

Attitudes to self-injury within a group of mental health staff

Nick Huband*

The Woodlands Unit, Leicestershire & Rutland Healthcare NHS Trust, UK

Digby Tantam

Centre for the Study of Violence and Reconciliation, University of Sheffield, UK

Background: Self-wounding is a behaviour which remains poorly understood and which can evoke strong reactions from clinical staff. Such reaction may adversely influence treatment outcome and there have been calls for changes in the attitudes of professional staff towards this client group through improved training and awareness. There has, however, been little systematic study of how clinicians perceive those who self-injure or of how their attitudes are modified by training and other factors.

Method: This study aims to identify and explore factors governing professional attitude towards self-injury through postal survey of a large group of mental health staff. The survey assessed attitudes towards a representative case described in a vignette.

Results: Five key factors were identified, with perception of control being the most dominant. Attitudes of clinical staff who had obtained additional qualification in counselling or psychotherapy differed significantly from those who had not. In contrast, no effect was found for specific training in handling self-injury. Attitude to the self-wounding woman was unaffected by gender, but was affected by age and work setting. The innate potential for the sample to self-polarize was examined statistically, a line of cleavage emerged between less tolerant staff who perceived her to have more control and to be more difficult to understand and those with opposing views.

Conclusion: Qualification in counselling or psychotherapy may modify attitude by reducing defensive attribution, allowing staff improved containment of their anxiety; alternatively, pre-existing attitudes may encourage certain staff to obtain such qualification.

Self-wounding, in the form of self-inflicted cutting, slashing, hitting or burning, is a behaviour which remains poorly understood and difficult to treat. Clinical management is complicated by the well-documented capacity for self-wounding patients to evoke powerful emotions and engender division in those involved in their care (Novotny, 1972; Simpson, 1980). Furthermore, the unsettling nature of self-injury tends to raise anxieties

for clinical staff which, if poorly contained, can result in strong reactions and adversely influence treatment outcome (Allen, 1995). There is also evidence that self-injuring patients are often critical of their treatment and particularly of the attitude of professional staff towards them (Arnold, 1995).

These, and other difficulties have prompted calls for changes in the attitudes of mental health staff towards those who self-injure and suggestions have been made for improving training and awareness (e.g., Babiker & Arnold, 1997). However, whilst information on attitude to self-poisoning and attempted suicide is available (Hawton & Catalan, 1982; Ramon, 1980), there has been little systematic study of how professionals think and feel about self-injury, and in particular about those self-wounding female patients who increasingly present to Mental Health Services as neither psychotic nor overtly suicidal, and whose behaviour does not appear directed towards major anatomical change.

This exploratory study investigates attitudes within a large group of multi-disciplinary staff towards one representative self-wounding female patient described in a case vignette. Answers to two questions were sought: firstly, what factors govern professional attitude towards this client group, and secondly, how these factors are affected by staff characteristics such as clinical experience and post-basic training. Information was also sought on how attitude differences might define inter-personal splitting within the group.

Method

A postal questionnaire was developed and sent to all 386 clinical staff working within the Directorate of General Psychiatry providing the NHS service to an English county. The survey method was as described by Huband & Tantam (1999) and required respondents to consider a single case vignette based on two, frequently-cited descriptions of a typical self-wounding patient (Favazza & Conterio, 1989; Simpson, 1976). The vignette provided limited information about a 24-year-old woman who had cut herself on several occasions but who exhibited no symptoms of psychosis nor major depression and for whom there was no current evidence of suicidal intent. No diagnosis was given in the vignette. A total of 213 questionnaires were returned, with 94% of respondents reporting some clinical responsibility for women who self-injured.

Attitudes towards the woman described were assessed by response to 23 questions derived from our experience of comments frequently expressed by clinical staff having firm opinions about self-injuring patients and their behaviour. These questions, listed as Appendix 1, were presented as unambiguous semantic differential pairs involving two extreme opinions, opposite in nature and separated by a line 50 mm in length. Respondents were asked to mark this line between the two extremes to show where their opinion lay. Responses were subsequently scored from -4 through to $+4$ using an overlay to divide the line into nine equal segments such that a line marked centrally carried a score of zero. Orientation of the semantic pairs was alternated in respect of the position of the more-favourable pole. Respondents provided information on their profession, number of years clinical experience, gender, age, and current work setting. Post-qualification training was also investigated; 42 respondents had received specific training in the handling of patients who self-injure (20% of sample) and 61 had obtained a qualification in counselling or psychotherapy (29% of sample). Many respondents wrote additional comments about their training; these comments suggested those in the former group had experienced a short, educational course whereas those with additional qualification had pursued longer-term, vocational study (predominantly psychodynamic in orientation).

The statistical procedures used to analyse results were factor analysis (principal component method), cluster analysis (K-means method), chi-squared tests and one/two-way analysis of variance using

Statistica v5.1 software. Within the principal component analysis, an orthogonal strategy (Varimax) was selected for rotating the factor structure, and the 'scree test' of eigenvalues – a graphical method described by Cattell (1966)—was used to determine how many factors should be extracted. Hierarchical factor analysis was also performed to provide information about the relevance of our choice of rotational strategy.

Results

Overall trends

Mean score values and confidence limits are given in Appendix 1. For each question, overall trends are reported here as that percentage of the sample marking the line within 17 mm of one pole. Using this criterion, the majority of respondents felt the woman described in the vignette would injure herself again (95%), that she had the same right to medical treatment of her wounds as any other (86%), that they would continue to work with her if she cut again (76%), and that establishing an empathic relationship with her was a first priority (80%). Many felt self-wounding was difficult to manage (75%) and that she would continue to cut even if there was no-one around to notice it (69%). Few admitted that self-wounding patients like the one in the vignette made them feel annoyed (10%) although 65% felt it would be difficult to build a relationship with her. Overall, 64% felt that she was likely to benefit from psychotherapy or in-depth counselling.

Factor analysis

Factor analysis was used to explore principal components of attitude towards the self-wounding patient using scores from all 23 questions. Guided by our inspection of the scree plot, we obtained a five-factor solution which accounted for 45.1% of the total variance. The salient variables and their loadings, which ranged from 0.40 to 0.78, are listed in Table 1. Interpretation of single factors based on these loadings appears relatively straightforward for the four most dominant components. The first (F1) is termed *ability to be in control of her actions*, related to perception of her capacity for consciously determining and moderating her behaviour, including her self-injury. F2 is termed *tendency to be undemanding vs. difficult*, reflecting a perception of how troublesome she was likely to be in her interactions with staff. F3 is termed *eligibility for tolerance and empathy*, which appears related to opinion of her right to perceive patience and warmth as well as preference for a philosophy of care which includes these qualities. F4 is termed *difficulty in understanding her actions*. Factor 5 is more difficult to interpret, but appears associated with respondents' *therapeutic confidence*.

In the hierarchical factor analysis, the same five primary factors emerged. Loadings on the salient variables were found to be slightly reduced, but only by a mean value of 0.08 with 19 loadings now falling in the range 0.40–0.68. No strong secondary or general factor emerged which would have forced us to alter our interpretation of the factor structure (as described by Wherry, 1984) and may have implied that an oblique rotational strategy was more appropriate.

To investigate how the four principal components were affected by staff characteristics, factor scores were first calculated by averaging the weighted responses across each set of

Table 1. Principal component analysis

	F1	F2	F3	F4	F5	Factor interpretation
Has control over extent of her cutting	.78	-.12	.00	.03	.01	F1:
Has control over her decision to cut	.75	.06	.05	.02	.12	Ability to be in control
Dependency on keyworker negative	.58	.31	-.10	.36	-.07	of her actions
Manipulation of staff unconscious	-. 47	.21	.29	-.13	-.09	
Unlikely to benefit from psychotherapy	.40	.14	-.24	.16	-.18	
Not expected to manipulate staff	-.11	.77	.09	-.10	.20	F2:
Dependency on keyworker unlikely	.10	.76	.04	.24	.04	Tendency to be
Unlikely to comply with treatment	-.07	-. 62	.21	.35	.06	undemanding vs.
Next cut with suicidal intent	-.13	.41	-.13	.25	.03	difficult
Would continue to work with her	.00	-.04	.73	-.11	-.11	F3:
Firm boundaries not first priority	.02	-.03	.55	.26	.19	Eligibility for
Empathic relationship not first priority	.11	-.02	-. 53	.16	.23	tolerance and
Doesn't make me annoyed	-.22	.15	.51	-.07	.29	empathy
Less right to medical treatment	.10	-.14	-. 49	.23	.24	
Me not uncomfortable if she cuts again	.31	-.19	.48	.03	.28	
No theoretical understanding	.13	.13	-.03	.73	-.14	F4:
Stop cutting if no-one around to notice	.19	-.16	-.29	.61	.24	Difficulty in understanding
Difficult to build relationship with her	-.31	-.27	.19	.42	-.20	her actions
Behaviour easy to manage	.06	.25	-.08	-.05	.68	F5:
Manage without info from her past	.12	.03	.14	-.10	.56	Therapeutic confidence
Unlikely to injure herself again	.00	.13	-.15	.21	.45	
Variance accounted for	14.3%	10.0%	8.6%	6.3%	5.9%	

Note. Variables with loadings >0.40 are in bold type.

salient variables defined in Table 1. For each factor, one-way analysis of variance was used to test these scores for the effect of gender, profession, age, work setting, clinical experience and additional training.

For the principal factor, those working in in-patient settings perceived her as having greater ability to control her actions, whereas staff in day hospitals, in out-patient settings, with 10 or more years of experience and with a counselling/therapy qualification thought her less in control (Table 2). No significant effect was found for gender, for profession, for age, nor for specific training in handling self-injury. However, in-patient staff were less likely to have a counselling/psychotherapy qualification (14% of in-patient workers cf. 34% of rest of the sample; $\chi^2 = 12.2$, $p < .001$). Because of this relationship, two-way analysis of variance was performed, entering the group effect first and the effect of counselling/therapy qualification second, allowing the effects of qualification to be examined independently of the group effect. In all cases, the qualification effect was the more dominant (Table 2, column 6).

Table 2. Mean scores and analysis of variance for the principal factor. (F1—*ability to be in control of her actions*)

Group	Mean scores		One-way anova <i>F</i> -ratios (group)	Two-way anova <i>F</i> -ratios	
	Group	Non-group		Group	Counselling/therapy qualification
Qualified in counselling or psychotherapy	-0.32	0.18	19.4***	—	—
Working in a day hospital setting	-0.30	0.13	10.4**	6.1*	8.9**
Working in an in-patient setting	0.15	-0.07	4.2*	0.2 n.s.	14.6***
Working in an out-patient setting	-0.07	0.15	4.2*	1.4 n.s.	18.4***
More than 10 years clinical experience	-0.13	0.15	6.7*	2.8 n.s.	16.5***

* $p < .05$; ** $p < .01$; *** $p < .001$.

Note. No effect found for gender ($F(1, 211) = 0.0$, n.s.), for specific training in handling self-injury ($F(1, 211) = 0.1$, n.s.) for profession ($F(2, 210) = 0.8$, n.s.) or for age ($F(3, 209) = 2.2$, n.s.).

For the remaining factors, findings significant at the 5% level are as follows. Medical staff ($F = 4.6$, $p < .05$; $N = 36$) and those working in in-patient settings ($F = 15.3$, $p < .001$) thought her more likely to be demanding. Younger staff (aged 18–26 years; $N = 18$) felt her less eligible for tolerance and empathy ($F = 4.2$, $p < .05$) whilst those working in day hospitals felt her more eligible ($F = 4.5$, $p < .05$). The younger staff group found it more difficult to understand her behaviour ($F = 8.8$, $p < .01$) whereas those with qualification in counselling/psychotherapy perceived less difficulty ($F = 9.8$, $p < .01$)—although here, as with the other factors, no significant effect was found for specific training in handling self-injury.

Cluster analysis

In an attempt to improve understanding about the nature of inter-personal splitting amongst those involved with self-injury, a statistical technique (cluster analysis) was used to explore how respondents in the sample might self-polarize on the basis of their attitudes towards the woman described. Data from the 18 variables defining factors 1 to 4 in Table 1 were used to force subdivision of the 213 cases into two distinct clusters of staff. These two clusters are compared in Table 3.

Table 3. Characteristics of the two clusters

	Cluster 1 'Softer' Group (<i>N</i> = 97)	Cluster 2 'Firmer' Group (<i>N</i> = 116)	Statistic
Female staff	55 (57%)	75 (65%)	n.s.
In-patient setting ^a	40 (41%)	66 (57%)	$\chi^2 = 5.2, p = .02$
Out-patient setting	55 (57%)	51 (44%)	n.s.
Day hospital setting	29 (30%)	16 (14%)	$\chi^2 = 8.2, p = .004$
Medical staff	18 (19%)	18 (16%)	n.s.
Nursing staff	65 (67%)	73 (63%)	n.s.
Having >10 years experience	46 (47%)	41 (35%)	n.s.
Counselling/psychotherapy qualification	42 (43%)	19 (16%)	$\chi^2 = 18.7, p < .001$
Specific training in handling self-injury	22 (23%)	20 (17%)	n.s.
Aged 18–25 years	3 (3%)	15 (13%)	$\chi^2 = 6.6, p = .01$
Aged 26–35 years	44 (45%)	58 (50%)	n.s.
Aged 36–45 years	37 (38%)	31 (27%)	n.s.
Aged >45 years	13 (13%)	12 (10%)	n.s.
Mean scores/F1: ability to be in control of her actions	−0.47	0.47	$F = 112.8, p < .001$
Mean scores/F2: tendency to be undemanding	−0.95	−0.92	$F = 0.1, n.s.$
Mean scores/F3: eligibility for tolerance and empathy	1.21	0.70	$F = 39.5, p < .001$
Mean scores/F4: difficulty in understanding her actions	−1.02	−0.06	$F = 127.8, p < .001$

^a 46 Respondents reported working in in-patient and another clinical setting.

The first cluster (here termed the Softer-Group) is characterized by perception that she was less in control of her actions, that she was more eligible for tolerance and empathy, and of less difficulty in understanding her behaviour—as compared with the second cluster, here termed the Firmer-Group. The Softer-Group, in comparison with its counterpart, had a greater proportion of staff qualified in counselling/therapy. This cluster also contained a greater proportion of day hospital staff and a smaller proportion of in-patient staff. Those aged 18–26 years were over-represented in the Firmer-Group. Differences between the two clusters were not significant on the other measured parameters.

Discussion

An exploratory study of this type is subject to certain limitations. We acknowledge that the factor analysis is based on less than 500 cases and that it would be necessary to confirm the solution with another sample of similar size to be confident of the results. However, the firm opinion evident in response to many of the questions implies that the information given was sufficient for respondents to make decisions and express views, and suggests that the vignette technique is effective. Overall, the majority of the sample favoured an empathic, non-rejecting approach to a woman they perceived as likely to cut again and whose behaviour would be difficult to manage. Strong feelings of discomfort or annoyance were not commonly expressed, although 65% felt it would be difficult to build a relationship with her.

Effect of training

Attitudes of those staff who had additional qualification in counselling or psychotherapy differed significantly from those who had not. Specifically, possession of a counselling/therapy qualification was strongly associated with perception that the woman in the vignette had less conscious control over her actions; it was also associated with perception of greater understanding of her behaviour. In contrast, no effect was found for specific training in handling self-injuring patients. We offer two possible interpretations of these findings.

The first centres on respondents' ability to contain their anxiety and the suggestion that this is somehow enhanced by therapy training. A self-injuring patient frequently raises anxiety in professional staff arising from fear for her safety, from concern about repercussions if she does 'one cut too many' and from complex counter-transference reactions (Feldman, 1988). This type of behaviour can also challenge professionals' views of their autonomy, competence and role (Breeze & Repper, 1998). One defence against such anxiety is for the clinician to attribute responsibility and blame away from themselves and onto the patient. The different views about locus of control reported here may represent different degrees of defensive projection as there is evidence that perceived control is strongly associated with the attribution of responsibility (Fincham & Emery, 1998). Training which leads to a qualification in counselling or psychotherapy is often lengthy, rigorous and geared towards insight and personal growth. These features, together with a strong educational component, may be effective in helping such staff reduce their defensive responses, allowing them to deal with an unsettling presentation without needing to attribute disproportionate levels of responsibility onto the patient. In contrast, those who undertake a short training course which is aimed at a single clinical problem may acquire information and technique but are unlikely to gain much insight into their own psychological functioning and projective defences.

A second interpretation is that these findings stem from pre-existing attitudes, and that those who have sought and obtained counselling/therapy qualification form a subgroup whose perceptions about the locus of control in self-injuring patients existed prior to this training. Attribution Theory suggests that a perception that a self-wounding patient has little conscious control over her actions would tend to evoke greater

willingness to offer help – in the same way that a man in the gutter clutching a stick evokes in bystanders a stronger desire to assist than does one who is clutching a bottle (Weiner, 1986). Although not tested here, the motivation to pursue an additional vocational training (which itself stresses unconscious determinants of behaviour) may stem from desire to offer help to such patients by seeking skills and understanding not provided by basic training in medicine or nursing.

Effect of gender and age

Gender was found to have no significant impact on the emergent factors, in keeping with previous findings on attitudes towards attempted suicide and self-poisoning (Platt & Salter, 1987; Ramon, 1980). Younger staff, in comparison with their older colleagues, had more difficulty in understanding a woman of whom they felt less tolerant, suggesting that maturity may moderate attitude towards this client group.

Effect of profession and work setting

Medically qualified staff experienced the patient as more likely to be difficult, which parallels findings of Bancroft & Hawton (1983) that psychiatrists frequently explain self-poisoning as a means of manipulating or punishing others, and may suggest they view self-wounding similarly. In-patient staff perceived her as more difficult and more in control of her actions. In contrast, day hospital and out-patient staff thought she had less control, and day hospital staff felt her more eligible for tolerance and empathy. This may arise because staff who work in acute settings regularly experience high levels of disturbance and unsettling behaviour against which they need to defend themselves. Arguably, prolonged exposure to disturbed behaviour inclines professionals towards a stance that is habitually more defensive.

Potential for splitting

Cluster analysis defined a potential line of cleavage in the sample and differentiated two subgroups of staff with contrasting attitudes. Interestingly, opinion about the patient's tendency to be demanding or difficult was not significant in this division. The contrasts were between less tolerant staff who perceived her to have more control and who found it harder to understand her actions (the 'Firmer-Group') and those with opposing views (the 'Softer-Group'). One possibility is that these differences are confounded because older, non-ward-based staff are more likely to have a counselling/therapy qualification and that differences between the two groups may be explained by the effect of such training. We note, however, that the two clusters differ in the way they prioritize empathic comforting and that they have a number of similarities to those described in the classic study by Main (1957) of staff caring for a group of hospitalized patients exhibiting 'recalcitrant distress', many of whom self-injured.

Conclusions

Results from this exploratory survey focus attention on staff perception about the locus of control of a typical self-injuring woman. The concept of perceived control emerged as the

dominant factor in defining attitude to self-injury and was interpreted as the defensive attribution of responsibility onto the patient. A significant finding, which we have not found reported elsewhere, was that differences in attitude exist between staff who have qualification in counselling/therapy and those who have not. However, no evidence was found that specific training in handling self-injury influences professional attitude. One explanation is that therapy training leads to reduction in defensive attribution and an enhanced ability to contain anxiety.

Acknowledgements

NHS Executive Trent is acknowledged for funding in the form of a Training Award. The authors are grateful to Sandy Geddes, Jayne Chapple and Elaine Tidmarsh for administrative assistance with the Survey. This work was carried out in part-fulfilment towards the Degree of PhD at Sheffield University and the corresponding author gratefully acknowledges the Smith & Nephew Foundation for the award of a Research Fellowship.

References

- Allen, C. (1995). Helping with deliberate self-harm; some practical guidelines. *Journal of Mental Health, 4*, 243–250.
- Arnold, L. (1995). *Women and self-injury: A survey of 76 women*. Bristol: Bristol Crisis Service for Women.
- Babiker, G., & Arnold, L. (1997). *The language of injury: Comprehending self-mutilation*. Leicester: BPS Books.
- Bancroft, J. H. J., & Hawton, K. (1983). Why people take overdoses: A study of psychiatrists' judgements. *British Journal of Medical Psychology, 56*, 197–204.
- Breeze, J. A., & Repper, J. (1998). Struggling for control: The care experiences of 'difficult' patients in mental health services. *Journal of Advanced Nursing, 28*, 1301–1311.
- Cattell, R. B. (1966). The scree test for the number of factors. *Multivariate Behavioral Research, 1*, 245–276.
- Favazza, A. R., & Conterio, K. (1989). Female habitual self-mutilators. *Acta Psychiatrica Scandinavica, 79*, 283–289.
- Feldman, M. D. (1988). The challenge of self-mutilation: A review. *Comprehensive Psychiatry, 29*, 252–269.
- Fincham, F. D., & Emery, R. E. (1998). Limited mental capacities and perceived control in attribution of responsibility. *British Journal of Social Psychology, 27*, 193–207.
- Hawton, K., & Catalan, J. (1982). *Attempted suicide: A practical guide to its nature and management*. Oxford: Oxford University Press.
- Huband, N., & Tantam, D. (1999). Clinical management of women who self-wound: A Survey of Mental Health professionals' preferred strategies. *Journal of Mental Health, 8*, 473–487.
- Main, T. F. (1957). The ailment. *British Journal of Medical Psychology, 30*, 129–145.
- Novotny, P. (1972). Self-cutting. *Bulletin of the Menninger Clinic, 36*, 505–541.
- Platt, S., & Salter, D. (1987). A comparative investigation of health workers' attitudes towards parasuicide. *Social Psychiatry, 22*, 202–208.
- Ramon, S. (1980). Attitudes of doctors and nurses to self-poisoning patients. *Social Science and Medicine, 14*, 317–324.
- Simpson, M. (1976). Self-mutilation. *British Journal of Hospital Medicine, 16*, 430–438.
- Simpson, M. (1980). *Self-mutilation*. Philadelphia: Temple University Press.
- Weiner, B. (1986). *An attributional theory of motivation and emotion*. Berlin: Springer-Verlag.
- Wherry, R. J. (1984). *Contributions to correlational analysis*. New York: Academic Press.

Appendix 1. Questions used to assess attitude

Semantic differential pair (parentheses indicate negatively scoring pole)	Mean score	95% confidence interval
The chances are that she will not (will) injure herself again	-3.36	-3.52 to -3.19
I would not feel particularly uncomfortable (would feel very uncomfortable) if she began cutting again	1.66	1.37 to 1.94
Her decision to cut is completely under (outside) her control	1.03	0.76 to 1.30
She has less right (the same right) to expensive medical treatment of her wounds as has any other patient	-3.02	-3.22 to -2.81
This type of patient doesn't (does) make me feel annoyed	1.66	1.36 to 1.96
She has complete (has no) control over the extent of her self-wounding	1.20	0.95 to 1.45
It will be difficult (easy) to build a relationship with her	1.97	1.75 to 2.19
If she cuts again, it will be (will not be) with genuine suicidal intent	-1.20	-1.44 to -0.95
I do not (I do) expect her to try to manipulate professional staff involved in her care	-1.43	-1.67 to -1.18
Attempts at manipulating professional staff are likely to be unconscious and unintentional (conscious and intentional)	0.51	0.24 to 0.78
She is unlikely to (likely to) comply with treatment and professional advice	0.99	0.77 to 1.20
She would stop cutting (would continue to cut) herself even if there was no-one around to notice it	-1.99	-2.24 to -1.74
I don't have (I have) a theoretical understanding of why she cuts herself	-1.53	-1.81 to -1.24
I would (not) continue to work with her if she began cutting again	2.32	2.07 to 2.57
Self-wounding behaviour is easy (difficult) to manage	-2.39	-2.59 to -2.20
She is not (she is) suffering from a treatable mental illness or mental disorder	-0.35	-0.64 to -0.05
She is unlikely to (likely to) develop a dependency on her key-worker	-2.03	-2.24 to -1.81
<i>Philosophy of care</i>		
A firm, authoritative approach is likely to increase (reduce) her self-wounding	1.27	1.00 to 1.54
Developing an empathic relationship with her is not (is) the first priority	-2.50	-2.75 to -2.25
Setting firm boundaries with her is not (is) the first priority	-0.97	-1.31 to -0.64
She is unlikely (likely) to benefit from psychotherapy or in-depth counselling	-2.00	-2.26 to -1.75
It is quite possible (impossible) to manage her self-wounding without further information about her past	-0.50	-0.80 to -0.20
Dependency on her key-worker is a negative and non-essential (positive and essential) stage in the overall therapeutic process	-0.81	-1.09 to -0.53