

Who cares for the carer: the impact of supporting those who self-harm on professional carers.

Laura Armstrong

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Declaration

This work is original and has not been submitted in relation to any other degree or qualification.

With thanks to my supervisor Dr Hannah Heath for her assistance with this piece of research.

Date	Topics Discussed	Actions
8/11/17	Initial meeting to discuss possibility of self-harm dissertation project	Application sent to university to apply for self-harm project
29/01/18	First meeting to discuss dissertation project- -decided to use residential care workers as participants	To start background reading around self-harm
07/03/18	Ethics form	To complete ethics form as soon as possible for hand in date. To obtain written confirmation from manager that participants can be approached
21/05/18	- Interviews and participant recruitment	To begin process of participant recruitment and interviewing.
16/08/18	Guidance about background literature, areas to focus on (help-seeking patterns and who self-harms)	To begin write up of background literature. -draft dissertation deadline 1 st September
06/09/18	E-feedback regarding introduction	Continue to work on introduction
21/09/18	Email- feedback for draft dissertation	Amendments to be made to dissertation

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Table of contents

Title page and word count	2
Declaration	3
Acknowledgements	4
Supervision log	5
Table of content	6
1. Abstract	7
2. Introduction	8
2.1 Background Literature of self-harm	8
2.2 Prevalence of self-harm	10
2.3 Help-seeking	12
2.4 Healthcare professionals	13
2.5 Effects of caring on professionals	16
2.6 Residential Care Workers	21
2.7 Aims and Objectives	22
3. Methodology	
3.1 Design	24
3.2 Participants	25
3.3 Data collection	25
3.4 Method of analysis	26
3.5 Ethical considerations	27
3.6 Reflection and limitations	27
4. Results	28
5. Discussion	46
5.1 Implications	55
5.2 Limitations	56
6. Conclusion	56
7. References	58
8. Appendices	
Appendix A	Participant information sheet
Appendix B	Participant consent form
Appendix C	Ethics application
Appendix D	Ethics amendment form
Appendix E	Interview Transcripts - CD attached to rear cover

Abstract

Self-harm is a serious health issue in the UK. One of the most vulnerable populations for self-harm is thought to be young people who are removed from their families and live in group home settings. There is existing literature about the effects and attitudes of medical professionals who care for those who self-harm, however very little that looks at self-harm from the perspective of residential care workers. From ten semi-structured interviews with residential care workers, analysed with Thematic Analysis, similar attitudes that have been reflected in recent studies with medical professionals were reflected in the residential care worker's accounts. Participants felt it is necessary for better and more robust self-harm training for staff, and more available and structured organisational and colleague support. Additionally, over time, the care workers became accustomed to the behaviours, with some becoming emotionally disconnected from the care they provided. The study explores the previously unheard voices of the residential care workers and highlights the need to provide better support for residential care workers.

Introduction

Children who are in residential care in the UK tend to be placed by their Local Authority and will live in small 'family style' group homes. Residential care staff are paid to look after them and work on a rostered shift pattern, typically two or three days at a time (Moore, McArthur, Death, Tilbury & Roche, 2018). Children in the UK are usually removed from their biological family home due to their parent's mental health issues, neglect, abuse or substance abuse and are then placed at a higher risk of developing mental health issues themselves, compared to peers who remain at home without such issues (Winsor & McLean, 2016).

Children and young people who are in care are a particular population in the UK who are more at risk of self-harm and suicide. These young people have childhoods that are usually steeped in trauma and abuse (Furnivall, 2013). For young people who self-harm and who live in residential care homes, support for them typically comes from their support workers or residential carers. Despite their prominent role in the lives of these young people, the voices of residential care workers tend to be overlooked.

The Background and Literature

Self-harm

Self-harm is a growing concern in the United Kingdom, it is one of the most common reasons for hospital presentations (Butler, 2016). An estimated 10-15 percent of young people report self-harming in the UK (Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell & Hawton, 2016). A key issue within self-harm literature is the chosen definition of self-harm that researchers choose to adopt, this issue has been at the heart of self-harm research over the last fifty years (Cleaver, 2014). In the literature many variations have been

adopted to define self-harm, for example *“a deliberate, self-initiated, and non-fatal act, carried out in the knowledge that it is potentially harmful. This includes self-poisoning or self-injury, irrespective of the apparent level of suicidal intention,”* (Crawford, Geraghty, Street & Simonoff, 2003, page 619), much of the literature has adopted similar definitions to this. Researchers may choose to adopt a definition that disregards suicidal or non-suicidal attempt, and these studies will encompass all forms of self-harm, other researchers will choose to limit definitions of self-harm as those limited to deliberate self-harm with no suicidal intent. Self-harm is defined by the World Health Organisation as *‘an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences’* (National Institute for Clinical Excellence, 2004, page 16). A more concise and also broader definition from the National Institute for Clinical Excellence (NICE) (2014) is self-injury or self-poisoning regardless of intent. For the purposes of this paper the definition adopted by NICE will be used. The NICE sets out guidelines for health and social care and these guidelines are established through evidence and practice. The NICE guidelines are often used in the academic literature on self-harm as they reflect the experiences of patients and people who seek help for self-harm, as well as the experiences of those providing the care (Egan, Sarma & O’Neill, 2012). As this research focuses on residential care workers who work within the realm of health and social care, using the NICE guidelines should reflect the way that the participants of this study work to care for young people who self-harm.

Many incidents of self-harm do not come to the attention of hospitals or medical professionals, and instead the care and support comes from family and friends for young people (Wadman, Vostanis, Sayal, Majumder, Harroe, Clarke, Armstrong & Townsend, 2018). Self-harm has been extensively researched, but is still often misunderstood, and in some regards remains an unknown, much of the focus of research has been on the reasons and motivations behind self-harming behaviours (Ferrey et al., 2016). Understandably much of the research in self-harm focuses on the experiences of those who self-harm (Furnivall, 2013). Self-harm is often thought of as having attention-seeking or help-seeking motivations, however, Nock, Prinstein and Sterba's (2009) study found that of their 30 participants only 3.9% endorsed interpersonal reasons as their main motivation for self-harming, and the majority of participants said that they self-harmed as a distraction from something negative. Professional's and academic understanding of self-harm has come a long way over the past decades, for a long time self-harm was understood by many to be a failed suicide attempt, and the definitions of self-harm make a very clear distinction between suicide and self-harm.

Prevalence

Self-harm is internationally recognised by most researchers as a growing concern and more among adolescents, some previous studies have reported the prevalence of self-harm as being as high as up to 38% of young adults reporting having engaged in self-harm (Hughes, Locock, Simkin, Stewart, Ferrey, Gunnell, Kapur & Hawton, 2017). Some research has reported that hospital admissions for adolescents in the UK due to self-harm as as high as 24,000 each year (Anderson and Standen, 2007). Females are believed by some to be most vulnerable to self-harming behaviours (Stewart, Hughes, Simkin, Locock, Ferrey, Kapur,

Gunnell & Hawton, 2018). Young females are reported by some of the literature to be more likely to engage in self-harm than young males, 15-19-year-old females have been reported as the most vulnerable demographic to self-harm (Rodham, Hawton & Evans, 2004). It has been reported as three to four times more likely for females to engage in self-harm than males (Hughes et al, 2017). Some research supports the claim that females are more likely than males to engage in self-harming behaviours, a meta-analysis of self-harm literature found that the prevalence amongst the literature is to report females as more likely than males to self-harm (Bresin & Schoenleber, 2015). However, the meta-analysis also reported that males are also less likely than females to ask for and to receive support for self-harm, and so it is possible that just as many males, if not more are engaging in self-harm and therefore the reported number of females will be higher (Bresin & Schoenleber, 2015). There are also thought to be gender differences in the type of self-harm that people engage in and the methods they use, the meta-analysis supported claims that males are most likely to engage in hitting, punching and head banging as methods of self-harming, it is possible that these methods are more private and easily concealed or less recognisable by others as a type of self-harm (Bresin & Schoenleber, 2015). Some studies have indicated that in fact self-harm prevalence for males is just as high if not higher than amongst females (Victor, Muehlenkamp, Hayes, Lengel, Styer & Washburn, 2018). A recent study also found that contrary to previous research the only difference in methods for males and females is the higher prevalence of pinching and scratching for females and burning and branding behaviours were more prevalent for males, no differences were found in the use of cutting as a method (Victor et al., 2018). The lack of difference between males and females in self-harm means that residential carers are highly likely to have experienced self-harm

regardless of whether they have cared for boys or girls, as the age group of adolescents and the looked after status of young people makes them particularly vulnerable to self-harm. Looked after young people, who live in residential care are at an even higher risk for self-harm than the general population (Wadman, Armstrong, Clarke, Harroe, Majumder, Sayal, Vostanis & Townsend, 2018). One study revealed that self-harm within the population of looked after children was 39% compared to 18% in the general population who are living with their birth parents (Piggot, Williams, McLeod & Barton, 2004). Childhood sexual abuse has been cited as a risk factor for self-harm (NICE, 2004). Self-harm can be a physical way of coping with emotional pain and trauma, as many of the young people in residential care have been placed there due to childhood circumstances that are likely to cause trauma, this explains why looked after young people are particularly vulnerable. For residential care workers much of their job is about helping young people to overcome past traumas and for some this includes supporting them during periods of self-harm behaviour. However, it is also true that young people from caring and loving homes have been found to be just as vulnerable to self-harm (McDonald, O'Brien and Jackson, 2007).

Who is most likely to seek help?

Young people who engage in self-harm are less likely to seek help than their peers who do not self-harm (Frost & Casey, 2015). Self-harm is only brought to the attention of professionals when they, or their families and caregivers choose to seek help (Frost & Casey, 2015). Many young people who engage in self-harm are unable to seek support from professionals, be it through general practitioners, psychologists or social workers (Frost & Casey, 2015), a lot of young people seek help online in the form of message boards and gaining support from their peers, and those who do so have been found to be less likely to

disclose their self-harm to others, or to seek help from people they know (Frost & Casey, 2015). A meta-analysis by Michelmore and Hindley (2012) highlighted a number of factors that were identified by existing literature to influence the likelihood of help-seeking for self-harm. They commented on the gender differences in help-seeking and found that in the majority of the research that they looked females were reported with higher levels of help-seeking than males (Michelmore & Hindley, 2012), it was also found that age can be factor affecting help-seeking, and that older age groups are more likely to seek help. Within residential care young people are cared for by professionals whose job it is to safeguard the young people, as such they are in a family environment but are scrutinised more closely than a typical family environment, many young people also receive therapy in residential care, as well as this young people have staff who care for them but do not have the guilt and shame that comes with disclosures to parents or family members; these are a number of factors that make disclosures and help-seeking more likely.

Who does the help come from?

For young people who do seek help offline support typically comes from families, carers and friends. In previous studies it has been found that young people report being able to seek support from a close friend before anybody else, and close friends are followed by mothers for help-seeking (Evans, Hawton & Rodham, 2005). In their study Evans et al (2005) asked students from year 11, some of whom had self-harmed and many of whom had not, who they are most likely to go to when seeking support, friends were most likely to be named as the person whom adolescents confide in about their self-harm. In their systematic review of self-harm literature, Michelmore and Hindley (2012) support the view that adolescents are most likely to seek support from their peers for self-harm, and that before seeking

professional help for their self-harm young people are more likely to go to their family members. When professional help is sought out for those who self-harm it usually comes in the form of emergency medical attention through accident and emergency healthcare, as such much of the literature regarding self-harm uses statistics which come from hospitals and focus largely on the experiences of frontline medical staff such as Emergency Department doctors, nurses and paramedics (Anderson & Standen, 2007). General Practitioners and mental health workers are also likely to be the first point of contact for professional help for young people who self-harm (Michelmore & Hindley, 2012). The importance of the relationship between patients and professionals has been stressed throughout self-harm literature, the quality of care that patients feel they receive, and the treatment by professionals can go on to influence future help-seeking as well as the motivation to heal and get better (Lindgren, Svedin & Werkö, 2018). Residential carers are sought out by young people for support, in a professional and care giving capacity, for young people in residential care they may not have family members who are appropriate source of support and so residential carers in this sense can fulfil the family support role as well as professional.

Health care professionals and self-harm

A great deal of research has focused on the attitudes and experiences of professionals working with and caring for those who engage in self-harming behaviours. Patients have historically reported feeling mistreated or discriminated against in their treatment of healthcare professionals for self-harm injuries (Cleaver, 2014). Rees, Rapport, Snooks, John and Patel (2017) reported that 43% of participants in one survey stated that they avoided emergency services after self-harming because of the unsympathetic responses of

healthcare professionals. Rees et al.'s (2017) research looked at the experience of caring for those who self-harm from the perspective of paramedics, it focused largely on the ethical considerations that healthcare professionals are required to make when caring for people who self-harm. Their research shows the importance of gaining as much information of the experiences of professionals from a range of services.

A literature review by Lindgren, Svedin and Werkö (2017) showed the importance of interactions with health care staff for people who self-harm, individuals reported the importance of feeling respected and cared for by health care staff; and that these interactions effected their ability to make progress in their personal development and recovery. Nielsen and Townsend (2017) suggest that many professionals lack an understanding of self-harm and that this can contribute to the dismissive or negative emotional reactions from healthcare staff that have been reported by many people who self-harm. Using vignette studies Nielsen and Townsend (2017) found that understandings of the complex nature of self-harm were higher than anticipated, perhaps reflecting the growing conversation around mental-health awareness and self-harm, as this study looked at the beliefs of the general public. However, their study highlighted the need for further understanding of self-harm as participants reported that they were less likely to help a person who self-harms if they thought their motivation for self-harming was interpersonal or to show others how badly they are feeling inside. It is vital that health and social care professionals have a good understanding of self-harm so as to avoid a vicious cycle whereby professionals' negative responses to self-harm reinforce an individual's negative feelings about themselves which may have caused them to self-harm in the first place (Nielsen & Townsend, 2017). Reports in the literature suggest that professionals tend to overestimate 'help-seeking' as a main cause of self-harm, believing it often to be a cry for help, despite

the fact that many self-harm behaviours are done privately and remain a secret (Nielsen & Townsend, 2017). The literature also suggests that many health care professionals tend to dismiss self-harm as an attention seeking and manipulative behaviour (Nielsen & Townsend, 2017).

It is thought that the attitudes of healthcare professionals depend on different factors involved in the care delivered or the circumstances for instance the training given to the care practitioners and as such their depth of knowledge about self-harm can lead to more positive attitudes towards self-harm and greater compassion for those they care for (Perboell, Hammer, Oestergaard & Konradsen, 2015). The amount of exposure that professionals have to self-harm is another factor; some studies have suggested that the greater exposure practitioners have had to self-harm then the more positive their attitudes tended to be towards self-harm and they are able to have more understanding and empathy (Cleaver, 2014). Cleaver's (2014) review of self-harm literature also found that exposure to other behaviours besides self-harm can have a negative impact on professional's attitudes towards self-harm, if they are having to deal with additional challenging behaviours from patients then they are less likely to want to help or have sympathy for the self-harming behaviours.

The relationship between care staff and health care professionals is important as it will affect future help-seeking; depending on the reactions of staff and the care received individuals were more or less likely to seek help in the future for later self-harm (Lindgren et al., 2017). In their literature review Lindgren et al. (2017) found that healthcare staff were often described as getting frustrated and annoyed at patients or clients for their self-harming, and feeling that treatment is pointless as those individuals will not get better. The literature review found that people reported more positive caring experiences from staff

who had received specific training for self-harm, and that staff who did receive training were equipped with the appropriate knowledge and so felt more able to help than staff who did not have self-harm training, again, further highlighting the need for self-harm training for frontline staff (Lindgren et al., 2017).

Effects of caring on the professional caregiver

There is a wealth of literature which has looked at the effects of caring for individuals on health care professionals, terms such as burnout, compassion fatigue and carer fatigue are well researched phenomena amongst the literature (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski, & Smith-Macdonald, 2017). Due to growing workplace adversity in the health and social care system, this issue has gained a lot of attention in healthcare research; factors such as long hours, shift patterns, budget cuts, abuse at work (violent patients and service users) as well as staff shortages and occupational health have come into focus in recent years, often these issues have been researched and developed from the experience of nursing professionals (Jackson, Firtko & Edenborough, 2007). Stress in the workplace has been conceptualised as an individual's perception of the demands that are being made on them by the job as well as their perception of their own ability to meet those demands; when these two do not add up then a stress response will be triggered in the individual (McVicar, 2003). Much of the literature which has looked at the effects of caring for others goes beyond stress and has highlighted elements of strain on the healthcare workforce which are specifically the cost of caring.

Compassion fatigue refers to the loss of compassion over time for health care professionals, in response to the stresses of caring for ill patients (Sinclair et al., 2017). Compassion and empathy are said to come at a cost to the caregiver, although this cost can be replaced with

satisfaction at having provided quality care for others (Figley, 2009). To act in a truly compassionate way requires empathy and an ability to put ourselves in the position of others, Figley (2009) stated that compassion means “to bear suffering,” and suggested that compassion fatigue is what happens when our ability to bear the suffering of others has been reduced, and as such we are no longer interested in the suffering of others. Sinclair et al. (2017) applied the term compassion fatigue to healthcare providers in general and conducted a met-narrative review of healthcare literature, they determined that although there does seem to be validity behind the phenomena, the term itself has been loosely adopted to apply to all manner of stress for healthcare providers. Compassion fatigue has been given many different definitions, Lynch and Lobo (2012) included a version that defines compassion fatigue as ‘a physical, emotional and spiritual exhaustion that reduces one’s ability to care for others, as caused by long periods of demanding caregiving,’ this definition has the potential to be applied to any caregiver, in mental health or the wider health care profession and could also be applied to those who work in residential care. Residential care workers support young people who demand a great deal of care and emotional support, and at times mental health needs.

Burnout in healthcare has been described as a depletion of energy, lowered self-esteem, a sense of helplessness or hopelessness, cynicism and being unable to see an alternative way of functioning, negativism and a general feeling of output exceeding input for health care workers (Farrington, 1997). Burnout is a well-established phenomenon, with a great deal of research around burnout in healthcare, particularly with regard to nurses and those in particular who work with the chronically or terminally ill, as well as mental health nurses (Taylor & Barling, 2004). The term burnout was first introduced by psychologist Herbert Freudenberger in 1974, who stated that term applied only to front line human service

workers, to which residential care workers certainly belong (O'Connor, Neff & Pitman, 2018). Other definitions of burnout include emotional exhaustion, negative or a cynical attitude towards others, a diminished sense of self-accomplishment, and applied to professionals who are working with individuals in challenging situations (Maslach, Jackson & Leiter, 1997) this offers a definition that can most certainly be applied to residential care workers. Burnout has also been referred to as 'carer's fatigue' in the literature when used to describe the exhaustion and lack of satisfaction of health care workers (Taylor & Barling, 2004). Taylor and Barling (2004) focused on carer fatigue and burnout among mental health nurses and found that self-reported levels of burnout and stress were high from their sample of 20 mental health nurses.

Secondary Traumatic Stress has been used to describe the possible impact on healthcare workers when working with trauma, vicarious trauma is another way of referring to this secondary trauma (Berger, Polivka, Smoot & Owens, 2015). This can occur when caring for those who have suffered from high levels of trauma, something that can have a close relationship with self-harming behaviours (Gladstone, Parker, Mitchell, Malhi, Wilhem & Austin, 2004). Figley (2009) described Secondary Traumatic Stress as "the stress resulting from helping or wanting to help a traumatized or suffering person," this definition has the potential to be applied to all health and social care workers who are working in close proximity with individuals who have trauma.

The cost of burnout and secondary traumatic stress not only falls on the individuals but also causes high levels of staff turnover for healthcare providers (Salloum, Kondrat, Johnco & Olson, 2015). This in turn leads to even greater burden for the staff who remain, particularly when more experienced and senior members of staff experience burnout and leave the

workforce, this leaves behind a skills gap that can lead to further stress for remaining staff members (Salloum et al., 2015).

Self-care for professionals

Resilience has been offered as a possible protective factor for professionals against burnout and compassion fatigue (Figley, 2009). Resilience is the ability to adjust positively to adversity, in terms of workplace resilience, being able to meet the challenges of the workplace in a positive way (Jackson et al., 2007). Resilience is discussed in some literature as the main characteristic that effects the outcome for professionals in the healthcare industry, nurses have been the focus of previous research into resilience (Jackson et al., 2007). Psychological resilience has been discussed as an individual's ability to bounce back from negative and stressful situations and emotions, in a positive way (Tugade & Fredrickson, 2011). Resilience has been studied from a multitude of directions, research has been conducted looking at resilience in babies, children, adolescents and adults of all ages (Jacelon, 1996). It is thought that resilience is an inherent trait, but that it is also a skill that can be developed and taught, if this is the case then for health care professionals, and residential care workers, it would make sense for companies and employers to develop this skill in their staff, as it could serve to strengthen the workforce (Jacelon, 1996).

An individual's sense of achievement is believed to be another protecting factor against the adversity of a challenging work environment, Figley (2009) highlights the importance that the sense of achievement can have in protecting psychotherapists against compassion fatigue. He argues that psychotherapists must recognise their own personal responsibility in the role of helping their client or patient as well as the client's role in helping themselves; that is, they cannot do all of the healing for them. To this end all professionals in the health

and social care workforce can provide the best care possible, but in mental health it must be recognised that clients also have a responsibility and their own choices to make. Some papers refer to this sense of achievement as 'compassion satisfaction' (Salloum et al., 2015). This is the sense of enjoyment that some professionals get from caring for others. It is thought that higher levels of compassion satisfaction can help protect individuals from the stress of caring for others that can lead to burnout and secondary trauma (Salloum et al., 2015).

Disengagement is a term that is used again to describe psychotherapists but can also be applied across health and social care. This is the ability of care providers to distance themselves from their client's or service user's misery; the ability to empathise but then let go at the end of the day and not carry their client's problems with them into their own lives (Figley, 2009). Disengagement is typically applied to therapists and counsellors who spend a lot of time hearing about the trauma of others' and describes their ability to step away from the trauma and leave it separate to their own lives, however, this could be applied to any professional who is caring for or working with individuals with high levels of trauma. Self-harm has been linked to childhood trauma and abuse (NICE, 2004), and self-harm behaviours can themselves be traumatising, therefore those who are working closely with individuals who self-harm are likely to be exposed to high levels of trauma, which they must be able to separate themselves from for their own mental health.

Families and self-harm

More recently research has been conducted which looks at the experience of the families of those who self-harm, in particular their parents. The research into families and self-harm is relevant to residential care workers because although they are caring for young people in a

professional capacity the relationships that they build with those young people most closely resemble parent and child relationships than they do other professional care roles, due to the time spent together and the nature of interactions. It may be that the experiences of residential carers are closer to family members than they are those of other professionals. Residential care workers are responsible for parenting children who are not their own (McLean, 2013). The research into family member's experiences has shown that for parents of children who self-harm there can be feelings of guilt, shame or embarrassment, as well as physical consequences, such as loss of sleep, anxiety or even re-lapses in their own self-harming behaviour (Ferrey et al., 2016). Interviews with parents of children who have self-harmed revealed that not every child who self-harms come from an abusive or neglectful family, as is often reported, but in fact parents showed a great deal of concern and worry over their children, and the impact of their self-harming behaviour was evident. Research into parent's and families' experiences of self-harm have also revealed that many families feel professionals have a negative attitude and approach towards their children when they have gone to them seeking help (Stewart et al, 2018). Although some families reported positive interactions with professionals such as General Practitioners, others reported that they felt judged and found interactions with such professionals to be unhelpful and unpleasant, some felt that if they presented their children to hospital more than once for self-harm then they were met with staff who became negative and 'switched off' (Stewart et al., 2018), receiving less compassionate care. Attitudes like this are likely to contribute to the lack of help-seeking that is displayed by young people who self-harm and can prevent those young people from receiving the care necessary. Parents themselves have also reported becoming more negative towards their child's self-harming and becoming worn down by the experience of caring for their child (Ferrey et al.,

2015). Compassion fatigue has been applied to family caregivers, and as such is thought to be applicable to caregivers in general, (Lynch & Lobo, 2012). In their analysis Lynch and Lobo (2012) applied compassion fatigue to family caregivers of chronically and acute ill family members. They found that by clarifying its definition the term compassion fatigue has the potential to be used outside of healthcare professionals, as such it has the potential to be applied to residential care workers, who are often deemed to be outside the lines of 'professional healthcare providers' but neither do they fall into the line of friends or family members.

Residential Care and Residential Care Workers

This cycle of burnout and loss of workforce can be observed across healthcare, and in child and youth residential care it is no different, one study, which looked at a single residential treatment centre revealed that in a period of three and a half years staff turnover was 46.1% in (Connor, McIntyre, Miller, Brown, Bluestone, Daunais & LeBeau, 2003). In residential care the high turnover rate also impacts the residents, creating instability in residential homes (Connor et al., 2003), and also threatening the stable relationships which are so vital for the recovery of residents (Moore et al., 2018).

There is a distinct evidence gap as far as residential care workers are concerned, they are not included in the literature amongst mental health or healthcare professionals, and they also do not fall into the bracket of family or friends who support those with mental health issues. Residential care workers are often referred to as corporate parents or a part of corporate state parenting (Bullock, Courtney, Parker, Sinclair & Thoburn, 2006) leaving them in a grey area between family and friend support networks and those who are considered professional healthcare workers. Residential workers spend the most time with children

who are in residential care and are more involved with the daily challenges and struggles than other professionals in the residential care system (Bastiaanssen, Delsing, Kroes, Engels & Veerman, 2014). The existing literature has not reflected the experiences or voices of residential care workers.

Aims and objectives

This project aimed to examine the effects of caring for young people who display self-harming behaviours on the professional carers who look after them. Residential Care workers are a neglected demographic in terms of the research into the effect of caring for mental health workers. Very little research has been undertaken to examine the impact that caring for those who self-harm can have on residential care workers, on researching this project only one similar study was found by the researcher (Williams & Gilligan, 2011). The aim of this study is to answer the research question “what is the effect of caring for people who self-harm on residential carers?”

Methodology

Design

A qualitative design allows for an in-depth and yet open analysis of experiences, which puts people’s voices at the forefront of the research (Vaismoradi, Turunen & Bondas, 2013). Qualitative methods are popular in health and social research, particularly when it is the goal of the researcher to look at the personal experiences of the individuals at the centre of health care (Vaismoradi et al., 2013). Qualitative methods have a long history of being adopted by researchers in the field of health and wellbeing as they provide a rich account of the experiences that individuals have (Braun & Clarke, 2014).

Participants

Participants were recruited through a residential care home; the manager was contacted and gave their permission for staff to take part. The manager then asked staff members to contact the researcher if they wished to volunteer to take part. The researcher explained that those with experience of caring for individuals who had self-harming behaviours were invited to take part. The experience of participants ranged from just over twelve months up to thirteen years.

Data Collection

Interviews were the chosen method of data collection. By adopting interviews with open-ended questions, the participants were able to expand and provide detailed accounts of their own experiences in the field of professional social care. Before each interview the participants were given an information sheet (appendix A), which explained the handling of the data collected and the issue of consent and assured them that should they wish to they could withdraw at any time. In the information sheets, participants were provided with numbers for counselling services in the unlikely event that they became distressed during or after the interviews. Participants provided informed consent and signed a consent form (appendix B). The participants engaged in a semi-structures interview with the researcher, which provided a series of questions whilst also allowing flexibility to cover additional topics. The interviews took place at a convenient location convenient for the participant and were recorded via Dictaphone. After completing the interviews, participants were thanked for their time, and were provided with the information sheet to take away with them that

listed all the details about the study, withdrawal, sources of support, and contact details of the researcher.

Method of Analysis

The interview were analysed using Thematic Analysis (Braun & Clarke, 2006) By using thematic analysis, the information shared in the interviews could be analysed to identify patterns and shared ideas from the different interviews, thematic analysis allows the information gathered to be rich and in-depth and does not demand that the information be reduced into less meaningful findings (Braun & Clarke, 2006) Each interview was transcribed, and the researcher familiarised themselves with the data, by reading, and re-reading the data. Initial codes were identified at this stage and mapped on separate sheets of paper. The interviews were studied thoroughly, allowing subtleties to be detected, and less obvious themes to be found. After generating initial codes within the data, that is the data was then studied again, this time looking for themes. The interviews were listened to multiple times and read at least three times, and then read with each theme in mind specifically to be looking for similar or relevant themes. The themes were then collated, and each theme defined clearly expanded upon in the research. The themes were split up and pooled into groups which made up the codes.

Ethical Considerations

Ethical approval was given by the Ethics committee of the University of Chester prior to the commencement of the research and adhered to the BPS guidelines. The study of self-harm is sensitive and as such the ethical considerations for this study were the well-being of the participants, and the handling of any confidential information that was revealed by the

participants in the interviews. Participants were informed beforehand that they could find some of the questions or the topic itself upsetting and as such could withdraw from the interview at any time. Participants were also provided with the appropriate resources to contact should they find that the information discussed did cause them upset.

Confidentiality was ensured by not including the names or any personal information in the transcripts.

Reflection and limitations

This paper adopted a social constructionist epistemological approach when the data was being read, that is there is an understanding that there is more than one truth, or knowledge and this needs to be understood when interoperating the data (Willig, 2001). For this reason, when the transcripts were being analysed, the researcher kept in mind that there are multiple truths and the participants' culture, history and own language shaped their experiences (Willig, 2001).

What was evident during the conduct of the interviews for this research, was that participants would answer the questions and seemed to be talking in an open and honest way, aware they were being recorded, and once the interview was completed and the researcher stopped recording then participants would reveal a lot more information about the topic that had been discussed in the interviews. When they were aware that they were no longer being recorded participants talked in a more frank and open way than they had during the interviews, most of them started to talk in detail about the impact that caring for people who self-harm has really had on them, when they had stated in their interview that it had not. This in turn meant that during the analysis process a different perception of what the participants were saying was held, because for some of the participants who had stated

they were unaffected in the post interview conversations that had admitted to feeling very affected.

All of the participants are aware that I also work as a residential care worker and this could have had a couple of different impacts on the interviews. I may have been afforded insider status during the interviews and the participants may have been more open to the questioning in the interviews and more forthcoming with their answers. It could also have been the case that because of this there was an element of participants trying to save face and not admit to feeling affected, as part of the culture of residential care and not wanting to be seen as a weak member of staff. It also may have led to shorter and less informative answers as a lot of assumptions could have been made about information I already knew, leading to participants only half explaining terminology or processes.

Results

From a Thematic Analysis of ten interviews with residential care workers, five main themes were generated. These were: 1) the support they felt in work, 2) disengagement from self-harm, 3) defence mechanisms and barriers, 4) coping mechanisms and 5) training.

1) Support in Work

The first theme that was identified across all ten of the interviews was that participants identified the importance of feeling supported in work. For many of the participants this feeling was not there, or they were unable to find support from the most obvious sources. The sub-themes were identified as clinical support, us versus them, manager support and blame.

Clinical Support

Participants spoke about their experiences of the clinical support available within work, the experiences differed and reflected an inconsistency of support available. Some participants spoke about clinical support being unavailable and wanting there to be more.

Emma: "I think that it is really, really good when they're available, I think it's just a shame that it's not available all the time and I think it would be good if they had something like that (clinical support for staff)." (Emma: 401-403)

Emma has two years' experience working in residential care and spoke passionately about self-harm and wanting the clinical support to be more available. Emma's experience of clinical support that she had received in work led to her feeling that it should be made more available to residential care workers.

Other participants reflected on clinical support as something that they felt was unnecessary and seemed to show a negative attitude towards needing to ask for extra support. Within a lot of the participant's responses there seemed to be an attitude of not wanting to appear to be weak. Grace is relatively new to residential care work and had the least experience of self-harm amongst the participants.

Grace: "I feel a bit silly going and saying 'I've seen this and now I need to talk about it'...it's just for myself I'd feel like I'm just making a big deal out of it" (Grace: 70-71, 73-74)

Grace's attitude towards clinical support seems to show a lack of willingness to seek support or ask for help. Grace's feelings about clinical support, or even just wanting extra space to talk about self-harm incidents were reflected in other participants' responses, with many explicitly saying that they had not received support. Despite the attitude that some of the

participants held towards therapeutic support, many of them went on to say they wanted more support to be available. Grace went on to say

Grace: "I think there should be a bit more after care for staff, as in like debrief wise or another, another way of like talking about it or expressing it or support from the company or something like that, erm, to support staff after an incident like that because it can have a big effect on staff" (Grace: 125-130)

Even after stating that she felt silly asking for the additional support, Grace went on to say there was more needed, perhaps revealing that labelling the support as 'therapeutic' has negative connotations for some of the participants, as opposed to normalising the support and calling it a debrief.

"Us versus them"

Some participants spoke about feeling that there was a culture of clinicians versus carers in work:

Michael: "The therapist sees somebody once a week or once a month and the care workers see them every day, and I don't think the communication with them was very good at all, I really think that could have been a lot better, a lot tighter, rather than us versus them, which it did feel like" (Michael: 206-210)

This feeling of us versus them is a potential barrier acting against carers seeking additional support. Many of the participants spoke about the clinical side of the residential setting as a separate part of the system, and not as their colleagues. Some participants felt that the clinical support was not a part of work that they could access and that they could not approach them to ask questions or gain support, they spoke about the support as not being available to them.

Manager support

Jane was one of the most experienced participants, having worked within residential care for the last sixteen years, with some breaks out of care work. Jane talked about feeling that when a self-harm incident happens then her manager is more concerned about the correct procedures and paper work being followed, stating:

Jane: "It's not about the staff at all. There's no interview after a self-harm to say how did that make you feel? At all, it's not a thing that exists, so no, not supported, and I think that's a social car thing because I've never had that in any place I've worked in self-harm[.]" (Jane: 194-197)

There are procedures put in place in houses to support care staff as well as to ensure that after an incident takes place then all staff involved learn from their actions and everything is covered, staff spoke about these procedures (debrief, supervisions and team meetings), and for many they felt that there was inconsistency across the different care homes and it can often depend on the manager and senior on shift.

Tina who has worked in residential care for only just over a year, but had experienced some extreme self-harm incidents, was one such participant, when asked if she felt supported at work she said:

Tina: "where I am now, yes, I feel that's not always the case across all homes, and it depends on your manager, it depends on your shift, it depends on your senior, erm, so me personally where I am right now, 100%- - where I was 12 months ago I wouldn't have said there was no. I would have had a completely different outlook on it, where I wasn't supported, I wasn't prepared for anything at all really" (Tina: 131-137)

This response stresses the importance of the team around carers and shows how unsupported carers can be if they are in a house where the supporting procedures are not followed. Other participants had similar experiences to this, for example Louise had worked in residential care for two years did not have any supervisions and very little in the form of debrief for the first ten months of working in her home:

Louise: "It was a new home, and kids were in crisis, so debrief and things like that, supervisions, didn't really exist" (Louise: 116-118)

These comments reflect what a difference having a supportive staff team and in particular a supportive manager can make for residential care workers. Emma felt that supporting a young person through a self-harm incident had an effect on her mental health after it triggered memories of her own son's self-harming, but because she felt supported in the house she works at she felt she was able to work through it and that thanks to her own personal experience she was able to provide high quality care to the young person.

Emma: "I think if it was bothering me, as in my work, I'm fortunate enough that I'm confident enough to go to my manager, so I've got a good relationship with my manager, I've got a good enough relationship with my team, so I do feel I could, I'm not afraid to" (Emma: 116-120)

Emma was happy to go to her manager and ask for extra support, the way she talks about not being afraid to go to her manager about the incident suggests that for others, in other houses or with other managers or different relationships that support may not always be available, which is evident in the way other participants talk about their experiences.

Blame

As part of the theme of support, feelings about blame were evident in some of the interviews, with some participants feeling not only unsupported by their co-workers and managers but also feeling that at times the blame of a self-harm incident was put on to them.

Jane: "There's a massive blame culture in care work, so if you work with a child that does self-harm- 'well what did you do wrong, why didn't you stop them?" (Jane: 228-230)

Other participants spoke about the responsibility of caring for young people who self-harm and the feeling of doubting themselves after providing care, due to the scrutiny of working for a care company. For some participants this had affected their position in work as they did not want to take on more responsibility. Participants felt that there was a series of questions after an episode of self-harm and that this led to the self-doubt because they did not always know if they had said or done the right thing.

2) Disengagement

The ability to leave work at work and shut off after an incident was talked about by almost all of the participants. For some participants this came easily to them, and they were unable to say how they achieved it. For other participants they talked about being unable to do this and feeling on high alert when they were at home as well as at work. Sub-themes that were identified were; offloading and having a natural ability to disengage,

Offloading

All of the participants spoke about the importance of being able to talk over an incident, so they could then move on from it, and mostly this did not mean talking to the therapists within the workplace, but instead to their colleagues.

Ben: "I suppose you off load really don't ya, with other members of staff, really or whatever ya know, - don't take it home" (Ben: 186-187)

Many of the participants named it as 'offloading' and stated that if they were unable to offload at work then they would find themselves doing so at home, either by talking to their colleagues from work or by discussing incidents with their partners at home. The result of staff offloading on each other may be that residential carers are ending up caring for each other as well as the young people they care for. One participant, spoke about herself in this way, and saw her role as a senior as being vital for ensuring that her staff are looked after as well as the young people, in the interview she said:

Emma: "who cares for the carer? And I say that all the time, who cares for the carer? Well I do, however, I'm not a professional so you need to go and speak to clinical" (Emma: 469-471)

She spoke about the burden of caring for her team and wanting to encourage carers to approach the clinical team more after an incident. She then went on to describe the difficulty she found in being a senior and feeling like she did not have someone to look after her professionally:

Emma: "but having somebody to offload to, because even as a senior, it's quite a lonely position, because you can't really share it with your team, you can't really, the stuff that you want to moan about, but then, not moaning, but you don't really want to go to your manager about" (Emma: 182-184)

For Emma she had to prioritise taking care of herself in her time off because she did not feel looked after during work all the time because of her position. As a senior she felt she had to look after the rest of the team, she also felt that this was not always the case for other care workers who were not on her team.

Natural ability to disengage

Some of the participants recognised that it was important to leave work at work and not bring the incidents of self-harm home with them, those who were able to do so were mostly unable to say how they could do this.

“Erm, well I-I never felt like I needed to take particular care erm, I just go home and uh and then continue on with where I left off before I went for my two day shift, carry on from where I left off, just go back into normal life” (Michael: 100-102)

For Michael and two other participants they were unable to say what they did that made it possible for them to leave work at work when they got home. Some participants felt that they had always been able to do this, and they were aware that for their colleagues this was not as easy and that some were unable to do so.

Unable to disengage

Participants spoke about being mentally and physically exhausted after providing care, and that this is worse when the houses are in crisis as everyone is on edge for the whole shift.

Louise: “you’re on high alert all the time, so when you’ve had two, three days of high alert- constantly being told you have to watch these kids, you can’t let them out of your eye sight in fear of them like doing something. So, like even if they go for a shower or a bath- asking for that razor, within a split second of them leaving the bathroom, it’s just constant so when you’re having that for like 72 hours, you go home and you’re like still in that mode of like “oh my god there’s a razor there, oh no, it’s allowed to be there”- because you’re in your own house.” (Louise: 60-66)

Participants talked about that feeling of being on edge 24 hours a day so when they come home their mind set can continue to stay the same as when they are on shift and this can make it difficult to relax during time off.

3) Defence mechanisms and barriers

Within the theme of defence mechanisms and barriers the sub-themes that were identified were; no effect, getting used to it, having less empathy, burnout, more support for other staff and job changes. Participants stated they did not feel affected by caring for young people who self-harm, some even stated that working in residential care had no effect on them. However later on in the interviews they would end up talking about how work affects them in other ways. For example, Ben stated very clearly that the work does not have an impact on him and then went on to say:

Ben: "I think the first day is the worst day, I say, when you leave work and it's on your mind, and I'm usually thinking about it when the night before, before I go to work."

(Ben: 206-208)

Ben also said that he tends to phone work while he is at home before he goes back on shift-

Ben: "that telephone call is the one that I- it puts you at ease really tell the truth sometimes." (Ben: 216-217)

Despite saying that caring for people who self-harm does not affect him he then talked about feeling on edge and not able to relax during his days off, like many of the participants his first response was to adamantly say that it has no impact on him and then go on to talk about ways it does impact on him, again this may reflect the culture within care work to not be seen as a weak member of staff.

Getting used to it

A number of the participants spoke about having gotten used to self-harm and being around it, as well as feeling that it is important to get used to it and not feel shocked by any situations they are confronted with.

Jane: "then I changed that way of thinking but, ye, now I just, I find it easier, I'm not shocked really at all, by anything that I see because I feel like I've seen it all, and when you've seen someone with a ligature round their neck and you're having to cut them down, I feel like that's kind of the limit of things that can shock me." (Jane: 163-167)

Jane, who had the most experience of self-harm out of all of the participants spoke about not only becoming used to self-harm, but described it as feeling dead inside to it, she said:

Jane: "I think that it's difficult because you can get to a point in this job where, if you do it for so long you do, you can end up feeling a bit dead inside, that you're not shocked and that you're erm, ye basically, you're not shocked anymore by what you see, and I think that it's ok to not be shocked" (Jane: 243-247)

She felt that it was necessary to be able to do the job well to reach the point of not being shocked, she used the term "dead inside" more than once during her interview, and this choice of words suggests a discomfort with the level of how accustomed she had become to self-harm, she also went on to say that sometimes she feels like a bad person because of this:

Jane: "you feel bad for not kind of sitting in debrief at the end of the day, in bits, and crying because somebody cut their arm open, you're more about the fact that you've been sitting in A & E for four hours, and you're quite annoyed about that, and that

can overtake actual, your actual feelings about it, because you're so used to it, and it's become the norm, and you can feel quite uncaring in that sense." (Jane: 256-261)

Jane's feelings seemed to be in contradiction, on the one hand she felt it was necessary to be able to support a child properly, to reach a point of not being shocked and being detached from personal feelings and on the other hand she felt that feeling that way can leave carers with a sense of being less caring. Jane's comments seemed to reflect a possible level of compassion fatigue or carer burnout.

Less empathy

Some participants spoke about feeling less empathy for young people who self-harm now that they have had so much experience, compared to when they first started in residential care work. Kate, who has worked in residential care for eight years said:

Kate: I suppose I had a little more, maybe a little empathy back then than what I do now after doing it for so long. (Kate: 116-117)

She went on to say why she thought her levels of empathy had decreased:

Kate: "When I first started to what I do now, I think from seeing it, and seeing, and seeing kids that used to self-harm a lot in placement and then leave placement and then not do it for so long, you sort of think oh is it worse because of being on placement" (Kate: 131-134)

Kate felt that self-harm within residential care is sometimes made worse because the young person is in care, and they receive staff attention and sympathy for the behaviour. Many of the participants voiced similar feelings to Kate, that their initial reaction to self-harm had been shock but also empathy and that this has decreased over the years of their experience.

Burnout

participants with the most experience spoke about self-harm in a very matter of fact way and expressed feelings of frustration from repeated behaviours and situations and reaching a point of having less empathy for the young people self-harming.

Michael: "At the last place I was, I was worried only, I wasn't worried for my safety, I wasn't worried for the safety of the children, I was worried for like erm, it was very tiring and uh very repetitive and therefore became very boring at times. And I was more worried about going away for two days and those two days just feeling like they were very, very long, so it's a bit selfish really." (Michael: 111-116)

Michael talked about the monotony and the repetitive nature of a lot of the children's behaviour, including self-harm, and feeling tired by doing the same thing over and over again. He also felt frustrated by the lack of progress he felt the children were making and therefore feeling very little reward from the job.

Michael: "because we weren't really making an awful lot of progress- it didn't feel like, if you looked over 12 months, yes there was progress, tangible progress that you can see, but week by week it was so gradual that you wouldn't see it so it became tedious." (Michael: 141-144)

The way Michael spoke about the nature of residential work sounds clear that he is feeling tired of caring for the children and not seeing changes in their behaviour. The language he uses signals a need that he has to see immediate change in behaviours and the frustration that is born out of making slow progress with young people.

More support for other staff

A few of the participants spoke about not needing any support and being unaffected by self-harm and then went on to talk about support that they felt was needed for others, because they had seen other people become effected.

Sandra has worked in residential care for two years, in the interview she talked about there being a lot of training and support for staff around self-harm, however she then went on to say:

Sandra: "I think that looking at how some people react to self-harm there should be more for people like them, it really gets to some people, there should be more for people like them but people like me it doesn't really bother me." (Sandra: 90-93)

Michael spoke about having seen the work effect his colleagues, he felt he was able to switch off totally from work when he is off shift but felt not everyone can do the same.

Michael has three and a half years' experience in residential care work:

Michael: A strategy to cope with that and to be able to compartmentalise work and home life and ye, that would be, that would be important because I've seen it bother people, you know, I've seen people crying when they're at home, and you know they really ought to, because they care so much and so on, and uh ye that would be handy. (Michael: 174-178)

He spoke about residential care as being a stressful and difficult job to do and something that he is aware as a source of stress for his colleagues but did not see himself as being affected as the stress, rather he wanted his colleagues to be able to cope with the stress as he is able to.

Job Changes

Despite being one of the most experienced residential workers and being offered senior roles, Kate chose to remain as an entry level residential care worker. She has led shifts and spoke about that experience as being overwhelmingly negative:

Kate: "the worry there is horrific because you just think oh my god what if this happens, or something had happened just because of a decision I made, am I going to get backed up on that decision, was it the right decision to make?" (Kate: 196-199)

When asked why she did not take the job as senior she spoke about not wanting to move up because of the increased responsibility and feeling like if she was a senior then she would no longer be able to remain unaffected by residential work.

Kate: "I think that's the worry ye, I don't, I don't think I would be able to shut off then from the work like, and I think ye the worry would, and if something did happen I think the guilt would be on my head. Whether or not it was my fault I think I'd still feel guilty." (Kate: 205-208)

This theme crosses over into the theme of support or lack thereof for residential care workers, Kate's reasons for not choosing to go for the senior position reflected the worries of other participants about the lack of support from the organisation or their managers and being afraid of the blame that can come with young people's behaviours or self-harm incidents. This illustrates the impact that fear can have, preventing workers from choosing to further their career or take promotions. Out of the ten participants five of them had worked in residential care for three years or more, all five of those participants had worked for multiple companies in their time and three of the participants had left care work for different periods before returning to new companies. All of those participants said that they did not feel personally effected by caring for young people who self-harm.

4) Coping Mechanisms

Coping mechanisms were identified throughout the interviews, these included; sleeping, drinking and smoking and support from family and friends.

Almost all of the ten participants named sleep as their first thing they do to look after themselves after a shift and spoke about their physical exhaustion that they feel after caring for young people, particularly after an incident of self-harm or other.

Louise: "talking isn't really a thing so like you try and find-exercise, but you're just so knackered after a shift you just can't be arsed." (Louise: 91-92)

Louise recognised other coping mechanisms which she would like to do but spoke about being too physically tired to do them, and that issues of confidentiality prevented her from talking about work at home. Other participants also recognised that they were not looking after themselves as well as they would like to and said that sleep deprivation was the main reason for this, as after shift they did not have the energy to do so and sleep is the priority. A few of the participants said drinking and smoking heavily is how they shut off from their shift. Louise spoke about her coping mechanisms after a shift:

Louise: "Drinking I reckon, and smoking a lot, of cigarettes [laughing]. – Super unhealthy yeah, totally. And eating a lot of junk food as well, because your body is just so tired." (Louise: 100, 105-106)

One participant said that he will drink more on his days off after having a bad shift than when the shift has been problem free. And another spoke about smoking as the first thing she does after shift. These actions are things participants cannot do whilst on shift, and by naming them as ways that they relax after shift or cope after a hard shift they were spoken about by participants as coping mechanisms, drawing a distinct line between home and work.

Emma spoke about the importance of coming home to a safe space, and how important it is that she has a supportive husband who she can offload on to. She spoke about crafting on her days off, and making cards which she then gives to charity:

Emma: "So I'll just go and do loads of the same stuff, get it out of my system that way. So, I create something quite pretty from something that might be quite negative and that's just my therapy really, so, that's how I do it." (Emma: 187-190)

Emma recognised the need to look after herself and spoke about being a reflective person so needing the space to be able to think over her shift when she gets home, in a safe way, which for her crafting provided her with that head space to do so.

Other participants named their partner at home as being an important part of their coping strategy, after a bad shift they might talk to their partner or rely on their partner to tell them when to look after themselves.

Ben spoke about his wife recognising in him when he needs to take time off,

"Ya know, wife can see in my face, because I've done it a number of years like, when I need to ya know." (Ben: 187-188)

For these participants the support of a significant other was highlighted as an important element to their coping strategy outside of work. None of the participants who did not have a partner spoke about their lack thereof, so it is unclear if a partner is a key part of being able to cope after a bad shift, but for those with a supportive significant other this was recognised as important by participants. This would also suggest that the separation between home and work life is blurred for those participants.

5) Training

Training generated two sub-themes; adequate and inadequate training.

Adequate training

Some of the participants began by saying that they felt there was an adequate amount of training. One of the participants talked about how often the training is on and felt that that is what made it adequate.

Sandra: "every time our training finishes we get put on the next course so, yeah, I think we have sufficient self-harm training" (Sandra: 35-36)

Sandra however went on to say she felt that self-harm training specifically needs to encompass more information about the after-care for young people and felt that much of the emphasis was on the practical and first aid aspect of care.

Ben, who has almost thirteen years' experience in residential care and had received several different forms of training felt that training has become much more comprehensive and more in depth. He talked about training he has received which includes a trainer who has previously self-harmed.

Ben: "And she was the trainer yeah, she was very good, she was ya know, she gave more of an insight" (Ben: 113-114)

Ben felt that receiving training from somebody who had been on the other side of self-harm and experienced the care from a young person's perspective was what gave him the insight to be able to support young people who self-harm, although he admitted he still could not understand why many of the young people he works with do self-harm.

Inadequate training

Most of the participants felt that the training they received was not comprehensive enough to prepare them for dealing with an incident of self-harm.

Grace: "I don't think it's enough training, because, when that incident happened I had an idea of what to do but I wasn't 100% sure." (Grace: 22-24)

Grace felt she was not sure of the correct procedure to follow and felt ill-equipped for the after-care for the young person she was looking after. One of the participants interviewed had never received any training on self-harm after having worked for the same company for over two years;

Sarah: "The only training that I've had in this company is attachment training and restraints." (Sarah: 135-136)

Some of the participants felt there was an over emphasis on the first-aid and practical side of self-harm and not enough to prepare staff for the more emotional side of it and preparing staff for being able to talk about self-harm.

Tina: "I feel like there should be more training of what to expect from self-harm, and the different forms of it, other than 'this is how to do the basic first aid' and the types there are and whether they need to go to the doctors or the hospital. (Tina: 108-111)

This feeling that staff are not trained well enough to prepare them for self-harm and arm them with the necessary tools and information to then be able to work well supporting young people who self-harm was echoed throughout all ten interviews. To sum it up, when asked if she felt there was enough training provided around self-harm, Jane said:

Jane: "No. Not in the slightest—it's a slideshow presentation, really basic" (Jane: 74-75)

Jane had received what she described as more comprehensive training in a previous company where she worked in the self-harm unit, but ended her thoughts on training with

Jane: "in a general care home, no, the training's terrible." (Interview 3: 93-94)

This statement from Jane summarises what nearly all of the participants ended up saying, even when they initially started off saying they felt the training was adequate, when asked at the end of the interview if there was anything they wished to add or felt residential care workers should be taught they all felt that self-harm training was the area that needed improvement in their workplace and through their experience.

Discussion

The current research set out to answer the research question ‘what is the effect of caring for people who self-harm on residential carers?’ Five themes were generated from the interviews. First, that the level of support carers receive in work differs, as do individual’s need and response to support. Second participants discussed the need to disengage from work and prevent themselves from bringing work home with them after a shift. Third, several of the participants felt that caring for people who self-harm has no effect on them at all, however, when discussed in further details they spoke about decreased levels of empathy and varying degrees of burnout. The fourth highlighted the importance of coping mechanisms and how carers look after themselves away from work. Finally, the need for more training was identified by every participant as being a high priority for things that care companies can improve.

Support

One of the key themes to emerge from the data was the topic of support for care workers. Participants discussed support in a number of different capacities, mentioning the support they receive from their co-workers, their managers and also the availability and sometimes lack thereof, of clinical support within work. Formal support was recognised by participants,

they knew that there were channels within work where they could in theory access clinical support for some of the incidents they had experienced, however, for some of the participants they seemed to have an attitude against the clinical support and this was expressed by some of them as being a service that they did not need and did not want to be viewed by their colleagues as needing extra support. Previous research has made calls for medical professionals to engage in more reflective practice, particularly when caring for individuals who self-harm (Hadfield et al, 2009). By engaging in more of a dialogue about how doctors are impacted by their caring role for self-harming patients, it has been suggested that they will be more reflective on their practice and therefore improve upon their skills and be able to further meet the needs of their patients (Hadfield et al, 2009). Much of the language and attitudes of the participants in the current research reflected a negative attitude towards the support offered, either through a perceived lack of availability or not wanting to engage in the service when it is offered. In this sense there is a possible barrier against care workers being able to further develop their practice, as they are not accessing the platform that would allow them to reflect and advance their practice. Many of the participants spoke about the support that they receive from their colleagues as well as from their management and organisation. The way many of the participants spoke of incidents of self-harm was with an element of blame, that they felt they would be blamed if they are involved in an incident and that for some they felt that instead of being supported as a staff member they felt they would be faced with questions about how and why they could have allowed self-harm to happen.

Disengagement

Many of the participants talked about how they are able to leave the issues and incidents of work behind them when they end their shift and return home, participants also discussed struggling to be able to do so. The ability to mentally and physically detach from work when at home is referred to as disengagement, (Smit, 2016). Disengagement has been used to describe this separation of home and work life in different areas of work, and not only in the healthcare profession, reports have shown that up to 72% of people questioned spend time worrying about work when they are outside their working hours (Smit, 2016). The importance and the value of detachment from work is clear in the literature, improved work performance has been found due to improved leisure time and more clear work and home separation (Smit, 2016). The well-being of employees is also improved by 'off-time' for individuals to recover from the stress of work situations (Hahn & Dormann, 2012). Some of the participants discussed the separation of work and home life in a very deliberate way and talked about the conscious efforts they make to keep the two separate and leave work behind them at the end of a shift, it has been found that this deliberate separation can promote psychological detachment from work (Hahn & Dormann, 2012), and in this case would aid participants to not feel negatively affected by being involved in incidents of self-harm.

Other participants spoke about the important role that their partners at home can sometimes play in helping them to offload from situations in work, and in those cases the separation of work and home life is less clear. Research has looked at the importance that the role individual's partners can play on their ability to disengage from work (Hahn & Dormann, 2012). For those participants who state they sometimes off load on their partners this could potentially have a negative effect for their partners as well as decreasing the participant's ability to detach from work and have a recovery period where they can rebuild

their energy and refocus for when they return to work (Hahn & Dormann, 2012). The evidence which suggests that increased recovery time and respites including scheduled days off can protect staff from burnout (Kuhnel, Sonnentag & Westman, 2009), would suggest that a healthy work and home life separation should be encouraged and promoted. One way of preventing staff from taking home the problems in work is through the implementation of debriefs for staff.

The use of debrief was talked about by all of the participants, it is identified as a procedure that is put in place by care companies to help staff to process events of each day and support each other at the end of a shift. The importance of providing staff with an opportunity to debrief after an event, as well as standard practice after each shift has long been established (Clark & McLean, 2018) and is used across a range of disciplines and professions. A debrief allows staff to discuss an event or incident, and reflect on ways practice might have been improved, as well as providing the opportunity for peer support amongst colleagues, particularly after a traumatic incident (Clark & McLean, 2018). The benefits of debriefing for individuals have been discussed, and are thought to be multiple, including; reassurance from their colleagues about decision making, as well as about their status in work and their ability to practice and perhaps most importantly providing the opportunity to talk about an incident (Clark & McLean, 2018), in much of the literature around debriefs nurses are typically at the centre of the discussions. Despite much of the emphasis in the literature being placed on the importance of debriefing for nurses in particular, it can be assumed that the same impact would be had for support staff after an incident, and in particular for those supporting people who self-harm, as the research says, debriefing is an important tool; useful for all healthcare staff (Huggard, 2013). Debrief can and will take many forms, and some residential care homes adopt a formalised debrief

where it might be structured and focuses mainly on strengths and weaknesses of the team's practice, however debrief may also be informal. Many of the participants talked about the importance of being able to talk about an incident with colleagues, and in this sense, this is an informal debrief, this ritual has been noted in other studies, where professionals will discuss their day at the end of shift, and therefore are able to leave work behind them, instead of taking issues home (Huggard, 2013).

'No impact'

Many of the more experienced participants began by saying that caring for young people who self-harm has no impact on them, however, with further discussion they went on to talk about decreased levels of empathy and using language that was harsh such as 'dead inside' suggesting levels of discomfort with their own antipathy towards self-harm. The language that was used by some of the participants to describe their experiences of self-harm was blunt and matter of fact, it seemed to trivialise the act of self-harm, removing emotion from the behaviour and incidents. Hadfield, Brown, Pembroke and Hayward (2009) referred to this type of reflection as 'silencing of the self.' In their study of Accident and Emergency doctor's responses to self-harm. They suggest that by trivialising self-harm and removing their emotions and place distance between themselves and the patient's self-harm. It is possible that residential carers do the same thing, they are often exposed to extreme self-harm, many of the participants described having to cut young people down and out of ligatures, but they described it as an everyday event, as though it should not have an impact on them. Participants who initially spoke about being unaffected later revealed different ways they had actually been affected by their work, suggesting that perhaps they felt the need to conceal the effect of self-harm on them. In their study which

looked at the experience of caring for people who self-harm from the perspective of nurses Wilstrand, Lindgren, Gilje and Olofsson (2007) found that nurses experienced similar feelings of distancing themselves from their emotions when caring for self-harming patients and that this can lead them in time to feeling cold or distant. Similar feelings were expressed by participants in the current study.

The language used by many of the participants hinted at a feeling of not wanting to let the team down or be the weak link in their work team, and that being affected by the incidents in work is something that happens initially in their career but they 'get used to it'. Other studies have found similar results to this present research, in that they found emergency staff held generally positive attitudes towards young people who self-harm (Crawford et al., 2003), and that there was no relation between training or time exposed to self-harming behaviours and attitudes. Such results suggest that it is possible to adapt to new situations, including caring for young people who self-harm, and will not always be negatively affected by such elements of care.

Participant's work experience and changes in companies reflects the concern over high turnover in the residential care workforce, this trend is evident elsewhere in health and social care, particularly among those who care for a high-volume of individuals who self-harm (McCann, Clark, McConnachie & Harvey, 2005). As McCann et al. (2005) highlight in their study of attitudes towards self-harm amongst Emergency Department nurses, due to the high level of turnover there is a further need to monitor staff attitudes and education around self-harm to ensure that staff remaining in the workforce maintain positive attitudes.

Coping mechanisms

Participants discussed the things they need to do after a shift to look after themselves, The most consistent was the emphasis that was placed on the need to sleep after a shift, regardless of the time a shift is over. Children are usually in residential group homes as a last resort and providing support for these children can be physically and emotionally demanding due to extremely challenging behaviours (Barford & Whelton, 2010). The participants spent their days off recuperating and resting due to the high levels of exhaustion that they felt after providing care at work.

The need for sleep, for the care workers, was of notable importance to the participants with some talking about physical exhaustion preventing them from engaging in healthier habits in their time off. Shift Work Disorder has been identified as something which can affect shift workers, and cause insomnia or severe sleep debt (Booker, Magee, Rajaratnam, Sletten & Howard, 2018). Shift work can have a negative effect on the health of individuals, including increased risk of obesity, cardiovascular disease, depression, high blood pressure and anxiety, (Booker et al, 2018) Although these specific symptoms were not discussed by participants, many of the effects of caring for young people who self-harm could also be exacerbated by the side effects of working shift patterns. Participants felt physical exhaustion and a need for sleep. However, they also discussed the impact that shift work has on them during their days off, some of the participants felt unable to take care of themselves in a positive way due to being too tired to do so. Not only are residential care workers working shift patterns, but the shifts they work are typically draining due to the amount of emotional labour involved in caring for young people with complex behaviours (Barford & Whelton, 2010). A few of the participants discussed other ways they felt they looked after themselves, referring to their need to smoke and drink after a shift, and more so if they have a particularly bad shift. These ways of looking after themselves were habits

that they cannot do whilst they are at work, creating a big separation between what they do at work and what they do at home.

Training

Without exception all of the participants felt that training around self-harm needed to be improved, particularly in general and non-complex needs care homes. Within the complex needs care homes participants felt that the training they received, if they had any at all, was basic and too much emphasis was placed upon the first aid administration and 'clean up' of self-harm. The care workers felt that this left them ill-equipped to deal with the more complex emotional side of self-harm. Previous studies have found that training can improve the attitudes of healthcare workers towards self-harm as it can develop their understanding, however, one study found that nurses even refused training, stating that they already knew how to care for people who self-harm, suggesting a belief that exposure is more important than formal training to understand or care for people who self-harm (Shaw & Sandy, 2016). Other studies have found that training has been associated with higher levels of empathy (Muehlenkamp, Claes, Quigley, Prosser, Claes & Jans, 2013). Muehlenkamp et al.'s (2013) study looked at the attitudes across four different professionals (Social worker, psychologists, psychiatric nurses and medical nurses), they found that the more training professionals received the higher levels of positive empathy were shown.

The participants in the current research have all but one received self-harm training, and yet some participants still reported feeling less empathetic now than they were when they first worked in residential care. Some of the participants reported the training in some cases was merely a slideshow presentation and they felt they did not learn about the motivations and

causes of self-harm and wanted a deeper understanding of self-harm. The importance of empathetic care, rather than simply administering first aid has been acknowledged in previous studies, including Piggot et al.'s (2004) study where they interviewed young people who had self-harmed in residential care, participants stated that the support they needed from their carers was empathy and someone to ask them why they were self-harming. The young people in Piggot et al.'s (2004) study said that feeling that their carers cared about them and were listening to them and showing them empathy made the difference in reducing their self-harm episodes. If residential care staff are feeling they have less empathy it may be impacting on the care they are showing towards the young people, they look after. The impact of fatigue that many of the carers expressed due to the pattern of shift work and the frustration of behaviours not visibly improving will also lead to less empathetic responses from the care workers. Because they are often seeing the same behaviours each shift the emotional labour of caring for the young people could lead to carer fatigue and a distancing of emotions.

It is significant to note that none of the participants held very negative views towards self-harm, contrary to what some of the literature states about professionals' attitudes towards self-harm, other research has also found that individuals across a range of professions hold generally positive attitudes towards individuals who self-harm (Muehlenkamp, et al., 2013). Some of the participants having expressed a decreased level of empathy did not go any further with negative attitudes, the participants felt that they had a good level of understanding about the nature of self-harm. Previous research into the experiences of residential care workers have found that a coping mechanism that some staff use to deal with negative behaviours is to seek meaning in the behaviours, which could explain why

staff feel there is a need for more in depth self-harm training, so they could understand the meaning behind the behaviour (McLean, 2013).

Training and education around self-harm has provided professionals with more confidence and enabled them to approach patients who self-harm in a way that they feel comfortable to care for them (Koning, McNaught & Tuffin, 2018). Some of the participants in this study felt unsure about whether they had handled incidents of self-harm correctly and particularly when they were new to caring for people who self-harm they felt unprepared by the training provided to deal with self-harm. Some research has found that the more experience medical staff have had with self-harm the less able they feel to provide the service, and they therefore felt an increased need for training (Egan et al., 2012).

This research highlights the need for professionals involved in the care of young people who self-harm to have further training (Crawford et al., 2003), and the current study provides further evidence that workers feel this is important. Training for self-harm highlights the need for empathic caring and the utilisation of active listening skills as well as looking after young people using the basic values of the caring professions, and these do not change due to someone self-harming (Foster, Birch, Allen & Rayner, 2014).

Implications

This research provides insight into frontline care work with self-harm. Residential care workers are often overlooked in the literature despite the fact that they typically spend more time with young people who self-harm than medical and healthcare professionals. A key implication is the need for more training for the staff who are working directly with young people. Residential care workers are most likely to be the first professionals who will be receiving disclosures of self-harm and administering care, therefore they need to be

prepared so they can react in a calm and non-judgmental manner. Second, the need to put in place more robust support systems for residential care workers came across as a key need for participants. Doing so could potentially counteract the high prevalence of burnout seen in the industry and it was something that the participants of this study felt was lacking in many of their own experiences. The participants highlighted that there was a high staff turnover, and this affected consistency of care. The current research reflects the views of the participants many of whom felt that self-harm was something that they got used to and that caring for young people who self-harm is something they have gotten better at. Retaining staff with experience who are better equipped to manage self-harm episodes and can serve to improve the experience of the young people being cared for.

Limitations

This study was limited in its size, with a participant pool of ten, it would be most beneficial for a larger sample size to take part in the semi-structured interviews to further develop the evidence. A possible limitation could have been the implication of participants knowing that the researcher was a residential care worker and attached to their organisation, this could have impacted how open and honest they felt they could be during the interviews.

Conclusion

This research found that not all residential care workers were impacted in the same way by caring for young people who self-harm, but that in general there are calls from workers for more support from their managers and clinical staff as well as training from their companies to prepare them for the responsibility of being first responders and support for many self-harm incidents. This is in line with what much of the existing literature has found with

regards to other professionals and their work with people who self-harm. The data gathered in this research provides a more three-dimensional view of the experiences of residential care workers, many of whom are supporting some of the UK's most vulnerable young people. The experiences of Residential Care Workers are markedly different to those of other care professionals as they have a lower status and yet spend the most time with young people. The young people who residential care workers support present differently in the home environment than they would in a hospital or a Doctor's or Therapist's office, and so the residential care worker will have an honest representation of young people who self-harm. Residential care workers also work more intensely with the young people, the exposure to self-harm behaviours is higher. This research reflects the lost voices of residential care workers who play a pivotal role in caring for young people who self-harm.

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Williams, D., Gilligan, R., (2011) Self Injury and the Challenges of Responding to Young People in Care: The Experiences of a Sample of Social Care Workers, *Irish Journal of Applied Social Studies*, 11, 1, 14-25, DOI: 10.21427/D7KX62

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Wilstrand, C., Lindgren, B. M., Gilje, F., Olofsson, B., (2007) Being burdened and balancing boundaries: a qualitative study of nurses' experiences caring for patients who self-harm, *Journal of Psychiatric and Mental Health Nursing*, 14, 72-78, DOI:
10.1111/j.1365-2850.2007.01045.x

Winsor, T., McLean, S., (2016) Residential group care workers' recognition of depression: Assessment of mental health literacy using clinical vignettes, *Child and Youth Services Review*, 68, 132-138, DOI: 10.1016/j.chidyouth.2016.06.028

PARTICIPANT INFORMATION SHEET

You are being invited to participate in a research study. Before you decide whether to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and feel free to ask me if you would like more information or if there is anything that you do not understand. I would like to stress that you do not have to accept this invitation and should only agree to take part if you want to.

You should take this information sheet with you after the interview so you have all the information necessary.

Thank you for reading this.

What is the purpose of the study?

This is an academic study investigating the impact on carers who support people who self-harm. It is being conducted as part of my dissertation for my Masters Psychology degree.

Why have I been chosen to take part?

You have been chosen to take part in this study as you are a Residential Care worker and have experience supporting people who self-harm.

What do I have to do?

You will be required to take part in an interview lasting around 30-60 minutes in length. The interviewer will ask you questions concerning your experience as a care worker, particularly your experience working with young people who deliberately self harm. All interviews will be audio recorded and downloaded onto a password protected computer so that they can be transcribed. Once transcribed, the audio recordings will be destroyed from the device used to record them.

Who is conducting the study?

I am the principle researcher and am currently studying Master's of Science in Psychology at the University of Chester. I will be responsible for conducting the study and analysing the data which will be the material for my dissertation. If you have any questions, problems or complaints regarding the study, please contact the leader for this assignment, Dr Hannah Heath on h.heath@chester.ac.uk.

You can also contact myself, Laura Armstrong, on lauralarmstrong@yahoo.co.uk.

Is participation voluntary?

Participation in the study is entirely voluntary. You can withdraw at any time during the interview. Once the interview is over and you leave the room, you will be unable to withdraw from the study. There will be no financial incentive or payment given relating to participation. There will be no recriminations should you wish to withdraw from the study and you can do so without giving me a reason.

What are the risks/benefits of taking part in the study?

The perceived risk involved in taking part in this study is that you feel the questions are of a sensitive nature. The aim of the study is to understand your experience as a Residential Carer Worker, please do not disclose any information that you are not comfortable with sharing. Some of the questions may cause you to think about potentially upsetting situations or aspects of your job, again you can choose to stop the interview at anytime should you wish, please do take your time when answering and feel free to ask for a break. There are no right or wrong answers and none of your responses will be used to identify potential problems in your views or your behaviour. All of the data I collect will be analysed by myself, it will also be kept anonymous, thereby limiting identification of individual participants. The benefit of participating in this study is that it will enable me to conduct a qualitative study that forms my dissertation and therefore an important module of my degree.

What about confidentiality?

All interview responses are confidential. I will transcribe the audio recordings and this will only be seen by my dissertation advisor and myself. I will conduct the main analysis but may gain advice from my dissertation advisor in terms of generating themes that answer the research question. All data will be kept secure on a password-protected computer and once downloaded, will be erased from the recording device. The recordings will also be stored on a CD in order to be submitted for my assignment but these will be kept in a locked office at the university. Confidentiality may be breached however if information concerning potential or actual harm to people or criminal activity has been disclosed and the researcher will take advice concerning the most appropriate course of action should this situation arise.

What about the results?

The results will be analysed and used for my dissertation. Any quotes will be anonymised and will only be used to illustrate the main results.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem, please contact Dr Hannah Heath (email: h.heath@chester.ac.uk telephone: 01244 511932) who will try to help you.

If you are affected by any issues raised, you can contact your staff support services.

Alternatively you may wish to contact your GP, the Samaritans (email: jo@samaritans.org, phone: 116 123), self-injury support (phone: 0808 800 8088), or your local support services, Chapter – who offer support to people experiencing mental health issues in Cheshire (phone: 01244 344409) [University of Chester].

Ethical Approval

Ethical approval for the study has been sought and obtained from The Department of Psychology Ethics Committee.

Appendix B

Consent Form

By signing below, you are agreeing that:

- [1] You have read and understood the Participant information sheet
- [2] Questions about your participation in this study have been answered satisfactorily
- [3] You are aware of the potential risks (if any)
- [4] You are taking part in this research study voluntarily (without coercion)
- [5] Anonymised data only may be shared in public research repositories

Participant's Name (Printed)

Participant's Signature

Date

Name of person obtaining consent (Printed)
consent

Signature of person obtaining
consent

*Participants wishing to preserve some degree of anonymity may use their initials (from the British Psychological Society Guidelines for Minimal Standards of Ethical Approval in Psychological Research)

Appendix C

Staff / Office Use Only

DOPEC NUMBER: *Click here to enter text.*

Umbrella project DOPEC number (staff) *Click here to enter text.*

APPLICANT SURNAME Armstrong

APPLICANT: UG PGT PGR Staff

REVIEW PROCESS: Accelerated Full

APPLICATION STATUS: New application Major amendment
Resubmission

APPLICATION FOR: Dissertation Teaching Research & publication

ATTENDANCE AT HEALTH & SAFETY BRIEFING: Yes No N/A

INCLUSION OF RISK ASSESSMENT FORM: Yes No N/A

NOTES ON THE ROLE AND FUNCTION OF THE DEPARTMENT OF PSYCHOLOGY ETHICS COMMITTEE.

- All decisions of the committee are based on the application form and reviewers comments ONLY. Forms should be as detailed and clear as possible. Verbal discussions are not considered as part of the application or review process.
- The review process strictly adheres to the University of Chester Research Governance Handbook and the BPS Code of Ethics.
- The decision of the committee is final. If you are a UG, PGT or PGR student you should discuss the decision of the committee with your supervisor. If you are a member of staff you may contact the chair of the committee for further clarification.

Before completing the form researchers are expected to familiarise themselves with the regulatory codes and codes of conduct and ethics relevant to their areas of research, including those of relevant professional organisations and ensure that research which they propose is designed to comply with such codes.

Department of Psychology Ethical Approval for Research: Procedural Guidelines.

University of Chester Research Governance Handbook

http://ganymede2.chester.ac.uk/view.php?title_id=522471

BPS Code of Ethics

http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf

BPS Code of Human Research Ethics

http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf

BPS Guidelines for Internet-mediated Research

<http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf>

BPS Research Guidelines and Policy Documents

Any queries email: n.davies@chester.ac.uk or psychology_ethics@chester.ac.uk

CHECK LIST.

Please complete the form below indicating attached materials. Prior to submission supervisors must confirm that they have reviewed the application by completing the supervisors column.

<i>Notes: Students to indicate where information is found, supervisor to confirm by ticking green column</i>	<u>Supervisor confirmation</u>	<u>Information sheet</u>	<u>Letter</u>	<u>Email</u>	<u>Email info. page</u>	<u>Consent Form</u>	<u>PowerPoint</u>	<u>N/A</u>
Brief details about the purpose of the study	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Contact details for further information	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Explanation of how and why participant has been chosen	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Notification that materials/interviews are not diagnostic tools/therapy or used for staff review/development purposes	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Explanation participation is voluntary	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of any incentives or compensation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of how consent will be obtained	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
If research is observational, consent to being observed	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Details of procedure so participants are informed about what to expect	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of time commitments expected	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of any stimuli used	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Explanation of right to withdraw and right to withdraw procedure	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Option for omitting questions participant does not wish to answer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Procedure regarding partially completed questionnaires or interviews	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
With interviews, information regarding time limit for withdrawal	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of any advantages and benefits of taking part	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Details of any disadvantages and risks of taking part	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					

Information that data will be treated with full confidentiality and that, if published, those data will not be identifiable as theirs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Debriefing details	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Dissemination information	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					
Further information (relevant literature; support networks etc)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>					

Supervisor Signature: Hannah Heath

Date :09/03/2018



**University of
Chester**

**DEPARTMENT OF PSYCHOLOGY
APPLICATION TO
DEPARTMENTAL ETHICS
COMMITTEE**

**WHEN COMPLETING THE FORM PLEASE REFER TO THE DOP ETHICS PROCEDURAL GUIDELINES HANDBOOK.
UG AND PGT STUDENTS CAN ACCESS A COPY ON THEIR RELEVANT MOODLE PAGE.
PGR AND STAFF SHOULD CONTACT n.davies@chester.ac.uk or
psychology_ethics@chester.ac.uk**

1. Working title of the study

Notes: The title should be a single sentence

Caring for Carers: the impact of supporting those who self-harm on professional carers.

2. Applicant name and contact details

Notes: The primary applicant is the name of the person who has overall responsibility for the study. Include their appointment or position held and their qualifications. For studies where students and/or research assistants will undertake the research, the primary applicant is the student (UG, PGT, PGR) and supervisor is the co-applicant.

Laura Armstrong, PGT, MSc Conversion Psychology

3. Co-applicants

Notes: List the names of all researchers involved in the study. Include their appointment or position held and their qualifications

Dr Hannah Heath, Lecturer University of Chester

4. Start and end dates of the study

Notes: The title should be a single sentence

March 2018- July 2018

5. Is this project subject to external funding?

Notes: Please provide details of the funding body, grant application and PI.

No

6. Briefly describe the purpose and rationale of the research

Notes: (Maximum 300 words). In writing the rationale make sure that the research proposed is grounded in relevant literature, and the hypotheses emerge from recent research and are logically structured.

If this application is for a PGR/Staff funded project please attach any detailed research proposals as appropriate.

In reading about self-harm studies much of the focus is on how best to support sufferers of self-harm, who supports them and how to approach the issue of self-harm (Whitlock, Powers and Eckenrode, 2006). There is criticism of some professionals about their support for self-harmers (Warm, Murray and Fox, 2002), that the health care professionals on the front line working with people who self harm need better training, however, this criticism does not mention carers. Carers typically do receive some training for working with self-harm behaviours, but little is published about whether this training is helpful for the carers or for the people they support. There is little written about the impact self-harm can have on the people who support those who suffer. We know that secondary trauma is high in the health and social care industry. There is very little written about secondary trauma for residential care workers, but there is much more published about secondary traumatic stress amongst nurses (Morrison and Joy, 2016), social workers (Bride, 2007) and teachers. Specifically there is very little written about secondary trauma from self-harm and about the implications of working in close proximity, caring for individuals who self-harm on potentially a daily basis. There is also research into how self-harm affects families (Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell and Hawton, 2015) (Kelada, Hasking and Melvin, 2016) . As a residential carer you are taught to be a 'professional parent,' so vicarious trauma could be expected to have an even greater impact on professionals who have less of a clear boundary between work and home. For many people who self-harm they may be in care, and their carers will in that case be their closest people to them, and certainly the people they see most often.

7a. Describe the methods and procedures of the study

Notes: (Maximum 500 words) Attach any relevant material (questionnaires, supporting information etc.) as appendices and summarise them briefly here (e.g. Cognitive Failures

Questionnaire: a standardised self-report measure on the frequency of everyday cognitive slips). Do not merely list the names of measures and/or their acronyms. Include information about any interventions, interview schedules, duration, order and frequency of assessments. It should be clear exactly what will happen to participants. If this is a media based study describe and list materials include links and sampling procedure.

The method used in this study will be 1-1 interviews. The interviews will be scheduled around the participant's work shifts; each participant will take place in one interview. The interviews will take place in different locations; as arranged with the participants, by myself, as all the participants are known to myself there is no danger in the choice of location be it at the participant's home or somewhere neutral of their choice. Attached is the script of interview questions (Appendix D). As well as the script for approaching participants both in person and via email (Appendices A & B). Before the interviews each participant will be given an information sheet (Appendix C), I will explain to them the nature of anonymity and confidentiality of the results and I will also explain to the participants that they may find some of the interview uncomfortable or upsetting and that if they wish to pause or terminate the interview at anytime then they can. Participants will be asked a series of questions about their experience working in residential care and to what extent they feel looking after residents who self-harm has on them outside of work, or within work, or if it even impacts them at all. There will be a debrief at the end of the interview. Once the interviews have been conducted then I will transcribe each of them. I will then conduct a Thematic Analysis (Braun & Clarke, 2006) of the results of the interviews; coding the information that I have transcribed, and selecting main themes to focus on to develop for the research.

7b. Provide details of your contingency plan

Notes: Please briefly describe your contingency plan. (100 words)

If I can not recruit enough, or any, participants from the Residential home that I used to work in then I will then contact other homes within the company, there are 12 residential homes in total that are all part of the same umbrella company, and all within driving distance for me to reach participants.

8. Provide details of the previous experience of the procedures by the person conducting the study.

Notes: Say who will be undertaking the procedures involved and what training and/or experience they have. If supervision is necessary, indicate who will provide it.

It will be myself conducting the interviews, with the guidance of Dr Hannah Heath. I have not conducting interviews before, I do however have a good understanding of confidentiality as well as working with sensitive issues from working as a residential carer. I have conducted Thematic Analysis as part of the Thought and Behaviour module of the Master's Programme.

9. Describe the ethical issues raised by this study and discuss the measures taken to address them.

Notes: Describe any discomfort or inconvenience that participants may experience. Include information about procedures that for some people could be physically stressful or might impact on the safety of participants, e.g. interviews, probing questions, noise levels, visual stimuli, equipment; or that for some people could be psychologically stressful, e.g. mood induction procedures, tasks with high failure rate, please include your distress protocol. Discuss any issues of anonymity and confidentiality as they relate to your study, refer to ethics handbook and guidance notes at the end of the form. If animal based include ethical issues relating to observation.

Discomfort

Participants could possibly feel discomfort during the interviews if they are discussing a situation that may be distressing or stressful. Before each interview I will inform the participants that should they wish to have a break or terminate the interview at any time they are free to do so. If the participants show they are upset but wish to continue with the interview I will be professional and make sure that I allow participants the opportunity to say what they want.

Anonymity

Participants will be informed that their interview will remain confidential and personal information revealed in the interviews will be anonymised, such as names and locations. Their personal information will not be shared.

10. Describe the participants of the study.

Notes: Describe the groups of participants that will be recruited and the principal eligibility criteria and ineligibility criteria. Make clear how many participants you plan to recruit into the study in total.

Participants will be Residential Carers, all ex-colleagues of mine, they have a range of experience working in residential care but all of them have experienced supporting young people who self-harm. I plan to recruit ten participants.

11. Describe the participant recruitment procedures for the study.

Notes: Gives details of how potential participants will be identified or recruited, please list any social media platforms that you will use and the message. Include all other advertising materials (posters, emails, letters, verbal script etc.) as appendices and refer to them as appropriate. Describe any screening examinations. If it serves to explain the procedures better, include as an appendix a flow chart and refer to it.

Participants are known to myself through personal connections . I will be writing a letter (Appendix E) to my ex-employer to ask her permission to contact the staff who work in her house. I will be contacting each of the participants separately, and I have a personal connection to each of the participants so will be contacting them personally either by email or face-to-face (Appendix A & B).

12. Describe the procedures to obtain informed consent

*Notes: Describe when consent will be obtained. If consent is from **adult participants**, give details of who will take consent and how it will be done. If you plan to seek informed consent from **vulnerable groups** (e.g. people with learning difficulties, victims of crime), say how you will ensure that consent is voluntary and fully informed.*

*If you are recruiting **children or young adults** (aged under 18 years) specify the age-range of participants and describe the arrangements for seeking informed consent from a person with parental responsibility. If you intend to provide children under 16 with information about the study and seek agreement, outline how this process will vary according to their age and level of understanding.*

How long will you allow potential participants to decide whether or not to take part?

What arrangements have been made for people who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?

If you are not obtaining consent, explain why not.

Participants will be provided with an information sheet (appendix C), and once they are happy to participate will be asked to sign a consent form (appendix)

13. Will consent be written?

Yes No

*Notes: If **yes**, include a consent form as an appendix. If **no**, describe and justify an alternative procedure (verbal, electronic etc.) in the space below.*

Guidance on how to draft Participant Information sheet and Consent form can be found on PS6001 Moodle space and in the Handbook.

[Click here to enter text.](#)

14. Describe the information given to participants. Indicate if and why any information on procedures or purpose of the study will be withheld.

Notes: Include an Information Sheet that sets out the purpose of the study and what will be required of the participant as appendices and refer to it as appropriate. If any information is to be withheld, justify this decision. More than one Information Sheet may be necessary.

Participants will be provided with an information sheet (Appendix C) listing full details of the study. No information will be withheld and they will be allowed to take the information sheet away with them.

15. Indicate if any personally identifiable information is to be made available beyond the research team. (eg: a report to an organisation)

Notes: If so, indicate to whom and describe how confidentiality and anonymity will be maintained at all stages.

No.

16. Describe any payments, expenses or other benefits and inducements offered to participants.

Notes: Give details. If it is monetary say how much, how it will be paid and on what basis is the amount determined. Indicate RPS credits.

None given.

17. Describe the information about the investigation given to participants at the end of the study.

Notes: Give details of debriefings, ways of alleviating any distress that might be caused by the study and ways of dealing with any clinical problem that may arise relating to the focus of the study.

Participants will be thanked and will be encouraged to take away the information sheet at the end of the interview listing points of contact and sources of support.

18. Describe data security arrangements for during and after the study.

Notes: Digital data stored on a computer requires compliance with the Data Protection Act; indicate if you have discussed this with your supervisor and describe any special circumstances that have been identified from that discussion. Say who will have access to participants' personal data and for how long personal data will be stored or accessed after the study has ended.

Data will be held on password protected computers and will be destroyed on confirmation of the degree.

SIGNATURES OF THE RESEARCH TEAM

Notes: The primary applicant and all co-applicants must sign and date the form. Scanned or electronic signatures are acceptable.

Hannah Heath
12/03/2018

Laura Armstrong

ETHICS COMMITTEE DATE

[Click here to enter a date.](#)

ACCEPTABLE

You may now commence data collection subject to approval from any relevant external agencies.

CHAIRS COMMENTS

Read and review all reviewers comments

DATA COLLECTION IS NOT PERMISSABLE UNDER THE FOLLOWING 3 CONDITIONS.

Please address the issues indicated.

ACCEPTABLE SUBJECT TO SUBMISSION OF AMENDMENT FORM

UG and PG students should discuss any recommendations with their supervisors.

ACCEPTABLE SUBJECT TO CONDITIONS OF CHAIR

Resubmit application for full review after addressing the issues described, ensuring you have indicated on the front page of the form that this is a resubmission.

REVISE AND RESUBMIT

Resubmit application for full review ensuring you have indicated on the front page of the form that this is a resubmission

SIGNATURE: [Click here to enter text.](#)

Appendix D

- 1) Please consider editing the PIS to improve readability (e.g., increase spacing between questions and use bold italics to differentiate the questions/answers).
- 2) Provide own name and email address (as well as Hannah's) on PIS
- 3) In the 'risk/benefits' I would suggest only providing information about the potential benefits to the participant (e.g., to advance our understanding of this important area) rather than any benefits to the researcher/student.
- 4) In your list of support services in the PIS, please clarify what 'Chapter' is.
- 5) Please remember to date (as well as sign) the application
- 6) Lone worker policy needs to be included
- 7) Participant distress: ensure that the information sheet with support services is taken away.
- 8) Specify how many people will be recruited
- 9) Permission to contact needed from the residential care home?
- 10) PIS: a) Withdrawal: change length for withdrawal, b) How partially collected data will be used