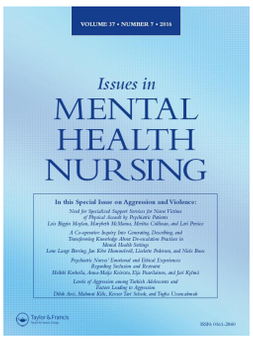

Issues in Mental Health Nursing

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/imhn20

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To cite this article: Britt-Marie Lindgren , Jenny Molin & Ulla H. Graneheim (2020): Balancing between a Person-Centred and a Common Staff Approach: Nursing Staff's Experiences of Good Nursing Practice for Patients Who Self-Harm, Issues in Mental Health Nursing, DOI: 10.1080/01612840.2020.1817206

To link to this article: https://doi.org/10.1080/01612840.2020.1817206

Published online: 16 Sep 2020.

ISSUES IN MENTAL HEALTH NURSING
https://doi.org/10.1080/01612840.2020.1817206

Balancing between a Person-Centred and a Common Staff Approach: Nursing Staff's Experiences of Good Nursing Practice for Patients Who Self-Harm

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ABSTRACT

The aim of this study was to describe nursing staff's experiences of good nursing practice in psychiatric in-patient care for patients with self-harming behavior. The participants were nine nurses and eight nursing assistants working in two in-patient wards in general psychiatry. Four focus group discussions were held and subjected to qualitative content analysis. The findings showed that good nursing practice balanced a person-centred approach with a common staff approach, allowing people who self-harm and staff to share responsibility for structuring everyday life, keeping to the plan, communicating decisions, and finding individual opportunities for relief. Reflective discussions among the staff concerning prejudice, emotional stress, lack of resources, and shortcomings in care planning could also prevent a stigmatizing culture and organizational deficiencies, which would be beneficial for both the people who self-harm and the staff.

Background

Self-harm is classified primarily as self-injury without suicidal intent (Nock & Favazza, 2009). The term 'deliberate self-harm' includes a broad spectrum of non-fatal self-harm, irrespective of degree, motivation, and level of suicidal intent. Thus, drug overdoses and suicidal attempts are both included in this definition (Hawton et al., 2012). In the present study we used the term non-suicidal self-injury according to the DSM-5 (American Psychiatric Association [APA], 2013). It is described as deliberate, self-inflicted damage of body tissue without suicidal intent and for purposes not socially or culturally sanctioned, such as cutting, burning, biting, and scratching the skin.

The function of self-harm is primarily to regulate emotional strain. It can be a way to communicate suffering, reduce anxiety, punish oneself and/or others, gain control, transform psychic pain to physical pain, and to feel alive (Åkerman, 2009; Edmondson et al., 2016; Ogden & Bennett, 2015; Tiffany & Thomas, 2013). The paradox is that people who self-harm are aware that self-harm is not beneficial for them, but it offers them relief from unbearable emotions that they cannot otherwise handle. People who self-harm describe feelings of shame, isolation, loneliness, and secrecy (Tiffany & Thomas, 2013; Tofthagen, 2018).

A systematic review by Lindgren et al. (2018) reports patients' experiences of being cared for when they have self-harmed. These patients describe not being taken seriously, not receiving proper care, and being seen as 'hopeless cases'. They say that staff consider it a waste of time to care for them, believing that they will continue to harm themselves again and again. They wish to be treated as human beings, not 'aliens'. However, they also describe having satisfying meetings with staff, in which they are respected and confirmed as people. Staff who are able to see their resources, not only their shortcomings, gain understanding, and their conviction that recovery from self-harm is possible induces hope in people who self-harm and their loved ones (Lindgren et al., 2018).

Research shows that nurses often struggle to meet the needs of people who self-harm when they need in-patient care (Tofthagen et al., 2014; Westwood & Baker, 2010), and staff in both somatic and psychiatric care describe care for people who self-harm as demanding (Holth et al., 2018; O'Connor & Glover, 2017). Challenges include ethical dilemmas, and conflicts among colleagues are common when people who self-harm are admitted to hospital. Such conflicts may be provoked by a dominant medical paradigm that hinders person-centred care, insufficient support structures, and sometimes being left alone in difficult situations (Karman et al., 2015). Staff report that they feel insecure about how to approach these patients, who they consider manipulative and attention seeking. They feel frustrated, angry, and hopeless, thinking such patients do not recover. Lack of knowledge about self-harm is a recurrent theme in many studies (Holth et al., 2018; Karman et al., 2015; O'Connor & Glover, 2017; Westwood & Baker, 2010). However, there are also studies showing that staff with specific education and/or competence in caring for people who self-harm report different experiences. They point out that with increased knowledge they have helpful tools and a

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better understanding of self-harm. This contributes to a more flexible way of working and seeing each persons' individual needs (Dickinson et al., 2009; Lindgren et al., 2015; Lindgren & Graneheim, 2015).

Studies reporting good nursing practice for people who self-harm are sparse. Good nursing practice in general mental health care emphasize a person-centred and recovery-oriented approach with focus on a collaborative interpersonal relationship and understanding of the unique person's needs in a unique situation (Gabrielsson et al., 2016; Tofthagen et al., 2014). Previous research on self-harm in a psychiatric in-patient care context reports both patients' and staff's experiences of care as challenging and stressful. Few studies have explored what staff consider good nursing practice for patients who self-harm. Therefore, this study aimed to describe nursing staff's experiences of good nursing practice in psychiatric in-patient care for patients with self-harming behavior.

Method

The study has a qualitative descriptive design and is based on four focus group discussions (Dahlgren et al., 2019) subjected to qualitative content analysis with an inductive approach (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020).

Context

The study was conducted at two general psychiatric in-patient wards in Northern Sweden. Each ward had 16 beds for adult people. The patients admitted had various diagnoses including personality disorders, depression, anxiety syndrome, schizophrenia, and eating disorders. The wards had locked entrance doors, and the patients were cared for both voluntarily and involuntarily in line with the Health and Medical Service Act (SFS, 1982:763) or the Compulsory Psychiatric Care Act (Swedish National Board of Health and Welfare [SFS], 1991:1128).

Participants

Information about the study was given to all staff at a monthly meeting on the wards by two clinical specialist nurses (CH, ON), and staff who were interested to participate and met the inclusions criteria were invited to sign up. The inclusion criteria were registered nurses and nursing assistants with permanent employment, and had experiences of caring for patients who self-harm. Nursing staff without permanent employment and with less than one year's work experience was excluded. In total 17 people gave their consent to participate, nine registered nurses and eight nursing assistants; eight men and nine women. Ages ranged from 26 to 64 years (median = 36), and work experience in psychiatric care from 2 to 24 years (median = 7). The focus groups were formed based on heterogeneity, in terms of age, type of work, length of work experience, which contributed to rich data illuminating a great variety of experiences.

The interviewers and the participants were colleagues which may have both strengths and limitations (McDermid et al., 2014; McEvoy, 2001), and will be reflected on in the methodological discussion.

Data collection

We selected focus group discussions as method for the data collection for its ability to elicit qualitative data by using the interaction between group members to enhance discussion and generate rich data (Peek & Fothergill, 2009). Four focus group discussions with four or five participants each were conducted by two clinical specialist nurses (CH, ON) acting as either moderator or observer. Based on the aim of the study, the literature review, and the researchers experiences the interview guide covered three main questions: 'Tell me about a situation when you felt a person with self-harming behavior received good nursing practice at the ward?', 'What facilitates good nursing practice for these patients?', and 'What can be done to improve nursing practice for these patients?' If the participants did not spontaneously reflect upon their initial answers, or if there was no discussion, probing follow-up questions were posed, for example, 'Do you recognize the situation?', 'Why do you think it worked well/badly?', and 'What do the rest of you think?' The moderator had the main responsibility to ask questions according to the interview guide. When needed the observer could add further exploring questions, and the observer was also responsible for presenting a summary in the end of the interview. The focus group discussions lasted 45 to 60 minutes and were held at the psychiatric clinic during the participants' workday. The focus group discussions were audio-taped and transcribed verbatim.

Data analysis

The transcribed text was subjected to qualitative content analysis with an inductive approach (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). Qualitative content analysis is a systematic way to break data down into pieces (decontextualization) and rebuild them into new patterns (recontextualization). First, we read the text to get a sense of the whole. Although we asked specifically for experiences of good nursing practice, we noticed that participants also described aspects that implied poor nursing practice. The research team reflected critically on this outcome and decided to include the data on poor practice, which could contribute valuable insights into changes needed to improve existing nursing practice. To create a fair picture of the data, we started the decontextualization by creating two content areas: aspects that facilitate good nursing practice versus those that hinder it. Then we divided the whole text in each content area into meaning units, which we eventually condensed and coded. The recontexualization started with sorting the codes by their similarities and differences and abstracting and interpreting them first into seven sub-themes and eventually into four descriptive themes. Qualitative content analysis is a non-linear process and

Table 1. Overview of content areas, sub-themes, and themes revealed during the analysis.

Content areas	Sub-themes	Themes
Aspects characterizing good nursing practice	Finding individual opportunities for relief	Practising a person-centred approach
	Sharing decision-making	
	Structuring everyday life and keeping to the plan	Practising a common staff approach
Aspects hindering good nursing practice	Being influenced by prejudices	Being part of a stigmatizing culture
	A disconnected group of staff	
	Lacking resources	Struggling with organizational deficiencies
	Dealing with shortcomings in care planning	

requires that the researcher move back and forth between the original text and parts of the text during the analysis process (Graneheim et al., 2017; Graneheim & Lundman, 2004; Lindgren et al., 2020). Furthermore, to create a wider analytic space and enhance trustworthiness, the authors jointly reflected on and discussed the selection of meaning units and the meanings of codes and themes during each step of the analysis. Special attention was given to codes and themes upon which the researchers disagreed (Malterud, 2012).

Ethical considerations

This study was performed according to the ethical guidelines described in the Helsinki Declaration (World Medical Association, 2013) and was approved by the head of the Clinical Department of Psychiatry. The participants received verbal and written information about the aim of the study. They were informed that their participation was voluntary, that they could end their participation at any time without having to provide a reason, and that their confidentiality was assured. All participants submitted written consent and none chose to discontinue participation. Nonetheless, there were risks that needed to be taken into consideration. Participants can feel violated by close questioning and can be afraid to disclose their shortcomings in front of colleagues. They can also fear that their narratives might be recognized by their superiors. However, the participants in our study could choose what they wished to disclose, and the act of disclosure in itself may provide relief to participants (Gaydos, 2005).

Findings

The participants described good nursing practice as facilitated by both a person-centred and a common staff approach. Hindrances were being part of a stigmatizing culture and struggling with organizational deficiencies. An overview of the content areas, sub-themes, and themes revealed during the analysis is presented in Table 1.

Aspects characterizing good nursing practice

Aspects characterizing good nursing practice were described as comprising a fair balance between using a person-centred approach and a common staff approach.

Practising a person-centred approach

The participants described a person-centred approach and emphasized that care should focus on patients' individual needs, and goals had to be based on their personal prerequisites. This theme is based on two sub-themes: *finding individual opportunities for relief* and *sharing decision-making*.

Finding individual opportunities for relief

Finding individual opportunities to relieve anxiety was described as an essential part of good nursing practice. The participants mentioned several interventions and distracting activities or equipment for patients such as scheduled dialogues, massage, acupuncture, acupressure mats, treadmills, and punching balls.

Scheduled dialogues with staff before and after a self-harming incident were described as helpful in preventing further self-harm. Such dialogues allow patients to express their thoughts and feelings about the function of their self-harming behavior and offer the nurse an opportunity to gain insight into the individual's preferred distracting activities. However, not all people who self-harmed wished to have scheduled dialogues, perhaps because they found it hard to communicate their suffering. In these cases, the staff had to find other ways to relieve their suffering:

> I have an example when we had a patient who thought it was hard to communicate and say that she had a hard time and wanted to cut herself… So, we had an agreement that she should go and sit down in a special armchair so we could notice that 'now she feels worse' and now she needs help. So then she could sit in the armchair and we could look after her (FG 3).

Dialogues after a self-harming incident were described as an important opportunity for the patient to gain insights about self-harm as a less effective anxiety-reducing strategy than other distracting activities. Thus, dialogues before and after a self-harming act were felt to be the most effective way to acknowledge people with self-harming behavior. By seeing patients, confirming them, and showing them patience, staff felt they instilled in them a sense of safety and security and that the patients seemed to feel happy and appreciated.

Sharing decision-making

The participants wished to share decision-making with patients and with the out-patient team. They felt patients needed to take an active part in decisions about their own care and care planning, and when decision-making was shared, it was easier to meet the patients in their reality and set realistic goals based on their individual needs. The

participants emphasized the need for patience as recovery from self-harming is a long-term process. To cope with the long time-frame, the in-patient care plan should comprise short-term goals. Rather than ending self-harm immediately, a first goal could be to cause less dangerous injuries. By planning together with the patient, the risk for failures decreased.

> Yes, it's important that they participate. It should be functional outside these doors, too. We are not just supposed to find something that works here; they should learn something that works outside, and then they have to participate. (FG 1)

The participants also described the importance of patients' responsibility for their own feelings and actions. By being supported in finding strategies to reduce their anxiety, the patients were able to take responsibility. As one participant said, "It's all about transferring responsibility to the patients, that they get aware of their own knowledge, as they are experts by experience" (FG 4).

Shared decision-making and good collaboration in care planning with physicians and out-patient care staff was also beneficial to patients. Frequent contact with the out-patient team during the admission was desirable. As the out-patient team grew to know the patient better, they were better able to identify the patients' resources, which could mean shorter in-patient admissions.

> When she was admitted to in-patient care, she still had a close relation to the out-patient team. They could come to the ward and support her and see her own resources, which they knew she had, but had lost during admission … she did not see them herself (FG 3).

Practising a common staff approach

A recurrent topic described as a characteristic aspect of good nursing practice for people with self-harming behavior was a common staff approach. This was described as close teamwork, both among in-patient staff, but also between in-patient and out-patient staff. This theme is based on one sub-theme: *structuring everyday life and keeping to the plan.*

Structuring everyday life and keeping to the plan

The importance of staff and patients agreeing upon a structure in patients' everyday life was emphasized as enabling good nursing practice. Examples of this were staff waking patients up in the morning and reminding them of their daily schedule including meals, medication, daily activities, and dialogues. The participants argued that it was also important that they approached the patients and acted in a similar way in order to keep to the plans they had agreed upon.

> Clear care plans and a structured team, or what should I call it, a tight team that works towards the same goal, you don't have to think and feel the same, but you should have the same goal. (FG 1)

It was easier to assess the nursing care if staff acted in a similar way toward a person with self-harming behavior. "To act in similar ways and, otherwise … if everyone acts in various ways the whole time, then it gets hard to try new things" (FG 2).

The participants emphasized the importance of having a joint predetermined and clear plan for handling self-harming incidents. Guidelines and a strict course of action for the care of patients with self-harming behavior were necessary, because if the staff acted in different ways it could result in a feeling of insecurity for both patients and staff. However, a common staff approach could be challenging. The participants described situations when they needed to balance between their own intuition and the predetermined plan; even if such a plan existed, there could be situations when staff disagreed and did not keep to the plan.

> The difficulty with such a plan is when half of the staff aren't convinced of the benefits but have agreed to follow it … the patients easily notice when staff are unsure and have doubts. In such situations, staff may have to choose between keeping to the plan or following their own experiences in the situation. (FG 1)

Aspects hindering good nursing practice

Aspects that hindered good nursing practice were related to a stigmatizing culture and struggles with organizational deficiencies.

Being part of a stigmatizing culture

The participants described a stigmatizing culture as a hindrance to good nursing practice for people with self-harming behavior. This theme is based on two sub-themes: *being influenced by prejudice* and *a disconnected group of staff.*

Being influenced by prejudices

The participants described how prejudices hindered them from providing good nursing practice. Commonly, staff tended to generalize patients and ignore their individual differences. They described perceiving these patients as suffering from similar problems and therefore in need of similar nursing practices. They experienced them as a 'difficult group' and not as unique people. They tended to "pull everyone over a comb" (FG 1), which they did not experience to the same extent with patients with other diagnoses.

Further, participants reported that people with self-harming behavior did not always get a professional approach. Between themselves, staff expressed their frustration over not being able to help these patients resist harming themselves and said that it was hard to feel empathy for them. The participants also said that, as a consequence of the frustration they felt, it was easy to induce guilt in these people after a self-harming incident. One participant said, "Somehow you still choose to cut yourself … then you have to solve it by yourself" (FG 3).

The participants perceived that people with self-harming behavior generally suffered from some kind of personality disorder, primarily borderline personality disorder. It was problematic when several people with self-harming behavior were cared for at the ward concurrently, because staff experienced self-harming behavior as contagious and said the

patients copied each other's behaviors and helped each other to find new ways to harming themselves during their stay at the ward.

The participants said a lack of knowledge was one reason why they experienced people with self-harming behavior as difficult to help. They were afraid to schedule dialogues with them about their self-harming behavior, of saying the wrong things and thereby causing further self-harming acts. One participant said, "Sometimes they [dialogues] stir up and start more than they relieve" (FG 4). Because they lacked knowledge, they felt uncertain about how to act when someone had self-harmed at the ward. They found it hard to find a good way to talk about the incident without inducing guilt. Sometimes this caused staff to hold back in a way that could be interpreted as ignorance.

> Perhaps you get stuck and go on without finding new paths to walk on, you just put in more and more resources [special observations] and I don't believe that it always is the best, because then … it only becomes worse for the patient. (FG 4)

A disconnected group of staff

The participants described a great variety of opinions among staff about how the care for these patients should be designed. Different opinions and endless discussions about how to act in various nursing situations were exhausting. Topics of disagreement included whether patients should dress their own wounds and wipe up their own blood, or should they get help from staff? Should staff pay attention to self-harming behavior, or should they ignore it? Should staff talk with patients about their self-harming behavior or not? Should these patients have special observation or not? The participants described how these patients and their behaviors evoked feelings of uncertainty, insecurity, fear, and even anger. One participant said, "You can feel anxiety just walking into the room because, you know … do I meet a bloodbath or is there someone nice in here?" (FG 2)

The participants also described how some people with self-harming behavior got more attached to some professionals in the team and these 'chosen' ones felt chained to these people. "It is like an emotional kidnapping … if you don't keep me company, I will cut myself" (FG 1). They were also frustrated over all the time they spent mapping and trying to find reasons why these patients harmed themselves, because it seldom gave any result. As a consequence, this frustration sometimes resulted in staff disengaging from the patients' problems. "You don't want to go in there and intervene too much, because then it just results in acting out" (FG 3).

The participants described patients with self-harming behavior as hard to communicate with, and it was common that staff divided into opposing camps when these patients were cared for at the ward.

Struggling with organizational deficiencies

The participants described organizational deficiencies as hindrances to good nursing practice. This theme is based on two sub-themes: *lacking resources* and *dealing with shortcomings in care planning*.

Lacking resources

Lack of time was described as the root of many organizational deficiencies and a hindrance to good nursing practice. The participants related lack of time to understaffing and high workload at the wards. They described lack of time sometimes contributing to self-harming incidents at the ward as patients sought the staff's attention. Many incidents could have been avoided if staff had had time to notice these people before they harmed themselves. "Because it had been possible to avoid many incidents if you had the opportunity to acknowledge them before they had harmed themselves" (FG 4).

Lack of time had a negative effect on participants' opportunities to support patients with self-harming behavior in developing their abilities. To save time, the staff often took over this responsibility from the patients. They did things that the patients could easily have done by themselves, which suppressed the patients' abilities. Lack of time also hindered the staff from helping these patients to find alternative ways to handle their anxiety. "Perhaps, there is not so many healthy ways to handle the anxiety when you are admitted to in-patient care, when it is lots of stress and things to do" (FG 3). Instead of becoming close to staff and involved in activities and dialogues, patients were given medication to relieve their anxiety in order to prevent self-harm.

The participants also described how lack of time had a negative influence as the patients were noticed only when they had harmed themselves, "It is important to be available at other times, not only when you have to take care of wounds or when you have to restrain them or when they knock themselves into pieces" (FG 2). Further, they described how the stressful environment made these patients withdraw to their rooms, which resulted in staff not noticing the risk of self-harm in time. "Then they start to feel worse and worse and they have to call for help because they feel so bad, and then it may be too late so to speak" (FG 1).

Medication, mainly sedatives, hindered these patients from finding alternative strategies to handle their anxiety, and also made them unreceptive to therapy when they were under the influence. "They never come anywhere, never, never, never, and I think it is disrespectful against the patients. We do cheat them in a way" (FG 2).

Dealing with shortcomings in care planning

The participants struggled with shortcomings in care planning that hindered good nursing practice. This was described as a consequence of staff acting under emotional stress, which contributed to prolonged hospital stays and an easiness about prescribing special observations. The participants described how patients with self-harming behavior were often admitted to in-patient care for too long, which was devastating and led to increased acting out, more self-harming incidents, and new ways to self-harm.

> The problem when you prolong the stay is that you end up in a vicious cycle of acting out … a tenth of the time admitted would be enough for many of them, so it is the care itself that makes it worse. (FG 4)

They also perceived it difficult to discharge these patients after a long hospital stay because of uncertainty among the staff. "The more they hurt themselves, the harder it becomes to find a physician who is willing to discharge them, who dares to discharge them" (FG 2).

The ease of prescribing special observation to prevent self-harm was described as devastating for the nursing practice. The participants said it not only often prevented patients from taking responsibility for their actions during the hospital stay, but could also create uncertainty about daring to be discharged. This contributed to longer hospital stays and it was a hindrance to continued out-patient care.

> We take it all [the responsibility] at the same time and don't give it back until they are going to be discharged and how will that be/ … /it's like they don't need any responsibility of their own … it's not … and how do you get healthy in this way? That's my question. (FG 2)

Discussion

This study aimed to describe nursing staff's experiences of good nursing practice within psychiatric in-patient care for patients with self-harming behavior. The findings showed that good nursing practice for patients with self-harming behavior is characterized by a fair balance between a person-centred approach and a common staff approach. Being part of a stigmatizing culture and dealing with organizational deficiencies hindered good nursing practice. Our findings reveal several dilemmas related to whose perspective should be in the foreground: the patient, treated with a person-centred approach, or the staff, employing a common staff approach.

The participants emphasized that an important task in practising a person-centred approach was conducting dialogues before and after a self-harming incident. The dialogues focused on mapping the motive of self-harm for the unique person and finding alternative ways to handle their emotional distress. Barker and Buchanan-Barker's (2005) nursing theory, the Tidal Model, provides guidance on recovery-oriented practice. This model emphasizes the significance of interactions and interpersonal relationships, drawing on Peplaus' (1991) theory in which a personal relationship is one between two people who come to know each other well enough to jointly face the problem at hand. However, staff's lack of time and fear of saying 'the wrong things' that could lead to increased self-harm hindered their ability to form such relationships. Earlier research reported that nurses' ideal was to have dialogues with patients, while their reality was that limited time and insufficient support made this difficult. Unclear responsibilities between out-patient staff and in-patient staff sometimes caused dialogues to be canceled (Graneheim et al., 2014). Gabrielsson et al. (2016) described enough time as a valuable asset and necessary in order to be present, to build relationships, and to treat patients in a dignified manner.

The participants in our study considered patients' own responsibility as facilitating care when they participated in their care planning and mapping their needs for help and support. By having faith in the persons' capacity to find their own solutions and strategies and being prepared to support them in carrying through their plans, nurses confirm the persons' expertise by experience (Lindgren et al., 2011). However, our findings also revealed that patients who self-harm are often deprived the responsibility for their actions during times of prolonged hospital stay and special observation. A literature review by Chu (2014) reported very little evidence that special observation is effective in decreasing the risk for self-harm and suicide. Ray et al. (2011) also reported that special observation is a complex and demanding task often performed by unexperienced and/or unskilled staff. Further, it is likely to be a counter-therapeutic intervention as special observations convey that staff do not trust the patient, thereby making it hard to establish therapeutic relationships. Beyene et al. (2018) report that practising shared decision-making is a way to balance power and responsibility to form a safe caring relationship. It is a continuous dynamic and arduous process that requires each staff member to facilitate patient participation and create a culture of trust in the therapeutic milieu.

Our findings revealed that the participants preferred joint short-term goals, including harm-minimization strategies. Harm-minimization for self-harm can be described as "accepting the need to self-harm as a valid method of survival until survival is possible by other means, and is about facing the reality of maximising safety in the event of self-harm" (Pembroke, 2009, p. 6). Harm-minimization is a strategy for supporting people who self-harm and means that staff can permit and even suggest how to reach the intended effect in a safer way (James et al., 2017; National Institute for Health and Care Excellence [NICE], 2016; Sullivan, 2017). James et al. (2017) report that staff with experiences of working with harm-minimization were more positive than staff without these experiences. Furthermore, they believed it had a powerful impact on a patient's recovery because they felt accepted and understood. Sullivan (2017) argues that harm-minimization can seem unethical, but that sometimes staff have a moral obligation to allow some self-harm to prevent worse.

Self-harming behavior is commonly seen as a provocative behavior that can generate disorder and chaos at the ward (Wilstrand et al., 2007). The behavior challenges the internal order (Foucault, 1983) and invisible norms that maintain the hospital culture and distinguish staff from patients. The participants in our study described a common staff approach as a good nursing practice and advocated the importance of having a standardized approach to each patient and keeping to the plan. However, research reports contradictory experiences of a common staff approach. Enarsson et al. (2007) found that a common staff approach was an important tool for staff to reestablish and maintain order. However, Enarsson et al. (2008) also showed that it could cause

dilemmas for staff when they had to choose between being loyal to their colleagues or focusing on the relation to the unique patient. Looi et al. (2014) describe staff's reasoning and decision-making in challenging situations in terms of solving the staff's problems or meeting the patients' needs. When the goal is to meet patients' individual needs a shift from discipline to empowerment as a guiding principal for psychiatric in-patient care is important.

Research also report patients' two-fold experiences of a common staff approach. Although patients felt safe and secure when rules and routines were established and maintained they also experienced that they were seen as a group and that no one cared about their suffering. This evoked feelings of disrespect, humiliation, abandonment, and of being denied the opportunity for dialogue. However, the absence of a common staff approach could evoke feelings of disappointment and unsafety (Alexander, 2006; Enarsson et al., 2011). When routines and rules are understandable, adapted to individual needs, and used consistently and equally among patients they offer safety (Lindgren et al., 2011, 2015).

The participants in our study described several prejudices about people who self-harm. These prejudices are in conflict with a person-centred approach and hinder good nursing practice. They described these patients as a homogeneous and difficult group that is hard to communicate with. Hume and Platt (2007), however, emphasize that people who self-harm are a heterogeneous group who need individual considerations in treatment. The participants in our study also stated that patients who self-harm are attention-seeking, manipulative, and hard to treat. These findings are similar to those in a Swedish report, which describes such prejudices causing a negative spiral with increased special observations, medication, and a repressive approach from staff (Swedish National Self-Injury Project, 2012). The perception that people who self-harm are attention seeking and manipulative is troublesome. This view increases the stigma already surrounding these people and hinder good nursing practice. If we instead interpret attention seeking and manipulation as ways to communicate experiences of feeling invisible and in need of help, we can understand that these patients are doing the best they can under their circumstances and adjusting their behavior to get their needs fulfilled.

Our findings revealed that people with self-harming behavior caused many and strong emotions among staff. Disagreements and divisions about nursing care practice arose often in discussions among staff. These findings correspond to earlier research reporting that conflicts among staff are common because people who self-harm adjust their behavior to the staff member they think may be best to fulfill their needs in the moment. This contributes to various opinions among staff about how to treat these people (Lindgren et al., 2018; Swedish National Self-Injury Project, 2012; Wilstrand et al., 2007).

Our findings reveal several dilemmas related to whether a person-centred and/or a common staff approach should prevail. One way of dealing with these dilemmas is to make space for recovery-oriented reflective practice groups. Recovery-oriented reflective practice is person-centred, strengths-based, collaborative, and reflective, thereby enabling staff in mental health care to address the needs and rights of unique individuals in unique situations (Gabrielsson & Looi, 2019). This would allow staff to discuss prejudice, divergent opinions, lack of resources, and shortcomings in care planning. The reflective dialogues should be conducted in a permissive environment and problematize which perspective should be predominant: that of the person who self-harms or that of the staff.

Methodological discussion

This study has both strengths and limitations that need to be addressed. One strength is the heterogeneity of the participant group, in terms of age, type of work, length of work experience, which contributed to rich data illuminating a great variety of experiences. The interviewers and the participants were colleagues which have both strengths and limitations and the insider and outsider perspective has been discussed by many researchers (McDermid et al., 2014; McEvoy, 2001). We have been aware of and reflected on the interviewers' dual roles and made thoughtful decisions about how to best manage them when designing the study (c.f. McDermid et al., 2014). McEvoy (2001) argue that shared experiences may facilitate the depth of the issue that is explored. On the other hand, it may be a risk that colleagues avoid stating the obvious. However, our data were rich and revealed a great variation of participants' lived experiences, both positive and negative, which indicate that they felt comfortable with the interview situation.

Our initial intention was to focus on good nursing practice. However, during the focus group discussions participants also discussed aspects that hindered good nursing practice. Although aspects hindering good nursing practice went beyond our original aim, we cannot deny that, unfortunately, they were predominant in our findings and contributed to highlight potential improvements to care for this vulnerable group of patients. In order to enhance trustworthiness, we have thoroughly described the analysis process. We acknowledge, however, that a text never implies one single meaning, and any interpretation represents just the most probable meaning from a certain perspective (Krippendorff, 2013). Thus, this is one possible interpretation of nursing staff's experiences of good nursing practice for patients who self-harm.

Conclusions

Good nursing practice is characterized by a fair balance between a person-centred and a common staff approach, through which people who self-harm and nursing staff share responsibility for structuring everyday life and keeping to the plan, communicating decisions, and finding individual opportunities for relief. Reflective dialogues among staff exploring their prejudices, emotional stress, deficient resources, and shortcomings in care planning may prevent a stigmatizing culture and organizational deficiencies. This would

be beneficial both for the people who self-harm and for the staff who care for them.

Acknowledgements

We thank the participants who shared their stories with us. We also thank Camilla Holmgren (CH) and Oskar Nyström (ON) who contributed during the data collection.

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