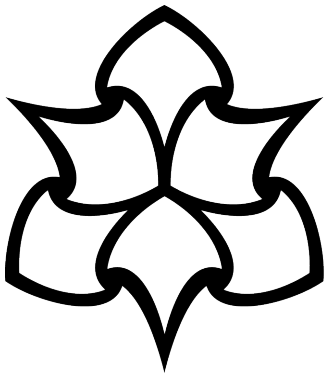

Emerald Journal of Forensic Practice

The PARALLEL Study
(imPAct of expeRiencing Another's seLf harm and suicidaL bEhaviour in hospitaL)

Journal:	*Journal of Forensic Practice*
Manuscript ID	JFP-01-2017-0001.R2
Manuscript Type:	Research Paper
Keywords:	Self-Harm, Suicidal Behaviour, Qualitative, Forensic Settings, Impact, Experience

Abstract

Purpose – This study aims to explore the experiences of both staff and patients in a medium-secure mental health unit of the self-harm and/ or suicidal behaviour of others. Suicide and self-harm is highly prevalent in forensic settings and evidence suggests that experiencing other people's self-harm and suicidal behaviour can lead to negative outcomes, both for staff and patients. This is particularly important in hospitals where patients are highly dependent on staff for support.

Design/methodology/approach - Semi-structured interviews were conducted with five staff members and six patients in a medium- secure male mental health unit in the North of England. Data was analysed following Interpretative Phenomenological Analysis (IPA) guidelines.

Findings – Three dominant themes were identified during analysis: the impact of suicide and self-harm; the role of others; and the importance of understanding and experience. Various impacts were discussed including desensitization, negative emotions and the desire to help. Other people played an important role in protecting against negative impacts, with shared experiences and peer support reported as the biggest benefits. Experiences of self-harm and suicide were found to increase understanding resulting in more positive attitudes. Additionally, the importance of training and education was highlighted.

Originality/value - This paper provides an insight into the experiences of staff and patients in medium- secure male mental health unit, which has benefits to practitioners when considering support mechanisms.

Keywords *Self-Harm, Suicidal Behaviour, Impact, Forensic Settings, Qualitative*

Paper type *Research paper*

Word Count 6000

Introduction

Patients in forensic services fall into a high-risk category for exposure to self-harm and suicide (Oddie, 2015). The majority of suicides occur in adult males (WHO, 2016) and those with a psychiatric diagnosis are eight times more likely to complete suicide (Lee et al, 2015). Many patients in forensic units have also spent time in prisons where suicide rates are now at an all-time high (MoJ, 2017). In inpatient settings self-harm has been found to be a response to psychological distress or restricted freedom, with prevalence highest on forensic wards (James et al, 2012). Reported rates of self-harm in forensic units vary widely but are consistently at least four times higher than the general population (Oddie, 2015).

Definitions for self-harm and suicidal behaviour differ and behaviours can be distinct (Leitner et al, 2008). However relationships between suicide and self-harm are often reported (Oddie,

2015) and self-harm is a key risk factor for suicide (Hawton et al, 2015); around half the people who complete suicide in prison have a history of self-harm, which increases the risk between six and 11 times (Fazel et al, 2008). This research therefore takes the approach of recognising self-harm and suicidal behaviour in their own right, but assessing and understanding them in combination (O'Rourke, 2013).

Previous research has highlighted many negative impacts of experiencing self-harm and suicide , including feelings of anger, shock, survivor guilt and denial (Ness & Pfeffer, 1990; Walker & Towl, 2016) disbelief, blame and self-scrutiny have been noted (Snow & McHugh, 2002; Walker & Towl, 2016). Contact with another's suicidal behaviour may be experienced as traumatic and/or lead to a sense of loss or a violation of one's"assumptive world"(Janoff-Bullman, 1992). Longer-term impacts have also been seen in terms of increased incidences of depression, anxiety, and posttraumatic stress disorder (Brent et al, 1996).This is a problematic conflict with factors such as connectedness; hope and optimism about the future, which are important to mental-health recovery (Leamy et al, 2011; Tew et al, 2011).

Research within secure environments is largely limited to prison settings yet demonstrates a need for concern yet. As such this research aims to provide an alternative perspective. An examination of contact with another's non-fatal suicide attempt and own self harming behaviour in prison found contact to be significantly associated with own self-harm (Hales et al, 2003). The authors concluded that imprisonment is a vulnerability factor for self-harm, possibly because length of time in prison was the factor that most increased the chance of knowing someone who had attempted suicide (Hales et al, 2003). This is also likely to be true of hospital settings. A comparison of men who had witnessed a peer's suicide-related behaviour in prison with men without such experience found heightened vulnerabilities among those exposed to suicide-related behaviours (Hales et al, 2014). Significantly higher levels of psychiatric morbidity and own suicide-related behaviours were found, even after controlling for other factors (Hales et al, 2014). Further exploration of the concerns of those witnessing another's suicidal behaviour demonstrated a negative reaction (Hales et al, 2015), suggesting a need for support. The authors concluded that staff should consider how to provide required care and support in an acceptable form. This is likely to vary between settings and this study aims to explore what might be defined as "acceptable support" within a secure hospital environment.

The impact of self-harm and suicidal behaviour on staff is more widely researched and understood than for patients. Again research is largely limited to prison settings and this study aims to explore if such commonalities exist between prison and secure health-care staff. Self-harm within a prison environment is a significant predictor of stress and adds

frustration, distress, anger, and anxiety to the staff role (Usher et al, 2010). Self-harm and suicidal behaviour remains difficult for many prison staff to understand as it violates the biological imperative toward self-protection (Favazza, 1998). High levels of frustration, tensions between healthcare and custodial staff, feelings of powerlessness, and low sense of job control (Marzano et al, 2015; Walker et al, 2016) have been noted. Such findings are unlikely to be limited to staff in prison settings. Best Practice Guidelines place the therapeutic alliance between staff and patients at the centre of high-quality care and treatment in secure settings (Jobbins et al, 2007). Therefore if this is also apparent in healthcare staff it may be detrimental to the quality of care provided; in healthcare settings the provision of emotional support is routinely part of care and staff play a crucial role in treatment and recovery.

It has been estimated that in one year 84% of psychiatric nurses will witness self-harm and 68% a suicide attempt (James et al, 2012). Worryingly however nursing staff have previously identified self-harm as the characteristic they found most difficult to work with (Saunders et al, 2012). A survey exploring adverse events with 280 healthcare staff revealed that in over half the cases suicide had the greatest impact. . One in eight respondents considered quitting their job as a result and almost 18% believed that the quality of care they provided was affected for longer than one month (Martens et al, 2016). Staff described a lack of understanding and feeling overwhelmed and powerless, leading to feelings of anger and frustration at service users(Wilstrand et al, 2007). Hospital staff have also reported finding it difficult to negotiate the different requirements of caring for those who self-harm, including boundaries of closeness but also distance, caring as well as not providing too much attention, and ensuring safety, as well as maintaining dignity (Wilstrand et al, 2007). Subsequently, staff working to support people with self-harm and suicidal behaviour, are particularly at risk of providing maladaptive responses, such as negative feelings and a focus on diagnosis and risk assessment, potentially impairing more adaptive responses such as containment of distress and safety planning (Smith et al, 2015). Positive attitudes, person-centred care and hope have all been found to be central to improvement in mental illness (Cleary et al, 2013). Indeed staff responses can directly contribute to self-harm (James et al, 2012) therefore; ensuring that members of staff are also adequately supported will enable them to provide better quality care.

Considering the high prevalence of self-harm and suicidal behaviour in forensic settings there is a high likelihood that patients will have been exposed to another person's self-harm and suicidal behaviour, potentially leading to negative consequences detrimental to recovery. Staff members are a vital source of support but are also at risk of distressing or

negative reactions, which may detract from the care provided.

Aims

The aim of this research was to use qualitative methods (Flick, 2009;) to explore the experiences of staff and patients in a male medium-secure mental health unit who have experienced self-harm and/or suicidal behaviour in other people.

Method

Participants

A convenience sample (Marshall, 1996) was selected for data collection. Convenience sampling is a form of non-probability sampling; participant's self-referred and all eligible participants (with consultant approval for patients) were included. Eleven participants were interviewed- six male patients and five members of staff, 3 male and 2 females. Staff held a variety of roles, both qualified and unqualified including clinical, managerial and administration.

No further participant information is provided in order to protect anonymity.

Interviews

The first author undertook qualitative interviews face to face in a private room within the hospital during summer 2016. Interviews followed a semi-structured interview schedule, informed by the literature review and lasted an average of 30 minutes. They were digitally recorded with participant's consent, obtained in writing before the interviews. Participants were invited to discuss their experiences of self-harm and suicidal behaviour in other people and what aspects are important when providing and receiving support.

Analysis

Data was analysed following Interpretative Phenomenological Analysis (IPA) guidelines (Smith et al, 2009). IPA was chosen as it provides a framework to understand how participants make sense of lived experiences and is centrally concerned with the meanings that such experiences hold for participants.

Interview recordings were transcribed and repeatedly read by the researcher. Initial analysis demonstrated that experiences could be grouped into broad themes which. were then agreed with a second author and re-checked across the data to confirm validity. This consolidated information supplied by participants and provided a coherent overview of their experiences.

An IPA was then applied to the information within each theme. The researcher further familiarised herself with the data, noting anything of interest in the margin. Using this information, themes were identified which depicted the experiences of each person. These themes were compared between each of the transcripts to identify recurrent patterns, agreed with another researcher and culminating in, a set of super-ordinate themes:, *the impact of suicide and self-harm; the role of others; and the importance of understanding and experience.*

Ethical considerations

Participants had an information sheet containing assurance of anonymity, information regarding the study, voluntariness of participation and the possibility to withdraw. Written informed consent was obtained prior to interview and the findings presented in a way that no one could be recognised. Ethical approval was granted by West Midlands - Solihull Research Ethics Committee (16/WM/0168) and NHS permission from Nottinghamshire Healthcare NHS Foundation Trust.

Results

Following the application of the IPA analysis to the interview transcriptions, three dominant themes emerged: “the impact of suicide and self-harm”; “the role of others” and “the importance of understanding and experience”. Quotes are included to illuminate the context and meaning of the themes. Data from patient transcripts are identified by ‘PP’ and staff transcripts by ‘PS’ .

The impact of suicide and self-harm

Participants felt that the impacts of witnessing other people’s self-harm and suicidal behaviour were linked to their relationship with the person, regardless of whether this was personal or professional:

> “If my mum started doing it, it would upset me yeah or my sister er if she started doing it, it would upset me obviously coz its part of me isn’t it …” (PP6)

Desensitisation

Desensitisation was highlighted by both staff and patients and related specifically to experiencing self-harm and suicide in other people:

> "(I)t shocked me and but it just become, it just seemed to be normality, that self-harm for people in prison is normal in that instance." (PP5)

> "(Y)ou've seen it that much its like, I say you get desensitised to it" (PS2)

There was a reduction in impact of self-harm and suicidal behaviour for both staff and patients over time. Previous research in prisons found that staff who became desensitised reported increased negative feelings towards prisoners which could affect both prisoner interaction and job satisfaction (Kenning et al, 2010). This was not reported in this research; however staff did acknowledge that previously there had been negative feelings. With regard to recent incidents good therapeutic relationships were reported, which were perceived to reduce negative feelings as a consequence of self-harm and/or suicidal behaviour. This is perhaps unsurprising since there is clear evidence that relationships are central to recovery and well-being (Tew et al, 2011)

Self-harm

Many patients reported own self-harm as a result of experiencing other people self-harming:

> P: [pause] Well, I from mates here that I've known of a mate cutting themselves it upset me and angered me
> I: mmmhmmm, and is there anything that you did as a result of being upset or angry?
> P: Yeah
> I: What did you do?
> P: I cut myself (PP2)

> "I was sat there and I'd got no cuts on my body whatsoever and I was just sat there and I saw the state. I saw what he'd done. I saw the state he was in and … that started the ball rolling." (PP5)

If self-harm becomes more familiar, inhibition may be reduced as non-suicidal self-injury desensitises an individual to self-harm, thereby increasing acquired capability to attempt suicide (Wester et al, 2016). A previous study of self-harm in psychiatric inpatients found it to be highly contagious, with clusters of incidents (Beasely, 1999).

Alternatively, other people discussed how observing others self-harming may a helpful means of coping with distress.

> "I'm going to self-harm because they'd seen so many people do it themselves they thought if its working for that person it's worth it for them" (PP1)

Should self-harm be viewed as helpful it could potentially become a way of coping. This places emphasis on ensuring other coping techniques and support are in place and allowing open discussions about self-harm to ensure this is not misconceived as beneficial.

Emotions

Throughout the interviews, staff and patients acknowledged a range of *emotions* they had felt in response to others' self-harm and suicidal behaviour:

> "I still live with that as a guilt trip" (PP4)

> "I just couldn't make sense of it and I couldn't understand why and that had a traumatic effect." (PP5)

> "(Y)eah staff are traumatised … er and staff take personal responsibility." (PS4)

> "(T)hey'll sometimes feel all the signs of bereavement almost, the grief, the anger." (PS4)

The emotions described by staff in this setting are different to those previously described in prison studies (Marzano et al, 2015). Members of staff are not describing frustration or negative feelings towards patients. Rather staff described a sense of loss and trauma. . One reason for the different emotions might again be due to good therapeutic relationships. Within prison environments security tends to take precedence over welfare (Short et al, 2009) and so the relationship between prison staff and prisoners is likely to be different. Since participants felt that impact was linked to relationship it is reasonable to assume that this impact will also differ.

Desire to Help

A final impact identified in most of thepatient interviews, was the *desire to help*:

> "(O)ver years you begin to understand why people are doing this a bit more and you start wanting to try and help those people" (PP1)

> "I wish I could have helped him or understood him." (PP3)

This was not as prevalent in staff interviews, possibly due to staff being in a position where they can and do help. This is an important impact as it is arguably the hardest to resolve; in some situations there may be little that patients can do to help, potentially leading to incongruence:

> "(D)efinitely, it's not just about me wanting to help somebody else. It is a part of that but it's about me helping mysen (sic) as well because you know you know when I self-harmed myself I needed, it was a cry for help and I needed somebody to reach out to me and it just feels like I want to do exactly the same. I want to reach out to somebody who's in need." (PP5)

In practice this need could be met by the facilitation of peer support. There is evidence for the effectiveness of peer support for a range of situations (Davidson et al, 1999) and the benefits of shared experiences suggest that this may be useful for patients affected by others' suicide and self-harm. Such benefits include an increased sense of empowerment (Corrigan, 2006, Resnick & Rosenheck, 2008); improved self-esteem and confidence attributed to shared development of solutions, exploration of feelings and the normalisation of emotional responses (Mead & Macneil, 2006); increased social support and social functioning (Davidson et al, 2004; Forchuk et al, 2005) leading to more successful community integration (Maton, 1990); and a sense of acceptance and empathy (Davidson et al, 1999). Feelings of compassion, resulting from shared experiences, have been associated with increased helping behaviour and the pro-social benefits of self-affirmation that can occur when helping others, should not be dismissed with regards to treatment and recovery (Lindsay & Creswell, 2014).

The role of others

A second theme identified during analysis was the role of others. Other people were viewed as having a key role in helping to limit or recover from the impacts of experiencing another person's self-harm and suicidal behaviour.

Talking

The opportunity to talk about experiences was highlighted as the most important form of support both for staff and patients:

> "(T)alking's the only thing that can really help, with something like suicide and self-harm, people can throw every other suggestion they want at you but it doesn't work, nothing else does." (PP1)

> "I think I've resolved it through talking" (PS2)

Support

However, while talking is clearly important, the participants felt that the role of others goes beyond that. The importance of *support* was consistent in both staff and patient interviews, however where the support came from and what it involved differed between groups. Even just knowing that another person was there made a difference to the patients:

> "(B)e there for them, I guess that's the only thing anyone can do really." (PP1)

> "I think in here it's, you're living in an environment where you know your patients and your staff try to work as close as possible. If I were to self-harm today … you know, that there's people I can reach out to and even if I felt like that, you know, I'm in a process where I can go to somebody and say listen, I'm struggling. In prison when you self-harm … you don't go to a prison officer and say "can you put me downstairs cause I'm going to kill --- hurt myself" cause they're not interested." (PP5)

This is clearly something that the patients appreciate in a hospital environment, which patients perceived did not occur when in prisons. The patient's feeling that there is someone to turn to is not inadvertent, the staff also recognise this as an important factor:

> "(W)hen patients come here they're better supervised, better observed, more understanding staff and people can listen to them, help them to find coping mechanisms and what have you in prison? It seems like people are left a bit more hopeless" (PS4)

Therefore, it is also important for staff to be adequately supported since staff experiences of self-harm can have a negative impact on patient care, for example, providing maladaptive responses (Smith et al, 2015).

With regards to support, staff also identified the benefits of other people However, often this was not necessarily a person fulfilling a professional role (e.g. a counsellor) rather peers were important as they had a shared experience, which the staff found helpful:

> "Yeah and they can understand you more than somebody who, you know it's it might just be a job to them type of thing to talk to you know and you can't really, some people like me. I wouldn't be able to let my true feelings out er I think to like a stranger type". (PS2)

> "So I didn't. I thought I'm not going to have counselling. I'm not going to. Why do I need to go to a debrief for and talk about it? … I was quite negative at the time. I suppose it's part of that whole situation but afterwards during I thought actually I've really … benefited from this. I was thinking yes you were there you knew you saw that look yes you saw that you've got this and you saw this. You witnessed everything and that the emotion and everything and you know the severity of what it felt like …so no I would. I think it was erm very helpful a big thing" (PS1)

> "(W)hereas you get everybody together it gives the whole picture so you've got a better understanding of the facts er 'cause that helps put things to bed if you like, and have a resolution in your head, so you do the facts you do the feelings cause you then start to realise that others have the same feeling, of the grief and they don't feel upset that they feel upset because they see that everyone else is feeling the same way." (PS4)

The subtheme of *support* has raised several points to consider. Firstly, while the patients do feel supported, they rely solely on staff and therefore staff wellbeing and attitudes are key factors of patient support. Furthermore, while patients have previously highlighted the desire to help others, they do not see other patients as a support network. Secondly, shared experiences are imperative to staff therefore, a peer support network, such as debriefing, for staff to share experiences should be encouraged and supported. It is important to acknowledge that this may also be the case for patients; previous research has identified the positive role that peers have; both on recovery (Laithwaite & Gumley, 2007) and the quality of life in prison a setting (Crewe et al, 2011).

The importance of understanding

Experience was also perceived by participants to increase understanding which both staff and patients identified as important in relation to suicide and self-harm:

> "(I)f you're in prison you feel like no one understands you 'cause you haven't got the support and people to help you but here people understand how you're feeling … and get the support when I feel like that." (PP3)

> "It's not the action that we need to tackle. It's the underlying issue of why they've done that and it's not as easy as saying don't do it … and understanding why they're doing it and you get the patient to understand why they're doing it because sometimes they don't know either."(PS4)

More specifically, through certain experiences, participants felt able to better understand the perceptions of others. Increased understanding may be associated with positive attitudes towards self-harm and suicide and a desire to try and help:

> "(Y)eah, I try I feel more for people that go through it and I understand what they're going through and and I've got a bit more tolerance and like and I try and help them a bit more." (PP3)

> "I think if you you've got somebody like that who understands exactly what you're, what you're going through, it becomes a lot easier because you can you're making associations that well "he knows because he's done it himself"." (PP5)

> "(M)ajority are experienced staff and so it's got erm there's not a negative feeling about self-harm. They can understand why people self-harm and want to support people who self-harm, rather than the early days of "oh they're just wanting bloody attention and they're just wanting this they're wanting that." I think it's that was the early days when we were inexperienced." (PS1)

Again this demonstrates the benefits of sharing experiences and peer support.

Training and Education

While experience was identified as important, recently the prevalence of suicide and self-harm at the hospital has declined which raises the question 'how do staff gain experience?'

Many participants identified a need for *training and education*. This was not necessarily identified as being self-harm specific for hospital staff but was recognised as important in a wider context:

> "(P)eople just didn't understand self-harm and and I think that until you educate them about self-harm it's just going to keep happening." (PP5)
>
> "(W)hy can't people learn about it, they should, people should be educated about mental health in … in school or in prison or, you know, they should but no-one's educated about it that much" (PP3)
>
> "I think there's a lot of deeper work and hopefully were starting to getting (sic) that across to staff, like I said new staff come along and it's about trying to educate them again" (PS4)

In a previous study, active training was found to lead to consistent improvements in attitudes and knowledge across wider healthcare settings (Saunders et al, 2012) and is worth considering.

Need for Clarity

Additionally the *need for clarity* was also a subtheme present in the data from both patient and staff interviews. A need to understand the situation and opportunity to make sense of what happened was highlighted as important to accept the situation and limit negative impacts:

> I: What has helped at that point do you think?
>
> P: Someone someone telling us how, what, how, why, why people start feeling like that and why they do the things they've done, and stuff like that. (PP3)
>
> "(S)omeone to let us know how they're doing and if they have got better and and like if they have gone to hospital and and if and and you know just to understand if they're getting, just to know if they're getting proper if they're getting well again or summat." (PP3)
>
> (D)ebriefing's very good 'cause we look at the facts, feelings and future so it gives everybody the full facts." (PS4)

Therefore, when trying to manage situations, rather than attempt to offer protection by limiting information provided, it may be more beneficial to provide updates, where appropriate, and clarity, as to what is happening. Thus promoting self-awareness and providing reassurance as opposed to increasing distress due to limited communication. The opportunity to debrief after an event was described by staff as beneficial may potentially be for patients also. Developing

an understanding as to what happened and why may also be helpful in is also the final link in accepting the situation and moving forward:

> "(W)hat I've learnt over bereavement counselling… if somebody's going to take their own life it doesn't matter what you put in place or what you do to resolve it if they get a chance if they're going to do it they will do it." (PP4)

Conclusion

Participants identified a variety of negative impacts which they believed were a result of observing another's self-harm and/or suicidal behavior. Many patients and staff had experience of prison and agreed that the hospital environment is fundamentally different to that of prison. It was reported that this group of hospital staff have a different and more therapeutic relationship with the patients and the impact appeared to be distinct from other research findings. Desensitisation was highlighted by both staff and patients; previous research has found desensitisation to be linked to negative attitudes towards self-harm (Kenning et al, 2010), but the results of this research do not reflect this and rather it appears to serve as a coping technique For patients however in some cases desensitisation has actually led to self-harming which is problematic as desensitisation has also been identified as a risk factor for suicide (Wester et al, 2016). Therefore, services likely need robust risk assessment, formulation and risk management plans in place for all patients, not just those presenting with self-harm behavior.

A further impact identified by patients was a desire to help others. Peer support was identified by staff as being helpful and is something, which, if appropriately facilitated may also be beneficial for patients. A range of positive benefits have been associated with helping others, such as feelings of compassion and self-affirmation (Lindsay & Creswell, 2014) which can only be advantageous to recovery. However, many challenges are involved in the development of peer support and careful training, supervision and management of all involved would need considering (Repper & Carter, 2011).

Patients described relying entirely on staff and do not see other patients as being part of their support network, which staff should be mindful of. Availability of staff is something to consider in order to promote open discussion as confusion and uncertainty around situations appears to further increase negative impacts. If appropriate to do so ensuring both staff and

patients are aware of all the facts and allowing opportunities to debrief may reduce negative outcomes.

A final consideration is the importance of training and education in increasing understanding to improve attitudes towards those who are self-harming and/or engaging in suicidal behavior. This is particularly important when staff do not have such experiences.

This study was limited to the experiences of staff and male patients at one medium secure hospital and further research in other settings would create a broader picture. The participants were selected by self-identification, which may have affected the results, with the potential that participants who were not as affected by such experiences did not volunteer to participate. Finally the researcher completed all data analysis and whilst every attempt was made to remain impartial experiences and attitudes may have influenced the results.

Implications For Practice

- Options for peer support for both patients and staff should be explored and facilitated to reduce negative outcomes if possible
- Staff should be mindful to provide information, where appropriate, when self-harm and/or a completed suicide incident occurs as patient uncertainty and lack of understanding and / or communication could increase negative impacts
- Staff training and education in self-harm / suicide prevention and management is warranted across forensic services.

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