ORIGINAL ARTICLE

Nurses knowledge and attitudes to individuals who self-harm: A quantitative exploration

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ABSTRACT

Objective: Self-injury can be described as the deliberate destruction of the body without the intent to die, and is a distinct clinical presentation needing to be assessed separately from suicide and para-suicide. Nurses attitude to self-injury is a largely unexplored area particularly within Australia. The aim of this paper is to explore Australian general and mental health nurses' attitudes towards self-injury taking into account their preparation as registered nurses (RNs) or enrolled nurses (ENs) and length of experience.

Methods: This was a mixed methods exploratory design study. Phase one used a combination of two established surveys, the Self-Harm Antipathy Scale (SHAS) and the Attitudes Towards Deliberate Self-Harm Questionnaire (ATDSHQ). Nurses who were either RNs or ENs, mental health educated (MHE) or not, working in the area of mental health or emergency departments (ED) were recruited through a number of professional nursing organisations. A total of 172 nurses completed the phase one online questionnaire. The results of this survey are reported in this paper.

Results: The key findings indicated a significant relationship between years of mental health nursing experience and mental health nursing qualification. A significant difference was noted in the knowledge level of self-injury between the mental health nurses who had a greater knowledge compared to those who were not mental health educated. Lastly, the attitudes of nurses to self-injury were generally found to be positive.

Conclusions: These results extend much of what is in the literature on knowledge, attitudes and beliefs of nurses to non-suicidal self-injury (NSSI) and place these results in an Australian context. Further research to assess the effectiveness of increased education and community engagement should be undertaken.

Key Words: Self-injury, Nurses, Mental health, Attitudes, Knowledge

1. INTRODUCTION

The phenomenon of non-suicidal self-injury (NSSI) is an area that has been explored, to a degree, in previous literature.[1–3] NSSI involves actions such as deliberate self-cutting or burning, in the absence of expressed suicidal intent.[4] This is a distinct field needing to be seen separately from suicide and para-suicide.[5,6] Self-injury needs to be understood as a meaningful behaviour displayed by the person in order to regulate emotions and stress.[7–9] In fact, the act of self-injury is aimed at the individual self-integrating and preserving life.[10] As a psychological issue that has in the past been conceptualised as a maladaptive coping mechanism, self-injury is complex, and can be seen as a strategy for disconnection from the self and others.[11]

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2. LITERATURE REVIEW

A literature search of CINAHL, Scopus, Pubmed and Proquest databases was performed using the terms NSSI, self-harm, registered nurses (RNs), enrolled nurses (ENs), mental health nurses (MHN), and attitudes to identify articles from 2000 to 2015. This revealed 45 articles whose abstracts were then screened for appropriateness. Seventeen international and two Australian articles were excluded due to there being a mix of medical and nursing staff. This resulted in a total of 32 articles, including nine from Australia being reviewed.

The incidence of NSSI is approximately 4% of the adult population worldwide with 21% of the clinical population engaging in NSSI, and life-time prevalence among adolescents of 17%.[12] The clinical population are individuals who are diagnosed with an identifiable mental illness.[13] However, it is difficult to accurately diagnose an individual who engages primarily in NSSI with any diagnosis within the American Diagnostic Association.[13] It is, therefore, only a minority of individuals with NSSI that have an associated mental health diagnosis.

The incidence of NSSI however, may well be underestimated as NSSI is well hidden in society. Statistics on the incidence and prevalence of NSSI are generally unreliable because NSSI remains a social taboo.[14] Many episodes of NSSI occur in private, are treated by the individual and do not reach the attention of the nurse.[9] Hence, an accurate identification of incidence of NSSI is hindered by individuals who continue to avoid health care.[9]

Self-injury remains a controversial issue that few nurses understand. Terms such as "deliberate" and "intentional" have negative connotations when used with self-injury.[15] Such terms imply that the individual could stop self-injuring if they wanted to, or that indeed they could exercise control over what they are doing but these are common misconceptions.[16] Self-injuring is not an attempt by individuals at manipulation, but rather a manner of expressing extremely unbearable inner pain,[15,17,18] a condition that many nurses misunderstand.

The misunderstanding between the meanings of the intentions of the self-injurer creates significant challenges for health professionals such as nurses who have the responsibility for providing supportive care.[19] The literature reports a tendency for nurses to feel negatively regarding NSSI.[20–22] The studies showing negative and punitive nurses attitudes towards NSSI included reports from services users themselves about treatment and care after self-injuring.[15,16,18,23] Important influencing factors on nurses' attitudes were found to be the fact that NSSI is self-inflicted and often repetitive.[24] These negative attitudes were thought to be due to the lack of education of nurses about NSSI.[2,9,25,26] There was a recommendation from these studies for a need for further education at an undergraduate and postgraduate level.[8,9] Some studies revealed,[27] however, positive attitudes towards NSSI, but this occurred less frequently than studies reporting negative attitudes. Where researchers noted nurses' views are predominantly positive,[28] McHale et al. also noted that education is an antecedent to more positive attitudes and increased knowledge about NSSI.[22]

One study revealed both positive and negative attitudes from nurses towards self-injury,[26] unlike other studies that discussed either negative or positive attitudes in isolation.[22] Although the majority of the participants in this study were mental health educated (MHE) nurses, the questionnaire also captured the views of some general nurses.[26] The study showed that attitudes were not simply negative or positive but rather there were a variety of different levels of responses with nurses' not necessarily demonstrating antipathy.[26] Further, the study showed that some nurses were clearly unprepared to work with NSSI and some clearly believed they lacked the skill set to work with these individuals.[26] This research was undertaken prior to the nurses' undertaking a course on "Approaches to self-harm", which supports this claim. The study concluded that identification of antipathy is not in itself sufficient to affect the care provided to the self-injuring individual.[26] The fact that these nurses were wanting to gain more knowledge on NSSI in itself meant they were more positive to begin with.

Nurses attitude to self-injury is a largely unexplored area particularly within Australia.[29] Much of the research on nurses' attitudes, however, has been collected using a variety of methodologies and not standardised structured instruments.[26] This may have an impact on the reliability of the findings from these studies. Most research on NSSI and nurses' attitudes towards this phenomenon has been completed in the UK[4,30–32] with a small number of studies in Australia.[9,25,33] Furthermore, none have investigated MHE nurses, or ENs attitudes regarding this behaviour. The education for nurses' towards NSSI over the previous years has been more detailed and thorough in content with little evaluation of the possible effect of this. Additionally, the literature does not reveal whether there has been a cultural shift over time and how this currently affects nurses' knowledge, attitudes and beliefs toward NSSI. This study aimed to address this gap.

3. METHODS

This study reports on one aspect of a larger mixed methods design which was used to assess nurses' attitudes, knowledge and beliefs towards individuals who engage in NSSI. As there

was little knowledge about nurses' attitudes and knowledge towards the self-injurer, this study used an explorative descriptive design where both quantitative and qualitative data were sought. Phase One, the quantitative phase undertook data collection using questionnaires and the results from this phase will be presented in this article.

Nurses who were either RNs or ENs were invited to participate in this study. The nurses were required to be currently registered with the Nursing and Midwifery Board of Australia, and hold membership with a professional nursing organisation. This study invited nurses employed in metropolitan public and private hospitals, emergency departments (ED) and mental health facilities in rural and remote areas across Australia to complete an online survey. The nurses were either RNs or ENs with or without mental health qualifications; and ENs with or without medication endorsement.

The professional nursing organisations that were accessed for the research study included: the College of Emergency Nurses' Australia (CENA), Senior Psychiatric Nurses Association, the Australian College of Nurses (ACN), the Australian and Midwifery Nursing Federation (ANMF), Health and Community Services Union (HACSU), and the Australian College of Mental Health Nurses (ACMHN). All were contacted by telephone by the researcher to assist with the recruitment of participants. Advertisements of the research were emailed to all professional nursing organisations contacted for placement on their websites along with a link to the survey. Prior to starting the survey there was a plain language statement for the participants to read. Consent was implied by the completion of the survey. Data was collected between January 2013 and December 2013. Ethical approval from the RMIT University Human Research Ethics Committee was granted prior to commencement of the study.

Demographic information was sought from the participants, including gender, age range, whether the participant was a RN or EN, if the participant held a mental health nursing qualification and if so, what type of qualification, the participant's current position, the type of hospital where the nurse was working, years of experience as a mental health nurse, years of nursing experience in any field generally, educational achievements, whether they were employed in a metropolitan or rural service, and whether this was a private or public facility.

The second tool used in this study was formulated by using two previously validated questionnaires in the literature: Attitudes Towards Deliberate Self-Harm Questionnaire - ATDSHQ[8] and the Self-Harm Antipathy Scale (SHAS).[26] Forty-three Likert Scale items were derived from the SHAS[26] and ATDSHQ[9] and compiled into a Qualtrics survey. Each of these surveys measured different aspects regarding nurses' and NSSI. The items from the ATDSHQ[9] measured whether or not the attitudes of nurses towards self-injury were positive or negative and the depth of knowledge nurses held about NSSI, the educational needs of nurses about NSSI and feelings towards self-injury and consequential feelings of disempowerment were included in the on-line questionnaire. Whereas, the SHAS[26] assessed beliefs and knowledge of the nurses towards NSSI, moral concerns the participant held about NSSI and the individual who self-injurers. Positive or negative attitudes towards NSSI, and thoughts that the nurse holds about the individuals who engage in such behaviour were also surveyed from the SHAS and the ATDSHQ. A reliability study of the 43 item research tool revealed an overall Cronbach's alpha of 0.901 demonstrating reliability of the instrument. Data was analysed using the Statistical Package for the Social Sciences (SPSS) Version 21 (SPSS Inc., Chicago, IL, USA). Chi-Square tests were used to analyse the demographic profiles of the participants. Independent sample *t*-tests were used to compare the mean values between groups of participants. To assess the relationship between years of experience, both as a nurse in general and as a mental health nurse, a correlation analysis and a regression analysis were conducted. The level of statistical significance was set at $p < .05$.

4. Results

A total of 172 nurses participated in the study. The majority of the participants were female (76.7%), RNs (88.4%), and between the ages of 40-59 (62.8%). In addition, a large number of the participants (62.8%) reported 16 years or more of nursing experience. Pertaining specifically to mental health nursing, 114 of the participants (66.3%) held a mental health qualification and of those, nearly 41% had 16 or more years of experience specific to mental health nursing. The majority of participants indicated working in a public facility (83.1%) and in a metropolitan location (70.9%). Table 1 provides an outline of the individual demographic characteristics.

In terms of gender and MHE and non-MHE status, a cross tabulation of the two categorical variables revealed a significant relationship ($p = .004$), indicating that a strong majority of males held a mental health qualification (85%), compared to 61% of the female nurses in the sample.

Cross tabulations of age groups (chi square = 0.184, $p = .912$), RN or EN status (chi square = 1.288, $p = .256$), and general nursing experience/years worked (chi square = 10.325, $p = .067$) failed to reveal any statistically significant relationship with mental health nursing qualification. Comparison of

years of mental health nursing experience however, demonstrated a predictable relationship with mental health nursing qualification (see Table 2), with a significant chi square (p = .000).

Cross tabulations of these same variables with the EN versus RN status in order to reveal any differences in the demographic variables according to nursing status, revealed no statistically significant relationships with gender (p = .186), age (p = .389), years of experience (p = .074), and years of mental health experience (p = .338).

The cumulative attitude scores for the entire sample ranged from 106 to 163 with a mean score of 130.30, a standard deviation (*SD*) of 12.0. Scores for MHE nurses demonstrated a mean of 130.78 (*SD* 12.1) and for non-MHE nurses, a mean of 129.26 (*SD* 11.9). Thus, the mean scores for the entire sample, as well as for both the MHE nurses and non-MHE nurses were in the positive attitude range of possible scores, as the calculated neutral score over all 43 items was 107.5 based on a possible range of scores from 43 to 172. However, there were no significant differences in these attitude scores between MHE and non-MHE nurses (p = .487).

The mean attitude score for MHE nurses working in the ED was 130.40 (*SD* 11.22) compared to the non-MHE nurses with a mean score of 126.58 (*SD* 12.89). For RNs the mean survey total attitude score was higher at 134.1 (*SD* 12.3) compared to ENs with a mean score of 129.6 (*SD* 11.53). Results of the independent samples t-test failed to support significant differences in mean scores between the MHE and non-MHE nurses working in the ED (p = .574) and between ENs and RNs (p = .182).

Table 1. Demographic characteristics of the participants (N = 172)

		n	%
Gender	• Male	40	23.3
	• Female	132	76.7
Age	• 22-39	49	28.5
	• 40-59	108	62.8
	• 60+	14	8.1
	• Missing	1	0.6
RN or EN	• RN	152	88.4
	• EN	20	11.6
General nursing experience	• 0-11 months	3	1.7
	• 1-3 years	10	5.8
	• 4-6 years	19	11.0
	• 7-10 years	13	7.6
	• 10-15 years	19	11.0
	• 16+ years	108	62.8
Mental Health Qualification	• yes	114	66.3
	• no	58	33.7
Years Mental Health Nursing Experience	• 0	29	16.9
	• < 12 months	13	7.6
	• 1-5 years	21	12.2
	• 6-10 years	19	11.0
	• 11-15 years	20	11.6
	• 16+ years	70	40.7

Table 2. Cross tabulation of years mental health nursing experience and mental health qualification

		Mental Health Nursing Qualification		Total
		Mental Health Qualification	No Mental Health Qualification	
Years of Mental Health Nursing Experience	• 0	0	29	29
	• < 12 months	1	12	13
	• 1-5 years	17	4	21
	• 6-10 years	14	5	19
	• 11-15 years	18	2	20
	• 16+ years	64	6	70
Total		114	58	172

Note. Chi square = 104.29, df = 5, p = .000

Separating out the survey items specific to nurses' knowledge of self-injury, there was a higher mean score among MHE nurses (M = 27.59, SD = 2.85) compared to non-MHE nurses (M = 25.66, SD = 2.73). These items generally asked about beliefs (items 1, 26, 27), morality (items 9, and 28) and knowledge (items 2, 29, 32, 36). This difference in knowledge scores between MHE and non-MHE nurses was statistically significant (p < .001). For each survey item, specific differences between the two groups were analysed and significant differences were noted for nine survey items. Table 3 includes these items and for all of these the MHE nurse group scored significantly higher.

5. Discussion

Based on demographics, the results for the study are comparable to the statistical data for nurses in Australia (Australia

Health Practitioner Regulatory Agency[34] with four in ten general nurses and ENs being greater than 50 years of age. In total there were 256,794 RNs and 59,112 ENs registered to practice in 2014,[34] which is comparable to the proportion of RNs and ENs for this study.

Table 3. Survey items with statistically significant differences between MHE and non-MHE

Survey Item	MHE	N	Mean	*SD*	Mean Difference	*p* (2-tail)
1. Self-injury may be a form of reassurance for the individual that they are really alive and human.	yes	114	3.11	0.648	0.355	.001
	no	58	2.76	0.683		
2. Self-injuring individuals can learn new ways of coping.	yes	114	3.48	0.502	0.224	.008
	no	58	3.26	0.548		
9. I can really help self-injuring individuals.	yes	114	2.96	0.637	0.258	.017
	no	58	2.71	0.676		
26. Individuals who self-injure have been hurt and damaged in the past.	yes	114	3.25	0.635	0.272	.013
	no	58	2.98	0.737		
27. I have the appropriate knowledge and communication skills to help individuals who self-injure.	yes	114	2.98	0.532	0.517	.000
	no	58	2.47	0.627		
28. I deal effectively with individuals who self-injure.	yes	114	2.99	0.489	0.302	.001
	no	58	2.69	0.537		
29. I often feel helpless in dealing with the problems of self-injuring individuals.	yes	114	2.65	0.704	0.270	.017
	no	58	2.38	0.671		
32. Overall, I am satisfied with the control I have in dealing with deliberate self-injury in my unit.	yes	113	2.76	0.602	0.313	.001
	no	58	2.45	0.567		
36. Individuals should be able to self-injure in a safe environment.	yes	113	2.31	0.769	0.292	.030
	no	57	2.02	0.916		

According to Mental Health Services in Australia,[35] one in sixteen nurses (a combination of RNs and ENs) employed worked in mental health. Of these, four in five were RNs and one in seven ENs, similar to the profile of the general nursing workforce and the findings of this study. The average age of MHE nurses in Australia was 47 years with three in five (61%) being 45 or older, and greater than 25% was 55 years or older with less than 1 in 20 (4%) being 65 or older.[36] Male gender consisted of 30% of MHE nurses and female was cited as 69%.[36] These demographic findings for MHE nurses in Australia are similar to the data collected for participants in this study.

The findings for this study indicated that there was an overall positive attitude of the participants to NSSI, whilst mental health education and whether an EN or RN, failed to be a significant factor influencing nurses' attitudes. Nonetheless, the literature has identified that nurses' attitudes towards the self-injurer have been related to a number of demographic and employment factors, such as age, length of experience, and previous education about self-injury.[8,25,31,37] For instance, the older and more experienced nurses have been found to have more positive attitudes than the younger and less experienced nurses.[32,38] Likewise, Bailey[33] found that the more experienced the nurse was, the more positive their attitudes were towards self-injury patients. Additionally, as nurses aged their attitudes were found to be more favourable toward the self-injury individual.[37] These findings support the outcomes of the current study where the majority of participants were aged between 40 to 59 years and had 16 years or more of nursing experience.

In relation to gender, studies have shown that female nurses compared to male nurses have more positive attitudes.[24,39] This is supported in another study which added that male nurses felt more irritation towards individuals after acts of NSSI than female nurses.[39] This may provide some explanation for the positive findings for nurses' attitudes for NSSI for this study, given 76.7% of participants were females. Males in this study, however, were found to be more likely to have mental health qualification compared to females (85% versus 61%), which has been previously shown to improve nurses' attitudes to NSSI.[22] It is unclear, however, why this has not influenced their attitude and needs further investigation.

The mean knowledge of NSSI scores were found to be greater for MHE nurses than non-MHE nurses. These results may be reflective of an increased frequency of dealing with these individuals among MHE participants compared to non MHE nurses and the resultant participants' feelings of responsibility for the care of their patients. In addition, the fact is that MHE nurses by their very nature have more education compared to non MHE nurses and would therefore expect to have more knowledge.

It is clear that education is a key factor influencing the attitudes of nurses. Education aimed at targeting negative attitudes and stereotypes may improve therapeutic optimism that encompasses the underlying belief that all individuals are capable of change, and the individual has unique experience.[25] For instance, a study found that nurses with greater than four years of postgraduate education reported overall positive attitudes towards those that engaged in NSSI.[40] McCarthy & Gijbels[37] also found that nurses who were undertaking postgraduate study and those who were further academically advanced, showed more positive attitudes towards the self-injurer. Likewise, education has been shown to improve attitudes in a sample of MHE nurses towards NSSI in a study by Samuelsson and Asberg.[38] Similarly, Patterson and colleagues[26] found that MHE nurses and those that had previous education about self-injury had more positive attitudes than general educated nurses and those who had no self-injury education at all. In contrast, nursing students who have much less education are generally reported to have a negative attitude to mental health nursing.[41]

The results from this study are in contrast to the majority of the literature which reports that nurses have a tendency to feel negatively regarding NSSI.[20–22] As mentioned earlier, some studies did reveal positive attitudes towards NSSI,[27] but this occurred less frequently than studies reporting negative attitudes. One study revealed both positive and negative attitudes from nurses towards self-injury.[26] Although the majority of the participants in this study were MHE nurses and the fact that the survey was completed prior to them undertaking some education on NSSI, could have meant that they had a more positive disposition to begin with.

A possible explanation as to why the results of this current study contrasted to much of the literature could be explained by the fact that the participants were predominantly MHE nurses (66.3%), female (76.7%), had more than 16 years of experience (62.7%) and were 40 years and older (70.9%). The results provide some insight into nurses' attitudes towards NSSI but conclusions are tentative due to the limitations of the study. The study recruited a small number of participants and as such the results are difficult to generalise to the greater population of nurses. This cohort also consisted of three different groupings, which dilutes these findings further. Despite these limitations, there has not been any research previously exploring ENs attitudes towards NSSI and this study has filled a gap that existed in this area. Furthermore, although there have been some recent reviews of the literature regarding NSSI and nurses' attitudes towards this phenomenon,[42] little research examining attitudes and knowledge of nurses towards NSSI has been undertaken in recent years.

6. Conclusions

Self-injury in the absence of expressed suicidal intent is a greatly unexplored area within mental health nursing. The results from this study indicated that the attitudes of nurses to NSSI were generally positive. This is in contrast to the majority of the literature which reports a tendency for nurses to be negative. There was a significant difference noted between the MHE who were found to have greater knowledge compared to those who were non MHE. Much of the literature confers with these results on the effect that knowledge has on attitudes with this study identifying more the differences between the groups of nurses that were previously not identified. These results, however, extend much of what is in the literature on knowledge and attitudes of nurses to NSSI. In addition, this study targeted nurses working in mental health units, an area that has had minimal research to date.

The findings from this study do point to the effect that education has for nurses at all levels in NSSI in order that they have a better understanding and therefore develop a more positive attitude to NSSI. This education should take place at undergraduate, postgraduate levels as well as through inservice education and conference presentations. Further, peer support and case review management strategies should be implemented in all workplaces that deal with a high turnover of individuals who self-injure, such as the ED and mental health services.

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Conflicts of Interest Disclosure

The authors declare they have no conflict of interest.

References

[1] Hawton K. The International Handbook of Suicide and Attempted Suicide (8^{th} ed.). Malden, MA: Wiley-Blackwell; 2008.

[2] Hopkins C. 'But what about the really ill, poorly people?' (An ethnographic study into what it means to nurses on medical admission units to have people who have harmed themselves as their patients). Journal of Psychiatric and Mental Health Nursing. 2002; 9: 147-154. PMid: 11966983. https://doi.org/10.1046/j.1365-285

0.2002.00473.x

[3] Mangnall J, Yurovick E. A literature review of deliberate self-harm. Perspectives in Psychiatric Care. 2008; 44: 175-184. PMid: 18577123. https://doi.org/10.1111/j.1744-6163.2008.00172.x

[4] O'Donovan A. Pragmatism rules: the intervention and prevention strategies used by psychiatric nurses working with non-suicidal self-harming individuals. Journal of Psychiatric and Mental Health Nursing. 2007; 14: 64-71. PMid: 17244007. https://doi.org/10.1111/j.1365-2850.2007.01044.x

[5] Fontaine K. Mental Health Nursing, 5^{th} Ed. Upper Saddle River, New Jersey: Prentice Hall; 2003.

[6] Harris J. Self-harm: cutting the bad out of me. Qualitative Health Research. 2000; 10: 164-173. PMid: 10788281. https://doi.org/10.1177/104973200129118345

[7] Bosman M, van Meijel B. Perspectives of mental health professionals and patients on self-injury in psychiatry: a literature review. Archives of Psychiatric Nursing. 2008; 22: 180-189. PMid: 18640537. https://doi.org/10.1016/j.apnu.2007.07.006

[8] McAllister M. Doing practice differently: solution-focused nursing. Journal of Advanced Nursing. 2003a; 41: 528-535. PMid: 12622862. https://doi.org/10.1046/j.1365-2648.2003.02564.x

[9] McAllister M. Self-harm in the emergency setting: understanding and responding. Contemporary Nurse. 2003b; 15: 130-139. PMid: 14649518. https://doi.org/10.5172/conu.15.1-2.130

[10] Whitlock JL, Knox K. The relationship between suicide and self-injury in a young adult population. Archives of Paediatrics and Adolescent Medicine. 2007; 161: 634-640. PMid: 17606825. https://doi.org/10.1001/archpedi.161.7.634

[11] Trepal HC. Exploring self-injury through a relational cultural lens. Journal of Counselling and Development. 2010; 88: 492-499. https://doi.org/10.1002/j.1556-6678.2010.tb00051.x

[12] McAllister M, Creedy D, Moyle W, et al. Nurses' attitudes towards clients who self-harm. Journal of Advanced Nursing. 2002b; 40(5): 578-586. PMid: 12437607. https://doi.org/10.1046/j.1365-2648.2002.02412.x

[13] American Diagnostic Association. Diagnostic and Statistical Manual of Mental Disorders, 5^{th} Ed. Arlington, VA: American Psychiatric Association; 2013.

[14] Favazza A, Conterio K. The plight of chronic self-mutilators. Community Mental Health Journal. 1988; 24: 22-30. PMid: 3370934. https://doi.org/10.1007/BF00755050

[15] Pembroke L. Self-harm a personal story. Mental health Practice. 1998; 2: 20-24.

[16] Arnold L. Understanding Self-Injury. Bristol: Bristol Crisis Service for Women; 1994.

[17] Beautrais AL, Gibb SJ, Faulkner A, et al. Postcard intervention for repeat self-harm: randomised controlled trial. British Journal of Psychiatry. 2010; 197: 55-60. PMid: 20592434. https://doi.org/10.1192/bjp.bp.109.075754

[18] Pembroke L. Damage limitation. Nursing Times. 2000; 96: 34-35. PMid: 11968396.

[19] Simpson A. Can mainstream health services provide meaningful care for people who self-harm? A critical reflection. Journal of Psychiatric and Mental Health Nursing. 2006; 13: 429-436. PMid: 16867127. https://doi.org/10.1111/j.1365-2850.2006.01000.x

[20] Gibb SJ, Beautrais AL, Surgenor LJ. Health care staff attitudes towards self-harm patients. Australian and New Zealand Journal of Psychiatry. 2010; 44: 713-720. PMid: 20636192. https://doi.org/10.3109/00048671003671015

[21] Gallop R, Tully T. The person who self-harms. In P. Barker (Ed.). Psychiatric and Mental Health Nursing: the Craft of Caring. London: Arnold; 2007. 236-243 p.

[22] McHale J, Felton A. Self-harm: What's the problem? A literature review of the factors affecting attitudes towards self-harm. Journal of Psychiatric and Mental Health Nursing. 2010; 17: 733-740. PMid: 21050340. https://doi.org/10.1111/j.1365-2850.2010.01600.x

[23] Harrison D. Vicious Circles – an exploration of Women and Self-Harm in Society. London: Good Practices in Mental Health; 1995.

[24] Mackay N, Barrowclough C. Accident and emergency staff's perception of deliberate self-harm: attributions, emotions, and wiliness to help. British Journal of Clinical Psychology. 2005; 44: 255-267. PMid: 16004659. https://doi.org/10.1348/014466505X29620

[25] McCann T, Clark E, McConnchie S, et al. Deliberate self-harm: emergency nurses' attitudes, triage and care intentions. Journal of Clinical Nursing. 2007; 16: 1704-1711. PMid: 17459135. https://doi.org/10.1111/j.1365-2702.2006.01555.x

[26] Patterson P, Whittington R, Bogg J. Measuring nurse attitudes towards deliberate self-harm: the Self-Harm Antipathy Scale (SHAS). Journal of Psychiatric and Mental Health Nursing. 2007; 14: 438-445. PMid: 17635251. https://doi.org/10.1111/j.1365-2850.2007.01102.x

[27] Anderson M. Nurses' attitudes towards suicidal behaviour – a comparative study of community mental health nurses and nurses working in an accident and emergency department. Journal of Advanced Nursing. 1997; 25: 1283-1291. PMid: 9181428. https://doi.org/10.1046/j.1365-2648.1997.19970251283.x

[28] Crawford MJ, Thomas O, Khan N, et al. Psychosocial interventions following self-harm: systematic review of their efficiencies in preventing suicide. The British Journal of Psychiatry. 2007; 190: 11-17. PMid: 17197651. https://doi.org/10.1192/bjp.bp.106.025437

[29] Aoun S, Lavan T. Suicide intervention in rural Western Australia. In: R. J. Kosky, H. S. Eshkevari, H. S. R. D. Goldnet & R. Hassan (Eds.), Suicide Prevention: the Global Context. US: lshSpringer; 1988. 231-236 p.

[30] Long A, Reid W. An exploration of nurses' attitudes to nursing care of the suicidal patient in an acute psychiatric ward. Journal of Psychiatric and Mental Health Nursing. 1996; 3: 29-37. PMid: 8696794. https://doi.org/10.1111/j.1365-2850.1996.tb00189.x

[31] Friedman T, Newton C, Coggan C, et al. Predictors of A&E staff attitudes to self-harm patients who use self- laceration: influence of previous training and experience. Journal of Psychosomatic Research. 2006; 60: 273-277. PMid: 16516659. https://doi.org/10.1016/j.jpsychores.2005.07.007

[32] McLaughlin L. Casualty nurses' attitudes to attempted suicide. Journal of Advanced Nursing. 1994; 20: 1111-1118. PMid: 7860857. https://doi.org/10.1046/j.1365-2648.1994.20061111.x

[33] Bailey SR. An exploration of critical care nurses' and doctors' attitudes towards psychiatric patients. Australian Journal of Advanced Nursing. 1998; 15: 8-14. PMid: 9807271.

[34] Australian Health Practitioner Regulatory Agency. Regulating Australia's health practitioners in partnership with the National Boards. 2014. Available from: https://www.ahpra.gov.au/

[35] Mental Health Services in Australia. Mental Health Workforce. 2015. Available from: https://mhsa.aihw.gov.au/resources/workforce/

[36] Australian Institute of Health and Welfare AIHW. Who are nurses and midwives? 2015. Available from: http://www.aihw.gov.au/workforce/nursing-and-midwifery/

[37] McCarthy L, Gijbels H. An examination of emergency department nurses' attitudes towards deliberate self-harm in an Irish teaching hospital. International Emergency Nursing. 2010; 18: 29-35. PMid: 20129439. https://doi.org/10.1016/j.ienj.2009.05.005

[38] Samuelsson M, Asberg M, Gustavsson JP. Attitudes of psychiatric nursing personnel towards patients who have attempted suicide. Acta Psychiatrica Scandinavica. 1997; 95: 222-230. PMid: 9111855. https://doi.org/10.1111/j.1600-0447.1997.tb09623.x

[39] Suominen K, Suokas J, Lönnqvist J. Attitudes of general hospital emergency room personnel towards attempted suicide patients. Nordic Journal of Psychiatry. 2007; 61: 387-392. PMid: 17990201. https://doi.org/10.1080/08039480701643381

[40] Purves D, Sands N. Crisis and triage clinicians' attitudes toward working with people with a personality disorder. Perspectives in Psychiatric Care. 2009; 45: 208-15. PMid: 19566693. https://doi.org/10.1111/j.1744-6163.2009.00223.x

[41] Gough K, Happell B. Undergraduate nursing students' attitude to mental health nursing: a cluster analysis approach. Journal of Clinical Nursing. 2009; 18: 3155-3164. PMid: 19619212. https://doi.org/10.1111/j.1365-2702.2008.02764.x

[42] Karman P, Kool N, Poslawsky IE, et al. Nurses' attitudes towards self-harm: a literature review. Journal of Psychiatric and Mental Health Nursing. 2015; 22: 65-75. PMid: 25490929. https://doi.org/10.1111/jpm.12171