

From judgement to understanding

The influence of positive attitudinal change towards self-harm on the behaviour of mental health nurses.

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Abstract

Background. Over the last decade, many articles were published on the treatment of self-harm and there has been an emphasis on the role of professionals' attitudes towards this behaviour. Literature shows that nurses experienced feelings of frustration, anger and fear when caring for self-harm patients. In response, several training programs were developed that aimed to positively influence nurses' attitudes. However, the influence of these training programs on mental health nurses' behaviour towards self-harm patients is unknown.

Aim. To investigate the influence of attitudinal change towards self-harm on the behaviour of mental health nurses.

Research questions. How do positive attitudinal changes towards self-harm influence the behaviour of mental health nurses? What factors contribute to these actual behavioural changes in nurses?

Methods. Participants were selected by means of purposive sampling. Nurses from three psychiatric organisations were included who had positively changed attitudes after a Dutch training program. Data were collected through semi-structured interviews. The constant comparative method was used to analyse the data in the three coding stages of grounded theory.

Results. Eleven mental health nurses participated in the study. Ten out of these eleven participants changed their behaviour after the training-program. They reported using less restrictive interventions, being more patient oriented and choosing a more empathic and exploratory approach than before the training. The changes were enabled by a positive atmosphere among colleagues and a non-directive ward-policy. The behavioural changes had mostly positive consequences on the care participants provided and on their work-satisfaction.

Conclusion. The insights from this qualitative study indicate that nurses perceive positive attitudinal changes towards self-harm to influence their behaviour to self-harm patients.

Recommendations. Future research should focus on patients' experiences with nursing care after a self-harm training program. Also, observational research is needed into the nurse-patient interaction before and after nurses' participation in self-harm training programs.

Samenvatting

Achtergrond. Er zijn de afgelopen jaren veel artikelen gepubliceerd over de behandeling van zelfbeschadigend gedrag. Hierin wordt de nadruk gelegd op de houding van professionals ten opzichte van dit gedrag. Verpleegkundigen voelen zich gefrustreerd, boos en angstig als ze zorg verlenen aan zelfbeschadigende patiënten. In reactie hierop zijn er verschillende trainingsprogramma's ontwikkeld die als doel hebben om verpleegkundige attitudes te verbeteren. De invloed van deze trainingsprogramma's op het gedrag van verpleegkundigen tegenover zelfbeschadigende patiënten is echter onbekend.

Doelstelling. In kaart brengen hoe positieve attitudeverandering ten opzichte van zelfbeschadiging het gedrag van psychiatrische verpleegkundigen beïnvloedt.

Onderzoeksvragen. Hoe beïnvloeden positieve attitudeveranderingen tegenover zelfbeschadiging het gedrag van verpleegkundigen in de psychiatrie? Welke factoren dragen bij aan deze gedragsveranderingen?

Methode. Participanten werden geselecteerd middels doelgerichte steekproeftrekking. Verpleegkundigen uit drie verschillende psychiatrische instellingen werden geïnccludeerd wanneer die een positievere attitude hadden door deelname aan een Nederlands trainingsprogramma. Data werden verzameld door semigestructureerde interviews en geanalyseerd in de drie stadia van grounded theory met de 'constant-comparative' methode.

Resultaten. Er namen 11 verpleegkundigen deel aan het onderzoek, van wie er tien aangaven dat zij hun gedrag hadden veranderd na de training. Zij gaven aan minder beperkende maatregelen te gebruiken, een meer explorerende en empathische houding te hebben en patiëntgerichter te werken. De veranderingen werden bevorderd door een positieve teamsfeer en de vrijheid om te werken naar eigen inzicht. De gedragsveranderingen hadden voornamelijk positieve consequenties voor de verleende zorg en de arbeidstevredenheid van de participanten.

Conclusie. De bevindingen van dit onderzoek tonen aan dat positieve attitudeverandering volgens de participanten invloed heeft op hun gedrag naar zelfbeschadigende patiënten.

Aanbevelingen. Er is onderzoek nodig naar de ervaringen van patiënten met de zorg van verpleegkundigen die hebben deelgenomen aan een trainingsprogramma over zelfbeschadiging. Daarnaast zou vervolgonderzoek zich moeten richten op de interactie tussen patiënten en verpleegkundigen na een dergelijk trainingsprogramma.

Introduction

Health care professionals frequently care for patients who show self-harming behaviours. Deliberate self-harm is the intentional, direct and indirect harming of body tissue with a non-fatal outcome (11). The prevalence of self-harm is around 4% in the general population (27). However, self-harm rates are much higher in mental health, where self-harm is seen in 40% of the patients (25).

Mental health nurses often take a central place in the treatment of self-harm patients. However, literature shows that negative attitudes towards self-harm regularly exist among nurses and that they feel inadequate and helpless when caring for self-harm patients (6,15,19). In addition, self-harm patients have expressed that they feel misunderstood and unsatisfied with the way nurses behave towards them (19). In reaction to these issues, many articles have been published on the underlying factors of nurses' attitudes towards self-harm and the way attitudes can be improved. The importance of education in positively changing nurses' attitudes towards self-harm has been widely recognized (2,13,15,18,28). Several education programs on self-harm have been developed and a number of these programs have a positive effect on nurses' attitudes towards self-harm (11,14,17,22). However, these attitudes were measured by self-report questionnaires and therefore they might be overly positive. Nevertheless, the assumption of scholars is that the nursing care for self-harm patients will improve due to these positively changed attitudes (17,22).

However, there is no evidence supporting this assumption. Therefore the influence of the previously discussed training programs on nursing behaviour towards self-harm patients is unknown. Insight is needed into this influence in order to determine whether the training programs address the reported issues in nursing practice. The term attitude refers to a disposition to respond favourably or unfavourably to an object, person, institution or event (1).

Problem statement

It is unclear how positive attitudinal changes towards self-harm influence the way nurses actually behave towards self-harming patients.

Aim

To investigate the influence of positive attitudinal changes towards self-harm on the behaviour of mental health nurses. On a broader level, this study aims to explore whether training mental health nurses, with the focus on improving attitudes, can contribute to an improved practice for self-harm patients.

Research questions

How do positive attitudinal changes towards self-harm influence the behaviour of mental health nurses? What factors contribute to these actual behavioural changes?

Method

Design

The study was conducted using a grounded theory approach. This qualitative approach is rooted in sociology and focuses on explaining social processes from the viewpoint of individuals (8). Grounded theory is suitable because the research question is explanatory in nature. Also, grounded theory is the appropriate scientific approach because we are studying processes of human behaviour based on interactions between nurses and patients.

Study participants

Participants were recruited from a quantitative study that aimed to determine the short-term effects of the training program 'I'm doing just fine.'. This training program aimed to improve the attitudes and competences of professionals in their care for patients who self-harm (14). Professionals from ten mental health care organisations around the Netherlands participated in the training program and over 400 people were trained. Participants were selected through purposeful sampling in order to include participants that had relevant information on the study topic. Mental health nurses were selected who:

- participated in the training program 10 – 14 months before the present study. This period was chosen because it is long-term and yet it still ensures participants to remember their behaviour directly after the training program.
- experienced a positive attitudinal change because of the training of at least four points between the pre-test and post-test on the measurements of the Attitudes towards Deliberate Self-harm Questionnaire (ADSHQ) (15). This definition was chosen because the first and second author found a four-point change relevant based on the outcomes of the study by Kool et al (2011).

Participants were first contacted by an email that contained information about the study. After this, the first author contacted them by telephone to provide further information and to answer possible questions. All the participants gave written informed consent before the interviews started.

The recommended sample size in grounded theory is between 15 – 20 participants (4). However, sample size should primarily be determined by saturation of the theory (12) and smaller samples are justified in interview-based research (5).

Data collection

Semi-structured interviews were conducted by using an interview guide. Interviews were chosen as the method for data-collection because the study aimed to understand the inside view of the participants on the study topic. The interview guide contained a small number of open-ended questions derived from the research questions. The interviews started with the question: “Did you change your behaviour after the training program?”. In cases of behavioural change, questions were asked about the nature, consequences and conditions of the change. In cases of unchanged behaviour, the interviewer asked the participant about possible explanations for the absence of behavioural change. As theoretical ideas were developed, the interview guide was changed in order to obtain information that was relevant for the emerging theory.

The interviews were expected to last 60 minutes and took place at a location that was convenient for the participant. The interviews could be stopped at any time if the participant felt uncomfortable or was called to an emergency situation. All the interviews were recorded with a digital recorder, after which they were transcribed verbatim by the first author. Descriptive characteristics of the participants were obtained by asking closed-ended questions during the interview.

Data analyses

In order to systematically analyse the data according to the method of grounded theory, analyses proceeded in three stages (8):

- The transcripts were read completely by the first author. After this, lines and pieces of text, that seemed relevant for answering the research questions, were coded. By comparing incoming pieces of data to existing codes, categories were saturated (open coding).
- The categories were then linked together to create a conceptual model that explained the process of behavioural change and the conditional/causal factors. Negative case analyses was conducted by thoroughly examining the conditions of the participant with unchanged behaviour. Based on this analysis, the model was adjusted (axial coding).

- Finally, all categories were linked to a major category. This core category represented the essence of participants' perceptions on the study topic (selective coding).

The constant comparative method was used to analyse the data (8). The theoretical ideas and emerging categories guided the content of data collection. The first author wrote memo's that included theoretical ideas and provisional ideas about categories.

The software program NVivo 9 was used to analyse the interview transcripts in a structured manner.

Trustworthiness

In order to enhance the quality of the study, the process, context and people in the research were described in detail (thick description). Independent peers discussed methodological decisions with the first author and interview-techniques were discussed within the research team (peer debriefing). Negative case analysis was conducted by thoroughly investigating the cases that did not fit with the emerging theory. The insights that arose from this analyses were incorporated in the theory. Finally, throughout the entire study-process, the first author adopted a self-critical stance to the research and his own role, relationships and assumptions (reflexivity) (12).

Results

In total, 25 eligible mental health nurses were approached to participate in the study and eleven of them agreed to participate. The most frequently mentioned reasons for not participating were a lack of time and insufficient contact with self-harm patients. The interviews lasted 40 to 60 minutes. The sample consisted of predominately female nurses (n=9). Participants' age ranged from 26 to 57 years and they worked in both inpatient and outpatient settings. More detailed sample-characteristics are described in Table 1. To ensure privacy of the participants, they will all be referred to as female in this article.

Ten out of the eleven nurses stated that they changed their behaviour after the 'I'm doing just fine'-training program. The behavioural changes they experienced were preceded by a change in the way nurses thought about self-harm, i.e. their attitudinal changes. First, these attitudinal changes are described as experienced by the participants. Next, the core category is presented and the behavioural changes are discussed, followed by the conditions and consequences of the behavioural changes.

Influence of the training program on nurses' attitudes of self-harm

Several participants indicated that they viewed self-harm differently because of the 'I'm doing just fine'-program. Before the training, self-harm was seen as a way to get attention or provoke others in order to get a reaction. Nurses also experienced self-harm as a personal attack on themselves and as a way to start conflicts. After the training, participants viewed self-harm not as a consciously planned act over which patients had control, but rather as an inability to deal with negative emotions and stress. One respondent said:

Yeah and it was also attention seeking. If you can't get it in a positive way, than you try it in a negative way. And now you see it's just inability to cope. And I think that's the biggest change.

One participant indicated that, despite the training, she still believed some patients used self-harm to get attention, but that this is not necessarily negative. It should also be noted that some participants stated that they had trouble really understanding self-harm, because they could never imagine performing this behaviour themselves.

Several participants indicated that after the training they focussed less on reducing the self-harming behaviour. They acknowledged that only the patients could stop their self-harming behaviour and that pressuring them into stopping just caused worked counter-therapeutic.

Behavioural changes

The core category that arose from the data and took a central place in the behavioural changes mentioned by the participants was: *from judgement to understanding*. This meant that instead of thinking *for* the patients, the participants were thinking *with* the patients.

Participants said that self-harm became something to explore instead of something to judge and reject. The core category consisted of three subcategories (i.e. behavioural changes): using less restrictive interventions, choosing a more emphatic and exploratory approach and being more patient oriented.

Using less restrictive interventions

Several respondents indicated that, before the training, they used restrictive interventions in order to make patients stop harming themselves. They believed that by not giving patients the opportunity to harm themselves, they would eventually learn to deal with tension differently. For this purpose patients were sometimes moved to seclusion rooms or sharp items would be removed from their rooms. Three participants indicated that patients were excluded from therapy if they harmed themselves frequently and could not stop on their own. Also, the goal of therapeutic conversations with patients was to find ways to stop self-

harm as soon as possible, regardless of the underlying problems patients were experiencing. This would often result in conflicts between nurses and patients. One participant said:

For me it felt like, I have to make her understand that this cutting has to stop, period. And now it is up to her to show that she really stops.

After the training, participants indicated that they put less pressure on patients to stop harming themselves. More emphasis was put on early recognition of stress and on timely using stress-reduction techniques. The goal of therapy became to first explore the patients needs and to get to know the patient. One participants reported this as followed:

The idea is that you take someone more seriously and that you encourage someone to show more of herself, because the other approach will lead to the patient resisting and distancing herself from us.

Nevertheless, several participants continued to believe that setting boundaries to self-harm was important in situations where someone was a danger to himself. In these cases, participants continued to justify the use of seclusion rooms and other restrictive measures. However, the same participants indicated that they used these measures less frequently and with more consideration of the patients needs than before the training.

Choosing a more emphatic and exploratory approach

Several participants indicated that they reacted in a neutral and distant way when they were confronted with self-harming behaviour prior to the training program. They reacted this way because they believed that emphatic reactions were rewarding and encouraged patients to harm themselves again. Other participants said that they did react to self-harm empathically before the training, but eventually avoided talking about the behaviour with patients. Discussing self-harm in group therapy sessions was also avoided, because they feared it would negatively influence other patients. Several participants indicated that they often made judgemental comments towards patients, such as:

We made a deal that you would not harm yourself and that you would come to see me if you felt distressed, why didn't you come?

Others said they did not make judgemental comments explicitly, but that they did have a rather disapproving attitude when they were confronted with self-harm.

After the training, most participants said they reacted with increased understanding of the patients' situation. Self-harm was more openly discussed in both group and individual therapy. The goal of participants became to explore the nature and background of the self-harming behaviour in order to treat self-harm more effectively. Self-harm was validated as a coping mechanism and this was communicated to patients by also acknowledging the stress-reducing function of self-harm for the individual patient. One nurse stated:

Well, before I was like: we need to get rid of this (i.e. self-harming behaviour). And now I just realize, well, so this is what you need right now.

However, several participants felt that self-harm should not be showed to easily to others. Especially when participants perceived that patients repeatedly used self-harm to consciously achieve something, the participants felt less inclined to react with understanding and sympathy. One participant illustrated this as followed:

People can just be open about it. You don't have to hide it. But you don't have to show it off either.

Being more patient oriented

A number of participants indicated that they focused their professional behaviour more on the individual and less on their self-harming behaviour or mental disorder. Therapeutic interventions (e.g. conversations, group sessions) were more tailored to the needs of patients and less on the preconceived ideas of the nurses. One participant illustrated this as followed:

I think that's the big difference. Really listening to what the patient is saying. Cause the patient sometimes doesn't know, and before I was like: "I do know, and I'm going to tell you what to do".

Also, there was increased focus on the healthy side of the patients and on their experiences in daily life. Participants realized that the only way to make self-harm stop was to work together with patients and set goals that the participants supported. This also meant that, when patients were not ready to talk about their self-harming behaviour, the participants would not address it until the patients were ready. Additionally, two participants asked for feedback from patients more frequently on the way they acted.

However, some participants indicated that there were limits to being patient-oriented that related to ward-rules and regulations. For example, one participant said that therapeutic conversations never lasted longer than 15-20 minutes and that the conversation was stopped regardless of the patients' need to continue it. Another participant said that she did not

accompany her patients to the hospital after a self-harm incident, because of the emphasis the ward put on patients' self-dependence. Also, talking about self-harm with patients before bed-time was avoided by several participant, because of the negative influence this would have on the patients' sleep.

Conditions for behavioural change

When participants were asked about conditions that facilitated their behavioural changes, a positive atmosphere among colleagues was a recurring theme. Also, the fact that team-members also participated in the training was a facilitating factor for several participants. The ability to openly discuss experiences concerning self-harm with colleagues was found to be essential in changing professional behaviour. In contrast, one participant indicated that working in a team inhibited her to change her behaviour in the past and that working independently enabled her to change her behaviour more easily.

Most of the participants indicated that they were given the freedom by their organisations to make their own professional decisions and change their behaviour in accordance to their changed insights.

Several participants stated that they experienced their changed behaviour to result in better care and that patients confirmed this by making appreciative remarks about the care they received. This caused the participants to be reinforced in their changed behaviour.

The one participant who reported no significant changes in her behaviour, explained this by the fact that she had many years of working experience on a ward where severe self-harm is a frequent phenomenon. Because of this working experience, the participant felt that she had a very rooted and stable way of working with self-harm patients. She saw the training as a confirmation of this work method.

Consequences of behavioural change

Seven participants indicated that their behavioural changes had a positive influence on their therapeutic relationship with self-harm patients. Specifically, more contact, trust and dialogue was experienced in the relationships. This enhanced therapeutic relationship resulted in less conflicts with self-harm patients. However, one participant indicated that her changed behaviour (i.e. taking more time for self-harm patients) caused her to have less time for other patients.

All participants who experienced behavioural changes felt more satisfied and confident about the care they provided to patients who self-harmed. Nevertheless, some participants from

clinical settings still found it difficult and frustrating to deal with self-harm at times, especially when they were repeatedly confronted with self-harm in one shift.

Discussion

The insights from this qualitative study demonstrate the value of training programs that focus on attitudinal change towards self-harm from the perspective of nurses. The fact ten out of eleven participants said they changed aspects of their behaviour after the training, suggests that attitudinal change followed by a self-harm training program can contribute to improvements in nursing practice. The core category found in this study (i.e. from judgement to understanding), was very well saturated and mentioned in every interview. It illustrates how the participants experienced self-harm after the training and how they changed their reported behaviour (see Figure 1). This is a hopeful finding, since self-harm patients often feel misunderstood by nurses (19).

The substantive theoretical model developed in this study, which shows that attitudes towards self-harm appear to influence behaviour towards self-harm patients, is in line with the theory of planned behaviour (TPB) (1). In this theory, a persons' attitude towards an object is one of the factors that predict the persons' behaviour towards this object.

Additionally, another predictor of behaviour in the TPB is the perceived social pressure to perform the behaviour (1). This social factor was also important for behavioural change in this study, given the fact that a positive atmosphere among colleagues was frequently mentioned as a facilitating factor to behavioural change.

This is the first study, to our knowledge, that focuses on this particular topic, i.e. the influence of positive attitudinal changes towards self-harm on nurses' behaviour. The insight gained by the study is important because it suggests that training programs can potentially address the reported dissatisfaction of self-harm patients with nursing care (19) and the feelings of dissatisfaction and helplessness of nurses with their care for self-harm patients (6,13).

Although the sample was relatively small, transferability of the findings is enhanced because the study had a heterogeneous sample with nurses from various fields of mental health and with a wide range of working experience.

Since only one participant did not change her behaviour, the theoretical model presented in this study has limited power in explaining why behavioural changes do not occur in mental health nurses after their attitudes are positively changed. Another possible weakness of the study is that most nurses who participated in the training-program did so voluntarily and therefore the findings of this study could be overly positive. Also, there is a possibility that nurses gave socially desirable answers, given the sensitivity of the study topic. However, this social desirability was minimized by asking the participants to reconstruct specific situations.

This study indicates that nurses should receive self-harm training on a regular bases, preferably with other team-members. Nurses who work on wards where severe self-harm is common, might need extra support form colleagues and managers in changing their behaviour. It appears to be beneficial for wards to have a non-directive policy on self-harm, because this was an important facilitating factor to behavioural change.

Conclusion

This study shows that positive attitudinal changes after the training program are associated with the following changes in nurses' behaviour: using less restrictive interventions, choosing a more exploratory and emphatic approach and being more patient oriented. The behavioural changes were enabled by a positive team atmosphere, positive feedback from patients and a non-directive ward policy.

Recommendations

This study was conducted from a nursing perspective. Future research should focus on patients' experiences with nursing care after a self-harm training program. To increase reliability, additional observational research is needed into the nurse-patient interaction before and after nurses' participation in self-harm training programs.

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Table 1. Participant' characteristics

	Age	Gender	Work experience	Healthcare setting	Frequency of self-harm
Participant 1	50	Female	24 years in mental health, of which 20 years in current setting	An open inpatient setting for people with personality disorders	High
Participant 2	40	Female	20 years in mental health of which 7 years in current setting	An open ward for short-term treatment	No self-harm on ward, self-harm is occasionally discussed
Participant 3	Unknown	Female	23 years in mental health of which 14 years in current setting	Outpatient treat for young people with personality disorders	Low
Participant 4	38	Female	12 years as a nurse of which 7 years in current setting	Outpatients treatment for young people	Low
Participant 5	57	Female	32 years as a psychiatric nurse, 15 years at current setting	Outpatient treatment for young people	Low
Participant 6	54	Female	20 years at current setting an unregistered nurse	Inpatients setting for intensive psychiatric treatment	High frequency of severe self-harm
Participant 7	43	Male	17 years as a nurse, 1 year at current setting	A closed inpatient ward for long-term treatment	Regularly
Participant 8	28	Male	4 years in current setting	Inpatients setting for intensive psychiatric treatment	High frequency of severe self-harm
Participant 9	46	Female	22 years as a registered nurse	Outpatient treatment for people with personality disorders	No self-harm on the ward, self-harm is discussed regularly
Participant 10	26	Female	5 years in current setting	Treatment clinic for addiction and psychiatry	Low
Participant 11	34	Female	10 years, of which 3.5 years in current setting	Inpatients setting for intensive psychiatric treatment	High frequency of severe self-harm

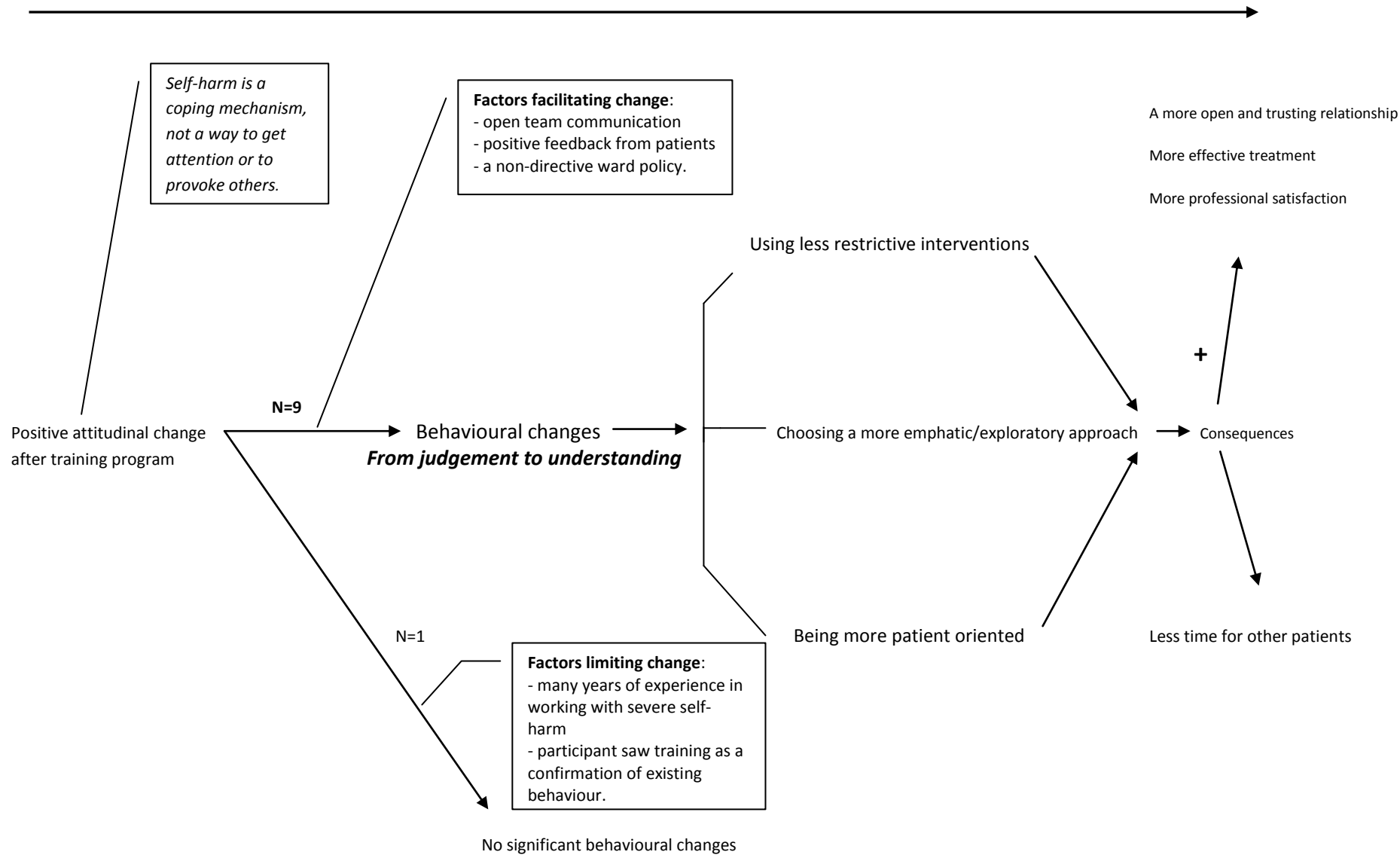


Figure 1. Process of nurses' behaviour.

