



Adolescents who self-harm: Professional staff knowledge, attitudes and training needs

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A B S T R A C T

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This study aimed to investigate professional staff attitudes and knowledge about adolescents who engage in self-harming behaviour and to identify training needs. Previous research has suggested that medical and health care staff perceptions may reinforce the stigma associated with such behaviour and therefore jeopardise the effectiveness of interventions. To date, no available research exists on the views of school teachers. Participants recruited for the study were 120 qualified professionals working within an Accident and Emergency Department (A&E), Child & Adolescent Mental Health Services (CAMHS) and a Secondary School, based within the West Midlands, United Kingdom. Results demonstrated statistically significant differences between the groups. CAMHS staff were more knowledgeable and felt more effective than either A&E staff or teachers, whereas A&E staff expressed more negative attitudes. 95% of all staff reported that they would benefit from further training. These findings are discussed in relation to practice issues.

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Introduction

Deliberate self-harm behaviour is a major concern for UK health care systems. The prevalence, repetition and the potential for suicide make this one of the greatest challenges for staff. Alarming, the UK has one of the highest rates of adult self-harm in Europe, at 400 per 100,000 population (Horrocks, 2002). Similarly research points to high rates of adolescent self-harm behaviour that is worthy of attention.

A national survey conducted by Meltzer, Gatwood, Goodman, and Ford (2000) of more than 10,000 children in the UK during the first half of 1999 found that the prevalence of self-harm among 11–15 year-old age group was 1.2% among those without any mental health issues, but rose to 9.4% among those diagnosed with an anxiety disorder and 18.8% in those diagnosed with depression. The prevalence was between 8 and 13% for children with conduct, hyperkinetic or less common mental disorders.

Hawton, Fagg, and Simkin (1996) estimated that about 19,000 adolescents under 16 years of age are admitted to Accident and Emergency departments (A&E) each year in England and Wales after attempting suicide. This figure increased to 25,000 adolescents following non-fatal deliberate self-harm. Self-harm becomes even more common after the age of 16 years; a later

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survey (Hurry & Storey, 1998) found that more than 60,000 young people aged 12–24 presented at A&E departments with recognised self-harm in 1996–1997, half of whom were admitted as in-patients. This figure may be an underestimation as many people do not seek help after an episode of self-harm (Turp, 1999). Furthermore, A self-report survey of more than 6000 pupils aged 15–16 in the UK found that almost 400 (6.9%) had self-harmed in the previous year (Hawton, Rodham, Evans, & Weatherall, 2002). Hawton, Hall, and Simkin (2003) also found that the numbers of girls who engage in self-harm behaviour was increasing.

Research has also shown that self-harm is often not a singular occurrence, but is commonly repeated and that the resulting pressure on services affects response to the assessment and treatment of self-harm (Hawton, Fagg, Simkin, Bale, & Bond, 1997). The investigation of self-harm behaviour in adolescence is important because initial self-harm in some young people may signal the start of a process of repeated self-harm, ultimately leading to completed suicide (Joiner, 2002). Those young people who do not present to services and therefore do not receive treatment may be at further risk (Hawton, Houston, & Shepperd, 1999).

Although the National Suicide Prevention Strategy for England (Department of Health, 2002) highlighted the need for improved management of patients who engage in self-harm behaviour, up to half the adolescents in the UK receive no formal therapeutic intervention following presentation to A&E departments for deliberate self-harm (Clarke, 2001; Nadkarni, Parkin, Dogra, Stretch, & Evans, 2000). Furthermore, a history of self-harm has been identified as a significant risk factor for suicide, with repeated episodes more likely to result in suicide than single episodes (Zahl & Hawton, 2004). Equally, concerns have been raised not only about inadequate standards of care and management, but also about negative attitudes received from frontline staff directly involved in the care of people who self-harm (NICE, 2004).

Turp (1999) proposed that self-harm behaviour should be seen as a multi-professional issue because those who self-harm may seek help from, or be referred to, a variety of different professionals within the community, such as GPs, social workers, A&E nurses, teachers, community mental health nurses and psychiatrists. This suggests the need to explore staff understanding and knowledge of adolescent self-harm behaviour across a wide range of professional areas.

House, Owens, and Storer (1992) suggested that there was a general perception amongst hospital staff that treatment of adult patients who self-harm was ineffective, leading to ambivalent staff behaviour towards assessment and subsequent referral for psychiatric follow-up. Furthermore, they reported that physicians had a more favourable attitude towards patients whose motives were interpreted as “wanting to die” than those whose behaviour was seen as “manipulative”.

Health professionals may be susceptible to prevailing stereotypes about adolescents who engage in self-harm behaviour (for example, that they are attention seeking and manipulative, Pembroke, 1998a, 1998b), which may have implications for their judgements. Staff in these services may therefore struggle to work effectively with the complex needs of this client group. Furthermore, inadequate training or understanding about adolescents who engage in self-harm behaviour may result in staff feeling unskilled and unsupported in caring for these clients (Crawford, Geraghty, Street, & Simonoff, 2003; Sprague, 1997).

McGaughey, Long, and Harrison (1995) argued that communication difficulties, together with the interplay of previously held perceptions, can reinforce the stigma associated with deliberate self-harm behaviour and jeopardise the effectiveness of professional interventions. Barriers can be erected between the professional and the young person because of such misunderstandings and/or a lack of knowledge concerning the reasons underlying adolescent self-harm behaviour.

In contrast, some studies have shown that health care professionals have positive and sympathetic attitudes towards adults who engage in self-harm behaviour, although variation exists between the attitudes of different professional groups (Platt & Slater, 1987). For example, a staff survey conducted within an A&E department suggested that nurses displayed generally positive and sympathetic attitudes towards patients who engage in self-harm behaviour (Sidley & Renton, 1996). Over 75% of the nurses in this study reported that these patients should have equal rights to medical treatments. However 55% also regarded self-harm as a form of “attention-seeking” behaviour. Therefore understanding staff appraisals about the reasons why young people self-harm may be key to improving care pathways and improving training.

Previous research has highlighted the importance of staff attitudes towards adults who engage in self-harm behaviour as these may adversely affect treatment outcomes (Arnold, 1994; Tantam & Whittaker, 1992). However, with the exception of two papers reported below (Anderson, Standen, & Noon, 2005; Crawford et al., 2003), and a report from the Samaritans (2005), little work has focused on adolescents.

In the UK, Crawford et al. (2003) investigated knowledge, attitudes and training needs of a variety of professionals involved in the assessment and management of adolescents who engage in self-harm behaviour. They found that staff who felt more clinically effective felt less negative towards adolescents who had engaged in self-harm behaviour and that 42% of participants wanted further training. Crawford et al. and Sprague (1997) identified a need for more systematic training for all staff groups with particular emphasis on providing support networks, regular supervision and improving links between paediatric and child psychiatric services. They proposed that training should focus on misconceptions and on education about young people who harm themselves particularly those at high-risk of potential suicide in the future.

Anderson et al. (2005) explored the range of perceptions held by nurses and doctors practising in an A&E department and child and adolescent community services towards young people who have been admitted following an episode of self-harm. The analysis illustrated that nurses and doctors perceived self-harm behaviour as a powerful form of communication and that “establishing effective communication with people who self-harm is recognised as an essential part of preventing further self-harm and suicide” (Anderson et al., 2005, p. 318).

In an extensive report, the Samaritans (2005) argued that since the vast majority of pupils who self-harm do not go to hospital, prevention may need to take place in the community, ideally within schools. They suggest developing educational

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