

# 'I can actually talk to them now': qualitative results of an educational intervention for emergency nurses caring for clients who self-injure

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**Aim and objectives.** This Australian study evaluated the effectiveness of a solution-focused education intervention in extending and improving emergency nursing responses to patients who present because of self-injury.

**Background.** Emergency nurses commonly report lack of training and feeling unskilled in managing people who present because of self-harm. Most educational interventions have provided content knowledge, yet rarely have they focused on conveying the value of health promotion strategies such as proactive skills and coping strategies.

**Design.** A mixed method pretest–posttest group design was used.

**Methods.** Nurses ( $n = 36$ ) were interviewed to examine differences in professional identity, awareness of self-injury and clinical reasoning.

**Results.** The qualitative results are presented in this paper and these showed improvements in knowledge and understanding of self-harm, self-belief in nurses' capacity to positively influence clients and the value of health promotion skills. The intervention produced a positive attitudinal shift towards clients and an expressed intention to act in ways that were more person-centred and change oriented.

**Conclusions.** The solution-focused education intervention appears to show promise as an intervention for enabling nurses to value their unique contribution to providing a health service that is more proactive and health-promoting.

**Relevance to clinical practice.** Interactive education bringing psychosocial skills to technical nursing staff builds confidence, competence and more person-focused care.

**Key words:** accident and emergency, education and practice development, evaluation research, health promotion, mental health, qualitative study

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## Introduction

Self-harm describes a wide range of things that people do to themselves in a deliberate and usually hidden way. Most commonly, this involves self-poisoning through overdose, self-injury through cutting and less commonly through hair pulling, head banging and hanging (Brophy 2006). Self-harm is a common health care issue, accounting for 20% of all

Australian hospital attendances and 7% of admissions (Berry & Harrison 2007). Self-harmers are more likely than the general population to become suicidal and there is growing understanding of the issues that impede recovery and reduce care (Hull & Haut 1999, Hurry & Storey 2000, Isacson & Rich 2001).

The most common service used is the emergency department and good care in this context can provide support and

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prevent escalating mental distress and disorder (Hawton *et al.* 1998). However, a recurring theme in many parts of the world is that clinicians have been untrained and feel unskilled in managing self-harm clients (Hemmings 1999, Eddleston 2000, McAllister *et al.* 2002a, Bennewith *et al.* 2005, Bosman & van Meijel 2006, Friedman *et al.* 2006, McCann *et al.* 2006). This lack of confidence in preparation and skills is significant because, as Patterson *et al.* (2007) argued, clinicians who lack therapeutic capabilities may actually contribute to 'dynamic risk factors' for suicide.

Conversely, enhanced treatment could help reduce the overall rate of suicide and enhance clients' health seeking. Whilst emergency (ED) nurses, like other front line clinicians and helpers, are not mental health clinicians and thus cannot be expected to provide all the necessary psychosocial care, the assumption underpinning this project was that there may be ways for mental health clinicians and ED staff to work more collaboratively and to apply some of each others' skills in their immediate encounters with clients, such as those who self-harm.

Several studies have been completed which successfully improve clinicians' attitudes through education and training (Crawford *et al.* 1998, Evans 2000, Samuelsson & Asberg 2002, Patterson *et al.* 2007). It is common in these approaches to teach participants psychosocial assessment and discuss the patterns associated with self-harm and suicide. With the exception of Patterson *et al.* (2007), these studies have tended to approach the education by conveying what may be considered lower order thinking skills in learners. Lower order thinking may occur when participants are asked to receive or recite factual information such as the prevalence and patterns of self-harm and suicide in populations. Higher order thinking is that which encourages analysis, explanation, interpretation, application of theory to practise and transfer of learning from one context to another (Brookfield 1997, Nokes *et al.* 2005). Whilst understanding of facts and figures in self-injury is important for replacing myths and misconceptions, also important to include are strategic response strategies and humanistic caring skills transferable and applicable to other contexts.

A related issue is that effective emergency care requires more than understanding and the ability to conduct a psychosocial assessment. It is known that a significant number of clients, especially young people, who present for emergency care because of self-harm do not stay for treatment and for many others, psychosocial assessment and follow-up are incomplete (Ryan *et al.* 1998, Bennewith *et al.* 2005). Reasons for this are various and include feeling exposed, judged, stigmatised, 'fobbed off', not listened to. Thus, many authors argue that all people working with those

who self-injure need to learn and demonstrate more caring behaviours and less judgmentalism (Perego 1999, McKinlay *et al.* 2001). They argue that being able to listen attentively, to give reassurance, to offer support and acknowledge feelings are vital skills in promoting therapeutic optimism and change.

### Solution-focused nursing

A model of care, known as solution-focused nursing (SFN) (McAllister 2003) may assist in the context of emergency care for the person who self-harms. Solution-oriented strategies focus on engaging the person, helping them to feel supported and optimistic about change have potential to be beneficial to clinicians and ultimately to clients seeking care for self-injury. Ultimately, it aims to circumvent the guilt shame cycle that can occur when the client presents for care but perceives rejection and thus reduce self-harm repetition. It offers brief intervention strategies that may be likely to help the clinician feel more confident and part of the whole recovery process, not just an adjunct to it. These are likely to have long-term benefits.

SFN works with what's going right with an individual or group, be it client or nursing culture and seeks to maximise those potentials by building on strengths, achievements and capacity. SFN, like other solution-focused approaches in psychology, business and education, shares a concern and criticism about the dominant approach taken with 'the client'. This dominant perspective becomes so pervasive it gets taken for granted and unquestioned. In the health context, the dominant approach is to look at the patient only in terms of their problem. But this can be dehumanising and upsetting for the patient. The problem also tends to be seen through a narrow bio-medical lens, rather than the wider context of the person's life. Furthermore, clinicians have tended to become preoccupied with problem identification, such as in making medical diagnoses or in asserting what is wrong with nursing, but not so skilled at generating solutions. SFN involves three phases: (i) joining, (ii) building, and (iii) extending. In the joining phase, effort is made to get to know who the person is, what their strengths and vulnerabilities and their condition physically and psychosocially. It is important to notice and develop areas in the person that are healthy and adaptive as this leads to appropriate behaviour.

In the building phase, the aim is to build health literacy, a sense of capability and inner strength and motivation to get through the present health challenge. Skill deficits and excesses, such as the mechanism of self-injury which can be very effective in managing pent-up distress, are addressed.

Together, the nurse and client might work on building a repertoire of coping skills to cope with the immediate situation, talking through issues such as relationships, tension management and being both capable and strong at the same time as sometimes feeling vulnerable and emotional. Being solution oriented in relation to young people requires that nurses work towards building partnership with young people, rather than in opposition or struggle (McAllister 2007).

In the extending phase, the emphasis is on encouraging the young person to transfer the skills learned in the nurse–patient relationship, so they can be used in other contexts such as when they are faced with social situations that are upsetting. It also involves setting the client up with social supports that can be used in place of the clinician–client relationship and therefore be more enduring and sustainable. This approach is not uni-directional, which is often the case in expert-care models, but rather this model emphasises working alongside the client and negotiating care with them (Shepperd & McAllister 2003).

## The study

### Objectives and methods

Whilst studied in the education context, SFN was yet to be tested for its clinical relevance. Thus, the objectives of the project were (1) to implement an education intervention that emphasised deep knowledge and skills to help frontline clinicians feel more confident and part of the recovery process; (2) to measure the change in knowledge, skills and professional identity and thus the efficacy of a specific, solution-focused education intervention and hence its efficacy as a clinical intervention in the Department of Emergency Medicine (DEM).

### Design

The study used a mixed-method, pretest–posttest design so that breadth and depth of knowledge were produced. The test group was given an education intervention and their results compared to a comparison group who received no intervention.

### The education intervention

A two-hour interactive discussion was provided on the nature of self-injury, theories for understanding and evidence based treatment techniques, followed by a break and then concluding with a one-hour training in SFN, applied to self-injury. In the latter part of the training, the group explored and

discussed brief communication skills that they could use in the context of a busy emergency department. It included practical ways to join with the patient and learn more about their personal needs – an example was for nurses to use the person’s name; to demonstrate respect – an example was for nurses to briefly explain the wait time and to check that the person felt safe; it explained an assessment tool that quickly explored the nature of the self-harm (BASK); it explained the CARE framework (McAllister & Walsh 2003) so that the focus would not simply be on the problem but also emphasise education, strengths and engagement; and finally, it recommended the distribution of brochures to provide information that affirmed self-harm as a coping strategy but which also aimed to move the client from lack of awareness towards feeling motivated to secure community supports and enact change.

### Participants

Emergency nurses working in two major Departments of Emergency Medicine (DEM) and acute care areas in South East Queensland were invited to participate in the study. Potential participants self-selected to participate. The DEM admissions unit one is in Queensland’s third largest hospital and serves a population of 400,000 and has a nursing complement of about 90-shift workers. The second DEM is smaller, serving a population area of 145,000 and has a nursing staff of about 70. Nurses were allocated to either an intervention or control group. See Table 1 for a description of participants.

### Procedure

Following ethics committee approval participants were involved in a preliminary one-hour interview to ascertain learning needs and prominent care issues in relation to self-injury. Two weeks later test group participants engaged in the

**Table 1** Description of group participants

|                         | Total | Group 1 | Group 2 |
|-------------------------|-------|---------|---------|
| N                       | 29    | 9       | 20      |
| Female, %               | 72    | 77.8    | 70      |
| Education               |       |         |         |
| Hosp cert               | 14    | 11      | 15      |
| Degree                  | 55    | 44      | 60      |
| Post-grad               | 17    | 22      | 15      |
| Other                   | 14    | 22      | 10      |
| Age, M                  | 34.6  | 36.6    | 32      |
| DEM employment, M years |       | 4.7     | 4.5     |

intervention that took place on site within the DEM. Two weeks following the intervention changes in learning and behaviour were measured qualitatively and quantitatively by interview, think aloud tests (Offredy 2002) and survey instruments (Professional Self-Concept in Nursing Inventory (Arthur 1995) and Perceptions of Nursing Scale (McAllister 2007)). This paper reports on the test group post intervention qualitative data.

## Analysis

Interviews were analysed through content analysis. This process began with two independent readings of all the transcriptions. Each of the transcripts was read through several times to obtain a sense of the whole then distilled down to identify pertinent codes. When each interview was analysed in this way, the codes were considered, compared and stratified into sub-themes and themes.

## Interview results

### Post-Intervention Interviews

Qualitative data emerging from interviews of 36 participants were analysed, sorted into five themes and 20 sub-themes and provides rich detail about the learning experience and the effect on nurses (Table 2). The overwhelming sentiment from participants was that the intervention provided them with new and effective skills in helping them to understand, respond to and cope with the person who presents as self-harming. Positive attitudinal shifts were claimed by participants and areas of ongoing educational need were clearly identified. Each of these themes will next be discussed so that detail on the ways participants were helped to improve their practice is provided. This will be useful in advancing evidence-based approaches to nursing education because it identifies learning outcomes, processes, useful resources as well as pitfalls to avoid.

### Equipped with new response skills

The overwhelming sentiment from participants was that the intervention provided them with new and effective skills to help understand, respond to and cope with the person who presents as self-harming. In particular, most participants reported that they learned more focused, strategic communication skills that they could use to both explore the client's concerns or to provide support. Nurses said that they now acknowledged the person's right to use the service and indeed validated their health seeking behaviour as these examples, using pseudonyms, illustrate:

**Table 2** Post intervention themes

| Themes                            | Subthemes                                                                                                                                                                                                                                        |
|-----------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Equipped with new response skills | Acknowledgement<br>Strategic assessment<br>Proactive responses<br>A framework for care<br>Referral skills and resources<br>Team approach<br>Transferable skills                                                                                  |
| Perspective transformation        | Seeing the complexity of self-harm<br>Seeing links between blame and destruction<br>The little things can facilitate change<br>The value of using a person-focus<br>Triggering change, rather than providing cure<br>Seeing self harm as a cycle |
| Positive Effects                  | More confidence<br>Positive attitudinal shift<br>Efficacy                                                                                                                                                                                        |
| Lessons for the future            | Resources are needed to ensure capacity to care<br>Provide the intervention to all clinical staff<br>Provide emotional support following the intervention                                                                                        |
| Nil effect                        | No perceived relevance to practice                                                                                                                                                                                                               |

I've been sitting them down and acknowledging that what they've done is OK - it's a coping mechanism and that's alright to try to cope, it's not necessarily a good coping mechanism and that we're here to teach you a better coping mechanism ... at least they've found a way to cope with their feeling rather than do something really negative, like commit suicide. (Kelly)

Related to this acknowledgement was the use of more strategic assessment skills, exemplified in this comment:

I can actually – if they're willing to – talk to them about why they did it, that they are not alone and that they should be here, this is where they are supposed to be. There was one person and I said to them 'it's ok – you need to be here, you're not wasting a bed and we want you here' and she felt a lot better in herself. It was good. (Eva)

Proactive response skills, such as helping to assuage guilt and providing early support were another positive outcome:

In future, I would ... recommend a course of action for them, give them information about the cycle and that they can break that cycle. And give them some positive encouragement, let them know that there is light at the end of the tunnel. (Dave)

Having a framework to guide care helped participants to see that they had a role that was beyond mere injury containment and that simply offering contacts and resources would be a contribution to the longer term recovery process:

Apply the CARE model and try greater containment, greater awareness, apply some appropriate resources to help develop their resilience and offer resources. So, yes, I'll just keep running that CARE model through my mind. (Marg)

Related to this shift in focus from an exclusive concern for the present situation, towards considering the client's future coping and well-being, participants appreciated that the relevance of using resources and tools to assist them to keep a focus on the bigger picture. Again, an indicative example from the data illustrates this point:

We were given a brochure and it broke down certain things and gave us more information. I really do think if we had more of those brochures that we could hand to patients just to give them a bit of empowerment so they didn't feel like 'oh okay I have come, I am stable, I am going to go home now'... so that they have some resources to follow up with. (Cleo)

New responses were not only related to individual improvements in nursing practice. Participants also referred to a desire to enact a new team approach that was likely to support ongoing practices within the emergency departments. The following statements from the data are indicative of these changes:

All the people who have gone through this work shop are trying hard to give [clients] the extra support that they need. (Hal)

Well I think there is a greater level awareness amongst a lot people about the solution focused nursing approach – so I don't think anybody's going to tolerate behaviours that are not acceptable from staff. So they are wanting to see people who are engaging and that people are safe, trying to make sure resources are available and that they provide empathy. So I think staff will be intolerant of people who practice outside that framework. (Marg)

The important point here is that there is evidence of a change of practice which does not rely upon individual effort alone, but is supported through collegiate interaction and common practices. Most likely, given the collective nature of nursing work, it is this kind of outcome, enacting a shared model of care that is likely to sustain emerging practice. Some participants also commented on the transferable nature of the skills they learned:

This is transformative teaching [in action] and that was great for me to actually see somebody who finally teaches the way that we are supposed to be going in the future I thought was just fantastic. And it

was great that self harming was the topic but yeah the techniques were useful for any person. (Tash)

In all, the participants typically reported that the educational intervention had improved an understanding of and responses towards self-harming patients. In particular, participants reported an expanded verbal response repertoire. These responses would be likely subtly, yet powerfully, to convey positive attitudes towards the client and thus break the vicious circle that can sometimes occur when a client perceives ill-feeling, which can lead to feelings of guilt and shame and a desire to self-punish. These responses also signify an emerging focus on the bigger picture of the client's future health and well-being. Encouragingly, some nurses are also transferring the knowledge and applying it to other client contexts. This demonstrates a future orientation as well as critical thinking and reflective practice.

### Perspective transformation

The study was seemingly successful in providing participants with new knowledge about self-injury and this altered the way both the client and the problem was viewed. This transformation in perspective indicates new awareness and growing insight and is an important outcome. Participants could for the first time see 'complexity' in the issue of self-harm and presumably would no longer swiftly assume care needs, or dismiss or invalidate the crisis that the person and their family were experiencing. Participants reported that being able to see self-harm in greater complexity, meant that they no longer 'blamed' the client for something that they had previously seen as 'self-inflicted'. Instead they saw self-harm as a coping mechanism or a need that was useful in the short-term:

The intervention helped me understand that self harm is not necessarily attention seeking, it can help a person, it's their way of coping and feeling like a person and expressing emotions that are otherwise difficult to show and perhaps a cry for help. Those discussions were important to change the 'blame' focus. (Bess)

The transformed perspective seemed to lead also to a (re)newed awareness that nursing does have an important part to play. There was appreciation that the nursing practices could be enacted in 'the little things' conveyed by attitude and verbalisations and that these could be successful in 'engaging' the client so that they would feel motivated to stay until the assessment and referral process was complete:

It hit the mark, it was good to hear some of the demographics about self harm and some of the statistics related to self harm and hear some of the psychology and the different theories related to self harm, what physiology that was there was nice to hear. (Marg)

Related to this renewed appreciation for the little things, participants could see the value in being person-focused and consciously using verbal strategies that would show to clients that their uniqueness is important and considered:

It doesn't actually take that much time. You can say 'hi this is my name, I'm really glad you came in and I'm here to help you'. (Deni)

The perspective transformation was also demonstrated in participants appreciating that their role may not always be about providing cure, but in triggering change, by setting in train future health behaviours that are the client's not the clinician's responsibility:

In recognising that sometimes they don't want us to do anything that removes a lot of the frustration – knowing that you don't have to fix everybody's problems takes away the pressure of feeling that you're not doing anything for the person. (Col)

Participants also reported the cycle of self-harm to be illuminating because they could see that using the emergency department could either be an experience that led to the cycle repeating, or becoming a turning point that led to positive changes for self-harming clients:

I keep remembering the cycle, the process of self harm and seeing the encouragement from that video of people who have broken that cycle. I can recommend to patients that there are ways to break the cycle and take some proactive ways to deal with their lives. (Dave)

Therefore, there is evidence that the intervention provided changes in how the nurses conceptualise self harming clients and, moreover, how they claim they will respond to such patients in the future. In particular, the idea that the emergency room intervention can lead to longer term benefits for patients, was identified as being an important goal with which these nurses could readily identify and direct their practices towards.

Providing an intervention and educational strategies that help to transform the perspective unconsciously used by clinicians to understand and care for the client and the presenting clinical problem is crucial to changing the emergency care response for the client who self-harms and all other clients who present because of psychosocial crises. As participants understood, not all clients may be at the stage of wanting to change and the nursing role does not have to be solely about 'fixing' the problem. Instead the role can be about conveying acceptance, optimism and a positive belief in change so that the client is motivated to think about change, to use alternative healthy coping behaviours and secure social supports to help clients make life changes.

## Positive effects

Most participants described a positive attitudinal shift in relation to both the issue of self-harm and their capacity to respond to clients and these are important positive outcomes for an education intervention. It shows that the intervention not only informed participants, but that it can lead to longer term benefits for the nurses' self-efficacy and resilience and of course improve care of the client. Verbatim examples illustrate greater confidence, positive attitudinal shifts, a belief that change is possible and greater self-efficacy:

I definitely feel more confident with the communication side of it. (Molly)

I can't say that I don't withdraw from those people a little bit, I do, but I find it much easier to deal with [self-harming clients]. I am more tolerant now and if I feel frustrated, I step back away from it and leave it to the [mental health] professionals but without producing a negative effect by putting attitude into it – you know, do no harm. (Kelly)

Cynicism, being judgmental, lack of confidence and empathy, were all mentioned in the pre-intervention interviews as attitudes that were present and unhelpful. They have also been identified many times in the literature as sometimes traumatising for vulnerable clients who present to the emergency department seeking comfort and care, yet who interpret the experience as traumatising, reinforcing negative self-perceptions and hopelessness, delaying future health seeking behaviours and triggering further episodes of self-harm and even suicide (Shaw 2002). Given that positive attitudes have been reported as an outcome of the educational intervention, then there is good reason to be optimistic that emergency nurses who have been trained in this evidence-based educational intervention will be better able reduce risks of repeated self-harm and other negative outcomes in future clients.

## Lessons for the future

Despite many positive changes resulting from the education intervention, some participants could still see obstacles to quality care for self harming patients continuing unless resource and structural changes were made. These criticisms related to the chronic lack of sufficient staff numbers including mental health specialists, the consequent lack of time and the need for architectural changes to provide safe rooms for clients.

Comment was made on the need for education to be provided in conjunction with ongoing staff support and not just as a one-time only event because ongoing support may sustain the improvements made to skills, proactive

orientation and positive attitudes as well as enhance the likelihood that the humanistic care shown to staff will cascade through the organisation at many levels.

Therefore, while there was evidence of initial positive outcomes from the educational intervention, the proposed change in practice is most likely to be realised and sustained in the long term, if some institutional arrangements and sentiments can also be transformed. Certainly, the broader application of the educational interventions may go some way to overcome barriers and other forms of resistance to change. Nevertheless, there will still be constraints to effective care for these self harming clients if hospital departments are so tight in their resources that effective interventions with self harming clients cannot be enacted. Here is the potential of a long-term gain through provision of strategic and effective inputs, such as by providing this education intervention to all clinicians.

### Nil effect

Despite most participants finding benefits in the workshop, there was one participant who believed that no positive effects occurred:

I don't see a situation where anything discussed in the workshop would be possible for me. (Wade)

In some ways, this is a welcomed response and perhaps indicates that the process and the data are valid. That is, it is unlikely that any intervention will be able to address the needs of all participants, or engage them effectively so that they reappraise their values and beliefs, or promote new practices. Consequently, while regrettable that the intervention was not able to reach all participants, this respondent and responses emphasise the humanness behind health work and health workers. Of course, different ways of engaging nurses of all kinds and perspectives need to be found. Yet, there can be no guarantees about human change arising from either individual or collective initiatives such as those exercised in this project.

### Discussion and conclusion

This was a small study that involved a purposeful sampling method. In addition the data were collected shortly after the intervention was completed and these are acknowledged limitations. Nonetheless because positive changes did occur, it is recommended that the study be extended and implemented with a larger sample size and changes monitored across time to increase the confidence that improvements in nursing practices are sustained.

### Relevance to clinical practice

Since mental health service use in emergency settings is growing, the need for multi-skilled holistic emergency clinicians is increasing and thus their need for brief, strategic helping skills for such clients is perhaps now becoming crucial. This study implemented an interactive education program that was successful in raising nurses understanding of self-injury. The evidence showed a positive attitudinal shift towards clients who self-harm. Nurses reported more empathy and tolerance. The program also led to new response skills, such as the ability to ask more focused questions and to communicate in more supportive and motivating ways. The program engendered a belief in nurses that they did have the ability to positively influence clients and the skills were being applied to other clients, in ways that nurses felt were more person-centred, change oriented and effective. Participants felt more able to help and had a clearer sense of the nursing role in the emergency care of clients who self-harm. Evidence was also produced that showed that the skills developed were not limited to the issue of self-harm in the emergency setting and could readily be transferred to other client contexts. These are indications that solution focused nursing is a model of nurse-client care that can be empowering and effective.

It is recommended that the education intervention be extended and made available to more emergency clinicians as well as others involved in early encounters with people who self-injure, such as teachers, counsellors, school health nurses and GPs. Further research could be undertaken to test the SFN model's effect on clients' health seeking behaviours and further episodes of self-harm. Additionally, it may be useful to measure other changes in clinicians' behaviours and values towards person-centredness, empathy and how knowledge is used in practice as these are components particular to the SFN model. Finally, the education model could become a model program, because it emphasised higher order thinking and skills and was not a one-time only lecture. To build on this innovation and sustain changes, support from administrators is needed. They could fund the roll out of a similar program and award Continuing Professional Development Points (CDP) and provide work release time to enable busy clinicians to participate.

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## Contributions

Study design: MM, WM, SB; data collection and analysis: MM, MZG, MM, SB and manuscript preparation: MM, MZG.

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