of the staff sub-groups as with initial group analysis is based upon Foucauldian theory. The use of the five-stage analysis process outlined at the start of the chapter allows the discursive process of the sample population to be analysed systematically. Each of the stages ensures that significant aspects of the groups' attitudes are dealt with. While stage one, four and five were used to highlight the discursive process of each group in turn, the remainder allows for cross group comparisons.

The second stage in the process concentrates on the production of statements. This deals with the background factors that shape the discursive process. As such, this stage will not be implemented till the discussion chapter of the thesis. This will allow for a comparison of the 'results' of the research and the issues identified within the literature review.

However, the remaining third stage is closely related to the second and this will allow comparisons of the discourses to be made. Within this stage, the identification of rules that delimit the sayable, it is possible to draw each discursive framework together. As already noted, Foucault describes the members of a discourse as capable of communication only within that discursive process. The comments made by each of the focus groups are thus particular to that discourse. However, Foucault deals not only with the production of a discourse but also with its limits. The comparison of what is not said as well as what is provides the framework for this stage of the analysis. Similarities between the groups will be examined first. This will then allow for each staff group in turn.

Given that the two 'student' groups of inexperienced staff were the first to be analysed individually comparison will begin with them.

5.6 (2) Inexperienced Staff

Within the second phase of the study, the two groups of students represented the inexperienced staff groups. One consisted of student nurses the other of medics. Both were at a similar stage of their training although the medical students had completed more calendar years. Given the closeness between the groups in terms of clinical exposure, it can be expected that there would be similarities in their attitudes toward child self-harm. Indeed, examination of the text of both sets of students identified a number of similar reposes. However, differences were also evident within their respective discourses and these are outlined below.

In terms of similarities a number of shared attitudes were identified between the two sets of students. The most evident of these is the use of the physical aspects of the case vignettes. The students saw a direct correlation between the disclosure of the act and limited suicidal intent. Evident in both groups was the universal acceptance of these statements. That both medical and nursing students saw such factors as accepted indicators of suicidal behaviour is suggestive of a shared nosology.

Yet, there were other aspects of the discourses that shared similar viewpoints. Both sets of students felt the need to approach child self harm in an open and compassionate manner. It was felt that this was expected behaviour and to act otherwise would deviate from the group discourse. In both sets trained staff were held as examples of how not to interact with this patient group. Instead, the emphasis was on understanding.

However, it is here that differences between the two discourses can be identified. While the student nurses keep their distance from the patient, the medics suggest avenues of care.

Although both sets of students stated the need to offer help to the children it was only the medical students who discussed ways in which they could be helped.

The nurses expressed their anxieties at compounding the factors that resulted in the act.

As a result, the discursive processes of the two groups can be seen to differ. The nurses accept that they are limited in their knowledge of child self harm and blame a lack of formal input on the phenomenon. By contrast the medical students expressed no such difficulty. Rather, they asked for more information about each case. This was done in order to formulate the appropriate response to the self-harm act. Whilst the nurses' discourse was fatalistic the medical students saw the possibilities of treatment. There was a need to identify every aspect of the vignettes in order to formulate the 'correct' attitude. This differed greatly from the student nurses who appeared to rely on their own and known experiences in order to qualify their attitudes. This compounds their stated inability to understand child self-harm. As the experience is outside their sphere of reference, it has no place in the discursive process. This fits Foucauldian theory in which the discourse is only capable of speaking of that which it has knowledge. The student nurses with their limited clinical experience will have little concept of child self-harm. The content of the vignettes is outside their known discourse so it must be explained by what is available to them, in the form of their own experiences.

However, this lack of clinical exposure is also true for the medical students. Yet, their discourse responds in a different way to the same phenomenon. While they too are conscious of their lack of knowledge, they are anxious to understand more about the phenomenon. For the medical students, the main aspect of their discourse toward child self-harm is the desire to increase their knowledge of all its facets. Here are the main differences between the two student groups. As noted, it is possible that the quest for knowledge of any medical condition is a central tent of the medical students' discourse, a factor outlined within Foucault's own writings (1973).

If this is the case then it can be expected that this quest should find fruition in the discourse of experienced physicians. That the lack of knowledge expressed by the student nurses should be replaced by the clinical awareness of the established staff nurse. Examination of the discourses of the two 'trained' groups should therefore provide an answer.

5.6 (3) Experienced Staff

Examination of the focus group texts of the 'experienced respondents has highlighted a number of important factors. Comparison of the two groups has also produced significant results.

The nurses and physicians who formed the focus group populations were equipped with a range of A & E experience. In some cases, this extended to several years' clinical involvement. It could be suggested that this shared experience would have an impact on the relative discourses. Indeed, initial examination of the focus group texts does indicate shared aspects. For both groups, there is heavy reliance on technical phraseology. Both nurses and physicians conduct aspects of the discourse in this manner, where use of medical terminology is an accepted part of the groups' communication.

Another similarity was the need for more information than that contained in the vignettes. Members of both groups stated from the first that greater detail would aid them in attitude formation. However, these requests were made for different reasons. Amongst the trained nurses, there was a degree of hesitancy in how patients could be perceived. Many of the respondents felt there was a need to introduce specialist care into the treatment process. This contrasted with the physicians who needed more information in order to establish what course of action they should take. The manner in which some physicians asked for greater detail indicates that such behaviour is an established part of their discursive process. The nurses need information because of their uncertainty in how to deal with the particular phenomenon.

The physicians appear to ask for details of all medical situations in that the vignettes could have contained incidents other than self-harm and be approached in the same way. Such behaviours by both groups are repeated in other aspects of the discursive process, which highlight further differences.

Within both groups, there were factors that established the credibility of the speaker.

However, the background to these factors is evidently from separate discourses. Amongst the physicians, diagnosis was required to allow the speaker to make further comment. The use of the diagnostic process provided the authority needed within the discourse. That all respondents made use of this aspect of the discursive process is of importance. Evident in the censure placed on those physicians who did not follow this set process. Within the medical discourse, emphasis is placed on this nosological system.

This is not so amongst nurses. Here expertise is based on experience. Again factors are introduced to establish the credibility of the speaker. To have been involved in self-harm incidents within the clinical environment is sufficient. Once this pattern has been established the majority of the respondents adopts it. For the nurses the ability to understand child self-harm can only be achieved through experience. As already noted, the physicians appear to implement a set procedure that can be adapted to a given medical condition once all variables have been considered. The use of diagnosis is therefore a continuation of this behaviour a proposition reinforced by other aspects of the discourse.

Given the importance of experience for the staff nurses, it can be of little surprise that another aspect of their discourse is the impact of such incidents. They describe busy departments in which workload is exacerbated by the demands of self-harm patients. This again contrasts with the physicians. Their discourse is based on a set procedure. While the nurses are too busy to cope, the physicians offer solutions. Methods of treatment are suggested which would end

further acts of self-harm. Throughout the physician remains in control of the process. If problems do arise then the discourse allows the patient to be blamed. It is this proactive discourse, where the physician has the means to prevent further acts of self-harm, rather than the reactive discourse of the nurses that separate the two staff groups. Given the differences between the two groups in terms of discourse content, greater differences can be expected when the equation of experience is introduced.

5.6 (4) General Comparisons

This section provides a straightforward account of differences and similarities amongst the various discourses. Further discussion and explanation follows in the next chapter. Yet a number of general issues can be identified.

It could be expected that differences would exist between the experienced and inexperienced respondents. However, examinations of the focus group texts have identified similarities. Indeed differences appear greater in terms of profession rather than experience. Evident in the use of diagnosis and experience by each clinical group.

The most identifiable difference was the stance taken on vignette details. Both trained and untrained physicians offered solutions that were absent from the nurses' discourse. Both sets of nurses in fact suggested no solution. For the nursing staff, child self-harm appears to be an event that impacts on them. A contrast to the position taken by the physicians.

Another difference between the two professional groups lay in the use of experience to justify the comments made. For nurses, personal or clinical experiences are seen as sufficient to authenticate the attitudes of the speaker. It is the use of clinical rather than personal events that separate trained and untrained nurses. It could be suggested that as their clinical careers progress the students nurse could make greater use of the events that they become involved in.

Their initial anxieties about saying the wrong thing could be replaced by the staff nurses desire to introduce specialists to treat cases of self-harm.

The above contrasts with the medical professionals. Both sets of physicians had a need to investigate all aspects of the vignettes and then adapt the medical process accordingly. A feature of both discourses that was so engrained that those who deviated from it would be reprimanded. Although the heaviest censure was found amongst those trained doctors who failed to follow the set procedure.

However, differences did exist within the two professional groups. Amongst the nursing students the discursive process did describe negative attitudes on the part of trained staff. This is confirmed by the staff nurses who accept that the impact of self-harming patients can have a negative affect on staff. Indeed, the need not to negatively label the patients was absent from the staff nurses' discourse.

5.6 (5) Conclusion

The reasons behind these differences and the actual content of the discourses themselves can only be obtained through the remaining phase of Foucauldian analysis. Examination of the analysis given above with use of the literature already identified will enable this process to be implemented.

Chapter Six

Discussion & Recommendations

6.1 Introduction

This chapter presents the results obtained from the study in the light of the existing body of knowledge. In order to do this the chapter is divided into a number of sections. The first section outlines the key findings of the study and acknowledges the unique contribution these make to the body of knowledge. Each phase of analysis is examined in turn first in terms of the objectives given at the start of the thesis. The results themselves are then discussed in light of the literature around self-harm. The weaknesses of each stage of data collection and analysis are discussed in turn and conclude with an overall discussion of the limitations of the thesis. The implications of the study in light of current policy and recommendations for further study conclude the chapter.

Key Findings

Given the exploratory nature of this thesis, there are clearly a number of new findings in terms of staff attitude. However, the most important contribution that this study may have made is in its acknowledgement of patient variables. Whilst the importance of patient type has been alluded to in other studies (Samuellsen et al., 1997) this study is the first to place them at the centre of its aims. By creating a questionnaire particular to the issues found in child self-harm the thesis has placed them within the realm of open discussion. It is the nature of the key findings within this research that makes them unique, in brief these findings are as follows:

1/ Age: Older female patients were felt to have carried out acts of greater lethality and intent.

2/ Gender: Patient: gender appears to influence attitude. Male patients were felt to have committed self-harm acts of greater lethality.

3/ Rate of Admission: Perceived levels of lethality and intent increased and then decreased according to admission rate.

Whilst the above variables are discussed in more detail later in this chapter the unique nature of these findings is a strong indication that there are aspects of the phenomena that had remained unexamined. It is accepted that further work is required into the issues identified in this thesis. However, the actual acknowledgement that patient variables do influence attitudes toward child self-harm is the most unique feature of this study.

6.2 Discussion of Phase One Results

The first question that must be asked is, did phase one of the study meet its objectives; to identify if staff and patient variables influence attitudes toward child self-harm?

The analysis of the data would suggest that was the case, both staff and patient variables produced significant differences in attitude amongst the respondents. The success of the study lies in the fact that it was possible to examine each of the research aims set out at the beginning of the thesis. Whilst the outcome variable of each, lethality, intent and communication are explored later in this chapter, the overall impact of the study itself can be acknowledged here.

One of the main achievements of the study within this first phase is the exploration of the variables themselves. As noted, the majority of previous attitude studies have concentrated on staff variables (McLaughlin, 1994). Those works that have included the exploration of patient type (Samuellsen et al., 1997; Ramon et al., 1975), have tended to explore a range of issues, based for the most part on the diagnosis of psychiatric illness. Given the particular features of self-harm amongst young people, with its high rate of admission (Hawton et al., 1996) and limited understanding of lethality (Gilbertson et al., 1996) it is important that any exploration of the

phenomenon should acknowledge these issues in an attempt to create as realistic picture as possible. Consequentially, the study incorporated a range of factors pertinent to child self-harm such as age and rate of admission. This can be evidenced in the selection of the two most common methods of self-harm amongst young people, ingestion and cutting. The high rate of significance within the examination of each of the patient variables suggests that the study has gone some way in identifying some of the salient features influencing attitudes toward child self-harm and advancing the body of knowledge around the topic.

As indicated earlier, the staff variables used in the study allowed for comparison with the self-harm literature. What is significant however, is the number of respondents used in this phase ($n = 152$) drawn from four separate clinical environments. Given the limited numbers in other studies (Anderson et al., 2000, $n = 59$), the first phase of the study can be seen to be one of the first comprehensive explorations of the phenomenon. However, the main contribution to the body of knowledge made by the first phase of this thesis, is the acknowledgement of the complex nature of attitudes toward child self-harm. As acknowledged at the end of the third chapter, the study accepts that to examine one patient variable in isolation is to ignore the fact that it is only one aspect of not only an episode of self-harm but also the interaction between patient and clinician that results in an attitude statement. This concept is discussed in more detail later in this chapter, discussions of the findings obtained in this first phase are given below in detail.

6.2(1) Staff variables

As with earlier self-harm studies, respondents were divided in terms of experience (McLaughlin, 1994; Anderson, 1997) between those with less than a year's employment in A & E and those with longer experience. Analysis of the data

indicated only one significant difference between the two groups (see table 4.2), this was based on perceived patient communication with inexperienced staff giving the greater mean score. Whilst the findings suggest that there is limited difference between respondents in terms of clinical experience this runs counter to previous work. Both McLaughlin (1994) and Anderson et al. (2000) noted differences in staff attitude based on clinical experience. However, differences exist in the two studies. Within McLaughlin's study experienced staff saw patients in a more positive light, whilst in the later work the same demographic saw self-harm as less than a normal act. This dichotomy is compounded by McAllister et al. (2002), who found no significant difference in attitude between staff in terms of clinical experience. An inability to find extensive differences between staff in terms of clinical experience may have been due to a number of reasons. Firstly, the lack of difference between group scores may be due to the artificial nature of the demarcation used. Whilst Anderson et al. (2000) used less than one years experience as a category within their study it was not department specific as in the current work. In this thesis it is possible that the less experienced staff had come into contact with self-harming patient whilst working in other departments. This is possible in the case of the physicians who all have a least one years clinical experience as pre-registration house officers. However, McLaughlin's work divided staff in terms of A & E experience with five years casualty staffing used as a dividing criteria. Yet, it should be noted that the results obtained in the above ran contrary to the hypothesis put forward by its author. This dichotomy of results within previous studies may provide a second explanation for the results obtained in the current work. Comparison of those studies is based on clinical experience showing a range of sample populations. McAllister et al. (2002) conducted their study in Australia, whilst Anderson et al. (2000) used a sample from a

range of settings. When an earlier study by Anderson (1997) used A & E nurses in the sample population, similar results to those of McLaughlin were found. Indeed both authors suggest that the differences obtained may be caused by exposure to the phenomenon of self-harming patients. If this is the case, then similar results could have been expected of this study. The answer may lie in the client group being treated. Both of the earlier studies dealt with adult patients, as already noted the issue of child self-harm is an emotive one. It may be that an act of self-harm carried out by a young person may elicit a universal response that no amount of clinical experience will alter. In the only other study that examines attitudes toward child self-harm, the authors suggest the results should be treated with caution and further research undertaken. Consequently, it could be suggested that there is no typical response to the phenomenon in terms of this staff variable. A further investigation is warranted in order to establish if clinical experience does impact on staff attitudes. What this study has achieved however is to bring such an issue into an open forum for debate. Whilst no clear conclusions can be drawn from this research aim, the second, proposition, that role would influence attitude did produce significant differences. As with earlier studies (Ramon et al., 1975) respondents were divided between physicians and nursing staff. Of the 152 respondents, 128 were nurses and 28 medical staff. Examination of the results (Table 3.1) indicated a number of significant differences between the two groups. The most common difference occurred in terms of perceived lethality with all but one of the outcome variables producing significance. Of the six remaining measurements of perceived lethality mean scores were higher amongst nursing staff in five cases with only male lethality achieving a 'higher score' amongst physicians.

That such a difference occurs between the two staff groups' mirrors earlier studies. From the earliest studies (Ramon et al. 1975; Hawton et al., 1982) differences occur between physicians and nurses. However, it is difficult to make direct comparisons with these earlier studies because of the outcome variables used in this instance. As previously acknowledged, the development of the questionnaire and vignettes used in this study saw a departure from those works that used an adaptation of the Suicide Opinion Questionnaire devised by Domino et al. (1982). As such, lethality is not one of the variables measured in these studies. Given the accepted impact of perceived lethality on the way a patient is viewed (Ryland & King, 1982; Bent-Kelly, 1992) it can be suggested that the physicians within the study viewed the actions of the vignette actors as less important than their nursing counterparts. Indeed, this would seem to be confirmed by the significant differences surrounding perceived patient intent.

Of the seven measurements of suicidal intent, significant differences occurred in three cases. In each of these outcomes nursing staff saw greater levels of intent, in all but one measurement the mean score of nursing staff was higher. If this is correlated with perceived lethality as an indication of negative attitude amongst physicians it supports the results of those earlier works.

Huband and Tantam (2000) found that physicians within their study described self-harming patients as difficult to treat and echo of earlier studies (Malone, 1996).

Consequently, attitude studies have shown that nurses seem to show a greater level of acceptance (Ramon et al., 1975; Hawton et al., 1981).

However, there are feature of these studies that do show a commonality of response amongst clinicians of both disciplines. McAllister et al. (2002) found that an inability to treat self-harming patients engendered negative perceptions amongst nursing staff.

Indeed within the 2003 study by Anderson et al., the attitude that self-harm in young people was a means of communication was shared by both nurses and physicians. Similar results have been obtained in the current study, with only one incidence of statistical significant difference in perceived patient communication. That closer scores were obtained for this outcome variable is suggestive of a common attitude toward the perceived motives of child self-harm. However, these results must be treated with caution given the range of respondent used and the acknowledged complex nature of the topic.

Despite these necessary reservations, the results do show variations in staff response, evident in the repeated significant differences in perceived lethality and intent. Evidently, the interpretation of self-harm is dictated by the individual's clinical role and that this manifests itself for medical staff in the lower scores given to actions of the vignettes actors.

In order to explain the above, it would be necessary to undertake further research.

Thus, in order to examine the concept in greater detail staff were divided in terms of role and experience. Analysis of experienced staff showed a similar pattern to the larger group (see Table 3.4). Again, significant differences occurred in the outcome variables of lethality and intent with lower scores achieved by the physicians.

The same study was undertaken of inexperienced staff. In this instance the number of significant differences was reduced (see Table 3.3). Yet, the pattern was evident with the medically trained respondents attaining a lower mean score for lethality and intent. That the incidences of significance have decreased suggests that there are aspects of the clinical environment that impacts on each staff group in a particular way. Huband and Tantam (2000) saw training as an influence. It is possible that this is

also the case in this study though it would be necessary to undertake further research to confirm this.

It is possible therefore to acknowledge the impact of clinical training in terms of attitude. Whilst other studies have observed the impact of role on how those that self-harm are viewed, it is this study that explored the phenomenon within the context of child patients. It has also identified the specific outcomes of these attitudes in terms of the features of the act itself, namely intent lethality and communication. Combined with these, is the exploration of the patient variables themselves.

6.2 (2) Patient Variables

Examination of the data obtained from the patient variables differs from that of care staff in one important way. As already noted, a unique feature of this study is its systematic use of patient variables to elicit staff attitudes. As a result, there are no other empirical studies on which to base comparisons. The use of patient vignettes in attitude studies of self-harm has already been discussed and is not repeated here. However, the issue of how to interpret the data must be addressed. It is intended to examine each patient variable category in turn and compare the results for each outcome variable in light of the existing self-harm literature.

The first variable explored is patient age. Whilst the attitude studies conducted by Anderson et al. (2003; 2000) do not deal with patient variables in particular, it is possible to identify reluctance on the part of some care staff to acknowledge the suicidal potential of young people.

This reluctance to accept the potential fatality of the act is identified within the current study. Amongst male patients, there was only one significant difference in terms of perceived lethality and one of intent, in each case the younger patient obtaining the higher 'score'. However, for attitudes toward female patients it would appear that age

is influential in shaping staff attitudes. In terms of perceived lethality, older female patients with either one or two to four admissions were felt to commit the most lethal acts. This pattern is mirrored by older patients seen as having significantly more intent.

A lack of significant difference in terms of perceived communication is of interest. Examination of the statistics showed only one case of significance, with the greater level of communication amongst younger female patients admitted for the first time ($P = 0.01$).

An explanation of the above can be found within the demographic details of child self-harm. Age, as an influence on perceived intent is evident from the literature. Kienhorst et al. (1992) noted that fatal acts of self-harm increased after the age of twelve. This supports the earlier works of Triolo et al. (1984) and Spirito et al. (1989) who both describe a marked increase in self-destructive behaviour in adolescence. Another cause may lie in the social ramifications of self-harm and suicide. Societies negative reactions toward the phenomenon have been acknowledged earlier in this thesis (Fedden 1938) with Durkhiem (1897) describing the attempt by families to hide suicides from the authorities. From the historical position of childhood in society (Aries, 1979) the self-destructive child runs contrary to what a young person symbolises. As noted within the literature review, from the suppression of Goethe to the sentimentality of the Victorian period, self-destructive behaviour is something that the young must be prevented from even acknowledging. It is possible that these social mores have transformed themselves into disbelief that children may wish to destroy themselves; a concept put forward by Greene (1994). The care staff within the study, as part of society may have been socialised into seeing such actions amongst the very young and put any act of self-harm down to causes other than suicidal intent.

Anderson et al. (2003) also hint indirectly at patient gender as an influence on attitude. Examination of the results of this thesis suggests that patient gender does influence attitudes. Amongst the younger patients boys were seen to commit significantly more lethal acts. Similar levels of male lethality also occurred amongst older patients, save those admitted for the first time.

Examination of perceived intent appears to show a more complex situation. Whilst statistical significance occurred throughout all patient variables, rate of admission appeared to dictate which gender was felt to have the most intent. Amongst the older patients females admitted for the first time and minor repeaters had the greater level though this was reversed for major repeaters.

Again, the communicative aspects of the phenomenon saw limited difference between patient genders. As with age, it was younger females on their first admission who were felt to carry out significantly different acts.

Possible causes for these staff responses can also be identified from the literature.

That care staff see male patients as committing the more lethal acts can be explained within the demographic studies of the phenomenon. The vast majority of studies show that whilst girls carry out the greater number of self-harm acts, it is boys who commit those of greatest lethality (Li et al., 1997; Kerfoot, 1988). These findings are confirmed in more recent studies. King (1999) found that 1 in 3 suicide attempts by adolescents males result in fatality compared to 1 in 25 females. Hawton et al. (1982) felt that the majority of self-harm acts amongst female adolescents were based on non-suicide behaviour. Menninger (1961) acknowledged that the wish to die does not appear in each act, thus it is possible that female patient engage in low lethality 'focal suicide' acts, with an actual wish to be found and treated. In comparison, males are seen to commit acts of greater lethality, presenting as more withdrawn and

uncommunicative when in treatment. However, it should be noted that the earlier work of Spirito et al. (1989) concluded that it was choice of method rather than a lack of intent that caused the low suicide rate amongst females. What is accepted is the high repetition rate amongst female adolescents, an aspect of the phenomenon highlighted in other studies (Shaffer et al., 1998; Kerfoot and Huxley, 1995).

Given that the accepted clinical picture is one of high male lethality and high female repetition, the results obtained in this study can be explained. The respondents may, through experience, see an act of self-harm by male as intrinsically lethal. The one incidence in which a female was felt to commit the act of greater lethality, may be caused by other factors contained within the vignette and could be due to a design fault within the instrument itself, a factor that may influence perceived intent. It should be acknowledged that the respondents saw a range of aspects within each vignette that could sway their opinions, evident in the low levels of intent ascribed for females with numerous admissions. Indicating that the respondents do not see each aspect of the vignettes in isolation, but rather as constituent parts of the whole phenomenon.

This complexity within the respondent's answers is evident in the examination of the final patient variable of admission rate. Examination of the Chi-square tests show that as rate of admission rate increases so does its impact on staff attitudes. Amongst younger males, the perceived lethality of the act for those with major admissions was significantly lower than the other two groups.

Younger female patients engendered a similar response with statistical significance occurring in the examination of the major repeaters. Examination of the older patients produced a pattern of 'scoring' that seemed to suggest levels of perceived lethality rose and then fell according to admission rate.

This pattern was repeated for patient intent, except younger males, the highest levels of intent was seen amongst those admitted between two and four occasions.

Evidently, rate of admission influences how the actions of the patient are viewed. Of interest is the evident pattern of rise and fall. The patient with more than one admission will be taken seriously. It is acknowledged that there is a strong correlation between a previous act of self-injury and eventual suicide (Davies and Ames, 1998).

However, as the number of admissions and thus the number of self-harm episodes increase, the suicidal intent and thus potential lethality of the act are diminished.

Therefore, whilst issues of age and gender do influence attitudes, once the young person has been given the label of major repeater it is probable that this overrides all other factors.

Again, the explanation for the above results can be found in the relevant literature.

Repeated admissions for self-harm behaviours are an accepted feature of child self-harm (Hawton and James, 1995). Spirito et al. (1989) describe high levels of acting out amongst those young people with numerous admissions. If the respondents are exposed to such behaviours, it would explain the results obtained in the current study.

However, the lack of significance in terms of patient communication is less easy to explain. That this outcome variable consistently failed to produce strikingly different results suggests that the communicative aspects of self-harm are universally acknowledged by care- staff. Yet, the results obtained for older female patients allows for an alternative explanation. The communicative aspects of the acts, committed by the major repeaters were significantly greater than those of the other patients. It is possible that the levels of exposure to this patient group cause A & E clinicians to have no alternative, but to see the incidence of self-harm as a means of communication. That this aspect of the phenomenon is included in this study, is an

indication that it is one of the salient features of self-harm. The major repeater, fits the profile put forward from the earliest studies such as Pao (1969) of a female adolescent committing self-harm acts of limited suicidal intent. The communicative aspects of such behaviour have been documented in other studies (Favazza and Conterio, 1989; Feldman, 1988) and the prescribed negative response of care staff noted (Bunclark and Adcock, 1996).

6.2 (3) Strengths of Phase One

The main strength of phase one lies in the fact that it allows for each research aim to be examined. As noted, this thesis has explored a range of factors pertinent to child self-harm. It was able to achieve this examination by the creation of a questionnaire that acknowledged the salient features of the phenomenon. Given the concerns around the increase in self-destructive behaviour amongst young people (NICE, 2004) and the impact of staff attitudes on treatment outcomes (McManus et al., 1997) it was surprising that there was not an already established instrument that incorporated the main features of child self-harm. By developing the questionnaire used in this study, this thesis has made a real contribution to our understanding of staff attitudes toward this patient group.

For the first time the age and gender of the young person are examined for their impact on attitudes. Authors such as Greene (1994) hint at the possible impact of patient age on how self-harm is viewed, a concept confirmed by the present study. A systematic approach to each patient variable has ensured that the distinct features of child self-harm are explored. The use of the Kreitman and Casey (1988) categorisation of admission acknowledged one of the salient issues within the topic. High readmission rates for self-harm behaviour have been noted throughout the literature (Hill, 1995; Hawton et al., 1992). This study is the first to examine its

impact on staff attitudes. Whilst the need for further research is accepted, the findings obtained to date confirm the relevance of the variables examined. It is evident that female adolescents carry out a high number of low lethality acts of self-harm across a range of studies (Brent and Perper, 1995; Gould, 1990). The findings obtained from the sample population show that this impacts on care staff attitudes with older female patients with a high admission rate seen as committing acts of low lethality and intent that were highly communicative.

Whilst this study's examination of patient variables is unique in terms of attitude studies, the inclusion of staff variables allowed for comparison with earlier works (McAllister et al., 2002; Anderson et al., 2000). However, as a departure from these other works phase one of the study concentrated on one clinical area. Therefore it was able to eliminate the possible impact of alternate working environments and limited interaction with self-harming children.

The incorporation of both staff and patient variables within the instrument allowed this thesis to confirm the speculation made by earlier studies of the complex nature of the self-harm act. Whilst previous attitude studies have concentrated on either staff or patient variables, the results obtained by this thesis suggests that to do so fails to acknowledge the myriad factors that shape attitudes toward child self-harm. That the issue of self-destructive behaviour among the young is an emotive topic, rich in complexity and requiring a range of research approaches to understand it fully.

6.2 (4) Limitations of Phase One

There are a number of methodological limitations to the first phase of this thesis.

Whilst some of these shortcomings are based on the instrument itself, others deal with its implementation.

The first consideration is the construction of the instrument itself, in particular the use of hypothetical case vignettes. As discussed, the use of patient variables specific to child self-harm is a major departure by this thesis from previous attitude studies. However, it must be acknowledged that in order to incorporate each of the patient variables in each of the vignettes, they are artificial in nature. Even though the vignettes were selected by a panel of psychiatrists to be as realistic as possible, it is possible that use of actual self-harm cases would increase that realism. This is also a consideration in terms of the methods of self-harm employed. It is accepted that there are a range of methods of self-injury, often gender and age specific (Pfeffer, 1986). Consequently, there are aspects of the phenomenon that have not been included within the instrument. To do so however would obviously make the instrument unwieldy and introduce a raft of other variables. It is possible that the instrument could be adapted to include other methods in later studies and this is discussed in detail in the next section.

Another problem lies in the range of variables themselves. Whilst the instrument has explored a range of issues, particular to child self-harm, there are other pertinent issues that have been excluded. Other attitude studies that deal with patient variables (Samuelsson et al., 1997) examine issues of mental illness; such concepts are not included in this study. The link between mental illness and self-harm has been well documented (O'Connor, 1997; Steer et al., 1993).

Apart from the instrument itself, there are issues around the actual process of data collection undertaken in this phase. Firstly, it should be accepted that the A & E departments are all contained within one regional health authority and serve similar populations in terms of demographic make up. Whilst this provides similarity and aids comparison a number of issues arise. Issues of regionality should be acknowledged.

The demographic make up of the populations each A & E serve may well influence how care staff view the act of self-harm itself. Authors such as Hawton et al. (1995) have noted that certain populations produce particular patterns of self-destructive behaviour. If some socio-economic groups display a consistent pattern of self-harm, in terms of method and rate of admission then this could well cloud staff attitudes. As each of the A & E departments in this study served mainly working class populations it is possible that a department in a middle class environment is exposed to different patterns of self-harm which may engender a different response.

The process of data collection itself could well have been improved. Whilst the return rate was high in comparison to other attitude studies (the lowest for this thesis being 50% for one hospital), it is possible that the size of the instrument itself may have prevented more clinicians from returning completed questionnaires. A & E departments are by their very nature busy places and as such, smaller questionnaires may have been completed by clinicians with a limited amount of free time, an issue discussed below.

6.2 (5) Recommendations for Further Research

The main feature of the first phase of this thesis is the creation of the questionnaire. Given its exploratory nature it is essential that further work be undertaken to ensure that the results obtained to date are an accurate reflection of the phenomenon. It is suggested that the study be replicated in other A & E departments, not only to confirm the reliability of the instrument but should also address any issues of regionality within the initial data collection.

The implementation of the instrument in other clinical areas would also provide a greater understanding of care staff attitudes. Whilst A & E departments are often the point of entry for self-harming children, other care settings become involved in their

treatment. The attitudes of psychiatric staff, often responsible for the assessment of need in terms of further care, will obviously play a major part in any successful treatment outcome. This is also the case in terms of staff working in general paediatric wards. Because of the lack of specialist beds, the majority of children admitted for the treatment of self-harm are placed in whatever bed is available. Whilst some tentative exploration has been made (Harrison, 1998) there is an obvious need to examine the area in more detail.

An alteration to the instrument itself may also be made prior to any further research. The hypothetical case vignettes could be replaced with actual cases once issues of anonymity have been acknowledged. Not only will this provide again an indication of the instruments reliability, it would also ensure that the complex nature of the phenomenon is taken into consideration.

6.3 Discussion of Phase Two Results

Phase two of the thesis saw focus groups utilised to elicit staff attitudes. As well as being the first time this method of data collection was used in an exploration of attitudes toward child self-harm, the groups themselves replicated the communal nature of working in an Accident and Emergency department. As with the first phase of the study, success is based on the extent to which the research questions were answered. The first, the identification of factors that shape attitudes, was comprehensively answered and provided a number of unique insights into the phenomenon. By using a Foucauldian framework, it was possible to explore not only the language used by the respondents but identify the physical manifestations of their attitudes. The acknowledgement of the dominant medical model and the perceived deviancy of the patient who self-harms is a departure from other studies that have no explanation for the attitudes of care staff (Ramon et al., 1975). By doing so, this thesis

was able to conclude that there are factors particular to both patient and staff member that influence attitude. However, of greater importance, is the acknowledgement that no one factor can be seen in isolation. Each staff and patient variable must be seen in the light of the other, with any of the results obtained constructed from a range of factors. The identification of this complexity is one of the unique features of this thesis and confirms the success of this phase of data analysis. By examining each of the focus group populations in light of the existing literature, it is possible to observe the interwoven nature of staff attitudes toward child self-harm.

6.3 (1) Physicians

Within the previous chapters of this thesis, the position of the medical model inside hospitals has been acknowledged. Evidence of a dominant theory of self-harm causation, presentation and treatment emerged from the literature. From biological theories (Partonen et al. 1999) to mental illness models (Appleby et al. 1997) the central tenet is one of medical dominance its position legitimised by its grounding in the physical sciences. Thus, any analysis of care staff attitudes would require an acknowledgement of this hegemony. Indeed, Feldman (1988) suggests that any diagnosis of suicidal behaviour in a patient discloses more about the doctor that gives it. Szasz (1972) takes this concept further and suggests that those patients who fail to recover face censure.

Analysis of the physician focus groups supports this concept. Throughout both groups, use was made of diagnostic criteria to explain the physician attitude toward the vignette actors. As previously noted, from the first vignette emphasis was placed on the speaker's ability to offer a diagnosis to explain patient behaviour. When the Foucauldian framework is put in place, it was possible to identify the use of this diagnostic procedure as a means of legitimisation. Not only are such actions crucial to

Foucauldian theory on discourse, they are central to his concept of the medical profession. As evidenced in the focus group, the member of the group who failed to follow the diagnostic process, failed to have their perception legitimised. Yet why is this justification necessary within the physicians discourse? The answer for Foucault lies in the nosology used by the medical profession. This process lies at the heart of any Foucauldian explanation of physician perception toward phenomenon such as child self-harm.

Within the 'Birth of the Clinic' (1973) Foucault discusses the medical penchant for classification. The process itself is based on an adherence to the physical sciences and all attitudes are so governed. The discourse itself is a composition of such pathological approaches. As the previous chapter shows each aspect of the physicians' discourse is conducted in this way, a concept described by Foucault as a process of 'tertiary spatialization' (Foucault, 1973, p17).

Each aspect of the Medical discourse is thus structured, defined and legitimised. If the various stages of the focus group dialogue are examined both in sequence and in isolation, this discursive process is evident throughout. The physical ramification of the physicians' focus group, its material manifestation, is one of treatment.

Examination shows that the treatments are not grounded in sentimentality toward the patient but rather in the diagnostic procedure used to arrive at the correct treatments for the patient:

'The previous acts are important. Intervention needs to take place.'
(PH1E)

For Foucault, this is the culmination of the active vision, open only to the medical profession, the clinical gaze. Yet, observation is only part of the process, it is continual, with diagnosis translated in what Foucault calls the essential language of the disease (1973). The gaze allows the physician to do this and it finds its expression

in diagnosis. Evidence of this exists throughout the physicians' discourse, in comparison to the other focus groups ambiguous statements are kept to a minimum. As noted, respondents would be precise and those who deviated from this process would be admonished.

'I don't think you can possibly jump to that conclusion without more information.' (PH1A)

Therefore, any aspect of the vignette is nothing more than a diagnostic aid; age, gender and rate of admission are seen as factors that allow the doctor to formulise a treatment process. Patients with numerous admissions were felt to warrant further investigation, in some cases referral to specialist services would be recommended. Yet, throughout the needs of the patient would be met by using the medical model. Proof, that physician attitude of child self-harm is embedded in this dominant framework, one that dominates each aspect of the medical discourse. Such dominance is further evident within the medical students' focus groups.

6.3 (2) Medical Students

Given the acknowledged dominance of the medical model within the physicians discourse, the identification of similar themes amongst the medical students would be expected. Examination of their focus group analysis confirmed this theory. Primarily, this similarity lies in the way in which the respondents use the information contained within the vignettes. As with the physicians, the medical students placed great emphasis on medical lethality of the act. Perceived intent would be based solely on the possible fatality of the action. For the medical students therefore any measurement of self-harm behaviour is based on its biological ramifications.

Further similarities between the two sets of respondents were found in the recommendation for specialist medical intervention in some of the cases. However,

unlike the physicians, the medical students do not offer any treatment solutions themselves. Is this a possible indication that the medical students do not yet follow all aspects of the medical discourse? As with the physician focus groups there was a need for greater information about the vignette actors. Yet, such a process did not result in diagnosis, in fact ambiguity of outcome was evident in the discursive processes of both medical student groups. This limited use of the medical model is further evidenced in the use the students made of *their own personal experiences* when discussing the vignette actors, particularly expressing empathy for the patient whose self-harm was precipitated by exam stress:

'From personal experience one can relate to her emotions.'

(MS1A)

Indeed, within the medical students' discourse the evidence of compassion for the vignette actors suggested links with nursing staff attitudes and the evidence for such behaviours was evident within the literature.

Firstly, if the ambiguity and hesitancy on the part of the medical students is examined then a number of possible causes arise. Michel and Valach (1992) noted that non-psychiatrists receive little training on the topic a factor which could possibly influence the training medical students receive. The issue could simply be a lack of exposure to the phenomenon. As noted, Scambler (1991) suggests that the medical student quickly learns to divide patients into categories of either rewarding or unrewarding. Given the paucity of knowledge amongst the majority of physicians toward the topic, they may not see child self-harm as an important issue in the training of the next generation of doctors.

However, a second explanation lies in Foucauldian concepts of how the medical profession trains its members. Foucault (1973) perceived medical education as a rigid process of law and examination, one controlled by the physicians themselves.

'Doctors would reserve the initiation into the clinic to themselves.'

(1973, p99)

Yet, it is the method employed within this initiation that would help explain why the medical students were reluctant to offer a diagnosis. Foucault saw the medical student being schooled by a process of familiarization with the language of disease. If this is the case and the lack of precise medical training on the phenomenon acknowledged, the students' hesitancy is understandable. This reluctance to offer a diagnosis may also lie in the benchmarks of ability medicine is felt to set for itself. For Foucault (1973) the position of medicine is based on the notion of physician competency, if the medical student is aware of this, a lack of subject knowledge will prevent them from offering any explanation, evident in the request from the students for more information about the vignette actors.

Indoctrination into the dominant medical discourse explains the main aspects of the medical students attitude. Indeed the students seem so absorbed by this process that the actions of vignette actors who self-harm for anomic reasons are perceived as unfathomable. Though it is possible that the concept of anomic suicide, by its very creation, has no place within medical discourse. It should be remembered, that Durkheim's concepts of suicide were developed to justify the development of Sociology as a discipline and as such are discourses of the 'Belle Epoch' not modern medicine.

'Where do they get the idea from, what makes young children inflict this harm upon themselves?' (MS2A).

Yet, it is this open admission of limited understanding that separates the medical students from the physicians. They lack the doctors' ability to be confident in offering a diagnosis. In fact, there are aspects of the students' discourse that has more in common with that of the nurses. The use of personal experiences to understand actions of vignette actors is far removed from the rigid diagnostic processes employed by the physicians. Instead, it lends itself more to the comments made by their nursing student counterparts.

6.3 (3) Student Nurses

If the analyses of the student nurse focus groups, it was evident that two main themes emerged, that the students expressed anxiety toward the phenomenon and the use of personal experience to justify their comments.

More than any other group, the attitudes of student nurses were affected by patient variables. This was particularly evident in their anxieties around the actions of the younger actors. As analysis indicated, the students expressed an inability to understand the causes of the child's self-harm.

'I cannot imagine a child doing this.' (SN1G).

That the student nurses made numerous such comments around the actions of the younger patients confirms the theories propounded by Pfeffer et al. (1997) and Greene (1994) who suggest that acts of self-injury amongst the very young would be in probability incomprehensible to the majority of people. If this is compared to the physician discourse, it is possible to acknowledge that within current society differing attitudes toward the phenomenon exist. As the second chapter of the thesis suggested, there is no universal concept of self-harm. Rather, the attitudes of the individual toward the issue are based on the overriding values contained within their society, as with the student nurses. Examination of Greco-Roman society showed that the

concept of the child as potential suicide was no different to that of any other member of society, as the child itself had a limited place within general social understanding (Jenks, 1996). As indicated above only when the child became a socially constructed entity in its own right, did the issue of child self-harm arise (Aries, 1979). To what extent then are the psychological formulations of Freud and Menninger simply an indication of the discursive processes of their own time, couched in the terminology of their own discourse? Of course, it would be impossible to suggest that the views of the student nurses mirror those of current society without further research. Yet, comparisons to the physicians discourse suggest that the factors behind their attitudes originate elsewhere.

Again, by using Foucauldian theory, it is possible to identify these differences. The student nurses acknowledgement of not being taught about the topic lies in direct contrast to the physicians' position of expertise. In the *Archaeology of Knowledge* (1972) Foucault acknowledges such divisions, with the development of what he calls the clinical discourse. The student nurses are unsanctioned to use such language (langue). Instead, their discursive process is justified from their own experiences, a true indication that the discourse is a representation of the formations that shaped it. For Foucault (1972) each individual occupies certain cultural and social environments. It is possible that the student nurses are not yet indoctrinated into the dominant medical discourse. As previously noted, the medical students discourse differs from the physicians in that they are unable to offer a diagnosis, and the same occurs for the student nurses, with levels of ambiguity similar in both groups. If Foucauldian theory is implemented, then the two unqualified groups must wait until their training is completed before they could offer any solutions to the actions of the vignette actors.

‘Who is qualified to do so? What is the status of the individuals who alone have the right, sanctioned by law or tradition.... to proffer such a discourse.’

(Foucault, 1972 p55)

6.3 (4) Staff Nurses

Examination of the staff nurse focus groups showed similarities to the structured discourse of the physicians and the more general one of the students. Evidence of technical phraseologies sat alongside ambiguous statements and an inability to understand the actions of the vignette actors.

However, it is the use made of their own clinical experiences that encapsulates the staff nurses’ discourse. As shown, a great deal of emphasis was placed on the acts of self-harm the respondent had been exposed to within their clinical work. This experience, combined with the general discussion of busy A & E departments showed that of all four respondent groups the discourse of the trained nurses is the one most affected by the phenomenon of child self harm. Within stage 3 of Kendall and Wickham’s (1999) analysis the process of socialisation into a particular discourse is discussed. For the staff nurses, entry to the discourse is based on these events. Thus, issues of repeated self-harm and the age of the vignette actor are discussed to found in other groups because they are the clinicians most affected by these variables. Indeed the staff nurses are the only respondent sub-group who acknowledge that child self harm impacts on clinical staff. The low morale caused by dealing with numerous self-harm admissions being acknowledged. Unlike the physicians who offered treatment solutions, the nurses spoke of limited time to deal with patients who self harmed and a view that time spent with this patient group could act as reinforcement for such behaviour.

The above ties in directly with previous attitude studies (McLaughlin, 1994; Anderson, 1997) that saw the act of self-harm as a process in which the individual outlines their need and distress. Indeed, the issue of rewarding self-harm behaviours has been identified throughout the nursing literature (Sebree and Popkess-Vauter, 1991; Allen et al. 1997).

Staff nurses attitudes are shaped by the phenomenon itself and its impact upon their working environment. This would explain the position of previous clinical experiences within the discursive process. As Foucault (1969) suggests, discourses are not simply a question of language and its use. Rather, the discourse is composed of experience and the context in which it takes place. If this standpoint is adopted, then the process of cross-group analysis is made easier.

6.3 (5) Cross Group Analysis

Within the previous chapter, it was felt that the second stage of Kendall and Wickham's (1999) Foucauldian discourse analysis be used for cross-group analysis. This phase, the identification of rules that produce statements, is based on issues such as education and socialization. From this perspective, it is possible to summarise each group's discourse and acknowledge the differences between them.

Examination of the physicians' discourse showed perceptions based not on the patient presented to them but rather on the dominance of the medical model. However, as previous attitude studies have shown, self-harming patients have engendered negative responses from physicians (Patel, 1975). Again, the answer lies with Foucauldian theory. Within 'Madness and Civilization (1964) he describes the physician as central to any chance of patient recovery. This is based on the relationship that develops between the doctor and those in their care, with the physician cast in the role of benign parent. By carrying out acts of self-injury, particularly repeated acts, the

patient could be felt to challenge the position of authority within that relationship, thus ensuring censure from the physician.

The dominance of the medical model is evident in the medical students' discourse. If Foucauldian concepts of discourse construction are accepted, then the students can be acknowledged as neophytes, learning the language of their chosen profession. Their incomplete induction is due to their current position in the education process. If the vignettes had been shown to newly qualified physicians, it is possible that the model will be more evident within their descriptions of child self-harm. The medical students therefore replace medical knowledge with personal experiences and ambiguity. These alternatives are kept to a minimum and they demand more information about the vignettes because they are sufficiently absorbed into the medical discourse to know that personal experiences lack the legitimacy needed within the clinical gaze.

Personal experiences are integral to the student nurses discourse. In direct comparison to the physicians' discourse, legitimacy lays not in scientific method but in first hand knowledge of the phenomenon. The students' understanding of the phenomenon is limited and they are able to acknowledge this. It is argued that the student nurses represent no particular clinical discourse but rather the current societal attitudes toward child self harm, this is evident in voiced concerns toward younger children and limited understanding of the potential lethality of the acts.

In comparison the staff nurses are able to draw on their own clinical experiences as justification for their attitudes. This discourse is a hybrid, with the use of technical phraseologies insitu with actual cases of child self harm that the respondents have dealt with. Yet, the staff nurses are the only group that show the impact of the phenomenon on their discourse, allowing comparison to previous attitude studies.

6.3 (6) Comparison with the Literature.

Before a comparison with the literature is made it must be acknowledged that phase two of this study deals with the factors behind attitudes rather than simply the attitudes themselves. The issues investigated in earlier works could be the manifestations of the themes identified in this study. A number of these authors acknowledge that the attitudes of care staff toward the phenomenon are complex (Anderson et al., 200; Samuelsson et al., 1997). Indeed, Anderson (1997) states that attitudes toward suicidal behaviour come from a number of sources and that these should not be viewed simply in terms of positive and negative viewpoints.

Given the above, the findings of the second phase would seem to take these earlier explorations further. If this is the case then the comparisons will lie in the results of the existing literature and the themes identified in the focus groups.

As acknowledged, there is only one published work that deals with attitudes toward child self harm (Anderson et al., 2000) this study along with others deals exclusively with staff variables. However, it is possible similar themes are within the results of this study. Probably the most striking similarity between this study and the focus groups used in phase two is unintentional. Anderson, like other authors makes use of the Suicide Opinion Questionnaire developed by Domino et al., (1982). As such, issues of busy departments and the impact of formal clinical education are not openly discussed. Yet, in the interviews conducted by Anderson and his co-workers, a pattern of response can be identified amongst the physicians, namely the use of diagnostic tools and treatments within their discussions of the phenomenon. Of course in order to confirm this link it would be necessary to examine the transcripts of all the physician interviews undertaken by Anderson, not just the examples given in the published article. Yet, it is interesting to note that within the quotations used as examples the

dominance of the medical model amongst the physicians is evident. Another similarity lies in the attention seeking behaviour that was felt to exist amongst self-harming patients by the respondents of both studies. The majority of these statements were made by nursing staff, echoed in the discourse of the experienced nurses within this thesis, who described their own experiences of dealing with young people who self-harmed. Indeed, role has been identified as a causative factor in a number of attitude studies (Ramon et al. 1975; Platt & Salter, 1987) that discuss the difference in response between physicians and nurses toward self-harm. Sidley and Renton (1996) noting that the majority of their nursing respondents felt that the actions of self-harming patients were attention seeking. However, it should be remembered that these studies often gave their respondents limited scope to explain their answers. Indeed, Bent-Kelly (1992) who described self-harming patients as unrewarding to nurse, based her assumption on the known literature rather than empirical research. One theme that is more identifiable is the impact of experience on perceptions. As evidenced in the study, the length of time exposed to the clinical environment influences the perception of the A & E clinicians toward child self-harm. These findings support the earlier work of McLaughlin (1994) and Anderson (1997). These studies suggest that differences in attitude may be caused by exposure to the phenomenon of self-harming patients; although there are limited explanations for these findings within the literature. Indeed, Ghodse (1978) suggests that greater sympathy for this patient group occurs amongst less experienced staff. The suggestion that exposure to the phenomenon may cause negative attitudes has been identified within this thesis. Within the experienced nurses' discourse reference was made to busy A & E departments and limited time or inclination to interact with 'needy' self-harming patients. Such comments also occur in previous studies

(Hodgeman and McAnarney, 1992) in which coercive efforts are made to deter self-harming patients repeating the act. Indeed, Gibbs (1990) found clinicians unwilling to undertake training around self-harm due to their negative attitudes. Whilst this was not evident within this thesis, it does tie in with the lack of formal training that both sets of nursing staff cite as a cause of their limited knowledge.

While the main body of attitude studies deal with staff variables, there are a number that examine patients (although there is no study that deals exclusively with patient variables). Here too similarities can be found between the focus group data and earlier results.

Patel (1975) identified negative issues toward patients with a number of self-harm admissions. Such comments are evident in the focus group discourse of the experienced staff and are an indication that admission rate does influence attitude of the self-harm act. Echoed by Sidley and Renton (1996) who saw repeated admissions for self-harm impinging on both staff and services.

That patient variables do affect attitude is further confirmed by the study undertaken by Samuelsson et al. (1997). Using patient vignettes of the causes of self-harm that ranged from substance misuse and depression, respondents graded the cases according to their willingness to treat, with those seen as mentally ill being the most acceptable. Whilst these vignettes dealt with adult cases, the responses gained are direct comparisons with the discursive processes of the focus groups. Issues of mental illness abound in the physicians' discourse, in which the supposed mental illness of the patient legitimises the treatment recommendations proffered. In an earlier, less complex work, that also used vignettes (Ramon et al. 1975) respondents simply divided acts of self-harm between 'genuine' depressive or manipulative. The latter viewed as less acceptable.

However, whilst the above is of interest, it must be seen as speculation given the fundamental differences between the methods employed in this thesis and these earlier attitude studies. Ramon et al. (1975) acknowledge that the findings of their study are limited and that the issues under investigation are complex. Given this, the unique features of this study need to be acknowledged.

6.3 (7) Strengths of Phase Two

In its most basic form the strength of the second phase of the thesis lies in the fact that it answered the questions set out at the beginning of the second phase. By answering each of these in turn, it is possible to acknowledge the comprehensive exploration of the phenomenon achieved by the study.

Firstly, it was suggested that there are identifiable factors that would shape attitude amongst A & E staff toward child self-harm. Whilst this was undertaken by using a qualitative method consistent with other studies on the topic (Johnson and Webb, 1995; Norris, 1997) there are features particular to this study. Previous works dealt only with attitudes toward the phenomenon, this study has explored the factors that shaped them, thus answering the first of the research question. Indeed, within the only study that deals with attitudes toward self-harm in children (Anderson et al., 2000) it is acknowledged that it is difficult to assume a relationship between the attitudes obtained and the actions of the respondents toward the suicidal patient. The intention of this thesis was to bridge that difficulty.

By using case vignettes of child self-harm it was possible to garner a response that indicated their possible action toward the individual. Indeed, amongst the experienced staff the use of previous clinical events as indicators of projected action toward the vignette actor identify the establishment of that link. Therefore, the significance of the study lies in its unique approach to the study of the phenomenon. The use of a

purpose built instrument that had been utilised in the first phase, not only added to the continuity of the study but also provided the framework for staff attitudes to emerge. As a result, the depth of the data generated ensures that the impact of clinical training and busy clinical environments are specific to the staff sub group investigated.

Anderson et al. (2000) acknowledge that given the complexity of attitudes toward suicidal behaviour they should be seen in more than just positive or negative responses. This complexity is evident throughout the suicide literature. Iconic texts such as 'Le Suicide', subdivide self-destructive behaviours into a range of causes. Given the acknowledgement that Durkheim produced the work in an attempt to prove Sociology's utility in moving society forward, evidenced in his views of altruistic suicide, the complex nature of his analysis mirrors the myriad features of the phenomenon.

The second aim examined the impact of staff role on perception. In keeping with earlier attitude studies (Huband and Tantam, 2000), differences in staff views were explored in terms of their influence. Whilst earlier studies (Ramon et al., 1975; Samuelsson et al., 1997) identified differences in the way care staff view self-harm, this thesis has shown that they are simply part of a combination of factors relating to both clinician and patient that shape the way the self-harm episode is interpreted and described. Using the case vignettes to elicit response, the study highlighted a number of issues ranging from clinical education to personal exposure to child self-harm.

It should be acknowledged that the study undertaken by Anderson et al. (2000) identified a number of findings similar to those in the thesis such as the 'cry for help' as a motivating factor within child self-harm. However, the use of focus group interviews allowed the topic to be placed in a more open forum. Morgan (1998) suggests that focus groups are preferable to individual interviews when topics under

discussion are seldom aired. Coupled with the above is the fact that the clinicians work in an environment where staff interaction is an integral part of the treatment process and as such the impact of group attitudes on respondents can be acknowledged.. This theory ties in with suggestions made for further research by McAllister et al. (2002) who acknowledge the need to identify what influences attitude toward the phenomenon.

The same issues occur in terms of the third hypothesis made in this phase, that clinical experience will affect attitude. Again, the study has mirrored earlier studies (McLaughlin, 1994) in examining the issue of experience in attitude development. However, these studies acknowledge that the use of qualitative techniques would have produced more rounded in-depth data (Anderson, 1997).

By using the framework proposed by Kendall and Wickham (1999) the systematic analysis of the focus group interviews took place. Each of the five stages outlined in the previous chapter, ensured that the rigour and depth asked for by these earlier works was addressed. Anderson et al. (2000) suggest that it would be difficult to examine the relationship between the attitudes of the respondents and their actions towards children who self-harmed given the methodologies they employed. Within the analysis used in this thesis the fifth stage of analysis examined the practical consequences of the discourse, in this instance how care staff attitudes manifest themselves. That this is greater evidenced in the discourse of the experienced staff provides not only an insight into the physical consequences of attitude but also the impact of clinical experience on the respondents.

Therefore, in conclusion, the data accrued in the second phase of the study can be seen to add to those works already undertaken. By employing a systematic approach to the analysis, it was possible to identify not only the attitudes of care staff but also

the factors that shape them. Again, as with the first phase, it is the complex nature of not only the phenomenon but also the socialisation of the individual that examines the event that must be acknowledged. The use of Foucauldian theory allows this complexity to be compartmentalised into a series of stages and goes some way in their identification. This is evidenced in the increased use of Foucault's theories within research (Bingham, 2002). Whilst previous studies have dealt with each of these aspects in isolation this thesis has explored them in tandem ensuring to a degree a more realistic picture of how these interactions are played out in the clinical environment.

6.3 (8) Limitations of Phase Two

There are a number of limitations within the second phase of this thesis. Some of these limitations are particular to the methods of data collection and analysis employed, others deal with the actual study itself and processes involved. Firstly, the use of focus groups as a method of data collection should be discussed. Even proponents of the method as qualitative research, such as Morgan (1998) acknowledge that there are limitations to its use when compared to other methods such as individual interviews. Issues such as reluctance to discuss opinions and attitudes in the presence of peers should be acknowledged. Coupled with this is the accepted limitations of the amount of data obtained compared to an individual interview of the same length. Depth of data and interviewer control are obviously greater when the two methods are compared. Reed and Rosell (1997) suggest that focus groups lack representative-ness and that the validity of any interpretation from using the method should be questioned. However, they did accept that the method does provide an indication of group perspectives and how they are developed and negotiated between group members.

Yet, issues of group dynamics and individual reluctance to openly discuss such a sensitive topic should be conceded and further examination of the phenomenon using alternative methods of data collection is recommended. Although, the quality and depth of the data obtained shows that the method employed was advantageous to the current research. This supports the theories of Nyamathi and Shuler (1990) who felt that focus groups are ideal for tapping into collective attitudes.

Secondly, the sample population used did not fully mirror that of phase one and thus any comparisons should be interpreted with caution. However, given the accepted purposive nature of the sampling used, this may be negated. Also, the data obtained from the experienced respondents indicates that the events discussed in the focus groups provide an explanation for the results obtained in phase one.

Limitations concerning the use of the hypothetical case vignettes are akin to those noted in the discussion of the first phase. The limited information contained within each vignette and the rigid inclusion of the patient variables is evidently synthetic and the use of actual cases of self-harm may have engendered a greater response from the group members. However, it should be remembered that the aim of the vignettes was to initiate a group discussion and the quality of the data obtained would seem to confirm that this was achieved.

Finally, the use of Foucauldian theory may have limited the range of data analysis. The use of a rigid, five-stage process of discourse analysis may have lead to the exclusion of some aspect of the group process, which another more fluid framework would have noted (Berry, 1981). The use of alternative theories of attitude it must be conceded may have produced different results. Foucault has been criticised by a number of authors of discourse analysis, who suggest that there are difficulties in implementing his concepts of the discursive as a method of qualitative research

(Hook, 2001). The use of grounded theory for instance would have allowed for a direct comparison with the work of Anderson et al. (2003). However, it must be remembered that the second phase of this study did not simply examine the attitudes of care staff toward child self harm but also the factors that shaped them. The benefits of using Foucault's concepts of attitude and knowledge within healthcare research are increasingly acknowledged (Paley, 2001) and it is hoped that further study will confirm the use of his theories within this thesis.

6.4 Overall Limitations of the Study

Whilst the limitations of both phases of this thesis have been explored its overall limitations should be acknowledged. There are issues both in the design and delivery of the study that limit its overall benefit in offering a contribution to the existing body of knowledge. In its defence the study has highlighted the impact of staff and patient variables on attitudes toward child self-harm. However, there remain a number of issues that have not been explored.

Alongside patient age and gender issues of ethnicity and social class could have been explored. The limited research on these variables points toward a possible gap within the research knowledge and vignette adaptation could easily have taken these into consideration. Another absence within the vignettes used in the study is psychiatric illness. The correlation between mental illness and self-harm is well established (Favazza, 1987) and the exploration of attitudes toward those with mental health problems has been made using vignettes by Barry and Greene (1992). Given the above, it is clear that the current research has failed to consider an important aspect of the phenomenon.

The study is also limited in terms of the clinical environments explored. Issues of regionality have already been noted but the limiting of the research to A and E

departments means that the attitudes of a number of key staff groups have not been examined, limiting the comparison of this work with a number of other attitude studies. If a fuller picture of attitudes toward this patient group is to be made then the views of other clinicians and care workers, as well as the attitudes of the young people themselves must be explored. With the importance placed on a multi-agency approach within current policy (Department of Health, 2001) an examination of a range of attitudes is clearly necessary. The impact of the current research in light of existing legislation is discussed below.

6.5 Implications for Policy / Education

The issue of child self-harm has attracted a raft of Government legislation. Whilst this study has explored staff attitudes a number of findings can be seen to reflect the concerns highlighted within current policy. Alongside the identification of these initiatives in current legislation, recommendations for further work particularly in terms of staff education are made.

What is evident within the current research is the limited impact current policy appears to have within the clinical environment. In the Department of Health document 'Saving Lives: Our Healthier Nation' (1999) the establishment of good working practice guidelines is seen as essential in order to reduce the high rate of self harming behaviours amongst the at risk groups. Examination of data from the second phase of the current research appears to highlight what can best be described as a fragmented approach to patient treatment. Amongst the physicians, who appear as the most clinically informed of the staff groups, there is little in the way of a uniform response to patient treatment. Within a discourse that places emphasis on informed clinical awareness the lack of an established pattern of treatment seems indicative of a limited national framework of treatment. The Royal College of Psychiatrists (1998)

called for the establishment of specialised units to deal with self-harming behaviours. No such units were mentioned amongst any of the focus group discussions. 'Every Child Matters' (Department of Health, 2004) called for the identification of lead professionals who would co-ordinate the treatment of this patient group. Again, no such posts were identified within the discourses examined.

One recommendation evident in all the policy documents examined was the increase in staff education on issues of self-harm behaviours. With the possible exception of the physicians, all the staff sub groups acknowledged their lack of understanding toward the phenomenon. This is particularly evident in terms of younger patients whose acts of self-harm were often greeted with a degree of disbelief on the part of the respondents.

'It's hard to imagine an 8 year old wanting to kill himself.' (TN1H)

That such expressions of limited knowledge occurred amongst the two student groups is an indication that the issue of child self-harm is not a standard part of the undergraduate programmes for these future clinicians. That the students do request more training on the subject is heartening but it is clear that an opportunity to improve care staff awareness at this early stage is not being taken.

' I agree, we don't get enough input, we get so little on this.

Will we ever be taught anymore?' (SN2E)

Of greater concern are the negative attitudes that appear to be prevalent throughout the clinical environments. The National Suicide Prevention Strategy for England (Department of Health, 2002) highlights the need for an anti stigma campaign and the Royal College of Psychiatrists (1998) recommends that all acts of self-harm by young people be taken seriously. Discussion within the focus groups appears to indicate a

negative environment, in which staff attitudes may increase the feeling of isolation felt by young people who self-harm.

‘ I have been to A & E with someone who tried to commit suicide....

The attitude of the staff toward them was awful. How that person felt I don’t know.’ (SN2E)

Given the above, it is clear that there is a need for raising staff awareness of the phenomenon. Results from phase one show that repeated admissions for self-harm behaviour caused a reduction in perceived lethality despite clear evidence that there is a correlation between self-harm and eventual suicide. To date, the researcher has attempted to address such issues within their own practice as a nurse educator but more is needed. It is intended that feedback be given to the clinical areas used in the study, hopefully raising awareness within those departments. However, there is a clear need to reach a wider audience and the intended publication of these results it is hoped will improve clinician awareness of the needs of self-harming children.

6.6 Recommendations for future research

The results of phase two indicate that there are complex ranges of factors underpinning care staff attitudes toward child self harm. Thus, it is clear that a more wide reaching study be undertaken in order to further explore the issues identified in this thesis. The importance of A & E clinicians in the treatment of child self-harm has already been established, however, they are not the only care staff that come into contact with this vulnerable patient group. For example, the attitudes of psychiatric staff in both community and hospital settings can be seen to have an important impact on issues such as suicide prevention (Samuelsson et al., 1997). The attitudes of non A & E clinicians have already been explored, if somewhat briefly (Harrison, 1988).

Given the acknowledged impact of self-harming children on paediatric wards

(Gasquet & Choquet, 1994) a more in-depth exploration of this staff group is warranted.

In light of the exploratory nature of this study, further research is also recommended in order to confirm the utility of the methods employed. The implementation of further focus groups utilising the same methods of data collection and analysis is warranted. The issues of regionalism and the use of hypothetical case vignettes have already been discussed in this chapter, yet, if this study is to have implications for further research then they should be acknowledged.

6.7 Overall Benefits of the Study

This study examined the attitudes of A & E clinicians toward the phenomenon of child self-harm, an area of limited research. As such, its benefits in adding to the body of knowledge can be accepted. Whilst research within this important topic is increasing (Anderson et al., 2003) its use of multiple methods of data collection and analysis have allowed for a comprehensive study of issues such as patient age and clinical training. By combining both staff and patient variables, it has attempted to provide as full a picture of the current situation within the A & E environment as possible. The acknowledgement of the complex nature of the phenomenon with its interplay of patient and staff variables indicates that there is no one stereotypical response to the issue of child self-harm. Rather, the study provides an indication of both societal and professional issues that result in a pattern of response. The impact of each variable, both patient and staff have been acknowledged and the importance of further exploration of these discussed.

Given the exploratory nature of the study it would be difficult at this stage to measure its impact for both staff education and future treatment. However, the recognised impact of limited training, particularly within the focus group stage suggests that

there are issues for both nurses and physicians that further research would confirm. Therefore, a more specific examination of the perceived educational needs of those who work with self-harming children may then be used to improve staff competencies and as a consequence treatment efficacy.

There has already been an impact of the study on the researchers own teaching and it is hoped that dissemination of the results of the study via publication will bring the issues identified into a wider forum.

6.8 Final Summary

Self-harm is accepted as an area of growing concern within healthcare. The researcher's experiences as a psychiatric nurse in dealing with those who self-harm and the care staff involved in their treatment lead to the present study being undertaken. By using hypothetical case vignettes of child self-harm in both questionnaires and focus groups this thesis has identified a range of factors that shape staff attitudes. The impact of patient age, gender and rate of admission suggests that there are features within child self-harm similar to those found amongst adults. A lack of staff awareness and a pervading sense of negativity toward those who self-harmed was one of the main reasons why the current study was undertaken. That these emotions are clearly identified within the focus group stages of the thesis is a cause for concern. Through the use of Foucauldian theories of discourse it was possible to identify the factors behind these views. It is of no surprise to the researcher that dominant attitudes are quickly adopted by newcomers to the clinical environment. On reflection the research simply confirms the perceptions that were noted prior to the study being undertaken. The researcher had previously encountered strong, negative attitudes amongst A & E staff toward those young people with multiple admissions for self-harm. Both phases of data collection confirm that the patient who has a

history of self-harm is viewed as limited in their suicidal intent and uses the act as a means of communication.

That the above attitudes exist despite a number of policy initiatives to improve awareness amongst care staff is a cause for concern. If the negatively held attitudes and limited knowledge that inspired this research are to be addressed then further work is needed. By bringing the issue of child self-harm into a wider forum it is hoped that the detrimental impact of staff attitudes on patient treatment can be reduced.

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Appendix 1: Ethical Approval.

Ref. harrisj

13 October, 1998

John Harrison
HEA
Tithebarn St

Dear John

I am pleased to inform you that the Ethics Committee has now considered your application for approval of the project entitled:

An assessment of the perceptions of care staff towards self harming children

and I am happy to confirm that it was approved, with no provisos set. However please note that if this application was to go onto phase 3, then the committee would need to see a new submission.

Please confirm in writing that you will carry out the above, having done so you need not re-submit your application to the Ethics Committee.

The Ethics Committee approval is given on the understanding that:

- (i) any adverse reactions/events which take place during the course of the project will be reported to the Committee immediately;
- (ii) any unforeseen ethical issues arising during the course of the project will be reported to the Committee immediately;
- (iii) any change in the protocol will be reported to the Committee immediately.

Please note that ethical approval is given for a period of five years from the date granted and therefore the expiry date for this project will be October 2003. An application for extension of approval must be submitted if the project continues after this date.

I am enclosing form EC5 and would be grateful if you could spare the time to complete the questionnaire and return it to me.

Yours sincerely



Marcellina Boyle
Course Information Co-ordinator
Ethics Committee Secretary
Tel: 0151 231 3365
E-mail: m.boyle@livjm.ac.uk

Enc.

cc: Charles Crosby, Cornelis Jonker, Christina Lyons (HEA)

Appendix 2: Letter of Introduction



Liverpool John Moores University

Dear Colleague

Thank you for agreeing to take part in this study.

The purpose of this research is to examine the perceptions of staff within an A & E department towards children who carry out acts of self harm. This is an area, which I am sure you feel has been long neglected in terms of academic input.

The research will take the form of a questionnaire based on the use of hypothetical case studies, to which you will be asked to make a number of responses. There will be no need to identify individual members of staff within the study and given the hypothetical nature of the case studies there is no need for patient involvement.

There is no obligation to take part in the study and there is no possibility of identifying those staff who decline to be involved in the study. However given the nature of the study I feel that you will see this study as dealing with an important clinical issue.

Any information you would require about the research can be given at your convenience by myself. I can be contacted here at the University at the address below or by telephone on (0151) 231 4115.

Thank you for your help.

Yours,

John Harrison.

Research Fellow in Child Mental Health

School of Health

Professor Jane Jacks - Director

79 Tithebarn Street, Liverpool, L2 2ER Telephone 0151-231 2121 Facsimile 0151 256 1593

Warrington Hospital (NHS) Trust, Lovely Lane, Warrington, WA5 1QG Telephone 01925 635911 Facsimile 01925 662229



INVESTORS IN PEOPLE

Appendix 3: Phase One Questionnaire

Questionnaire

An assessment of the perceptions of care staff towards self harming children.

Please read the hypothetical case studies attached and respond by ticking the box you feel most fits the information given. The questionnaire is totally confidential and you are requested to only provide the details needed below. Once completed, please put the questionnaire back in the envelope and place it in the box provided.

Age (.....) (years)

Role (Doctor / Nurse) Delete as appropriate.

Length of clinical experience within an A & E department:
(.....) (years) (.....) (months)

If you have any questions regarding the study, please feel free to contact me here at John Moores University, (0151 - 231 4115).

Thank you for your participation in this research.

Yours,

John C Harrison.

Case 1

An 11 year old girl has been brought into the A & E department by her mother after she cut her arms with a razor.

Anna, is well known to staff within the department as she has had five previous admissions for self harm. Anna's father died two years ago after a long battle against heart disease, an event that left both Anna and her mother greatly traumatised. As a consequence of this, Anna's mother has not been able to deal with her daughters emotional needs and Anna has become increasingly withdrawn. As with her other acts of self harm, this episode ties in with an event linked to her father, such as his birthday.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:

Low Lethality ☐ ☐ High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:
Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ High Communicative

Case 2.

Ten year old Sofia lives at home with her parents and older sisters. The baby of the family, she has a close relationship with all, particularly with her older sister Emily, despite the eight year age gap. Sofia has expressed her concerns around 18 year old Emily's leaving home to start University, in that she feels that Emily will leave for good. Despite the efforts of the family, Sofia has become increasingly agitated as the date of Emily's departure draws closer. Two days before Emily leaves for University, a family row ensues, in which Sofia accuses Emily of not loving her. After this argument, Sofia cut her arms with a broken audio cassette box and was found by her mother who brought her to the A & E department.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:

Low Lethality ☐ ☐ High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent :

Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ High Communicative

Case 7.

Paula has been brought to the A & E department by her father after he had found that she had cut her arms with broken glass. Paula's relationship with her family is a difficult one, with a good deal of resentment between Paula and her stepmother. This difficulty has manifested itself in problem behaviour in school, for which she has been suspended in the past, an event that precipitated her cutting her arms with her father's razor blade. This act of self harm has also followed an incident at her junior school, in which Paula fought with another child; an event which her stepmother felt was due to Paula's father spoiling her.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:



High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:



9

High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:



High Communicative

Case 8.

Rachel is a student at a local girls grammar school, who is about to sit her GCSE exams. A bright but shy pupil, she lives at home with both parents, her brother is away at University. As the time of her exams has drawn closer, Rachel has become increasingly agitated and has expressed her anxieties that she will fail. Three days ago, Rachel sat the first of her exams and despite answering all questions, she has convinced herself that she has failed. This morning, Rachel was due to sit the second of her exams and when her mother went to wake her, she found that a tearful Rachel had awoken early and had cut her arms with a broken glass.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:



High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:



High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

[illegible]

High Communicative

Case 11

A pair of anxious parents have brought their 14 year old daughter into the A & E department after she had cut her arms with a disposable razor.

Louise has difficulties in school with a group of older children who bully her. Louise has had an episode of self harm in the past, again after an incident of bullying. This episode followed an incident in which two girls followed Louise home, called her names and spat in her hair. Both girls told Louise that worse treatment awaited her on her return to school after the weekend.

A shy withdrawn child Louise is unable to mention the bullying to staff, despite her mothers requests that she does so.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:

High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:

High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

High Communicative

Case 12.

A 15 year old girl, who has had six previous admissions for self harm behaviour has been brought into the A & E department by her mother. Elaine has cut her arms with broken glass after an argument with her mother around her boyfriend. This incident follows a pattern similar to all her previous attempts, Elaine's mother has difficulty with her daughters relationship with a much older boy; which often leads to conflict. Elaine normally becomes tearful and accuses her mother of not listening, after which she leaves the house before informing her mother of her actions on her return.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:



High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:



High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:



7

High Communicative

Case 3.

Jake is a pupil at a local junior school and lives at home with his parents and older sister Natalie. The family is a close knit one and Jake has a good relationship with all members. Natalie has been recently diagnosed with motor neurone disease and as a result has been admitted to hospital. Jake's parents have been extremely distressed and have been unable to spend time with Jake who has also been anxious about his sisters failing health. After a very difficult hospital visit, Jake locked himself in the bathroom and cut his arms with his father's razor blade before informing his mother.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:



High Lethality

Do you feel that the patient in the above vignette carried out the act with high or low suicidal intent:

10

114

High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:



High Communicative

Case 4.

Ben is the 11 year old son of a couple who live quite close to the hospital, he has been brought into the A & E department after he cut his arms with a craft knife. This is the second time that he has been admitted to the department for the treatment of self harm behaviour. Both occasions have followed the death of a grandparent, Ben's relationship with both was close. Ben has displayed high levels of distress since his Grandmother died, actions that his father has found hard to accept, leading to a number of family arguments.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits the case:



High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:



High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

11

High Communicative

Case 9.

At 15, Carl is well known to the staff in the A & E department after several admissions for self harm. Carl lives with both parents and four younger sisters. Carl has a poor relationship with his father, who places high demands on Carl, who often has to care for his younger siblings. As with his previous acts of self harm, Carl has used a broken glass to cut his arms, this follows a violent argument with his father who has accused Carl of failing to carry out the tasks assigned to him and locked Carl in his bedroom for a day.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:

Low Lethality ☐ ☐ High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:

Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ High Communicative

Case 10.

An 8 year old boy has been brought into the A & E department by his father after he had been found to have used a knife to cut his arms. Ryan has been admitted to the department on several occasions within the last year. Ryan's mother has suffered from depression intermittently for the last six years and has made a number of suicide attempts herself. Ryan's acts of self harm follow those of his mother and often he is withdrawn for a number of days prior to the act, something that his father attempts to hide from her.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits this case:

Low Lethality ☐ ☐ High Intent

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:

Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ High Communicative

Case 5.

Shaun has been brought to the A & E department by his father after he was found to have cut his arms with a cassette box. Shaun is a popular student in his fifth year at a local comprehensive, where he is expected to do well academically. Shaun has had a relationship with Lisa a girl in his class for over a year. Recently, Lisa has ended the relationship, much to Shaun's distress. The day he carried out his act of self harm, Shaun had attempted a reconciliation with Lisa, who refused a tearful Shaun, who then locked himself in his bedroom to cut his arms before he told his parents of his actions.

Acts of self harm can be of either high or low lethality. Given the information contained above please indicate which description best fits this case:

Low Lethality ☐ ☐ High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:

Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ High Communicative

Case 6.

Alan is a 14 year old boy, who lives at home with both parents. Alan has had two previous admissions for self harm behaviour, both within the last year. This behaviour began with the death of a close friend, Alan has expressed anger at the death of his friend and guilt at not dying himself. Alan, cut his arms with a disposable razor after a family row around what Alan's father describes as "unacceptable despondency" on the part of his son. After he had carried out the act, Alan informed his mother of his actions, who brought him to the A & E department.

Acts of self harm can be of either low or high lethality. Given the information contained above, please indicate which description best fits the case:

Low Lethality ☐ ☐ High Lethality

Do you feel that the patient in the above vignette carried out the act with low or high suicidal intent:

Low Intent ☐ ☐ High Intent

Acts of self harm can be a means of communication. Do you feel that the actions of the patient are low communicative or highly communicative:

Low Communicative ☐ ☐ Highly Communicative

Appendix 4: Patient Variable Chi Square Results

Table 3.9: Male 1st Admission: Lethality

M< 12	M12 +	
	Low	High
Low	64	9
High	33	46

McNemars Test: P = 0.01

Table 3.10: Male 2 – 4 Admissions: Lethality

M <12	M 12+	
	Low	High
Low	42	33
High	16	61

McNemars Test: P = 0.21

Table 3.11 Male 5+ Admissions: Lethality

M<12	M12+	
	Low	High
Low	40	11
High	24	77

McNemars Test: P = 0.41

Table 3.12 Female 1st Admission: Lethality

F<12	F 12+	
	Low	High
Low	45	57
High	9	41

McNemars Test: P = 0.01

Table 3.13 Female 2 – 4 Admissions: Lethality

F <12	F 12+	
	Low	High
Low	38	51
High	6	57

McNemars Test: P = 0.01

Table 3.14 Female 5+ Admissions: Lethality

F <12	F 12+	
	Low	High
Low	69	12
High	23	48

McNemars Test: P = 0.90

Table 3.15 Male 1st Admission

M <12	M 12+	
	Low	High
Low	40	11
High	24	77

McNemars Test: P = 0.41

Table 3. 16 Male 2 – 4 Admissions

M <12	M 12+	
	Low	High
Low	44	33
High	32	43

McNemars Test: P = 1.00

Table 3.17 Male 5 + Admissions

M < 12	M 12+	
	Low	High
Low	54	17
High	33	48

McNemars Test: P = 0.03

Table 3.18 Female 1st Admission

F <12	F 12+	
	Low	High
Low	63	72
High	3	14

McNemars Test: P = 0.01

Table 3.19 Female 2 – 4 Admissions

F < 12	F 12 +	
	Low	High
Low	43	70
High	7	32

McNemars Test: P = 0.01

Table 3.20 Female 5+ Admissions

F < 12	F 12+	
	Low	High
Low	111	6
High	23	12

McNemars Test: P = 0.01

Table 3.21 Male 1st Admission

M < 12	M 12+	
	Low	High
Low	32	24
High	22	74

McNemars Test: P = 0.88

Table 3.22 Male 2 – 4 Admissions

M <12	M 12+	
	Low	High
Low	31	18
High	27	76

McNemars Test: P = 0.23

Table 3.23 Male 5 + Admissions

M <12	M 12+	
	Low	High
Low	39	13
High	15	85

McNemars Test P = 0.85

Table 3.24 Female 1st Admission

M <12	M 12+	
	Low	High
Low	23	18
High	39	72

McNemars Test P = 0.01

Table 3.25 Female 2 – 4 Admissions

M <12	M 12+	
	Low	High
Low	33	17
High	29	73

McNemars Test P = 0.10

Table 3.26 Female 5+ Admissions

M <12	M 12+	
	Low	High
Low	26	18
High	17	91

McNemars Test P = 1.00

Table 3.27 Male/ Female 1st Admission

M <12	F <12	
	Low	High
Low	67	6
High	35	44

McNemars Test P = 0.01

Table 3.28 Male/ Female 2 – 4 Admissions

M <12	F <12	
	Low	High
Low	63	12
High	26	51

McNemars Test P = 0.03

Table 3.29 Male/ Female 5 + Admissions

M <12	F <12	
	Low	High
Low	46	5
High	35	66

McNemars Test P = 0.01

Table 3.30 Male/Female 1st Admission

M 12 +	F 12+	
	Low	High
Low	51	46
High	3	52

McNemars Test P = 0.01

Table 3.31 Male / Female 2 – 4 Admissions

M 12+	F 12+	
	Low	High
Low	34	24
High	10	84

McNemars Test P = 0.02

Table 3.32 Male / Female 5+ Admissions

M12+	F 12+	
	Low	High
Low	57	7
High	35	53

McNemars Test P = 0.01

Table 3.33 Male / Female 1st Admission

M<12	F <12	
	Low	High
Low	110	7
High	25	10

McNemars Test P = 0.02

Table 3.34 Male / Female 2 – 4 Admissions

M <12	F <12	
	Low	High
Low	63	14
High	50	25

McNemars Test P = 0.01

Table 3.35 Male / Female 5+ Admissions

M <12	F <12	
	Low	High
Low	59	12
High	58	23

McNemars Test P = 0.01

Table 3.36 Male / Female 1st Admission

M 12+	F12+	
	Low	High
Low	58	54
High	8	32

McNemars Test P = 0.01

Table 3.37 Male / Female 2 – 4 Admissions

M 12+	F 12+	
	Low	High
Low	32	44
High	18	58

McNemars Test P = 0.01

Table 3.38 Male / Female 5+ Admissions

M12+	F 12+	
	Low	High
Low	82	5
High	52	13

McNemars Test P =0.01

Table 3.39 Male / Female 1st Admission

M<12	F<12	
Low	24	32
High	17	79

McNemars Test P = 0.04

Table 3.40 Male / Female 2 – 4 Admission

M<12	F<12	
Low	27	22
High	23	80

McNemars Test P = 1.00

Table 3.41 Male / Female 5+ Admissions

M<12	F,12	
Low	25	27
High	19	81

McNemars Test P = 0.30

Table 3.42 Male /Female 1st Admission

M12+	F 12+	
Low	30	24
High	32	66

McNemars Test P = 0.35

Table 3.43 Male / Female 2 – 4 Admissions

M 12+	F 12+	
Low	33	25
High	29	65

McNemars Test P = 0.68

Table 3.44 Male / Female 5+ Admissions

M12+	F12+	
Low	33	21
High	10	88

McNemars Test P = 0.07

Table 3.45 Male <12. 1st & 2 – 4 Admissions

M<12 (1 st)	M<12 (2-4)	
Low	Low	High
	47	26
High	28	51

McNemars Test P = 0.90

Table 3.46 Male <12. 1st & 5+ Admissions

M<12 (1 st)	M<12 (5+)	
Low	Low	High
	33	40
High	18	61

McNemars Test P = 0.01

Table 3.47 Male <12. 2- 4 & 5+ Admissions

M<12 (2 –4)	M<12 (5+)	
Low	Low	High
	36	39
High	15	62

McNemars Test P = 0.01

Table 3.48 Female <12. 1st & 2 – 4 Admissions

F<12 (1 st)	F <12(2-4)	
Low	Low	High
	75	27
High	14	36

McNemars Test P = 0.06

Table 3.49 Female <12. 1st & 5+ Admissions

F<12 (1 st)	F <12 (5+)	
Low	Low	High
	74	28
High	7	43

McNemars Test P = 0.01

Table 3.50 Female <12. 2- 4 & 5+ Admissions

F <12 (2-4)	F <12 (5+)	
Low	Low	High
	63	26
High	18	45

McNemars Test P = 0.29

Table 3.51 Males 12+. 1st & 2-4 Admissions

M 12+ (1 st)	M 12+ (2-4)	
	Low	High
Low	47	50
High	11	44

McNemars Test P = 0.01

Table 3.52 Males 12+. 1st & 5+ Admissions

M 12+ (1 st)	M 12+ (5+)	
	Low	High
Low	48	49
High	16	39

McNemars Test P = 0.01

Table 3.53 Males 12+. 2-4 & 5+ Admissions

M 12+ (2-4)	M12+ (5+)	
	Low	High
Low	35	23
High	29	65

McNemars Test P = 0.48

Table 3.54 Females 12+. 1st & 2 –4 Admissions

F 12+ (1 st)	F12+ (2-4)	
	Low	High
Low	32	22
High	12	86

McNemars Test P = 0.12

Table 3.55. Females 12+. 1st & 5+ Admissions

F 12+ (1 st)	F 12+ (5+)	
	Low	High
Low	38	16
High	54	44

McNemars Test P = 0.01

Table 3.56 Females 12+. 2-4 & 5+ Admissions

F 12+ (2-4)	F 12+ (5+)	
	Low	High
Low	36	8
High	56	52

McNemars Test P = 0.01

Table 3.57 Males <12. 1st & 2 – 4 Admissions

M <12 (1 st)	M <12 (2-4)	
	Low	High
Low	67	50
High	10	25

McNemars Test P = 0.01

Table 3.58 Males < 12. 1st & 5+ Admissions

M <12 (1 st)	M <12 (5+)	
	Low	High
Low	55	19
High	71	81

McNemars Test P = 0.01

Table 3.59 Males <12. 2- 4 & 5+ Admissions

M <12 (2-4)	M <12 (5+)	
	Low	High
Low	39	38
High	32	43

McNemars Test P = 0.55

Table 3.60 Females <12. 1st & 2 –4 Admissions

F <12 (1 st)	F <12 (2-4)	
	Low	High
Low	105	30
High	8	9

McNemars Test P = 0.01

Table 3.61 Females <12. 1st & 5+ Admissions

F <12 (1 st)	F <12 (5+)	
	Low	High
Low	107	28
High	10	7

McNemars Test P = 0.0

Table 3.62 Females <12. 2- 4 & 5+ Admissions

F <12 (2-4)	F <12 (5+)	
	Low	High
Low	89	24
High	28	11

McNemars Test P = 0.67

Table 3.63 Males 12+. 1st & 2- 4 Admissions

M 12+ (1 st)	M 12+ (2 – 4)	
	Low	High
Low	61	51
High	15	25

McNemars Test P = 0.01

Table 3.64 Males 12+. 1st & 5+ Admissions

M 12+ (1 st)	M 12+ (5+)	
	Low	High
Low	67	45
High	20	20

McNemars Test P = 0.01

Table 3.65 Males 12+. 2-4 & 5+ Admissions

M 12+ (2-4)	M 12+ (5+)	
	Low	High
Low	45	31
High	42	34

McNemars Test P = 0.24

Table 3.66 Females 12+. 1st & 2 –4 Admissions

F 12 + (1 st)	F 12+ (5+)	
	Low	High
Low	33	33
High	17	69

McNemars Test P = 0.03

Table 3.67 Females 12 +. 1st & 5+ Admissions

F 12+ (1 st)	F 12+ (5+)	
	Low	High
Low	58	8
High	76	10

McNemars Test P = 0.01

Table 3.68 Females 12+. 2-4 & 5+ Admissions

F 12+ (2-4)	F 12+ (5+)	
	Low	High
Low	46	4
High	88	14

McNemars Test P = 0.01

Table 3.69 Males <12 1st & 2-4 Admissions

M <12 (1 st)	M <12 (2-4)	
	Low	High
Low	32	24
High	17	79

McNemars Test P = 0.34

Table 3.70 Males <12 1st & 5+ Admissions

M <12 (1 st)	M <12 (5+)	
	Low	High
Low	30	26
High	22	74

McNemars Test P = 0.66

Table 3.71 Males <12 2-4 & 5+ Admissions

M <12 (2-4)	M <12 (5+)	
	Low	High
Low	30	19
High	22	81

McNemars Test P = 0.75

Table 3.72 Females <12. 1st & 2- 4 Admissions

F <12 (1 st)	F <12 (2-4)	
	Low	High
Low	21	20
High	29	82

McNemars Test P = 0.25

Table 3.73 Females <12. 1st & 5+ Admissions

F <12 (1 st)	F <12 (5+)	
	Low	High
Low	22	19
High	22	89

McNemars Test P = 0.75

Table 3.74 Females <12. 2-4 & 5+ Admissions

F < 12 (2-4)	F <12 (5+)	
	Low	High
Low	24	26
High	20	82

McNemars Test P = 0.46

Table 3.75 Males 12+. 1st & 2 –4 Admissions

M12 + (1 st)	M12+(2-4)	
	Low	High
Low	28	26
High	30	68

McNemars Test P = 0.68

Table 3.76 Males 12+. 1st & 5+ Admissions

M 12+ (1 st)	M 12+ (5+)	
	Low	High
Low	31	23
High	23	75

McNemars Test P = 1.00

Table 3.77 Males 12+. 2- 4 & 5+ Admissions

M 12+ (2-4)	M12+ (5+)	
	Low	High
Low	31	27
High	23	71

McNemars Test P = 0.67

Table 3.78 Females 12+ 1st & 2 –4 Admissions

F 12+ (1 st)	F 12+(2-4)	
	Low	High
Low	42	20
High	20	70

McNemars Test P = 1.00

Table 3.79 Females 12+ 1st & 5+ Admissions

F 12+ (1 st)	F 12+ (5+)	
	Low	High
Low	21	41
High	22	68

McNemars Test P = 0.02

Table 3.80 Females 12+ 2- 4 & 5+ Admissions

F 12+ (2-4)	F12+ (5+)	
	Low	High
Low	25	37
High	18	72

McNemars Test P = 0.01

Appendix 5: Phase Two Interview Schedule.

Interview Schedule.

1/ Invite the respondents to examine each vignette in turn.

2/ What are your overall feelings toward this case?

3/ Do you feel the age of the patient is an issue?

4/ Do you feel the gender of the patient is an issue?

5/ Do you feel the number of admissions is an issue?

6/ What other factors do you feel are important?

Appendix 6 Transcript codes

Transcript Codes:

The transcript codes used within the second phase of this thesis serve two purposes. Firstly, the identification of respondents within the focus group process. Secondly ensuring the anonymity of the respondents.

The code is based on a series of numerical and alphabetical identifiers. The prefix letter corresponds to a staff sub-group to which the respondent belongs:

PL = Pilot Study.

TN = Trained Nurse.

PH = Physician.

SN = Student Nurse.

MS = Medical Student.

The number equates to the group and the last letter to that particular respondent. For example:

A medical student in the first group the fifth of ten respondents = MS1E.

Appendix 7 Time-line of Project

Time-line of Research:

October 1997: Enrolment.

October 1998: Registration for MPhil study.

1999 – 2000: Phase One Data collection & Analysis.

2000: Transfer to PhD study.

2001 – 2002 Phase Two Data Collection & Analysis

February 2003: Study suspended

May 2004: Study recommenced.

July 2005: Submission of Thesis.

Appendix 8: Associated Publications

Harrison, J; Crosby, C; Jonker, C; Lyons, C (1999). *Attitudes toward child self-harm*. APSA Conference London. Poster Presentation.

Harrison, J; Crosby, C; Jonker, C; Lyons, C (2000). *Perceptions of Care Staff Towards Children who Self-harm*. 5th European Mental Health Nursing Conference. Manchester. Concurrent Session.