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## **Attitudes towards young people who self-harm: age, an influencing factor**

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## **ABSTRACT**

### **Aim**

To determine the attitudes of emergency care staff towards young people (aged 12– 18 years) who self-harm and to gain an understanding of the basis of attitudes that exist.

### **Background**

Young people frequently attend emergency services following self-harm; it is unclear whether being a young person influences attitudes held.

### **Design**

Mixed methods using a triangulation convergent design

### **Methods**

Survey of 143 staff from four accident & emergency departments and one ambulance service. Semi-structured interviews with seven children's A&E nurses and five ambulance personnel from the same locality. Data were collected during 2010.

### **Results/findings**

Pearson's product moment correlation coefficient confirmed a strong positive correlation between scores on the two scales used to measure attitudes; paired samples t-test revealed a statistically significant difference in scores across the scales; practitioners held more positive attitudes towards young people who self-harmed than young people per se. Both data sets confirmed the presence of ambivalence and ambiguity in attitudes held. The qualitative data revealed that because of their age and immaturity young people were not held responsible for their self-harming behaviours.

Being young did though influence subsequent admission, with particular difficulty in securing admission for those aged 16 – 17 reported.

## **Conclusion**

Age is a factor in shaping practitioners' attitudes; age also directs and influences a young person's journey through emergency care, although due to ambiguity there is inconsistency in determining where those aged 16- 17 years of age fit.

## **KEY WORDS**

Young people; adolescence; self-harm; attitudes; emergency care; accident & emergency; nursing.

## **SUMMARY STATEMENT**

Why is this research needed?

- Young people frequently access emergency care following self-harm; to date research that has examined attitudes of practitioners working in pre-hospital and hospital based emergency care towards young people who self-harm, is limited.
- The response young people receive when first disclosing their self-harm is important; ambulance personnel are often the first to assess a young person, previous research has excluded their perspective.
- Young people are often subject to negative moral evaluations; existing research does not consider whether, or how, being a young person influences attitudes.

What are the key findings?

- A strong positive correlation exists between attitudes towards young people generally and the attitudes practitioners hold towards young people who self-harm; such a relationship has not previously been explored.
- Because of their age, practitioners attribute low controllability and thus more willingness to help young people who self-harm; the findings extending understating of the basis of practitioners' helping behaviours
- The ambiguity that is associated with adolescence as a life stage is reflected in guidelines which dictate young people's pathways through emergency care following self-harm

Implications for Policy/practice/research/education

- There should be consistency across policy makers when developing guidelines for young people's pathways through emergency care, as to the age at which young people transfer to adult services.
- Young people aged 16 – 17 years of age should be consulted to gain their perspective as to where they feel their needs would be best met (adult or children's services).

- Further research is needed to more fully explore the relationship between attitudes towards young people per se and how/whether this influences the care they receive.

## **INTRODUCTION**

Self-harm is a global public health concern. Young people who self-harm are identified as a priority in England's Suicide Prevention Strategy (HM Government 2012) as self-harm is associated with suicide and reduced life expectancy (Bergen et al 2012). Young people who self-harm face particular challenges (Stewart et al 2006, RCPCH 2012), and for some young people, accessing emergency services means that their self-harming behaviour is, for the first time, disclosed. Young people have revealed that how a person responds to them when they first disclose self-harm has a bearing on whether they go on to engage with services (Brophy & Holstrum 2006), thus the response young people receive from practitioners working in pre-hospital and hospital based emergency services is of interest.

## **BACKGROUND**

Attitudes have many attributes including intensity, some are more enduring, some are deeply held, personally (opinion) or philosophically (Oppenheim 1992), or, are linked to societal norms and values (Ajzen & Fishbein 2005). Historically research that has explored attitudes individuals' hold has focused on attitudes towards minority groups, or attitudes towards stigmatising illnesses such as mental illness. Consequently the focus is on how an individual responds or behaves towards a member of a minority group or a person with a stigmatising illness. An alternative way of examining attitudes is examining the attributes that the person who is stigmatised or discriminated against might possess in order to obtain a better understanding of the basis of attitudes, exemplified by Weiner's (1980, 1985) attribution model of helping behaviour. Weiner's model is based on the premise that an individual's likelihood of engaging in helping

behaviours is related to the extent to which they perceive that the cause of a person's distress, or requirements for help, are due to controllable or uncontrollable causes.

Studies examining attitudes towards self-harm that have drawn on Weiner's model used hypothetical patient vignettes, manipulated to provide different causes of self-harming behaviours (Mackay & Barrowclough 2005, Law et al 2008, Wheatley & Austin-Payne 2009). These studies confirmed the predictive nature of the model. Where self-harm was reported to have been caused by factors that an individual has control over, for example drug misuse, financial debt, the individual was more adversely judged than when the self-harm was reported to be caused by factors out with the control of an individual, i.e. abuse or bereavement. However the extent to which, or indeed whether, the age of an individual acts as an uncontrollable factor, is not examined in these studies.

Research confirms that staff working in accident & emergency departments (A&E) find caring for young people who self-harm frustrating (Anderson et al 2003); self-harm in young people is seen as means of communicating distress (Anderson et al 2005a), and is not seen as a puzzling behaviour nor more acceptable in older people (Anderson & Standen 2007). Crawford et al (2003) noted a link between feeling effective at providing care and reduced negativity, a finding subsequently confirmed in Wheatley & Austin-Payne's (2009) study. None of these papers examine attitudes of ambulance personnel.

Research that has examined attitudes of practitioners towards young people who self-harm in other services indicates that the setting, as well as the characteristics of the

young people themselves, has a bearing on attitudes (Cleaver 2014). Staff working with young offenders demonstrated high levels of antipathy towards young people who self-harm (Dickinson & Hurley 2011), whereas those working in child and adolescent mental health services (CAMHS) demonstrated more positive attitudes than their peers working in adult psychiatry (Wheatley & Austin-Payne 2009), A&E and schools (Timpson et al 2012).

As Dickinson & Hurley (2011) observe, young offenders are frequently stigmatised and stereotyped, can be challenging and difficult to manage, and postulate that this might explain the antipathy found in their respondents. Overall though, studies that have previously considered attitudes towards young people who self-harm do not address the young person's self-harming behaviour within the context of being a young person, and how young people generally are perceived, thus it is not possible to determine whether attitudes towards young people who self-harm are bound up in attitudes towards young people per se.

Concerns around young people's antisocial behaviour, mental health, drug and alcohol misuse, self-harm and suicidal behaviours are evident (Office for National Statistics 2004, Fox & Hawton 2004, Green et al 2005 Brophy & Holstrum 2006, Margo & Dixon 2006). However, while young people are increasingly perceived as stressed and unhappy, negative media promoted stereotypes of young people as 'feral' and out of control prevail (Sergeant 2009). This moral panic (Cohen 1972) is reflected in research; press coverage about teenage boys in the UK is predominantly focussed on crime, with the most commonly used term to describe boys being "yobs" (Bawdon 2009, Mason

2011), ‘yobs’ being a slang term used to depict uncouth, working class males, in the UK.

A study undertaken by Anderson et al (2005b), measured attitudes towards young people in the context of young people and crime, in acknowledgement that while there has been much preoccupation with young people and their behaviours, little systematic information is available. The findings identified communities’ concerns regarding lack of opportunities for children and young people, as well as young people ‘hanging around’ on streets, consuming alcohol, drugs, and the associated concerns with crime, including vandalism and graffiti. Indeed respondents in Andersons et al’s (2005b) survey substantially overestimated the level of crime committed by young people.

## **THE STUDY**

### **Aims**

This study aimed to determine attitudes, using a previously untested tool, of pre-hospital and hospital based emergency care staff in England, towards young people (aged 12–18 years) who self-harm and to gain an understanding of the basis of attitudes that exist.

### **Design**

A mixed methods approach, using a triangulation convergent design (see figure 1.) Data were obtained concurrently through survey and semi-structured interview methods; the two data sets were integrated and analysed to identify where they were consistent and whether/where discrepancies existed (Creswell & Plano-Clark 2007). Data were collected during 2010.

## **Sample/Participants**

Nurses and doctors employed in four emergency departments and paramedics and ambulance technicians located in five ambulance bases local to the departments, were surveyed (n=143). A census approach to sampling was adopted, with sufficient questionnaires distributed to all sites, allowing all members of staff opportunity to participate. As principal component analysis (PCA) was to be used to ascertain the validity of the two scales adopted for the survey, in line with the assumptions required for PCA, the aim was to recruit 150 participants. Ultimately the sample size was 143; the Kaiser-Meyer- Olkin Measure of sampling adequacy was 0.65, thus the sample size met the requirements for sampling adequacy (Pallant 2007).

Purposive sampling was used to select interview participants; 12 practitioners were interviewed, 7 registered children's nurses from a paediatric accident & emergency department and 5 ambulance staff working in the locality. Written consent was obtained. Inclusion criteria required interviewees to have experience of delivering emergency care to young people following self-harm.

## **Data Collection**

### *Quantitative Data*

Quantitative Data were obtained through the administration of a questionnaire. An extensive search of the literature located only one study that had measured attitudes towards young people (Anderson et al 2005b). The Suicide Opinion Questionnaire (SOQ) is the most widely used tool to assess attitudes towards suicidal behaviour (Anderson et al 2008, Kodaka et al 2010), but its use in studies to assess attitudes of A&E staff had not been contextualised and applied to young people. Thus the 'Attitudes

Towards Young People' (AYP), and 'Attitudes Towards Young People who Self-Harm (AYPSH) scales were developed, their use in this study a pilot. For both scales, respondents were required to state their level of agreement on a five-point 'Likert'-type scale. Scores for the negatively worded items were reversed for the purposes of analysis.

#### *Attitudes Towards Young People' (AYP)*

Anderson et al's (2005b) survey addressed five areas including, 'the way that young people are viewed by adults', in an attempt to determine '*whether the current generation of young people is seen as different from its predecessors, and the extent to which positive and negative constructions coexist in prevailing adult views*' (Anderson et al 2005b:P2). The seven statements contributing to this element of the survey were initially used. Two additional statements were included which concerned the role of parents in young peoples' behaviours as research that has discussed moral evaluations of young people as patients found that it is parents who are the focus of any negative evaluations (Dingwall & Murray 1985, White 2002). A further statement regarding young people and stress was included to reflect the alternative framing of young people as stressed, unhappy, and vulnerable, as emphasised in reports published by UNICEF (2007) and The Children's Society (2008).

#### *Attitudes towards Young People who Self-Harm (AYPSH)*

A number of studies have previously employed variations of the SOQ to assess attitudes of A&E staff towards self-harm (McLaughlin 1994, Anderson 1997, Anderson et al 2000, Anderson & Standen 2007, McCann et al 2006, McCann, 2007, Sun et al 2007). McLaughlin (1994) and subsequently by McCann (2006, 2007) included 14 statements

from the original SOQ, the basis for selection being that the variables chosen pertained to attempted suicide only and were those that had been proven to yield highly significant effects (DeRose & Page 1985). These items were reviewed and applied to young people for the AYPSH scale; an additional item was included reflecting the ‘normality’ of self-harm within youth-subcultures such as “Goths and EMO’s” (Fox & Hawton 2004, Young et al 2006, Adler & Adler 2007); four statements were included which reflect motives for self-harm, as identified by young people themselves (Hawton & Rodham 2006).

### *Qualitative Data*

Qualitative Data was obtained through semi-structured interviews. In line with a mixed methods approach, the interviews provided an opportunity to explore whether the findings from the qualitative data were consistent with, and/or added to findings emerging from the quantitative data. The interviews gave participants opportunity to discuss their own perceptions and experiences of caring for young people and young people who self-harm, the attitudes participants had encountered in their own practice, perceptions of attention seeking behaviour, and how they as participants thought the care of these young people might be further enhanced.

### **Ethical Considerations**

Ethical approval to undertake the study was obtained through the National Research Ethics Service (NRES). Approval was also gained from the Research and Development (R&D) departments of the five NHS Trusts involved in the study.

## **Data analysis**

Data were analysed using SPSS. Reliability of the scales was determined using the Cronbach alpha score and factor analysis using principal component analysis (PCA). Pearson's product moment correlation coefficient was used to determine if there was a relationship between scores across the two scales. A paired samples t-test was undertaken to determine whether differences in mean scores across the scales were statistically significantly different. A one-way-between groups ANOVA was used to look at the variation amongst the independent variables, occupation, age and length of experience and the dependent variables of AYP and AYPSH. Independent sample t-tests were used when the independent variable was a categorical variable.

The interviews were transcribed and subjected to thematic analysis, using Braun & Clarke's (2006) framework. The approach adopted for integrating the data following the separate (statistical and thematic) analysis was the use of case analysis and matrices. The matrices were reviewed and analysed to determine patterns in order to identify where the two data sets were consistent and whether/where discrepancies existed (Creswell & Plano-Clark 2007).

## **Validity and Reliability/Rigour**

### *Reliability of the "AYP" Scale.*

Although logistic regression was used to analyse the variables used in the survey on Public Attitudes towards Young People and Youth Crime, (Anderson et al 2005b), only seven statements from this survey were relevant to this study, and were not therefore within the 'block of variables' (Pallant 2007) which formed the basis of that analysis. The Cronbach Alpha test was used to check the reliability of the scale and

showed a mean inter-item correlation of 0.94 with a range of -0.317 to 0.793, suggesting a weak correlation between the items. The inter-item correlation matrix identified two items demonstrating negative values, 'girls are more badly behaved than boys nowadays', and 'young people don't get care and attention' (See Table 1). Removing these two items resulted in a Cronbach Alpha of 0.56, although the mean inter-item correlation of 0.13 was lower than recommended (Pallant 2007). Factor analysis using principal component analysis (PCA) was undertaken on the revised version of the scale. The suitability of the data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of coefficients of 0.3 and above; the Kaiser- Meyer-Olkin value met the required level suggesting an adequate sample size and the KMO and Bartlett's test reached statistical significance,  $p < 0.001$ , thereby supporting the factorability of the correlation matrix (Pallant 2007:197). The two-component solution explained a total of 43.8% of the variance. Oblimin rotation was performed which revealed a simple structure, generally variables loading only on one component. Overall the factor analysis using PCA demonstrates that by employing eight items the AYP scale hung together reasonably well, although the relationships within the two components are to some extent open to interpretation.

#### *Reliability of the 'AYPSH' Scale.*

Despite its frequent use, it is widely acknowledged that there have been debates about the validity and reliability of the SOQ (Kodako et al 2010) with a number of variations of the tool subsequently developed (Domino 2005, Anderson et al 2008, Kodaka et al 2010). McLaughlin's (1994) study reported a reliability score of 0.7 for the iteration used in her study, which provided the basis for McCann's (2006, 2007) and subsequently this iteration of the tool.

The Cronbach Alpha reliability score for the AYPSH scale was 0.52. The Inter-Item correlation matrix identified two items demonstrating negative scores, 'young people who self-harm should be required to undergo therapy' and 'self-harm is a normal part of youth culture', these were therefore removed from the scale, which resulted in a Cronbach Alpha score of 0.62. As with the AYP scale factor analysis using PCA was performed, the AYPSH scale likewise meeting the suitability requirements. A two-component extraction using PCA was undertaken. Both the pattern and structure matrices revealed that the two components represented positive statements (component one) or negative (component two). However the item, 'most young people who harm themselves don't want to die' did not feature in either component and was consequently removed from the scale for analysis purposes. Removing this item resulted in a Cronbach Alpha score of 0.63. Removing three items from the AYPSH scale and performing PCA on the remaining 11 items revealed that both components showed strong loadings, the interpretation from the two components matched with the positively and negatively worded items and the revised scale therefore hung together well. As with the AYP scale, items removed from the scale were analysed separately.

Following adjustments to both scales the distribution of scores were reviewed. The minimum score on the AYP scale was 13, maximum 33 with a mean overall score of 23.96. The Kolmogorov-Smirnov statistic was 0.105 ( $p=0.001$ ); as the P value was less than 0.05, the assumption of normality was violated, which Pallant (2007) advises can be expected in larger sample sizes. A review of the distribution histogram and Q-Q-plots demonstrated a reasonably normal distribution. Possible scores on the AYPSH ranged from 24 – 54 with an overall mean score of 37.83. The Kolmogorov-Smirnov

statistic was 0.159 ( $p < 0.000$ ); the histogram and Q-Q plot likewise indicated a reasonably normal distribution. On the basis of the distribution (see Figures 2 & 3), it was determined that both scales met the requirements for parametric testing.

## RESULTS

A total of 610 questionnaires were distributed. The ambulance bases employed large numbers of staff and the numbers of questionnaires delivered to these sites represented 67% ( $n=408$ ) of total questionnaires circulated; response rates from the ambulance service ( $n=68$ , 17%) affected the overall response rate ( $n=149$ , 24%). Six returned questionnaires were incomplete and were not included in the final analysis. The final sample contained reasonably equal group sizes in terms of occupational group, and spread of hospital and pre-hospital cares responders (ambulance technicians  $n=34$ , paramedics  $n=34$ , nurses  $n=47$  doctors  $n=28$ ). Likewise, the sample was reasonably equally split according to gender (males  $n=67$ , females,  $n=73$ ). Figure 4 provides a description of the sample by occupation and gender, figure 5 by age and figure 6 by length of experience.

Pearson's product moment correlation coefficient confirmed that there was a strong positive correlation between scores on the two scales used, ( $r = .84$ ,  $n = 139$ ,  $p < .001$ ), with high scores on the AYP scale being related to high scores in the AYPSH scale. Paired samples t-test revealed a statistically significant difference in scores across the two scales, mean scores on the AYPSH scale being higher ( $M=37.83$ : $SD 4.21$ ) than those on the AYP scale ( $M=23.96$ :  $SD 3.78$ );  $t(137) = 38.25$ ,  $p < 0.005$ , with a 95% CI ranging from 13.15 – 14.59. The eta-squared statistic (0.9) indicated a large effect size.

The results from the one-way-between groups ANOVA revealed little variation amongst the independent variables of occupation and age, likewise gender. However a statistically significant variation does exist in relation to length of experience on the AYPSH scale; scores at the  $p < 0.05$  level between those with 11-15 years experience when compared with those with 6- 10 years and more than 16 years experience:  $F(3, 133) = 3.09, P = .030$ . The effect size calculated using eta is 0.06, a moderate effect size. Table 1 provides details of means scores (and standard deviation). A two-way between groups ANOVA was undertaken to determine if there was an interaction between occupation and length of experience, the results indicated no significant difference between groups.

### **Table 1**

Analysis of mean scores against each component of the scales reveals little variation with the exception of the statement, '*most young people who self-harm don't want to die*'. Analysis of results against this statement showed that 50% of nurses disagreed with the statement compared with 17% of paramedics and 33% of doctors; no ambulance technicians disagreed with the statement, this difference being statistically significant ( $P = 0.05$ ). Tables 2 & 3 provide a breakdown of mean scores (with standard error)

### *Attitudes Towards Young People*

The survey data identified that while 44% of respondents agreed that young people are seen as helpful and friendly, 69% of respondents perceived that young people's behaviour had got worse, and 45% agreed that young people had no respect for adults.

In respect of 'not receiving care and attention from parents' and 'having respect for adults' there was a level of ambivalence in responses to this as 34% and 30% respectively neither agreed nor disagreed with these statements. There appeared to be some ambiguity around girls' behaviour, as while only 17% agreed that girls were now more badly behaved than boys, fifty percent of the respondents neither agreed nor disagreed with this statement. The survey data indicates that parents are held responsible for their children's behaviours; 70% agreed that 'young people are not disciplined by their parents'; 48% agreed that young people don't get enough care and attention from their parents.

These ambiguous views were apparent in the qualitative data; one interviewee felt that, 'young people are seen as, it's probably not fair to generalise, but they have a bad reputation.... a lot of them are expected or seen to be in gangs and that's the expectation',

However, it was also noted that,

'once in an ambulance, they're [young people] scared, hurt, they tend to revert back to being a child (I 08).

Similarly other responses were contradictory, an interviewee reported that,

'most teenagers now, as you probably know are taller than me and I wouldn't take them on'

but then went on to say,

'young people, might not be able to cope with it, you've got to protect them' (I 01).

Participants' accounts acknowledged how difficult the teenage years are, and to that end indicated that they understood teenagers and their behaviour. For example one interviewee acknowledged that,

‘Its, very difficult for them and it’s getting worse rather than better for teenagers (I 11).

#### *Attitudes Towards Young People who Self-harm*

As noted above, mean scores on the AYPSH scale were higher than those recorded on the AYP scale. The survey data indicates that the respondents (correctly) recognised that young people who self-harm are likely to repeat this behaviour, and are more at risk of completing suicide, but were unsure as to whether young people who self-harm are mentally ill. They recognised that the young people need help, and generally did not see them as being attention seeking; there was a high level of agreement that young people who self harm are trying to get sympathy from others.

The more positive attitudes towards young people who self-harm were explained in the interview data; interviewees expressed the view that young people who self-harm, by virtue of their age, did not fully appreciate the implications of their actions, and to that end their perceptions of young people who self-harm were more benign, as illustrated in the following comment:

I think it’s always that people can be more accepting of children, you know or young people sort of like, you know you’ve got your whole life ahead of you whereas someone who’s older it’s a case of “pull yourself together, sort yourself out girl” isn’t it, you know so I think it’s a bit more sympathetic.

**And that's because they're younger?**

Yeah, yeah and it's not like, you know, it's more... you do, you sort of think well what's pushed you to this point at your age, you know when you're a bit older sort of like, you know, and you maybe put yourself in situations you've got more option to make your own choices I think so maybe from that point of view (I 06).

The above account indicates that comparisons with young people and adults who self-harm are made, with young people who self-harm viewed more benignly due to their immaturity, a perspective that was evident in the responses from other interviewees, for example:

I think the younger they are the more sympathy I tend to feel for them which right or wrong is just the way I react (I 05).

Due to their immaturity children and young people are seen as being unable to fully distinguish between behaviours that are right or wrong,

Children a lot of them are too inexperienced too immature, they haven't experienced life to know the difference between what you do and what you don't (I 01).

The vulnerability of young people came across in terms of young people's (lack of) understanding of the consequences of their self-harming behaviour;

Some young people take the over the counter, take the Paracetamol... genuinely thinking they're going to die or not really knowing what the consequence is going to be and they just do it (I 02).

This lack of understanding resulted in the respondents being more acceptable of their self-harming behaviours:

I think there is a sort of, a more tolerant attitude towards children who self-harm because you sort of think they, you know they don't really, they haven't really cottoned on to the implications (I 03).

Young people's age did though present challenges to nursing staff, which were particularly evident for young people aged 16 or 17.

If... a young person is very disruptive they won't get admitted onto the [children's] ward and then we've got a real problem in terms of management from our perspective (I 02).

For the 16-17year olds... it's a big black hole ... no one really wants them one way or another and they're the ones who we really struggle with... xx will quote all the time the studies out there that have shown if you put adolescents between 16-18 on a mental health ward with adult patients they have a very poor prognosis, which I can well believe is the case, but it's not the 16-18 year olds fault that that's the age group and we don't provide better care for them (I 11).

## **DISCUSSION**

Analysis of the survey data revealed a correlation between professionals' self-reported attitudes towards young people per se and their attitudes towards young people who self-harm, the survey respondents' self-reported attitudes towards young people who self-

harm more positive than their attitudes towards young people generally. Findings from the qualitative data provide an explanation for this, as the data clearly suggest that young people's immaturity influenced the practitioners' attitudes towards young people who self-harm, with a prevailing view that young people were too immature to fully understand or appreciate the implications of their (self-harming) behaviours.

The qualitative data from this study supports Weiner's (1980, 1985) attribution theory. Practitioners attribute low controllability and thus more willingness to help young people, as age and thus immaturity is as an uncontrollable cause/factor associated with self-harm in young people; young people are therefore, held to be less responsible for their self-harming behaviours than an adult would be. There was however ambiguity, an ambiguity which reflects how societal norms and values (Ajzen & Fishbein 2005) are perhaps contradictory in relation to young people, such ambiguity also noted in Anderson et al's (2005b) study.

This ambiguity affected the young person's progression through emergency services, which was particularly notable for those aged 16 – 17 years. In accordance with the guidelines published by the National Institute of Health & Clinical Effectiveness (NICE 2004) young people were admitted for psychosocial assessment, however availability and access to CAMHS was difficult, a difficulty widely acknowledged (RCPCH 2012, NHS England 2013). Moreover the children's ward were reportedly reluctant to admit those aged 16 – 17 years of age, and likewise, adult mental health services did not view admission to these services appropriate. The difficulty in placing this particular age group reflects inconsistency within policy guidance; the Royal College of Paediatrics and Child Health (RCPCH 2012) define a child as being a person under the age of 18,

but in a joint statement on the urgent & emergency care of children and young people (RCPCH et al 2011) young people are referred to as aged 16 and under, as is the case in the NICE (2004) guidelines on self harm.

The findings from the quantitative data indicate that there was no significant difference between occupational groups and their attitudes towards young people or their attitudes towards young people who self-harm, findings which are consistent with other studies that specifically examine attitudes towards young people who self-harm (Anderson et al 2000, Crawford et al 2006, Anderson & Standen 2007). There were no discernable differences in relation to age and gender, and as McCarthy & Gijbels (2010) note the relationship between attitudes and factors such as gender, age and experience, remain unclear.

There was however a difference in relation to length of experience, this trend (experience equating to more positive attitudes) reported in earlier studies (McLaughlin 1994, Anderson 1997, Friedman et al 2006, Patterson et al 2007). McCarthy & Gijbels (2010) also found a positive correlation with experience and attitudes, with the same dip in terms of lower scores post 16 years experience.

An association between length of experience and stress and associated burnout has previously been noted (Friedman et al 2006 Suokas & Lonnqvist 1989, Glasberg et al (2007). Glasberg et al's study (2007) confirmed that staff who had little support, worked long hours, were older, and had low resilience were more prone to 'stress of conscience', (defined as '*a product of the frequency of the stressful situation and of the perceived degree of troubled conscience*' Glasberg et al (2007:393). This was

associated with having to lower aspirations to provide good care (due to competing demands). These factors could be associated with the more experienced participants in this study as they are more likely to be in senior positions, and because of their seniority may not attract the same level of support and supervision than their more junior colleagues do; notably, the more experienced nurses interviewed were responsible for the challenging task of locating beds.

## **LIMITATIONS**

The AYP and AYPSH scales were developed for this study and as such their use was as a pilot. While PCA and factor analysis demonstrated that with the removal of some items, the scales hung together well, further refinement and testing of the scales' reliability is needed.

The inclusion of medical staff as interviewees would have been useful; the views of young people would also have added to the study; however circumstances precluded the planned inclusion of either doctors or young people in the interviews.

## **Conclusion**

As this is an exploratory study, the conclusions drawn are tentative. It appears though that while age ameliorates negative attitudes towards self-harm, it is the ambiguity of the period of adolescence, which has a significant influence on the care that young people who self-harm receive from emergency services. This ambiguity both shapes practitioners' attitudes and directs young people's pathways through services. Policy and guidelines need to adopt a unified stance in determining when paediatric services end, providing clarification for nurses and others seeking to admit a young person for a

thorough assessment following an episode of self-harm. Young people aged 16 – 17 years of age should be consulted to gain their perspective as to where they feel their needs would be best met.

Education and training programmes around self-harm in young people should address the values and attitudes individuals hold towards young people, the scales devised for this study would provide a useful basis for this purpose and, given the confirmed relationship between attitudes across the scales, they may also be useful as a basis for assessing perceptions of and attitudes towards young people in potential applicants to nursing. Further research is though needed to more fully explore the relationship between attitudes towards young people per se and how/whether this influences the care they receive.

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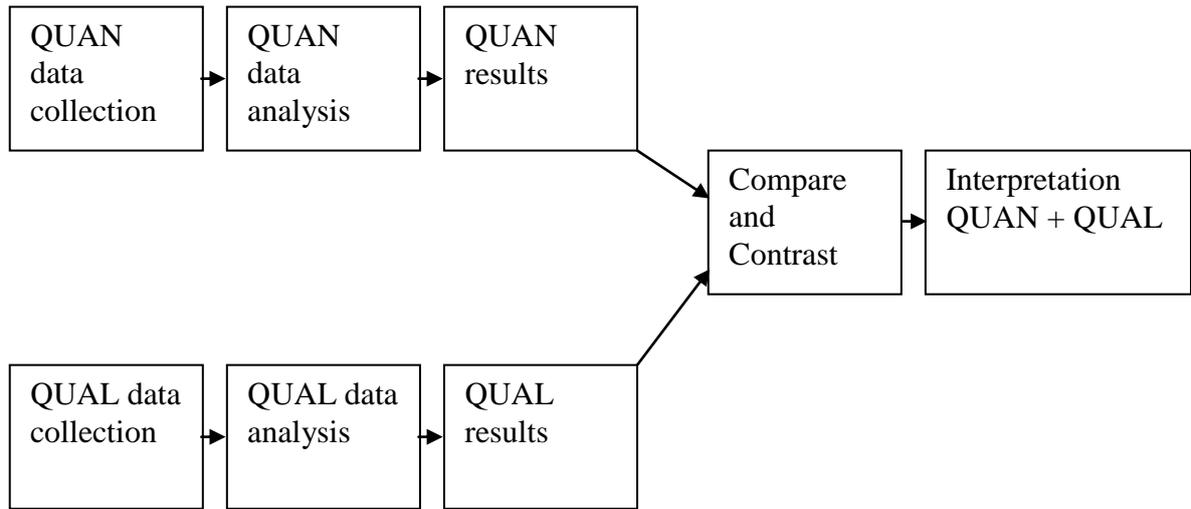
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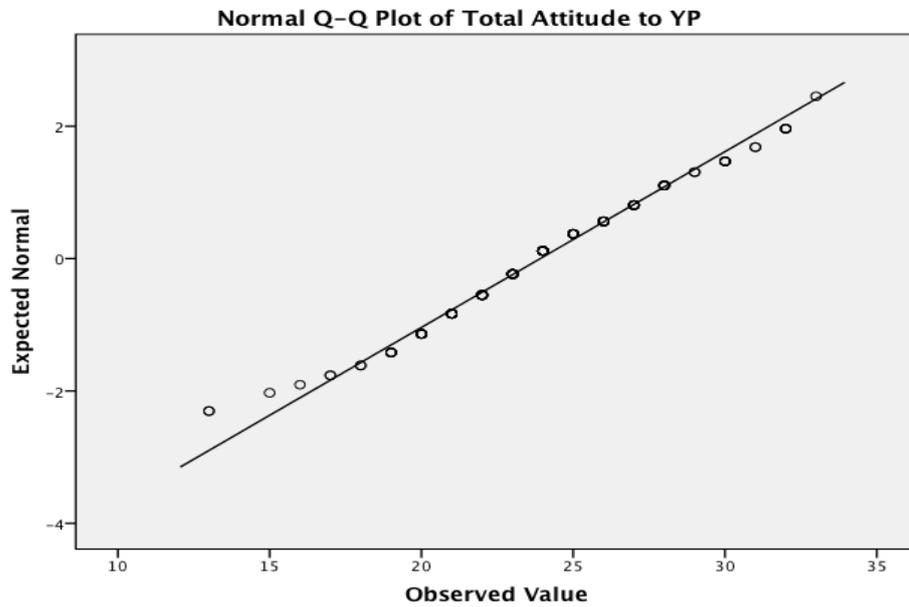
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**FIGURE 1 Triangulation Design: Convergence Model**

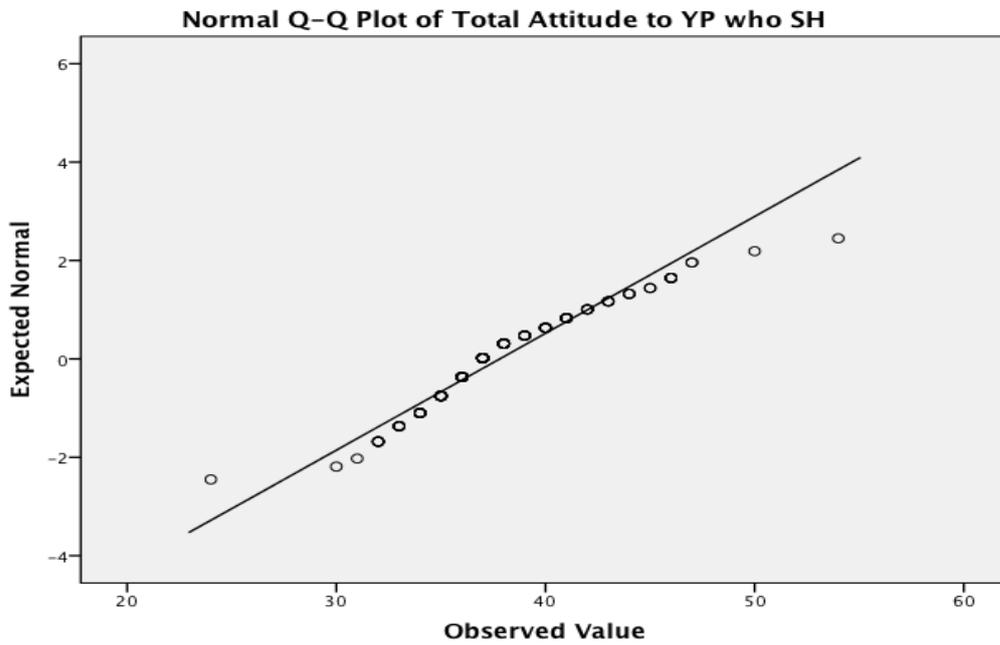
(Creswell & Plano-Clark 2007:63)



**Figure 2:**

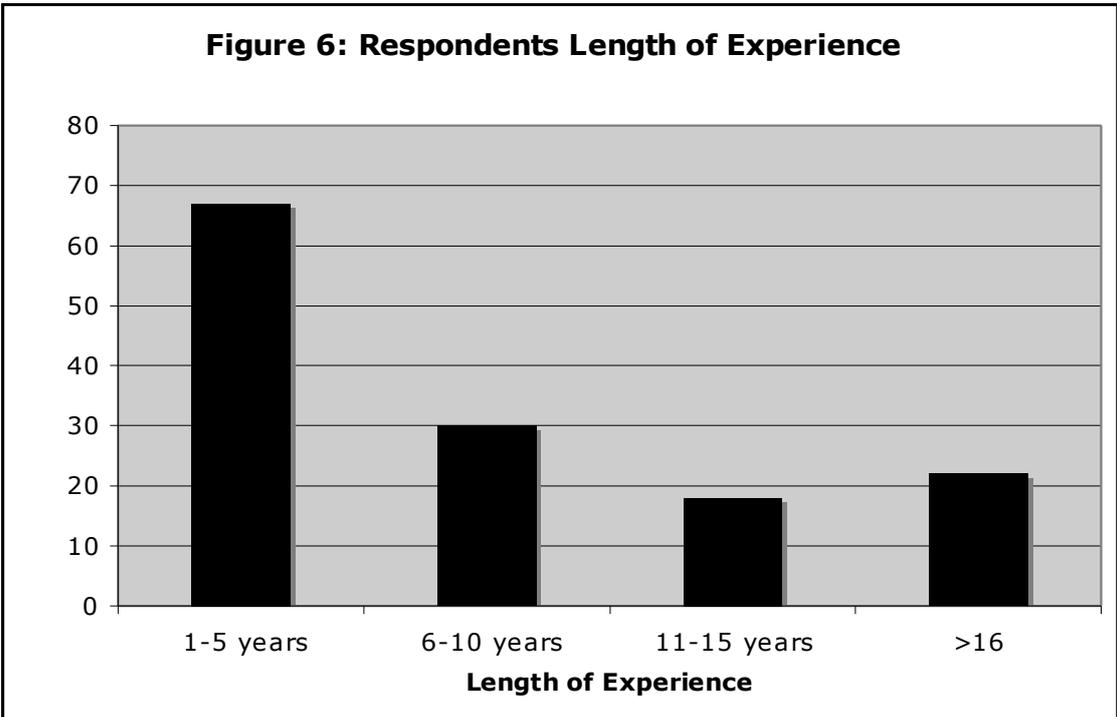
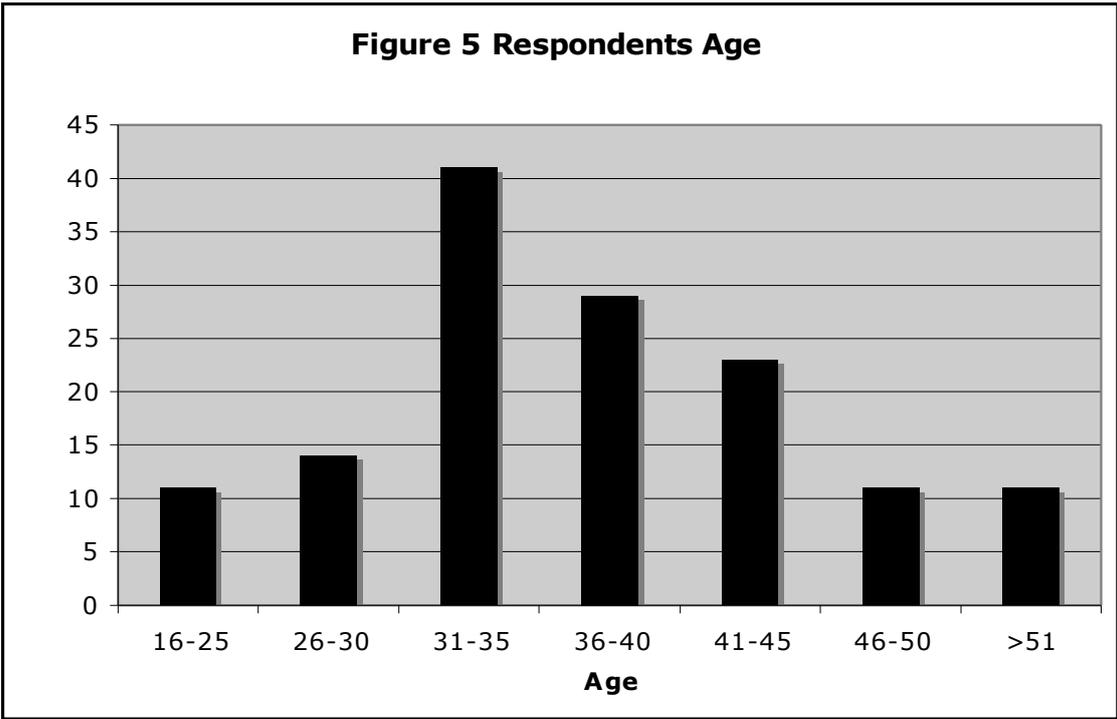


**Figure 3:**



**Figure 4: Respondents by Occupation & Gender**





**Tables 1. Summary of Mean Scores on Both Scales**

<b>Scale/Variable</b>	<b>AYP</b>		<b>AYP SH</b>	
<b>Occupation</b>	Mean Score (SD)		Mean Score (SD)	
Nurse	24.13	(3.29)	37.26	(4.60)
Paramedic	24.29	(4.31)	38.68	(4.73)
Ambulance Technician	22.94	(3.63)	37.70	(3.50)
Doctor	24.25	(3.77)	37.71	(3.68)
<i>P=</i>	<i>p = 0.406</i>		<i>p = 0.549</i>	
<b>Age</b>				
16- -25	23.00	(3.22)	37.00	(2.16)
26-30	24.71	(2.84)	39.50	(3.82)
31-35	22.46	(4.25)	37.20	(3.66)
36-40	24.34	(3.42)	37.97	(4.50)
41-45	25.09	(3.45)	38.17	(4.80)
46-50	24.81	(4.14)	37.27	(6.34)
>51	24.73	(3.47)	38.00	(3.77)
	<i>p = 0.081</i>		<i>p = 0.701</i>	
<b>Gender</b>				
Male	23.45	(4.11)	37.64	(3.84)
Female	24.26	(3.37)	37.96	(4.61)
	<i>p = 0.210</i>		<i>p = 0.257</i>	
<b>Years Experience</b>				
1- 5 years	23.90	(3.92)	37.76	(3.28)
6 - 10 years	22.84	(3.49)	37.13	(4.09)
11 – 15 years	25.41	(4.53)	40.50	(6.20)
> 16 years	24.41	(2.75)	37.04	(4.31)
	<i>p = 0.135</i>		<i>p = 0.029**</i>	

**TABLE 2 Mean Scores (Standard Errors) by Occupational Group for Each Item Relating to Attitudes towards Young People (AYP).**

	<b>Overall level of agreement</b>	<b>Nurse (n=47)</b>	<b>Paramedic (n=34)</b>	<b>Ambulance Technician (n=34)</b>	<b>Doctor (n=28)</b>	<b>Overall mean (n=143)</b>	<b>P =</b>
The behaviour of young people is no worse than it was in the past	19% agree 12% neither 69% disagree	2.45 (0.16)	2.06 (0.18)	2.03 (0.17)	2.64 (0.25)	<b>2.30</b>	<b>0.070</b>
The views of young people are not listened to enough	48% agree 27% neither 25% disagree	3.23 (0.14)	3.44 (0.16)	3.18 (0.15)	3.04 (0.18)	<b>3.23</b>	<b>0.398</b>
Girls are more badly behaved than boys nowadays	17% agree 50% neither 33% disagree	3.21 (0.11)	3.15 (0.13)	3.09 (0.14)	3.14 (0.18)	<b>3.15</b>	<b>0.924</b>
Most young people are responsible and well behaved	47% agree 27% neither 26% disagree	3.20 (0.13)	3.47 (0.18)	3.00 (0.16)	3.29 (0.22)	<b>3.23</b>	<b>0.274</b>
Young people today have no respect for adults	45% agree 30% neither 25% disagree	2.81 (0.16)	2.65 (0.18)	2.59 (0.16)	2.75 (0.21)	<b>2.71</b>	<b>0.792</b>
Most young people are helpful and friendly	44% agree 32% neither 24% disagree	4.00 (0.10)	4.35 (0.11)	4.18 (0.13)	4.21 (0.12)	<b>4.17</b>	<b>0.138</b>
Young people today are not disciplined by parents	70% agree 19% neither 11% disagree	2.49 (0.14)	2.06 (0.12)	2.03 (0.15)	2.25 (0.18)	<b>2.23</b>	<b>0.068</b>
Adults have no respect for young people	15% agree 36% neither 49% disagree	2.51 (0.11)	2.82 (0.15)	2.68 (0.13)	2.50 (0.15)	<b>2.62</b>	<b>0.280</b>
Young people today don't get enough care & attention from their parents	48% agree 34% neither 18% disagree	2.68 (0.12)	2.44 (0.17)	2.71 (0.14)	2.50 (0.20)	<b>2.59</b>	<b>0.540</b>
Young people today have more stress in their lives than they did before.	59% agree 15% neither 26% disagree	3.28 (0.15)	3.44 (0.19)	3.36 (0.20)	3.57 (0.20)	<b>3.39</b>	<b>0.714</b>

**TABLE 3. Mean Scores (Standard Errors) for Each Item Relating to Attitudes towards Young People who Self-Harm (AYPSH)**

	<b>Overall level of agreement</b>	Nurse (n=47)	Paramedic (n=34)	Ambulance Technician (n=34)	Doctor (n=28)	<b>Overall mean (n=143)</b>	<b>P=</b>
Most young people who self-harm don't want to die	85% agree 11% neither 4% disagree	3.83 (0.12)	4.26 (0.13)	4.32 (0.10)	3.96 (0.14)	<b>4.08</b>	<b><i>p</i> = 0.007**</b>
Young people who self-harm are trying to get sympathy from others	48% agree 29% neither 23% disagree	2.74 (0.13)	2.71 (0.19)	2.55 (0.20)	2.57 (0.17)	<b>2.65</b>	<b><i>p</i> = 0.796</b>
Young people who self-harm are in desperate need of help	88% agree 10% neither 2% disagree	4.00 (0.10)	4.35 (0.11)	4.18 (0.13)	4.21 (0.12)	<b>4.17</b>	<b><i>p</i> = 0.138</b>
Most young people who attend having deliberately harmed themselves are likely to repeat this behaviour	93% agree 7% neither 0% disagree	4.08 (0.08)	4.27 (0.11)	4.32 (0.09)	4.29 (0.10)	<b>4.22</b>	<b><i>p</i> = 0.217</b>
Young people who self-harm are attention seekers#	28% agree 40% neither 32% disagree	3.13 (0.14)	3.18 (0.18)	3.21 (0.16)	2.82 (0.20)	<b>3.10</b>	<b><i>p</i> = 0.418</b>
Young people who self-harm should be required to undergo therapy	71% agree 18% neither 11% disagree	3.89 (0.13)	3.79 (0.14)	3.73 (0.16)	3.43 (0.17)	<b>3.74</b>	<b><i>p</i> = 0.178</b>
Young people who self-harm are more at risk of successfully completing suicide	56% agree 29% neither 15% disagree	3.42 (0.12)	3.74 (0.15)	3.29 (0.16)	3.71 (0.18)	<b>3.55</b>	<b><i>p</i> = 0.117</b>
Young people who self-harm are mentally ill	29% agree 38% neither	2.85 (0.14)	2.97 (0.16)	3.12 (0.16)	3.00 (0.18)	<b>2.97</b>	<b><i>p</i> = 0.649</b>

	33% disagree						
Young people who self-harm are more likely to have difficult relationships with their families	70% agree 23% neither 7% disagree	3.61(0.13)	3.88 (0.12)	3.56 (0.13)	3.96 (0.11)	<b>3.73</b>	<b><i>p</i> = 0.080</b>
Self-harm is a normal part of youth culture	3% agree 13% neither 84% disagree	1.96 (0.13)	1.62 (0.12)	1.85 (0.13)	1.89 (0.11)	<b>1.84</b>	<b><i>p</i> = 0.240</b>
Young people who self-harm do it because they want to show how desperate they are feeling	67% agree 23% neither 10% disagree	3.52 (0.12)	3.68 (0.14)	3.65 (0.10)	3.71 (0.13)	<b>3.63</b>	<b><i>p</i> = 0.687</b>
Young people who self-harm do it because they want to frighten someone#	21% agree 37% neither 42% disagree	3.47 (0.14)	3.15 (0.14)	3.12 (0.15)	3.25 (0.16)	<b>3.27</b>	<b><i>p</i> = 0.255</b>
Young people who self-harm do it because they want to find out if someone really loves them	25% agree 44% neither 31% disagree	3.13 (0.15)	3.18 (0.14)	3.06 (0.12)	2.96 (0.14)	<b>3.09</b>	<b><i>p</i> = 0.773</b>
Young people who self-harm do it because they want to get their own back on someone	13% agree 37% neither 50% disagree	3.63 (0.13)	3.59 (0.13)	3.35 (0.13)	3.21 (0.13)	<b>3.47</b>	<b><i>p</i> = 0.171</b>

