

**A Grounded Theory Exploration of Staff and
Patients' Experiences of Self-harming by
Ingestion**

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OVERVIEW

This thesis addresses the issue of self-harm by ingesting foreign bodies, a form of self-harm which has received little research attention. Part one presents a systematic review of the literature on deliberate ingestion in adults. This aimed to critically assess the literature to ascertain the current theoretical understanding of ingestion and identify gaps in the evidence base. Most of the literature identified was predominantly surgical in orientation, meaning there is to date little understanding of the psychological processes which underpin ingestion. No qualitative research has been undertaken into the experiences of those ingest, or the staff who work with them, which could serve to redress this deficit.

Part 2 presents a qualitative study utilising a constructivist Grounded Theory approach which investigated the meanings and functions of ingestion from both a patient and staff perspective. Six patients and six members of staff were recruited from independent sector providers and the NHS. Analysis of the semi-structured interviews revealed a core category of a 'Journey through Ingestion' which was characterised by the three stages, 'Starting Swallowing' 'Discovering the Benefits' and 'Breaking Free'. The category 'Struggling with Swallowing' identified interpersonal and systemic processes within the inpatient environment which were key to understanding ingestion.

Part 3 offers a critical reflection on the process of conducting this research. It focuses on four key areas: recruitment, the interview process, transcription and analysis, and the integration of staff and patient perspectives. In light of these discussions it offers recommendations for future researchers and clinical services providing treatment for patients who ingest.

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PART 1:
LITERATURE REVIEW

Deliberate Foreign Body Ingestion in Adults

ABSTRACT

Aims: This review aimed to identify and evaluate literature on the deliberate ingestion of foreign bodies in adults, in order to ascertain the important characteristics and current theoretical understanding of this phenomenon. This review also aimed to identify important gaps in the evidence base.

Method: A systematic literature search of PSYCHINFO, EMBASE and MEDLINE, including hand searching the reference lists of relevant papers identified a total of 21 appropriate papers.

Results: The literature on deliberate ingestion focused on three populations: individuals with personality disorders, with psychiatric illnesses, and prisoners. Functions provisionally identified varied according to the population, and included attempted suicide, self-harm, or secondary gains including manipulation of the environment or to access care.

Conclusions: The current literature is predominantly surgical in orientation, and therefore the consideration of psychological processes in ingestion is limited. Methodological constraints make it difficult to generalise any findings, and several important areas remain to be explored, including the subjective experiences of those who ingest, the functions this form of self-harm serves, and potential treatment approaches.

Introduction

The ingestion of foreign bodies refers to the swallowing of non-digestible solid objects such as glass, razor blades, cutlery, stones, wire or coins. The term does not cover the ingestion of poisonous liquids, such as bleach, or over-doses of illicit, prescription or over the counter medication, which are separately categorized as self poisoning.

The ingestion of foreign bodies is widely reported in medical and surgical literature, and usually refers to the accidental swallowing of foreign bodies such as pins, needles, toothbrushes and pens, or food bolus impaction (in which ingested food becomes lodged in the oesophagus) (Palta et al., 2009).

Paediatric and geriatric populations are at the greatest risk for accidental ingestions, and thus the majority of literature focuses on these populations (Arana, Hauser, Hachimi-Idrissi, & Vandenplas, 2001). In the geriatric population, ingestion is usually the result of wearing dentures, which interferes with oral sensation resulting in the accidental swallowing of large items of food, bones, or part of the dentures themselves (Brady, 1991).

The other population which features predominantly in the literature are those with a diagnosis of Pica, which is the compulsive, recurrent ingestion of non-nutritious substances, either non-food items such as faeces and plant matter or inappropriate food items such as raw potatoes and starch (see Appendix I for the DSM-IV-TR, 2000, diagnostic criteria). Pica most frequently occurs in young children and pregnant women due to iron and zinc deficiencies or cravings for specific minerals, and in those with developmental disorders in response to stressful life environments and lack of engagement with people or activities (Steigler, 2005).

Thus ingestion due to Pica may best be characterised as a compulsive action rather than accidental ingestion per se.

Of all foreign bodies ingested, 80-90% will pass spontaneously without causing harm once they have reached the stomach. A further 10-20% will have to be removed endoscopically, which usually occurs when the object becomes lodged in the oesophagus (Webb, 1995). Around 1% of ingestions have to be treated surgically, when the object has passed into the stomach or lower GI tract, and either threatens to or results in perforation or bleeding (Webb, 1995). Whilst the morbidity and mortality rates associated with the removal of foreign bodies are low (below 1%), ingestion itself results in an estimated 1500 deaths per year in the USA (Lyons & Tsuchida, 1993).

Current Reviews of the Literature

There are a number of reviews about the phenomenon of accidental ingestion and medical management, within a paediatric/geriatric population (Arana et al., 2001; Brady, 1991; Hachimi-Idrissi, Corne, & Vandenplas, 1998; Webb, 1995), where ingestion either occurs due to placing objects into the mouth, without the intention of swallowing, or due to the wearing of dentures which interferes with oral sensation. In contrast, there is only a small body of literature which deals with the deliberate ingestion of foreign bodies, during which the person consciously and intentionally ingests, a phenomenon which is often noted in psychiatric populations, those with personality disorders, and prisoners.

However, even within these populations it can be difficult to ascertain whether ingestion is truly deliberate, in regards to being consciously and freely chosen, with the intention of obtaining desired outcomes. For instance, those with

Schizophrenia may ingest objects due to a regression of eating habits – therefore whilst they may consciously ingest objects, it could be argued that this is a compulsive action which is not deliberately or freely engaged in. Those with psychosis who ingest in response to command hallucinations may do so consciously, but it is unclear as to whether the person is making a free and deliberate choice, with the intent to ingest. In contrast, ingestion can be more clearly identified as deliberate in the absence of psychiatric illness, when the person makes a free choice to ingest, intentionally swallowing a foreign body in pursuit of desired outcomes. This is more clearly identified in prisoners and those with personality disorders, in the absence of psychosis.

A greater understanding of ingestion within these populations is important due to differences in the nature of the phenomenon which render it potentially life-threatening. As the American Society for Gastrointestinal Endoscopy guidelines note, ingestions in those who are mentally impaired or psychiatrically unwell are more likely to go unrecognised and untreated (Eisen et al., 2002). They are also more likely to present to services after a greater delay, providing time for the object to pass beyond the pylorus, further increasing the risk of complications (Palta et al., 2009), which can be as high as 35% (Eisen et al., 2002). These populations are also more likely to swallow sharp or long objects, which have a higher risk of perforation or becoming stuck at the duodenal sweep (Palta et al, 2009). Sharp or long objects often require higher rates of endoscopic retrieval (up to 76%) or invasive surgical management (up to 11%) which increases the risk of medical complications, as well as being resource intensive, costly, and distressing for the patient (Palta et al, 2009).

However, despite these issues there has been relatively little research into the field, and whilst deliberate ingestion is discussed briefly in some of the review or

medical management papers (Ayantunde & Oke, 2006; Selivanov, Sheldon, Cello, & Crass, 1984; Weiland & Schurr, 2002) there has to date been no systematic review of the literature about the deliberate ingestion of foreign bodies.

Aims

The aims of this literature review were fourfold:

- 1) To systematically identify and review the existing literature on the deliberate ingestion of foreign bodies;
- 2) To define important characteristics of this phenomenon such as frequency, severity, and at-risk populations;
- 3) To examine the current theoretical understanding of deliberate ingestion;
- 4) To identify important gaps in the existing literature.

The review aimed to identify papers which met the following criteria:

- English language
- Published in a peer-reviewed journal
- Study population was aged 18-65

Papers were excluded from the review according to the following exclusion criteria:

- Ingestion was accidental
- Study population was under the age of 18
- Ingestion was due to a diagnosis of Pica
- The entire sample was drawn from a learning disability population
- Articles focused solely on the surgical management of deliberate ingestion

It was anticipated that a systematic review would identify the following types of literature on the deliberate ingestion of foreign bodies:

- 1) Large sample epidemiological studies or reviews of prison/hospital records, which identified the prevalence rates of deliberate ingestion; associated demographic information about those who ingest, and complication, morbidity and mortality rates.
- 2) Individual case studies, or case series which provided detailed information about psychiatric history, including diagnoses which conform to the DSM or ICD-10 classifications; consideration of the important psychological processes predisposing and underpinning deliberate ingestion; and information about the motives and functions of ingestion, either as reported by the patient, or with the provenance of the information clearly reported.

However, as will be discussed in the ‘Limitations of the Review’ the majority of the literature identified was surgical in nature, and consisted predominantly of single case studies. The majority of papers had significant methodological limitations, including a lack of clearly stated diagnosis, no consideration of key psychological processes, and little information as to the provenance of any information regarding potential functions or motives for deliberate ingestion. No large scale epidemiological studies of deliberate ingestion were identified.

Method

To conduct a systematic search the following procedure was employed:

- 1) The following were identified as appropriate sources of literature:
PSYCHINFO, which covers psychological literature and psychological

aspects of related disciplines; EMBASE, which covers biomedical and pharmacological literature and MEDLINE, which covers nursing, medicine, dentistry, the health care system and preclinical sciences.

- 2) Search terms were generated to identify relevant papers, which were: 'foreign' AND 'body', and 'ingest*' OR 'swallow*' OR 'digest*'. Broad search terms were used in order to identify all relevant papers, as it was hypothesised that there was a dearth of relevant psychological literature. An earlier review of the literature had indicated that terms used to refer to ingestion were varied, and therefore broad search terms maximised the effectiveness of the literature search.
- 3) Search limits were identified. These were set as 'peer reviewed journals' and 'English language' and the presence of search terms as keywords. EMBASE and MEDLINE did not support the limit 'peer reviewed journals', and therefore this was excluded from the search on these databases. The MEDLINE search returned a large volume of papers utilising the above criteria (2707) therefore additional limits were imposed to narrow the search. These were 'human subjects'; 'adult 19-44 years' and 'middle-aged 45-64 years'. These search limits were employed as they reflected the inclusion/exclusion criteria.

The search was run with the above search terms and search limits across the three databases. See Table 1 for a breakdown of the articles generated during the search. Results were combined and replications were removed, identifying a

total of 1472 papers. Additional relevant papers were identified by the 'similar to', 'cited by' and 'citing' functions in the databases. Once these papers had been collected, hand searches of the reference lists of all identified papers were undertaken to identify additional relevant papers, and these additional papers were scrutinised as outlined above. This process was repeated until no new papers were identified.

- 5) The abstracts of all identified papers were assessed to identify the presence of any of the exclusion criteria previously discussed. Where it was not possible to identify the suitability of the paper from the abstract, the full paper was obtained and reviewed. Large numbers of papers were excluded due to focusing on paediatric populations, accidental ingestion, or because they were predominantly surgical in orientation, with no consideration of psychological processes. This resulted in a final total of 21 papers, which are outlined in Table 2, delineated by the key focal areas of the review.

Table 1. Number of Journal Articles Generated by Search Terms and Database

Database	Search Terms	Search Limits	Number of Papers Returned
PSYCHINFO	Foreign	English language	124
	Body	Peer reviewed journals	
	Ingest*		
	Digest*		
	Swallow*		
EMBASE	Foreign	English language	971
	Body		
	Ingest*		
	Digest*		
	Swallow*		
MEDLINE	Foreign	English language	2707
	Body	With additional limits:	881
	Ingest*	Human	
	Digest*	Adults 19-44 years	
	Swallow*	Middle-aged 45-64 years	
Total number of papers without duplication:			1472

Review of Relevant Studies

The identified papers were grouped into three specific populations – those with a personality disorder, a psychiatric diagnosis, and those in prison or secure psychiatric settings. The findings from the literature will therefore be discussed according to these three subgroups. Where studies consider more than one population these aspects are discussed separately and links made to the relevant additional sections.

When reviewing the papers, the quality of the study was assessed according to the presence of the following desirable criteria:

- 1) Large sample size/ long-term review of records
- 2) Sample drawn from multiple sites
- 3) Clear psychiatric diagnoses from the DSM or ICD-10 and history recorded where applicable
- 4) Demographic information recorded
- 5) Information about important psychological processes in ingestion provided
- 6) The motives for and functions of ingestion were recorded
- 7) The provenance of information was clearly stated, which is preferably self-report from the patient/prisoners.

Deliberate Foreign Body Ingestion and Personality Disorder

Many of the studies identified involved single case studies of an individual with a personality disorder. Soong, Harvey & Doherty (1990) presented a case study of a 37 year old single man of below average intelligence (WAIS Full Scale IQ score of 74), with a diagnosis of personality disorder in the absence of mental illness. The study states that this was characterised by dependence, attention-seeking behaviour, and poor tolerance for stress, although a precise diagnosis was not described.

In this case study, intentional foreign body ingestion occurred within the context of other forms of self-harm, including overdoses of medication and household cleaning fluids, and superficial cutaneous injuries. This may provide preliminary support for the function of ingestion as being a form of self-harm in those with personality disorder. Furthermore, overdosing on medication and cutting temporally preceded ingesting, which may indicate a progression in the methods of self-harming employed.

Soong et al. (1990) discuss a number of precipitating factors for ingestion which includes emotional crisis preceded by family friction and alcohol use. At these times, the patient would swallow needles, cutlery and nails. These ingestions are reported as being impulsive and frequent, with over 60 occasions within a six year period.

However, the findings of Soong et al. (1990) are limited by the single case study design and the lack of a clearly defined personality disorder diagnosis, which prevents the comparison of findings with other studies. These findings require additional investigation with a large sample of participants with clearly specified personality disorder diagnoses, which would be useful in clarifying whether these features form part of the general clinical presentation of ingestion, or whether they are idiosyncratic to the case presented by Soong et al. (1990).

Table 2. Relevant Papers Shown by Focal Areas of Review

Area of Review	Author and Publication Year	Methodology	<i>N</i> of Study Sample
Personality Disorder	Gitlin, Caplan, Rogers, Avni-Barron, Braun, & Barsky, 2007	Review of Previous Literature	
	Soong, Harvey, & Doherty, 1990	Single Case Study	1 male
Psychosis/ Psychiatric Disorder	Abraham & Alao, 2005	Single Case Study	1 male prisoner with Schizophrenia
	Basu, Gupta, Akthar, & Sarawagi, 2003	Single Case Study	1 male with Schizophrenia
	Fishbain & Rotondo, 1983	Single Case Study	1 male with Schizophrenia
	Han, McElvein, & Aldrete, 1984	Single Case Study	1 female with Schizophrenia
	James & Allan-Mersh, 1982	Case Study Series	5 patients
	Koscove, 1987	Single Case Study	1 male
	Teimourian, Attila, Cigtay, & Smyth, 1964	Review of Hospital Records 1920-1963	101 patients
	Tsai, 1997	Review of Psychiatric Inpatient Records 1988-1995	7 patients

Area of Review	Author and Publication Year	Methodology	N of Study Sample
Deliberate Ingestion in Prisoners	Bisharat, O'Donnell, Gibson, Mitchell, Refsum, Carey, Spence, & Lee, 2007	Case Study Series, 1998-2007	11 prisoners
	Gaio, Marioni, Bruzon-Delgado, Marchese-Ragona, & Staffieri, 2004	Single Case Study	1 prisoner
	Karp, Whitman, & Convit, 1991	Review of Hospital Records 1985-1988	19 prisoners
	Lee, Kang, Kim, Kim, Im, Huh, Choi, Kim, Lee, & Jung, 2007	Review of Hospital Records, 1998-2004	33 prisoners
	Losanoff & Kjossev, 2001	Case Study Series	9 prisoners
	Losanoff, Kjossev, & Losanoff, 1996	Single Case Study	1 prisoner
	Martinez, 1980	Theoretical Paper/Case Study Series	15 prisoners
	Marasco, Cocco, Pinacchio, & Pascalis, 1995	Review of Prison Records 1992-1994	339 incidents
	O'Sullivan, Reardon, McGreal, Hehir, Kirwan, & Brady, 1996	Case Study Series, 1989-1992	36 prisoners/ patients
	Smit & Kleinhans, 2010	Review of Surgical Consultations in Prison	45 prisoners
	Vassilev, Kazandziev, Losanoff, Kjossev & Yordanov, 1997	Case Study Series	6 prisoners

Other studies (James & Allen-Mersh, 1982; Gitlin et al., 2007) have explicitly classified the deliberate ingestion of foreign bodies by those with personality disorders as a form of self-harm. James and Allen-Mersh (1982) include deliberate ingestion as part of a syndrome of self-inflicted injuries comprising drug use, alcoholism and superficial cutting of the wrists. Consistent with the findings of Soong et al. (1990), in all three cases ingestion had been repetitive, and occurred in the context of other forms of self-harm including cutting, self-poisoning and the injection of toxic substances into the abdomen.

However, methodological limitations affect both the strength and generalisability of these findings. The case reports do not provide a precise personality disorder diagnosis, limiting the extent to which these findings can be verified against other studies. In addition, the authors present no evidence of additional features which would support the personality disorder diagnosis. Therefore it may be that the authors are concluding that the cases presented have a personality disorder due to the ingestion of foreign bodies. Whilst self-harm is a diagnostic feature of Borderline Personality Disorder (BPD), the current evidence base has not established ingestion as a form of self-harm, or a feature of personality disorder. Therefore the authors are making links between self-harming, ingestion and personality disorder which are not supported by the strength of evidence in their case studies.

Another criticism is the presence of psychiatric co-morbidity within their sample. James and Allen-Mersh (1982) deem ingestion in one case to be the result of personality disorder, although the patient's medical records indicate a history of depressive illness and ingestion in response to command auditory hallucinations. Some personality disorders such as BPD can be marked by transient psychotic

features, which may account for these auditory hallucinations. However, as James and Allen-Mersh (1982) do not provide the precise personality disorder diagnosis, it is not possible to determine whether the auditory hallucinations are a feature of personality disorder or an additional psychotic illness and therefore ingestion in this case may be more accurately interpreted as a symptom or consequence of psychosis.

Gitlin et al. (2007) provide stronger evidence for the link between the deliberate ingestion of foreign bodies and personality disorder, as they present five case reports of patients with BPD and Antisocial Personality Disorders (ASPD). Consistent with the findings of Soong et al. (1990), patients with personality disorders often present complex clinical pictures, including co-morbid Post-Traumatic Stress Disorder, Major Depressive Disorder, Bipolar Disorder and poly-substance abuse.

Gitlin et al. (2007) report an extensive history of self-harm using additional methods in all of the cases reported, which included lacerating the skin, placing sharp objects in orifices such as the vagina and overdosing. The deliberate ingestion of objects was preceded by the use of other forms of self-harm, again indicating a progression of methods.

Several patients in the Gitlin et al. (2007) study reported that the ingestion of foreign bodies was impulsive rather than planned. Ingestion was preceded by tension due to life stressors which subsequently dissipated. This is consistent with the affect regulation function of other forms of self-harm (Chapman, Gratz, & Brown, 2006; Kleindienst et al., 2008) lending support to the hypothesis that in those with personality disorders ingestion functions as a form of self-harm. However, it should also be noted that in one case deliberate ingestion was also a means of attempting suicide.

Whilst some patients in the Gitlin et al. (2007) study alerted medical professionals or carers to their actions, others did not proffer this information when presenting to services. Others denied ingesting objects when directly asked until it was confirmed by physical investigation. Gitlin et al. (2007) outline several hypotheses about the functions of ingestion as a form of self-harm. Gitlin et al. (2007) propose that ingestion serves as a form of anger management and self-punishment, particularly in those with abuse histories. This is based on Green (1978) who states that a child's self-hatred, which develops from parental rejection and abuse, may be expressed as self-destructive behaviour due to impaired impulse control and ego deficits. However, Green (1978) notes that this self-punishment is not motivated by feelings of guilt or conflict, but rather stems from learned patterns of behaviour from early interactions with abusive care-givers. It is unclear whether Gitlin et al. (2007) are in accordance with the conceptualisation of self-punishment by Green (1978), or whether their definition follows other theorists who view self-harm as a means of self-punishment due to feelings of self-hatred (Himber, 1994).

In addition, Gitlin et al. (2007) argue that ingestion can be interpreted as an expression of anger towards others who have harmed or failed to protect them and thus ingestion may be conceptualised as the punishment of others, although no evidence is put forward to support this function.

Others also cannot tell that a patient has ingested an object, which creates a sense of secrecy and control. This is enhanced by the fact that the object may not cause physical harm at the time of ingestion. Instead, it becomes a potential 'time bomb', creating a long period of anxiety in both the patient and professionals, who are 'forced' to provide care due to the potentially fatal nature of the injuries caused by ingestion. Gitlin et al. (2007) hypothesise that this struggle for power, as well as

the frustration and challenge to the treating professionals may be a conscious or unconscious motivator for ingestion.

Gitlin et al. (2007) note that previous studies indicate a poor long term prognosis for deliberate ingestion in comparison to other forms of self-harm, and may be more resistant to intervention. The lack of treatment efficacy in ingestion has also been noted by Soong et al. (1990) and James and Allen-Mersh (1982) although neither provides information about what interventions were implemented or why they were not efficacious.

The Gitlin et al. (2007) study is limited by a small sample of five heterogeneous cases. This limits the utility of the findings in establishing links between ingestion and specific personality disorders and prevents a direct comparison with other samples. In addition, the authors do not report the provenance of the information provided for each case, meaning it is unclear whether the information accurately reflects the subjective experiences of the patients, the objective observations or speculations by medical professionals or the views of the authors. This consequently limits the validity of the study in representing the subjective experience of patients, which is important in establishing the functions of this phenomenon. Gitlin et al. (2007) also do not present supporting evidence for their hypothesised functions, particularly in relation to the subjective experiences of medical professionals treating this presentation. Further research is required to explicitly test these hypotheses, utilising a rigorous methodology on a homogenous sample.

Deliberate Foreign Body Ingestion and Psychiatric Disorder

The majority of literature about ingestion in those with psychiatric disorders focuses on those with psychosis, usually Schizophrenia. However, a few studies discuss ingestion in those with affective disorders such as Major Depressive Disorder and Bipolar Disorder which are often co-morbid diagnoses in many cases of psychosis. Nonetheless, as shall be discussed, the motivations for ingestion are varied even amongst this relatively homogenous group.

Attempted Suicide

Han, McElvein and Aldrete (1984) present the case of a young woman with Schizophrenia, with a long history of repeated ingestion, often swallowing multiple objects in a single episode (56 items swallowed over 17 occasions). The motivating factor in the current episode was suicidal ideation although no information is presented as to whether this was the primary motivating factor on each occasion. Additionally, no information is presented as to the reasons why the patient chose ingestion as a means of attempting suicide, or about the role, if any, that the patient's psychotic illness played in the ingestion or suicidal ideation.

In another single case study, Abraham and Alao (2005) discuss the case of a 30 year old prisoner with Paranoid Schizophrenia and Major Depression, who also ingested as a means of attempting suicide. As in the previous study, this patient had a history of prior ingestions also motivated by suicidal intent. The prisoner had previously attempted suicide by other methods including medication overdoses, which preceded the use of ingestion, indicating a progression of methods also noted in the literature regarding deliberate ingestion, self-harm and personality disorder (Gitlin et al., 2007; Soong et al., 1990). It is of note that the patient attempted suicide

by ingesting a sharp metal can lid, rather than using it to cut the skin, which may have been a more efficient method. However, no information is presented as to the patient's reasons for this decision. Interestingly, the patient was experiencing hallucinations at the time of ingestion of his deceased mother instructing him not to ingest, in contrast to other studies where command hallucinations facilitated self-harm. However, the patient reported that he felt he had to swallow the object "because he had let her down" (Abraham & Alao, 2005, p. 316).

The study by Abraham and Alao (2005) relies on single case data making it difficult to draw firm conclusions about the function of ingestion as a form of suicide in those with Schizophrenia. However, the study has a number of strengths. Clear diagnoses and a detailed description of the psychiatric history is provided, including details of previous suicide attempts by ingestion. Additionally, the authors discussed the patient's motivation for ingestion during assessment, allowing direct access to his reasons for swallowing. Whilst these idiosyncratic motivators cannot be extrapolated beyond this case, it provides strong support for the hypothesised function of ingestion as a means of suicide.

Tsai (1997) conducted an eight year review of a psychiatric ward's accident reports and inpatient records, and identified two cases of ingestion as a means of attempted suicide. Of these, one had a diagnosis of Major Depressive Disorder and one Bipolar Disorder (who at the time of the suicide attempt was depressed) and both patients had a history of suicide attempts utilising alternative means. Notably, Tsai (1997) identified patients who had ingested foreign bodies whilst already in contact with services, in contrast to other studies in which the ingestion precipitated the involvement of medical/mental health professionals.

Both patients were on suicide watch at the time of ingestion, and it is therefore hypothesised that the choice of ingesting (including a toothbrush, chopsticks, chess pieces, a ring and coins) as a means of suicide may have been due to the lack of alternative methods. However it is difficult to assess the accuracy of this hypothesis due to the retrospective nature of the study which relies solely on information documented at the time. Interestingly, Tsai (1997) reports that one patient attempted suicide by ingesting sewing needles following discharge. This may indicate that the ingestion of objects as a suicide attempt was actually a preferred method for this patient, rather than being due to a lack of alternative means. Alternatively, it may reflect a progression in methods of self-harm/suicide previously discussed.

In addition to those ingesting as means of attempting suicide, Tsai (1997) identified a further five cases which included three patients with Schizophrenia, two of whom swallowed objects in response to auditory hallucinations.

Auditory Hallucinations

Tsai (1997) provides no further information about the cases of ingestion in those experiencing auditory hallucinations, therefore the precise mechanism by which auditory hallucinations precipitated ingestion remains unclear. Han et al. (1984) similarly report that the patient in their single case study swallowed foreign bodies 'upon auditory hallucination' but without more detailed information, it is impossible to determine whether the auditory hallucinations motivated the ingestion. However, a number of causal links could be hypothesised – the hallucinations may consist of commands to swallow objects, or patients may ingest as a means of

committing suicide to escape the voices. Further research is required to determine the precise role, if any, that auditory hallucinations play in ingestion.

Delusional Beliefs

Two studies, (Fishbain & Rotondo, 1983; Basu, Gupta, Akthar, & Sarawgi, 2003) discuss the role of delusional beliefs as a potential motivator for ingestion in those with Schizophrenia. Fishbain and Rotondo (1983) present a single case study of a 32 year old black male with Schizophrenia, who had a history of ingesting whilst acutely psychotic. This included ingesting foreign bodies from rubbish bins, including glass, nails and metal pins. Following admission to hospital after being injured in a mugging, the patient was referred for psychiatric evaluation, during which his motivation for ingestion was explored.

The patient stated that he ingested the objects because they ‘contained herbs and other good things’ (p.322) and that ‘God told him that he was special because he ate metal’ (p.322). In contrast to previous studies, the patient denied any suicidal or self-harming intent to his ingestion. The patient continued to ingest during the initial stages of his hospitalisation, whilst he continued to hold these delusional beliefs. When the patient stabilised on medication, these abated and he ceased ingesting foreign bodies, demonstrating a strong link between the delusional beliefs and ingestion.

Although a single case study has limited generalisability, the study has a number of strengths. The patient was offered a psychiatric evaluation, which included a direct exploration of his motivations for ingesting. The inclusion of follow-up data also provides supporting evidence for the role of delusional beliefs as

it allows observation of the prevalence of the phenomenon when delusional beliefs are not present.

Additional support for the role of delusional belief systems as a motivator for ingestion is presented in a single case study by Basu et al. (2003) of a 25 year old Indian man with a diagnosis of Paranoid Schizophrenia. During his fourth hospital admission in a seven year period, the patient began to ingest dead animals and bones, although he was guarded about his reasons for doing so. A month after discharge from hospital, follow-up examination revealed that the patient had previously swallowed 36 metallic items, including spoons, nails, screws and razors. Upon questioning, the patient revealed that he had been ingesting for many years, because he believed that by eating these things he would make himself immune to attack from his enemies. The patient believed that dead animals and metallic objects would help him “imbibe universal powers” (p.27) and that the metals would become absorbed by his stomach and end up in his organs, making them impregnable.

These beliefs formed part of a paranoid delusional system which was clearly linked to the ingestion. In contrast to the previous study (Fishbain & Rotondo, 1983) no information is offered about ingestion after the amelioration of the delusional beliefs as the patient continued to experience these beliefs until he committed suicide. The authors did explore additional factors which may have motivated the ingestion, including religious beliefs, sub-cultural norms, or organic brain damage but no evidence was found which supported these alternative explanations.

A single case study by Koscove (1987) highlights the role of delusional beliefs in ingestion in those with altered mental states, rather than psychiatric illnesses per se. Koscove (1987) discusses the ingestion of Taser barbs by a male exhibiting agitated behaviour, whom police believed to have ingested phencyclidine

and cocaine. The prisoner stated that he had swallowed one of the taser barbs, because he had believed that the police intended to kill him, and the barb would provide evidence of this at autopsy. Koscove (1987) characterises these beliefs as paranoid delusions characteristic of an altered mental state due to drugs. These findings should be accepted with caution, as the author was unable to establish whether the prisoner had in fact utilised illicit substances. No information is recorded about potential psychiatric disorders, which also limits the utility of the findings. However Koscove (1987) highlights an important potential motivator for ingestion, namely the presence of delusional beliefs due to transitory fluctuations in mental states resulting from illicit substance misuse. This may affect larger populations than those solely with psychiatric disorders and additional research is required in order to investigate this area in more detail.

Regression

Teimourian, Cigtay and Smyth (1964) hypothesise that the prevalence of foreign body ingestion in patients with Schizophrenia is due to abnormal eating habits characteristic of the later stages of Schizophrenic regression. In a review of hospital records over a 43 year period (1920-1963) 101 cases of ingestion were identified, of which 70 involved patients with Schizophrenia.

They conceptualise the ingestion of foreign bodies as the final stage of changes in eating habits in those with Schizophrenia which starts with the development of a large appetite and progresses on to extremely rapid eating and a loss of control over the selection of ingested items. This moves from eating foods in terms of preference, to eating foods indiscriminately, to ingesting items without consideration as to whether they are edible.

Whilst this may account for the reported higher prevalence of ingestion in those with Schizophrenia, which is supported by evidence from studies about altered pain and taste sensation in Schizophrenia (Basu et al., 2003), there are a number of flaws in the study. No detail is provided about the hospital records from which the information is drawn, and no information is provided about the stage of the patients' Schizophrenia at the time of ingestion. Thus, it is not possible to determine the percentage of patients who ingested whilst in the final stages of Schizophrenic regression. No information is provided about the presence of the other potential motivators for ingestion identified by the literature. It is therefore unclear as to whether all 70 reported cases of ingestion in those with Schizophrenia were due to the regression discussed by Teimourian et al. (1964) or whether additional motivating factors were present. Furthermore, the age of the study means that research into Schizophrenia itself has substantially progressed, and thus 'regression' may no longer be valid or clinically useful concept.

Deliberate Foreign Body Ingestion in Prison Populations

The largest body of literature about deliberate foreign body ingestion is research within a prison population, both those with psychiatric disorders and those without. Prisoners with psychiatric disorders present a complex clinical picture, in which ingestion may serve a variety of different functions, linked both to psychiatric disorders and the restrictive prison environment. This section will initially review the literature regarding ingestion in prisoners with psychiatric disorders, before considering those without a psychiatric diagnosis.

Prisoners with Psychiatric Disorders

There are high levels of psychiatric disorders amongst incarcerated prisoners in Western countries. It is estimated that 3.7% of male prisoners and 4.0% of female prisoners have a psychotic illness, whilst 10% of male and 12% of female prisoners had a diagnosis of Major Depressive Disorder (Fazel & Danesh, 2002). According to Fazel and Danesh (2002) 65% of men in prison were diagnosed with having a personality disorder, of which 45% had ASPD. Furthermore, 42% of female prisoners had received a diagnosis of personality disorder, predominantly ASPD or BPD. This represents a two to four fold excess of psychotic or depressive illnesses, and a ten fold excess of ASPD in comparison to age-matched British or American community populations (Fazel & Danesh, 2002).

O'Sullivan et al. (1996) note that prisoners who ingest are more likely to have histories of psychiatric disorders and display violent and impulsive behaviour. Karp, Whitman and Convit (1991) in a three year retrospective review of the medical records of prisoners admitted to the prison ward of a general hospital found that 18 out of 19 prisoners were given a psychiatric diagnosis. These included Schizophrenia with co-morbid Personality Disorder (5), Personality Disorder (5), Adjustment Disorder (4), Schizophrenia (1), Major Depression with psychotic features (1) and Organic Mental Syndrome (1).

Ten patients reported their motive for ingestion as being suicidal ideation and command hallucinations, whilst two patients reported suicidal ideation *without* command hallucinations. Conversely, two patients reported that command hallucinations precipitated their ingestion in the absence of suicidal ideation, whilst two defined their intention as a desire to self-harm (due to depressed mood) in the absence of suicidal ideation.

In the sample of 19 discussed by Karp et al. (1991), the psychiatric disorders appear to predate the prisoners' current period of incarceration. Of the sample, 84% reported making a suicide attempt prior to ingesting foreign bodies, utilising methods such as cutting, hanging, overdosing and jumping from heights. For 63% of the total sample, these suicide attempts pre-dated incarceration, indicating that psychiatric disturbance and suicidal ideation was not merely a reaction to the prison conditions. In contrast to other findings (Bisharat et al., 2008) none of the sample reported ingesting objects prior to being incarcerated, although just over half reported multiple episodes of ingestion after being imprisoned.

Gaio, Marioni, Bruzon-Delgado, Marchese-Ragona and Staffieri (2004) present a single case study of a prisoner with a history of psychiatric disorder including Depression and personality alterations who ingested as a means of attempted suicide whilst in prison. Given the role of suicidal ideation in ingestion in psychiatric disorders, the use of ingestion as a means of suicide in this prisoner may be due to his psychiatric disorder rather than his status as a prisoner per se although being imprisoned would undoubtedly impact upon mental health. In the episode of ingestion reported, the prisoner had removed the prongs of a fork prior to swallowing it, which led the authors to conclude that in this instance, the motivation for ingestion was to obtain secondary gains, such as transfer to medical facilities outside the prison (Bisharat et al., 2008; Karp et al., 1991; Lee et al., 2007; Losanoff & Kjossev, 1996; Martinez, 1980; O'Sullivan et al., 1996; Tsai, 1997; Vassilev, Kazandziev, Losanoff, Kjossev, & Yordanov, 1997). However, no information is provided about the evidence on which this conclusion is based. Therefore it is possible that the prisoner removed the prongs of the fork for other reasons, such as to facilitate ingestion.

Prisoners without Psychiatric Disorders

The remaining literature focuses on prisoners without a psychiatric diagnosis in whom the nature and motivation of ingestion may differ.

Characteristics of Ingestion

Bisharat et al. (2008) conducted a retrospective review of hospital case notes for a nine year period (1998-2007) during which 11 prisoners presented with foreign body ingestions including razor blades, batteries, coins and a watch. All the ingestions were classed as intentional, and almost half of the prisoners had previously ingested. Bisharat et al. (2008) also note that it is common for prisoners to swallow multiple objects in one incidence.

O'Sullivan et al. (1996) conducted a consecutive case series (36 cases) with a mixed sample of psychiatric inpatients (10), prison inmates (20) and non-institutionalised patients (6). They note that prison inmates are more likely to present with symptoms, including severe constant upper abdominal pain, dysphagia (difficulty in swallowing) and haematemesis (vomiting of blood). Two inmates also admitted cutting the lining of their cheeks and lips in order to bleed convincingly. In contrast, seven of the ten psychiatric inpatients complained of mild or no symptoms. O'Sullivan et al. (1996) present no hypotheses about the differing presentation of prisoners and psychiatric patients, although they do note that there was 'rarely objective evidence for true upper gastro-intestinal haemorrhage' (p.294) which led them to conclude that symptoms in prisoners were frequently exaggerated.

The findings of Basu et al. (2003) and Teimourian et al. (1964) regarding altered pain sensation in those with Schizophrenia may account for differing levels of self-reported symptoms in prisoners and inpatients. However, additional information

about psychiatric diagnoses would be required to test this hypothesis, which is not provided by O'Sullivan et al. (1996). Additional research into the differences in presentation and methods of ingestion between prisoners and psychiatric inpatients is required in order to fully understand these patterns.

Psychological Risk Factors for Ingestion

Martinez (1980) presents a theoretical account of 'manipulative self-injurious behaviour' (SIB) including ingestion, based on personal experience of treating 15 cases of manipulative SIB within the mental health facility of a Department of Correction. Martinez (1980) outlines the characteristics which may make prisoners vulnerable to engaging in SIB. These include a lack of adequate socialisation, a history of substance misuse (Lee et al., 2007; Gaio et al., 2004), high levels of dependency (Karp et al., 1991), poor self concept and poor problem solving skills. However, Martinez (1980) does not provide any supporting evidence about the prevalence of these difficulties in those prisoners who ingest in comparison to those who do not.

Martinez (1980) also stresses the role of difficulties with delaying reinforcement in SIB. Within prison, the inmates' options and problem solving strategies are necessarily limited by the restricted nature of the environment. Many prisoners adapt to the restricted environment by forming longer term plans, and adjusting their reinforcement options in line with the limited opportunities available. However, Martinez (1980) argues that those who ingest are unable to adapt to these restrictions by delaying reinforcement. They therefore resort to harming themselves, as their body remains one of the few things over which they can exert full control. Injuring their body forces a response from staff which immediately gratifies their

need to exert control and receive desired outcomes such as access to analgesia, staff attention, or removal to hospital. However, Martinez (1980) offers no explanation or evidence to support this characterisation of those who ingest as being different from the general prison population.

Environmental Risk Factors for Ingestion

Marasco, Cocco, Pinacchio and De Pascalis (1995) reviewed the records from an Italian prison over a three year period (1992-1994) and identified several forms of self-harm including ingestion of foreign bodies. They suggest that ingestion is more likely to occur in those who struggle to adapt to the prison environment, for instance, if it imposes a greater upset to their 'normal' way of life. In support of this hypothesis, they note that 50% of the ingestions in 1994 were accounted for by foreign prisoners, proposing that these foreign prisoners are more likely to find the prison regime disruptive. However, no evidence is presented to support this. It may be that foreign prisoners face additional pressures due to language barriers, other cultural and religious differences or loss of contact with friends which reduce the resources they may use to cope with the increased pressures of prison life.

Functions of Ingestion

Self-harm

Marasco et al. (1995) offer a two factor typology of self-mutilative behaviours within prison, focusing on psychological factors (psychosis, mood and personality disorders) and socio-environmental factors (self-harming as a protest against environmental conditions). They propose links between the type of self-harm used, and the underlying factors – refusal of food, knife injuries and foreign body

ingestion are due to socio-environmental factors, whilst attempted hanging and suicide are due to psychological factors. The marked increase in reported ingestions (1 case in 1992, increasing to 30 cases in 1994) may be explained by prisoners using ingestion as a means of expressing dissatisfaction with socio-environmental conditions such as overcrowding. However, no supporting information for this typology is presented and, in common with much of the literature no information is obtained directly from the prisoners about their motives for ingestion.

Transfer to Hospital

O'Sullivan et al. (1996) report that three of the 19 prisoners in their sample ingested foreign bodies as a means of obtaining a transfer to hospital. This was also the stated intention of a prisoner in a single case study by Losanoff, Kjossev and Losanoff (1997). Greater weight can be given to these findings as they are based on the verbal account of the prisoners at the time of ingestion.

Both O'Sullivan et al. (1996) and Karp et al. (1991) note that the objects selected for ingestion, such as glass, razor blades and batteries are those likely to cause maximal injury, thereby necessitating a transfer to hospital (Lee et al., 2007). In addition these objects are radio-opaque, which means that x-rays can be used to verify the existence of ingested objects. In other studies, prisoners have deliberately fashioned oesophageal 'stars' or 'crosses' (Losanoff et al., 1996; Losanoff & Kjossev, 1999; Losanoff & Kjossev, 2005; Losanoff et al., 1997; Vassilev et al., 1997). Stars are fashioned from hypodermic needles or bent paper clips which are suspended in the oesophagus, springing open into a star shape after a period of several hours or days, causing perforation. Crosses are swallowed without the string, resulting in the object passing into the stomach or further down the gastro-intestinal

tract, where it opens, remaining in-situ and causing perforation (Losanoff & Kjossev, 2005). At the point of perforation, immediate surgical intervention is required to prevent serious illness or death. As the shape prevents endoscopic removal the prisoner is usually transferred to hospital for medical attention.

Access to Analgesia

Lee et al. (2007) conducted a retrospective review of medical records for prisoners admitted to two Korean hospitals for foreign body ingestion between 1998 and 2004. They identified 52 episodes of ingestion by 33 prisoners. In addition to transfer to medical facilities, Lee et al. (2007) also discuss additional secondary gains such as access to narcotic analgesia which may be particularly relevant to those prisoners with substance misuse histories (Gaio et al., 2005). However, no information is presented about the substance misuse histories within the sample.

Martinez (1980) presents an interesting formulation of foreign body ingestion within prisoners as both a form of self-injury and as attempts to elicit desired consequences, such as attention from staff, temporary removal from prison, or access to analgesia. By providing adequate treatment to potentially life threatening injuries caused by ingestion, staff may actually inadvertently reinforce the behaviour by providing what the prisoner wants.

This theory would also suggest that the more positive the consequences (e.g. high levels of staff attention and analgesics), the greater the likelihood of other prisoners imitating this behaviour (Martinez, 1980). This modelling of the positive consequences of SIB may account for the ‘epidemics’ of ingestion which have been reported in some prisons. Losanoff et al. (2005) noted nine prisoners within a five

year period presenting after ingestion of ‘crosses’ whilst Vassilev et al. (1997) identified six cases within one month.

Once a prisoner engages in self-injurious behaviour, Martinez (1980) suggests they are caught in a *compulsive cycle* in which they are forced to continue ingesting until the environment cedes to their demands. This may account for the repeated and multiple ingestions in many of the studies discussed. After the *compulsive cycle* Martinez (1980) states that prisoners enter the *hypochondriacal cycle*, during which they become concerned about the physical damage they have inflicted. They become hypervigilant to bodily sensations, interpreting these as signs of severe harm such as infection. In some cases, this anxiety may result in the manifestation of plausible physical symptoms, and levels of anxiety could reach phobic intensity, which triggers further self-injury. This may partially account for the findings of O'Sullivan et al. (1996), who note that prisoners are more likely to experience or report physical symptoms following ingestion. Thus, the increased symptomatology in prisoners may be due to greater levels of hypochondriacal anxiety which manifests in physical symptoms, rather than being an attempt to manipulate the system per se.

Martinez (1980) suggests that the restrictive prison environment prevents inmates from being able to exercise their sense of power and freedom in ‘normal’ ways, whilst limiting the problem-solving options available in solving this dilemma. This parallels the hypotheses of Smit and Kleinhans (2010) who reviewed surgical practice in a maximum-security prison. They suggest that the high rates of foreign body ingestion (45 cases in a 6-year period) can be understood as prisoners attempting to force their will upon the prison authorities. They hypothesise that as prisoners adapt to the circumstances of their incarceration, they become

‘institutionalised’ and refrain from protests such as ingestion. This hypothesis would suggest that rates of ingestion are higher at the start of a prisoner’s sentence, and decline over time as they become acclimated to the prison environment. However, no information is provided about the rates or timing of ingestions in relation to length of the prisoner’s sentence, making this hypothesis difficult to corroborate. In addition, no information is reported about whether prisoners were asked directly about their intentions in ingesting, therefore additional research is required to verify these hypotheses.

Martinez (1980) offers a valuable theoretical exploration of the factors underpinning ingestion which helps to explain many of the findings outlined in other studies. This contrasts with the majority of the literature reviewed, which is surgical in orientation. However, the paper does have a number of limitations. Firstly, the sample is drawn from one site and was treated by the same staff member. Secondly, as Lee et al. (2007) note, the phenomenon of ingestion is influenced by the immediate environment in which it occurs, and therefore the factors identified may only apply to this specific sample and environment. Whilst Martinez (1980) highlights some interesting behavioural characteristics and environmental influences which may contribute to ingestion, further research is required to ascertain whether these factors generalise to a more diverse sample.

Interventions for Foreign Body Ingestion

As well as describing the characteristics and functions of ingestion, some papers suggested methods of intervention. Martinez (1980) outlines an environmental treatment for ingestion within prisons which focuses on removing the opportunity to engage in the compulsive cycle of self-injurious behaviour. This is

managed by removing objects from the environment which could be ingested, including thoroughly searching both the prisoner and their cell, and providing meals which require no cutlery.

In addition, Martinez (1980) argues that the reinforcers of ingestion should be systematically minimised in order to extinguish the behaviour. This includes minimising staff attention subsequent to self-injury and using analgesics without euphoric effects. To counteract the problem solving deficits which Martinez (1980) hypothesises are prevalent in this population, he advises that staff should help prisoners think more flexibly about how to get their needs met appropriately. This models a flexible approach to problem solving, as well as counteracting feelings of powerless which can themselves trigger ingestion.

In managing the hypochondriacal cycle which follows compulsive self-injury Martinez (1980) advocates progressive relaxation to reduce high levels of anxiety. If this is not sufficient, or the fears are phobic in nature, then systematic desensitization can be used. Subsequent to working through the compulsive and hypochondriacal cycles, cognitive interventions can be employed to help prisoners identify legitimate means of obtaining reinforcement. Unfortunately no information is provided as to the success of these interventions.

Other papers outline potential treatment options, including behaviour modification therapy (Bisharat et al., 2008), medication and electroconvulsive therapy (Tsai, 1997). However, no details are provided about the implementation or outcome of these interventions with those who ingest foreign bodies. Interestingly, Teimourian et al. (1963) report a sharp drop in the numbers of reported cases of ingestion after the introduction of psycho-pharmacologic drugs in 1956, indicating the utility of medication in managing ingestion in those with psychosis.

Both James and Allen-Mersh (1982) and Soong et al. (1990) note that psychiatric treatment is not effective in preventing a recurrence of ingestion in those with personality disorder, but no information is provided about the content of this treatment. Gitlin et al. (2007) report on the efficacy of psychological therapies such as Dialectical Behaviour Therapy (DBT) in treating self-injury in those with BPD. In addition, pharmacological interventions such as Naltrexone and Clonidine have demonstrated some efficacy in reducing the rates of self-harm in those with personality disorder. However, Gitlin et al. (2007) note that these treatments have not yet been tested with those who self-harm by ingesting, and draw on the findings of earlier research to suggest that this form of self-harm may be more resistant to treatment, and have a poorer prognosis. The potential application of existing treatments for self-harm to those who ingest will be discussed below.

Summary of Reviewed Papers

A systematic review of the literature indicates that deliberate ingestion of foreign bodies is most common in three distinct populations – those with personality disorders, psychiatric disorders such as affective disorders and psychosis, and those being held in secure prison or psychiatric environments.

The features of foreign body ingestion are similar across these three populations. Research indicates that in personality disordered and psychiatric populations, both male and females engage in ingestion across a wide age range, although the majority of literature on prison populations was based on male-only samples. Further investigation is required as to whether gender differences in ingestion exist within prisoners. Once commenced, ingestion is likely to be repeated

in all populations, leading to a prolonged history of ingestion, and the swallowing of multiple objects in a single episode.

A key difference which was noted within different populations was the extent of planning which preceded the ingestion. Whilst in some studies the ingestion was impulsive, prisoners are more likely to engage in planned ingestion which may stem from differences in the functions underpinning ingestion. The literature identifies several potential functions of ingestion present in all three populations. These include ingestion as a means of attempting suicide or self-harm. Other functions are unique to specific populations.

Those with psychiatric disorders such as Schizophrenia ingest objects as a response to auditory command hallucinations, delusional ideas or due to Schizophrenic regression. In prison populations ingestion is a means of manipulating staff and the environment in order to obtain secondary gains such as transfer out of prison and access to analgesia. These functions share similarities with those in people with personality disorders, which also focus on the exertion of control over the environment and others, to elicit care.

Clinical Utility

Identifying At-risk Populations

The research findings highlighted have significant utility in regards to working clinically with those who engage in deliberate ingestion. Identifying demographic factors associated with ingestion such as previous self-harm, suicide attempts, poor problem-solving skills, substance misuse, personality disorder, Schizophrenia, or being placed in a restrictive environment will allow the identification of populations who are at risk of engaging in ingestion. Furthermore,

the identification of potential functions which vary according to population provides vital information for clinicians in predicting situations in which people may ingest.

Identifying Potential Treatments for Ingestion

Whilst clients may present with the same phenomenon the efficacy of treatment will vary depending on how closely the treatment approach targets the specific population and the underpinning reasons for ingestion (Simpson, 2006).

Self-harm

The current NICE Guidelines for Self-harm (NICE, 2004) (for those deemed to be at risk of repetition) recommend access to intensive intervention with greater therapist contact, home treatment and telephone contact. Guidelines also state that outreach approaches should be used when the service user misses an appointment, and that the therapeutic intervention plus outreach should continue for a period of at least three months.

However, NICE (2004) offers little guidance about what this ‘intensive intervention’ should consist of, and the literature indicates a proliferation of different treatments for self-harm, including psychosocial interventions such as Intensive Intervention and Outreach, Problem-Solving therapy, Emergency Cards, Inpatient Behaviour therapy, General Hospital Admission, Home-Based Family therapy and pharmacological treatments including antipsychotic and antidepressant medication (Hawton et al., 1998). In a review of the literature to date, Hawton et al. (1998) only found promising results for problem-solving therapy, and trends favouring the use of emergency cards which allow 24 hour access to a psychiatrist or inpatient hospital bed. Evidence suggests that female patients with BPD may also benefit from

Dialectical Behaviour Therapy, whilst a single study indicated the efficacy of depot neuroleptic medication. However, the authors stress that almost all of the research evidence was limited by poor methodology, including a lack of appropriate control groups and insufficient statistical power.

Personality Disorder

There is an increasing evidence base for the efficacy of treatments for those with personality disorder who self-harm, such as DBT in outpatient (Linehan et al., 2006), inpatient (Bohus et al., 2004) and high-security settings (Low, Jones, Duggan, Power, & MacLeod, 2001). DBT is a cognitive behavioural therapy for self-harm in those with BPD which directly targets suicidal behaviours and non-suicidal self-injury and other dangerous behaviours. Individual weekly sessions with a therapist are augmented by group behavioural skills training sessions, with a focus on distress tolerance and mindfulness, problem-solving skills, emotion regulation and interpersonal effectiveness. In addition, clients can access support from therapists between sessions via the telephone, and therapists have regular group consultation and supervision (Gratz, 2007).

As identified in the review, those with personality disorder including BPD are an at-risk population for ingesting. Therefore it could be hypothesised that DBT may be an effective treatment for those with BPD who ingest, although more research is required to determine whether ingestion serves the same function as other forms of self-harm within this population.

Difficulties in Emotion Regulation

One of the key deficits identified in personality disorder is emotional dysregulation, in which the person experiences intense emotions which they are unable to adaptively manage. Instead, they try to avoid the emotion, or engage in maladaptive regulation strategies such as self-harm (Gratz, 2007). Whilst emotional dysregulation was not formally identified as a risk factor in the extant literature Soong et al. (1990) stated that ingestion in their case study of a patient with personality disorder was precipitated by periods of emotional crisis, which may reflect underlying difficulties with emotion regulation. Similarly, Gitlin et al. (2007) noted high levels of tension prior to ingestion, which was followed by relief upon swallowing, which may also indicate an emotion regulation function. If ingestion can be understood as an emotion regulation strategy consistent with other forms of self-harm such as cutting, interventions designed to increase emotion regulation may be efficacious in treating self-harm by ingestion.

In addition to DBT, other interventions such as Acceptance-Based Emotion Regulation therapy (Gratz, 2007) may be appropriate for those who ingest as a means of regulating emotions. Acceptance-Based Emotion Regulation therapy is a cognitive behavioural intervention which aims to increase the awareness, understanding and acceptance of emotion, as well as promoting a willingness to experience negative emotions when required for the pursuit of important goals. In addition, it aims to increase peoples' ability to manage impulsive behaviours whilst experiencing negative emotion and promotes the use of appropriate strategies to regulate the duration and intensity of emotion, whilst discouraging complete avoidance of negative emotion. The therapy is designed to be delivered in a group setting, in 14

weekly sessions, and can be administered alongside individual therapy of differing theoretical orientations.

Preliminary data from a controlled trial with 10 women with BPD showed significant changes in rates of self-harm, emotion dysregulation, and experiential avoidance, as well as improvements in levels of depression, anxiety and stress, some of which were reduced to normative levels (Gratz & Gunderson, 2006).

Auditory Hallucinations/Delusions

As command auditory hallucinations, delusional beliefs and Schizophrenic regression were identified as motivators for ingestion in those with psychosis, it may be hypothesised that effectively treating the psychotic illness would ameliorate ingestion (Fishbain & Rotondo, 1983). In support of this hypothesis, Teimourian et al. (1963) report a sharp drop in the numbers of reported ingestions after introduction of psycho-pharmacologic treatment in 1956.

NICE Guidelines (2009) recommend the provision of oral anti-psychotic medication, including the use of Clozapine to those who do not respond to at least two different second-generation antipsychotics. Depot medication may be used if there are issues with non-compliance with medication. Additional interventions include the provision of Cognitive Behavioural Therapy (CBT) and family interventions for those living with their families.

Attempted Suicide

Ingestion as a means of attempting suicide was identified as a function in several studies (Han et al., 1984; Abraham & Alao, 2005; Tsai, 1997), usually in the presence of Depression and other co-morbid psychiatric disorders. Effective

management of the Major Depressive Disorder is likely to reduce suicidal ideation and remove the patients' motivation to ingest. NICE guidelines (2009) for complex and severe depression include the use of crisis resolution and home treatment teams, inpatient treatment at times of high suicide risk and electroconvulsive therapy in instances where all other treatments have been unsuccessful, or in which the depression is deemed life threatening. This is in addition to front line treatments such as antidepressant medication (preferably an SSRI) and high-intensity psychological interventions such as CBT or Interpersonal Therapy.

Expression of Dissatisfaction/Attempts to Manipulate the Environment

Marasco et al. (1995) propose that ingestion in a prison population is a means of communicating dissatisfaction with the environment, a function already established in other forms of self-harm (Nock, 2010). Other studies (Karp et al., 1991; Lee et al., 2007; Martinez, 1980; O'Sullivan et al., 1996) in prison/inpatient populations focus on the use of ingestion as a means of achieving secondary gains.

A mechanism which may underpin both of these functions of self-harm is a deficit in social problem-solving skills, which is also present in those who self-harm by other means (Nock & Mendes, 2008). Social problem-solving deficits prevent people identifying and enacting more adaptive social responses to problems, and thus they resort to maladaptive strategies like self harm. Brief Problem-Solving therapy (Townsend et al., 2001) posits that those who self-harm face a range of problem situations, including interpersonal difficulties, housing problems, unemployment, financial difficulties and social isolation, and they have deficits in their problem-solving abilities. Increasing peoples' adaptive problem-solving skills will enable them to more effectively manage the problems they face, reducing the need to self-

harm. Brief Problem-Solving therapy attempts to do this by helping people define their problem in detail and select an appropriate goal. A stepwise approach to meeting this goal and managing the problems are then implemented. However, research findings have been mixed, with some studies indicating no benefit (Tyrer et al., 2003); an improvement in depression, hopelessness and ability to manage problems, but no change in the frequency of self-harm (Townsend et al., 2001) or a reduction in the frequency of self-harm when problem solving is implemented in conjunction with another form of therapy (Weinberg, Gunderson, Hennen, & Cutter, 2006).

However, it should be noted that the presence of problem-solving deficits has not been empirically established amongst those who ingest. In addition, as Martinez (1980) states, the restrictive prison environment will undoubtedly limit the problem-solving options open to prisoners. Thus, the decision to engage in ingestion as a form of problem solving may reflect a real dearth of alternative, socially appropriate options, rather than an intrinsic problem solving deficit, particularly those in restricted environments.

Limitations of the Current Review

The interpretation of the findings discussed in this review are constrained by the limitations of the research methodologies employed. The majority of research is surgical in nature which has significant ramifications with regards to the methodologies utilised and the consideration of psychological factors important in ingestion.

Many of the studies which draw upon a personality disordered or psychiatric population do not report clear diagnoses conforming to a nosological system such as

the ICD-10 or the DSM-IV-TR. Instead studies relied on descriptive explanations of symptoms which limit the extent to which findings can be compared across studies or generalised to a wider population. In addition, whilst many studies offered hypotheses about the potential functions of ingestion, the origins of these hypotheses were not clearly reported. Whilst a few studies stated that the functions were obtained from the participants at the time of ingestion, it was not always possible to determine the origin of information. Thus, the functions reported may reflect the opinions of the treating clinicians, the formulations of the researchers themselves, and only more rarely information provided directly by patients or prisoners.

This lack of information from the patients and prisoners themselves is in part influenced by the methodologies employed. Most studies relied on single case studies, case series at individual hospital sites, or retrospective reviews of medical records, which did not employ a rigorous qualitative methodology. This limited the extent to which the participants' own ideas about the function of ingesting could be elicited. In addition, the methodologies employed also make the generalisation of the findings to a wider population problematic as the use of single case designs mean that the findings may reflect idiosyncratic factors which are not applicable to the wider population of those who ingest.

Areas for Further Research

Whilst the existent literature is clearly valuable in informing clinical work with populations who ingest, the limited methodology and scope of the current research highlight several important areas for future research. Replicating the research which has been conducted utilising a more rigorous methodology will allow researchers to corroborate these findings. This should include the presentation of

clear psychiatric diagnoses where appropriate, reporting the source of any hypothesised functions presented (e.g. staff member or client), and the utilisation of larger, more homogenous samples.

It is notable that there are no qualitative studies of ingestion, and thus there is a significant dearth of information about people's lived experiences of ingesting. Obtaining a more detailed, first person account of people's experiences of ingestion would allow an investigation of whether the functions reported in the literature corroborate with individual accounts. Furthermore, it would facilitate an exploration of whether staff, researchers, and those who ingest have differing hypotheses about the functions of ingestion.

This more detailed research will also allow researchers to compare the functions of ingestion to the functions and processes which underpin other forms of self-harm, such as cutting and burning the skin (Klonsky, 2007; Nock, 2010). As discussed, many studies included people who had progressed to ingesting following a history of other methods of self-harm. Further investigation of the factors precipitating this shift to ingestion may be useful in planning treatment interventions. The literature to date indicates a lack of efficacy of standard psychiatric and psychological treatments in addressing this phenomenon (James & Allen-Mersh, 1982; Soong et al., 1990). However, if ingestion shares common underpinning processes and functions with other forms of self-harm then existing treatments, as previously discussed, may be suitable for those who ingest. Further investigation of potential treatments must therefore be a priority focus of any future research.

Conclusions

The current literature on the ingestion of foreign bodies, as outlined in this review, indicates that this is a serious form of self-harm present in three overlapping populations – those with personality disorders, those with psychiatric disorders, and those in prison. Whilst the literature presents hypotheses about the functions served by ingestion, there is little focus on psychological factors due to the prominence of surgical approaches and the use of limited methodologies. Thus what is required to further the understanding of this phenomenon is an in-depth qualitative study utilising a transparent and rigorous methodology, which explores the psychological processes of ingestion and the functions it serves from the individual's perspective. A study of this nature would undoubtedly provide a more detailed understanding of the ingestion of foreign bodies which would inform more effective intervention.

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PART 2:
EMPIRICAL PAPER

**A Grounded Theory Exploration of Staff and Patients’
Experiences of Self-harming by Ingestion**

ABSTRACT

Aims: Whilst functions of cutting and burning are well established, self-harm by ingesting foreign bodies has not been researched. This study aimed to better understand the meaning, function and processes of ingesting foreign bodies; and to enrich this understanding by exploring the experiences of staff working with this behaviour.

Method: Six patients and six staff from an independent sector provider of mental healthcare and the NHS were interviewed about their experiences of self-harming by ingestion. Semi-structured interviews were conducted and analysed using Grounded Theory (Charmaz, 2006).

Results: A core category of 'Journey through Ingestion' was characterised by three stages: 'Starting Swallowing,' 'Discovering the Benefits' and 'Breaking Free'. The category 'Struggling with Swallowing' identified interpersonal and systemic processes within the inpatient environment which were key to understanding ingestion.

Conclusions: This exploratory study identified some unique functions of ingestion such as allowing patients to prolong self-harm and regain control of the self and the environment. Further research is needed to develop a more comprehensive understanding of this behaviour.

Introduction

Self-harm remains a significant problem for front line clinical services. Prevalence rates of self-harm stand at 2-6% of the population (Gibb, Beautrais, & Surgenor, 2010) which increases to 33% in psychiatric out-patients (Zlotnick, Mattia, & Zimmerman, 1999). Self-harm is a significant risk factor for suicide, with up to 2% of those who self-harm completing suicide within a one year period, rising to 7% within nine years (Thompson, Powis, & Carradice, 2008).

There remains little consensus about definitions of, or labels for self-harm. Terms which reflect differences in type and function include: self-harm, deliberate self-harm (Pattison & Kahan, 1983), self-injury, non-suicidal self-injury, self-mutilation (Favazza & Rosenthal, 1993) parasuicidal behaviours (Ogundipe, 1999) and self-wounding (Tantam & Whittaker, 1992).

This study will use the term self-harm to refer to behaviours which result in the deliberate infliction of physical harm upon one's body, in a socially unacceptable manner, in the absence of conscious suicidal intent. Self-harm includes: cutting, puncturing or burning the skin, self poisoning, either by ingesting caustic substances like pesticides, or by overdosing on over-the-counter or prescribed medication or recreational drugs, over-using laxatives, head-banging, biting, hair pulling, breaking bones, inserting objects into/under the skin, or into orifices such as the urethra, rectum or vagina and swallowing non-ingestible foreign bodies.

Risk Factors for Self-harm

Static risk factors for self-harm include: the loss of a parent through death or separation (Croyle & Waltz, 2007), childhood abuse (van der Kolk, Perry, & Herman, 1991), sexual abuse (Briere & Gil, 1998), incest (De Young, 1982),

witnessing domestic violence (Boyle, Jones, & Lloyd, 2006) and bullying (Matsumoto et al., 2004). Traumatic events in adolescence or adulthood can also trigger self-harm, including rape (Zlotnick et al., 1997) and combat (Pitman, 1990).

Dynamic risk factors include psychological processes such as: higher levels of physiological arousal in response to stress and a reduced ability to tolerate distress (Nock & Mendes, 2008), difficulties regulating affect (Herpertz, 1995), impulsivity (Herpertz, Sass, & Favazza, 2007), poor verbal communication (Nock, 2010), and poor social problem-solving skills (Nock & Mendes, 2008).

Functions of Self-harm

Nock (2010) proposes that people engage in self-harm as a means of regulating their intrapersonal experience, such as cognitive and affective states, as well as their interpersonal experiences. However, as Suyemoto (1998) notes, self-harm is likely to be ‘overdetermined’, therefore whilst any act of self-harm has a primary function, the same act is likely to serve multiple secondary functions (Kleindienst et al., 2008).

Intrapersonal Functions

Self-harm can serve to *regulate affect*, for instance by *sensation seeking*, which generates feelings of excitement or exhilaration (Kleindienst et al., 2008, Shearer, 1994) or by increasing *positive affective states* such as feeling invulnerable and superior (Himber, 1994). It can also function to *release tension* or *discharge painful feelings* (Klonsky, 2007; Nock, 2010). These negative emotions can include anger at the self/others (Himber, 1994), anxiety, depression, or being overwhelmed (Horne & Csipke, 2009). The self-reported decline in tension after self-harm

correlates with decreasing levels of physiological arousal (Welch, Linehan, Sylvers, & Chittams, 2008).

Self-harm can also *end states of dissociation*, in which people feel disconnected from their bodies or ‘unreal’, which is reported in 7-54% of self-harmers (Brown et al., 2002). In contrast, Himber (1994) suggests self-harming can *induce dissociation* as a means of regulating affect.

Self-harm also *prevents suicide*, by helping people to manage the conflict between life-and-death drives (Suyemoto, 1998). Individuals self-harm as a means of safely managing their destructive impulses, thus ultimately protecting them from committing suicide (Himber, 1994; Klonsky, 2007).

Interpersonal Functions

Self-harm may be employed to *influence the social environment* (Klonsky, 2007; Nock, 2010), such as eliciting *social support* (Klonsky, 2007; Nock, 2010) and *attention* (Kleindienst et al., 2008). Self-harm also *communicates distress* (Kleindienst et al., 2008), and may be more effective in eliciting support than verbal requests, particularly in the context of poor verbal communication skills (Conterio, Lader & Bloom, 1998).

Self-harm, particularly by cutting the most basic boundary of the self, the skin, serves as a way of delineating the *boundaries between the self and other*, and promoting a *sense of ownership* over the body (Laye-Gindhu & Schonert-Reichl, 2005). It can also act as *self-punishment* (Klonsky, 2007), which is linked to distress over specific ‘wrong’ actions, low self-esteem (Lundh, Karim, & Quilisch, 2007) or feelings of self-hatred (Nock & Prinstein, 2004).

Ingesting Foreign Bodies as a Form of Self-harm

The literature outlined above focuses on cutting, burning and self-poisoning, whilst less prevalent forms of self-harm, such as the insertion or ingestion of foreign bodies remain under-researched. The literature identifies three populations in which ingestion is most prevalent – those with psychiatric disorders, those in prison, and those with personality disorders. In those with psychiatric disorders, ingestion predominantly occurs in response to command hallucinations (Han, McElvein & Aldrete, 1984, Tsai, 1997), delusional beliefs (Basu, Gupta, Akthar & Sarawgi, 2003; Fishbain & Rotondo, 1983; Koscove, 1987) or as a feature of regression in Schizophrenia (Teimourian, Cigtay, & Smyth, 1964). Ingestion during a psychotic illness can perhaps be best characterised as a *feature* of psychosis. Ingestion in those with psychiatric disorders may also be a form of attempted suicide (Abraham & Alao, 2005; Han et al., 1984).

Ingestion in prison can serve as a means of obtaining secondary gains, such as transfer to hospital (Karp, Whitman, & Convit, 1991, O'Sullivan et al., 1996), access to analgesia (Lee et al., 2007), attention from staff (Martinez, 1980), or as a protest against the environment (Marasco, Cocco, Pinacchio, & De Pascalis, 1995).

In those with personality disorders, ingestion is most clearly identified as a form of self-harm, often following a history of self-harming by other methods (James & Allen-Mersh, 1982; Soong, Harvey, & Doherty, 1990). It is hypothesised that the ingestion of foreign bodies serves important functions such as releasing tension, gaining control over a situation, or eliciting care (Gitlin et al., 2007).

Published studies on ingestion are hampered by methodological issues, such as a reliance on single cases, small sample sizes or retrospective reviews. Unclear methodologies make it difficult to judge the source of hypotheses about the functions

of ingestion, and to date no qualitative research into the experiences of those who ingest has been conducted. Furthermore, no studies have been conducted into the impact of ingestion on staff, and the literature on the effects of other forms of self-harm on staff focus on either staff or patients' views, rather than utilising a dual perspective.

Whilst the functions proposed by the current literature appear similar to those of cutting and burning, there are aspects of self-harming by ingesting which appear markedly different. The invisible nature of swallowing results in internal damage with no outward sign of harm to the boundary of the self, the skin, thus rendering others unaware of the act unless the person chooses to disclose. Additionally, those who cut and burn usually retain some form of control over the severity of the harm they inflict, whilst in ingestion the person loses control over what damage the object may cause after it has been swallowed. These unique features may serve different functions to other forms of self-harm already documented.

Aims of the Study

Due to the lack of in-depth qualitative research on the functions of self-harm by ingesting foreign bodies, this study aimed to explore the experiences of individuals who ingest, with the following goals:

- 1) To better understand the meaning, function and processes of ingesting foreign bodies for individuals;
- 2) To enrich this understanding by exploring the views and experiences of staff working with such clients, including the personal impact ingestion has on staff.

Method

Ethical Approval

Ethical approval for the study was received from the Local NHS Research Ethics Committee. Amended ethical approval was obtained for non-NHS sites, and to include staff (Appendix II).

Grounded Theory Approach

A constructivist version (Charmaz, 2001) of the original Grounded Theory methodology (Glaser & Strauss, 1967) was deemed appropriate, due to the fact that the analysis moves beyond the direct experiences of those interviewed, to provide an increasingly abstract and theoretical understanding of the data. This allows for the generation of a clinically relevant theory about ingestion, which can be compared with the current theoretical understanding of self-harm by other methods such as cutting or burning. This may help clinicians ascertain whether current treatments for self-harm can be used with ingestion, or can inform the development of new interventions, as well as teaching and training for staff.

This generation of theory, rather than merely testing out hypotheses which have been logically deduced from existing theory, using quantitative methods (Glaser & Strauss, 1967) is vital given the current lack of knowledge and literature about self-harming by ingestion. In addition, the focus on the individual's experience, which forms the source of data within Grounded Theory is also lacking in the existent literature, which is a substantial flaw. Therefore, research using a qualitative research methodology will start to address this deficit.

The decision to use the Charmaz (2001) revision of Grounded Theory, informed by a symbolic interactionist perspective reflected an acknowledgment of

the interpretive nature of research, during which the researcher shapes the gathering and analysis of the data, and thus the generated theory. This approach explicitly acknowledges that “we *construct* our grounded theories through our past and present involvements and interactions with people” (Charmaz, 2006, p.10).

Researcher’s Perspective

I am a female, White British, middle-class Clinical Psychology trainee, with experience of working in medium-secure settings where some female clients ingested objects, along with other forms of self-harm. Despite attempting to ‘bracket’ these experiences, I will have analysed and interpreted the data collected through the lens of my previous experience, and my awareness of the theoretical models and literature about other forms of self-harm.

Research Setting and Recruitment

Patients and staff were recruited from an outer London NHS Mental Health Foundation Trust, and an independent sector provider of secure mental health services in the East Midlands. Patients were identified and approached by the local collaborator. NHS staff were recruited via the local staff electronic newsletter, whilst staff from the independent sector were approached by the local collaborator.

Patients were selected on the following criteria: 1) had not suffered a traumatic brain injury, 2) not currently psychotic, 3) not suffering from a learning disability or pervasive developmental disability, 4) did not have a diagnosis of Pica, 5) spoke English well enough to not require a translator and 6) over the age of 18. The first four criteria ensured that participants were consciously and intentionally ingesting, rather than ingestion being a feature of an underlying psychiatric or

neurological disorder. The fifth criterion was deemed necessary given the qualitative nature of the research.

Staff were selected on the following criteria: 1) over the age of 18, 2) spoke English well enough not to require a translator and 3) had experience of working clinically with at least one patient who had self-harmed by ingestion. Following early stages of data analysis, theoretical sampling was undertaken to gather data to enrich the emerging categories, by increasing the diversity of the staff in the sample. This included recruiting staff from different disciplines with varying levels of experience of treating ingestion, and who were both ward-based and providing input into the ward as outpatient therapists.

Participants

Twenty-five patients were approached, of whom six agreed to be interviewed. Six staff members were recruited (three from an Outer London NHS Mental Health Foundation Trust, three from the independent sector provider). Descriptions of participants are given in Tables 1 and 2.

Procedures

Informed consent was obtained and recorded prior to conducting the interview (See Appendix III and IV for information sheets and consent forms). Patients were informed that the interviewer would break confidentiality in the following cases: 1) if the patient disclosed that they had recently or were planning to self-harm or attempt suicide or 2) if other people were at risk of harm. Staff were informed that the interviewer would break confidentiality if they disclosed any substantial risk issues.

All interviews were audio recorded. Following the interviews, participants were debriefed, offered grounding and relaxation exercises, and given information on sources of support should they feel distressed. No participants requested this information.

Interviews

Patient interviews lasted between 32 and 66 minutes (mean length 47 minutes) and patients 3 and 4 were interviewed on two occasions (represented as P3.2 and P4.2). Staff interviews lasted between 67 and 125 minutes (mean length 91 minutes). At the end of the interview, I recorded observations of the setting and interview in a reflective journal to gather additional information to enrich the data set (Pidgeon & Henwood, 1997).

Interview Guide

Five areas relevant to the research question were identified, based on the previous experience outlined above and knowledge of the existing literature on self-harm. These were developed through discussion with the research team who had experience of conducting Grounded Theory research and working with self-harm. These areas formed the basis of the interview guide, and were: 1) timeline of self-harm, 2) the experience of self-harm by ingesting, 3) help seeking behaviour, 4) functions of ingestion and 5) psychiatric or psychological treatment received. In addition, staff were asked to reflect on what they thought the patients' experiences of swallowing were, what the patients had directly reported about their reasons for swallowing, and the personal impact of working with self harm by ingestion.

The interview guides were updated after each interview to include additional areas of interest raised, which were explored with subsequent participants. However, the interview guide formed a *point of departure* (Charmaz, 1995) to help observe the data, generate new ideas and think analytically. As such, not all participants were asked all of the questions, and the interview process was guided by participants' responses (Appendix V).

Measures

Quantitative measures were used to collect demographic information to contextualise and supplement the qualitative data obtained from the interviews (Elliott, Fischer, & Rennie, 1999). Prior to the interview commencing, the patients were asked to complete the Symptom Checklist 90-R (SCL-90-R) in order to identify the presence of psychosis (for exclusion). The other measures; International Personality Disorder Examination Screening Questionnaire (IPDE), the Self-harm Inventory (SHI) and the demographic sheet were completed at the end of the interview, to ensure that answering the questionnaires did not influence patient responses (for further information and measures see Appendix V1). Information from the questionnaires is presented in Tables 1 and 2.

Table 1. Demographic and Psychometric Information for Patients

P No	Age	Gender	Ethnicity	Diagnosis using DSM-IV criteria	Section	Length of Inpatient stay	Location at First Ingestion	IPDE Screening Questionnaire	Other forms of self-harm	Time since last ingestion
P1	19	Female	Mixed-Black/White	Antisocial, Paranoid, Avoidant and Borderline Personality Disorders	3	4 years	Adolescent Inpatient unit	Paranoid Schizoid Histrionic Antisocial Borderline Compulsive Dependent Avoidant	Overdosed Cut Self Hitting Head Banging Abused Alcohol Driven Recklessly Self Scratching Prevented wounds healing Made medical conditions worse Been promiscuous Abused prescription medication Attempted suicide Exercised an injury on purpose Self defeating thoughts Starved self	7 months
P2	21	Female	White British	Borderline Personality Disorder	3	4 years	Adolescent Inpatient unit	Schizoid Histrionic Borderline Avoidant	Overdosed Cut Self Hitting Head Banging Self Scratching Prevented wounds healing Starved self	24 months

P No	Age	Gender	Ethnicity	Diagnosis using DSM-IV criteria	Section	Length of Inpatient stay	Location at First Ingestion	IPDE Screening Questionnaire	Other forms of self-harm	Time since last ingestion
P3	40	Female	White British	Borderline Personality Disorder	3	Current admission 1 year	Inpatient Unit	Schizotypal Histrionic Antisocial Borderline Compulsive Dependent Avoidant	Overdosed Cut Self Hitting Head Banging Driven Recklessly Self Scratching Made medical conditions worse Abused prescription medication Attempted suicide Exercised an injury on purpose Self defeating thoughts Starved self Abused laxative	13 months
P4	26	Female	White British	Psychosis, Borderline Personality Disorder	3		Community	Paranoid Schizoid Schizotypal Histrionic Antisocial Borderline Dependent Avoidant	Overdosed Cut Burnt Self Hitting Head Banging Abused Alcohol Driven Recklessly Self Scratching Prevented wounds healing Made medical conditions worse Been promiscuous Abused prescription medication Engaged in emotionally abusive relationships Engaged in sexually abusive relationships Attempted suicide Exercised an injury on purpose Self defeating thoughts	4 months

P No	Age	Gender	Ethnicity	Diagnosis using DSM-IV criteria	Section	Length of Inpatient stay	Location at First Ingestion	IPDE Screening Questionnaire	Other forms of self-harm	Time since last ingestion
P5	24	Female	White British	Psychosis, Borderline Personality Disorder		2 years (current admission)	Prison	N/A	Overdosed Cut Burnt Head Banging Abused Alcohol Made medical conditions worse Abused prescription medication Lost a job on purpose Attempted suicide Starved self	24 months
P6	24	Female	White British	Borderline Personality Disorder	47/49		Prison	Paranoid Schizoid Schizotypal Histrionic Antisocial Borderline Dependent Avoidant	Overdosed Cut Burnt Self Hitting Head Banging Abused Alcohol Driven Recklessly Self Scratching Prevented wounds healing Made medical conditions worse Been promiscuous Abused prescription medication Engaged in emotionally abusive relationships Engaged in sexually abusive relationships Attempted suicide Self defeating thoughts Abused laxatives	Unable to remember – described it as ‘months’

Table 2. Demographic Information for Staff Members.

Participant Number	Age	Gender	Ethnicity	Highest Professional Qualification	Years working since qualifying	Place of employment when working with clients who ingest	Professional Role whilst working with those who ingest	Frequency of working with patients who swallow?	Specific training about self-harm?
S1	50-59	Female	White British	MSc	4	NHS – Acute inpatient ward	Psychological Therapist (outpatient services)	Once	No
S2	40-49	Female	White British	RMN	25	NHS - Acute inpatient ward	Ward Manager	Once	Yes
S3	30-39	Female	White British	D.Clin.Psy	4	NHS - Acute inpatient ward	Clinical Psychologist (outpatient services)	Once	Yes
S4	18-29	Female	White British	PG Cert Integrative Counselling and Psychotherapy		Independent sector – Medium-secure ward	Healthcare Assistant	Daily	Yes
S5	18-29	Female	White British	BA Psychology	4	Independent sector – Medium-secure ward	Healthcare Assistant	Daily	Yes
S6	30-39	Female	Black African/ Caribbean	Diploma in Nursing and Midwifery	10	Independent sector – Medium-secure ward	Acting Ward Manager	Daily	Yes

Analysis

Each audio recording was transcribed verbatim by the researcher in order to become *immersed in the data*. Following repeated reviews of the transcripts, the researcher began *line by line coding*, assigning each line of the transcript a label that ‘categorizes, summarises and accounts for each piece of data’ (Charmaz, 2006, p.43). Further *focused coding* was conducted on larger sections of the data. The method of *constant comparison* allowed the researcher to compare and contrast codes from different participants, across different time points in the analysis process (see Appendix VII for an example of data analysis). *Clustering techniques* were employed to synthesise the major codes for each participant, and *Memo writing* helped define the properties of codes, compare codes, and identify gaps in the data (see Appendix VIII for an example of a memo). These techniques, along with the keeping of a *reflective journal* (see Appendix IX for an example) helped elaborate the processes described by the codes, and moved the analysis towards a more abstract theoretical explanation which remained grounded in the data. Whilst staff and patient data were initially analysed separately, due to the substantial level of overlap in the emerging analysis the themes were merged for the final stages, although unique themes were documented.

The analytic process resulted in the development of initial categories and identified gaps and ambiguities in the data, which were explored in subsequent interviews. This process continued until no new themes or areas of interest emerged. However, it is unlikely, due to the small sample size, and the patients’ difficulties in understanding and articulating their own experiences, that all the categories reached saturation (Levitt, Butler, & Hill, 2006).

The analysis was subject to stringent checks, including sending patients and staff copies of the initial categories developed for respondent validation (see Appendix X for feedback handouts). Five staff and five patients responded with feedback, stating that the categories developed accurately reflected their experiences of ingestion. During the course of the research several patients commented that the interviews had helped them to reflect on their ingestion, which had been beneficial. The development of codes and the coding of transcripts were subject to consensus checks within the research team, who also discussed the theoretical integration of categories and the emerging theory. Criteria for assessing quality and rigour in qualitative research were consulted throughout to increase the validity of the emerging theory (Elliott et al., 1999).

Results

Grounded Theory analysis of patients' and staff accounts identified a core category of a 'Journey through Swallowing' which reflected the patients' journey through using swallowing as a form of self-harm (see Table 3). This consisted of three major categories reflecting different stages of the journey, 'Starting Swallowing', 'Discovering the Benefits' and 'Breaking Free'. The category 'Struggling with Swallowing' reflected parallel interpersonal and systemic processes operating between the patients, staff and the inpatient environment which may have served to unintentionally reinforce patients' swallowing. The important processes (in bold) and sub-processes (in italics) underpinning each stage of the journey are described. The inpatient environment and treatment approach is described briefly below, along with the patients' and staff experiences of trying to understand ingestion, which provides a context for the subsequent analysis.

Context

Inpatient Environment

All of the patients had been in restricted environments, including adolescent services or prison prior to being transferred to their current secure unit. Patients were managed on a series of six risk status levels, and they were granted increased and finally unsupervised access to objects which could potentially be used for self-harm as they progressed through the risk levels.

Staff also employed contingencies for self-harm behaviours, which followed the RAID approach (Reinforce Appropriate, Implode Disruptive Behaviours, Davies, 2001) and Dialectical Behavioural Therapy (DBT) principles (Linehan, 1993). After an incident of ingestion, ward doctors assessed the patients to determine whether they required medical assessment at the general hospital. Staff removed potential objects of ingestion from patients' rooms and general ward environment. Patients' observation levels were increased, and some had separate meal times. Patients were asked to complete behavioural chain analyses (see Appendix XI) either on their own in the DBT ward, to be reviewed later with staff, or in conjunction with staff if on the medium-secure ward.

Struggling to Understand Swallowing

What emerged strongly from both staff and patients was a struggle to understand swallowing. Patients found it difficult both to recall or understand their experiences of swallowing, including identifying associated emotions, thoughts and motivations.

At times, patients had an understanding of their behaviour which they wished to communicate, but felt unable to clearly articulate this. This was also noticed by

staff, who felt that these patients relied upon their behaviour to express their needs.

However, staff felt that some patients were choosing not to explain their motivations, or that they were **“just trying to tell you what you want to hear” (S6)** rather than discussing the ‘real’ reasons behind their ingestion. Some staff felt discussing ingestion was **“not really an appropriate conversation” (S6)** or they didn’t talk to patients about their experiences due to fears that it would push them into **“reliving something that was quite distressing” (S5).**

Staff suggested that a lack of experience of ingestion may have contributed to difficulties in understanding the phenomena. Staff attempted to explain ingestion by applying their knowledge of existing theories of self-harm, but felt that these did not adequately explain all aspects of ingestion.

Table 3. Core Categories, Major Categories and Sub-Categories

Core Category	Major Categories	Sub-Categories
Journey Through Swallowing	Starting Swallowing	Needing new methods of self harm Finding the answer Swallowing as a ‘safety net’
	Discovering the Benefits	Preventing prevention Prolonging the harm Causing more extreme damage Regaining control of the self Regaining control of the environment Bringing about care
	Struggling with Swallowing	Struggling to manage risk Dealing with the impact Becoming inured to self-harm Being forced to respond in unhelpful ways
	Breaking Free	‘A light bulb’s clicked’ Making use of support Recovery isn’t a smooth path

Starting Swallowing

Needing New Methods of Self Harm

All patients reported experiences of self-harming which predated admission to their current unit, often *using multiple methods* of self-harm, such as cutting or burning. Only one patient had ingested prior to admission as a means of committing suicide after a traumatic incident. Patients widely regarded their self-harming as a means of coping:

“cause I couldn’t cope in any other way, I didn’t have any other coping strategies” (P1)

For some, self-harm functioned as a means of regulating emotional distress, and releasing tension. For others, it was a method of punishing the self for perceived wrongs such as abuse, or for being a bad and worthless person. Less frequently, methods such as swallowing liquids, or taking overdoses were connected with a desire to commit suicide. Patients could identify triggers for self-harm, which were consistently connected to increased levels of emotional distress. These included flashbacks to traumas, such as rape or abuse, and associated distressing thoughts:

“cause if I self-harm they [thoughts of the rape] go away” (P1). Struggling to manage difficult life events, such as bereavement or being bullied also triggered self-harm.

Patients arrived on the inpatient unit or in prison with an established need to self-harm to manage distress. The restricted environment inhibited access to their usual means of self-harm, and thus inadvertently encouraged swallowing:

“swallowing stuff is a lot easier to do than getting razors and glass and stuff, 'cause it’s really hard to get it.” (P4)

Thus, while the environment had removed access to previous methods in order to *keep them safe* it had not removed the patients' need to self-harm, and so they **needed to find new methods of self-harm**:

“so they have everything removed from them and that’s when they resort to more invasive things like swallowing things” (S3)

Finding the Answer

Patients and staff both reported that *learning from others* was an important process in beginning to swallow. Patients either copied ingestion after **“I’ve seen other people do it” (P1)** or were actively instructed in what to do by others:

“She was like if you were like if you do this...you can get in a lot of pain and end up hurt” (P4)

Other patients described how the idea of swallowing **“just popped into my head one day” (P3)** but were often unable to explain how or why the idea came to them. Staff proposed that inpatient settings provided the perfect environment in which to think about new ways of self-harm, as patients have *time on their hands*, and they acknowledged the *resourcefulness* of patients in making use of whatever they could access in the environment:

“yeah, you’re taking away what they use to look after themselves...when you’re left with nothing, and you’re also left with twenty four hours a day when you’ve also got no stimulation, you could spend a hell of a lot of time...being really innovative about what you can do to harm yourself” (S3)

Once the patients had come across the idea of swallowing it was difficult to prevent the behaviour, as it is virtually impossible to ‘swallow-proof’ any environment. Even necessities like toilet paper and tampons can be swallowed, making ingestion an easier option than other methods:

“yeah swallowing is a lot easier ‘cause you just nip to the toilet and get a load of paper towels and swallow them, I’ve nearly killed myself several times doing that” (P4)

Swallowing as a ‘Safety Net’

Patients discussed how swallowing was a form of self-harm which they could continue to access on the inpatient unit. For staff, swallowing represented **“having a safety net” (S6)** which ensured that patients still had access to a means of harming themselves:

“So I think a lot of them obviously have a last resort or a fall back plan, and it’s swallowing ...So I think if swallowing was your only option left, they probably would do it.” (S5)

Discovering the Benefits

Whilst patients’ decisions to start swallowing may have been influenced by having restricted access to their established methods of self-harm, they also **discovered the unique benefits** of swallowing. Patients were often able to distinguish between the functions of swallowing and the other types of self-harm they used:

“swallowing ‘cause I’ve got more control and stuff like that, and bleeding ‘cause when I see blood it calms me down” (P2)

Preventing Prevention

Both staff and patients were keenly aware of the intrinsic nature of swallowing as something which **prevented prevention**. The speed and invisibility of swallowing meant that patients were able to swallow without staff being aware, thus *avoiding detection*, both during and after ingestion:

“I suppose it was just so they didn’t know what you was up to, and they couldn’t take any action because they didn’t know anything” (P5)

Some developed strategies for maximising their chances of avoiding detection, including modifying objects to make them easier to swallow:

“If I swallowed it just like that I’d most probably end up choking or summat and someone would have come in and knew that I did something, so I wrapped it up in chewing gum” (P1)

The fact that staff were unaware prevented them from intervening, and many patients reported *choosing not to disclose* to staff that they had ingested for this reason. However, the internal nature of swallowing also means that there is very little staff could do on the ward once a patient had swallowed, even if they became aware of it:

“if you were head banging or something, they could stop you doing that, but if you’ve got something inside you they can’t stop you” (P2)

The only interventions available to end the episode of self-harm after the patient has ingested are surgical, including removing objects by forceps, endoscopy, or by surgery.

Prolonging the Harm

The fact that once ingested, an object was very difficult to remove resulted in another perceived benefit, that *self-harming by swallowing is continuous*, as the object continues to do damage for as long as it remains inside:

“If I leave it in there like it’s still doing damage and it’s still self-harming. If you take it out then I’m not self-harming” (P1).

Extending the act of self-harm through time also *reduced the need for further self-harm* for some patients:

“you don’t need like to do other self-harming or that lot because you know that you’ve already got something which no one can do anything about” (P2).

Conversely, having the object removed or the physical pain decreasing signalled the end of the self-harming episode, which triggered a need to engage in another act.

Causing More Extreme Damage

Swallowing objects was viewed by patients as riskier and more likely to cause serious damage than other forms of self-harm, an opinion also shared by staff members:

“I suppose the idea that came into my head that it would do more damage if I swallowed things” (P4.2)

Patients discussed selecting objects, when possible, to maximise the damage they were inflicting, including swallowing multiple objects:

“ with the razor blades I swallowed three in one go... I was hoping they would do more damage” (P5)

Swallowing objects therefore marked a stage in a journey through a variety of methods of self-harm, which was partly driven by the need to inflict increasing levels of damage:

“I started cutting myself on my arms and things, and then like after a while ...I just think like...what’s next? Then the more you go on the like more dangerous stuff that I do... with me, it got up, it goes up and up and up” (P2)

Increasing the level of damage also provided opportunities for *escalating the risk*, as the patients were often exposed to ongoing and potentially life threatening harm. Treatments such as surgery provided the means of inflicting still greater damage. Whilst patients denied ingesting with the sole intention of needing an operation, which would create a scar which they could interfere with, the opportunities for further self-harm the scar provides could be interpreted as a

secondary gain. In contrast, some staff did wonder whether patients engaged in ingestion for the sole reason of additional self-harm by interfering with the wound:

“I just like made it really deep...had to have staples put in and everything...I just wanted to like get into my stomach...just to do damage, like pull my intestines or something out” (P2)

The desire to cause serious damage was not, for most, connected to suicidal intent, as many patients **“didn’t want to die” (P1)**. However, staff worried about the risk of accidental death, as they felt many patients didn’t realise the risks:

“I don’t think they realise it, and that’s the worry sometimes. I don’t think that they always get how dangerous it can be” (S5)

Ingesting therefore required patients to walk a fine line between maximising damage to meet their needs, and ensuring that their actions did not result in death.

Regaining Control: Of the Self

Some patients described using swallowing as a means of regaining control in an environment in which **“you feel that everything’s out of your control” (P6)**.

Patients re-asserted ownership of their actions by choosing to ingest:

“the member of staff was expecting her to be one way, so she was showing her she wouldn’t be that way, she would be something else, and in that way she would get control over what she was doing in that situation...she’d taken charge of the situation and she had a choice to do one thing or do another. And she swallowed.” (S4)

Ingestion also allowed patients to regain control of their bodies, which was particularly important for those whose lives had been controlled by people who abused them. By ingesting objects, patients damaged their own body, taking on the role of abuser as a means of re-asserting ownership and control:

“when I was a kid, I was hurting inside from everything that was happening to me, but I wasn’t in control of it...and now I am...’cause I can hurt myself as much as I want to” (P4)

However, although swallowing was a means of gaining control, patients paradoxically lost control once the object was ingested. Some reported *going too far* in terms of inflicting often *unintended physical damage*:

“when I swallowed stuff that got stuck in my neck, I swallowed it because I thought it would go into my stomach. I never, I didn’t plan for it to go into my neck or anything...it was like an accident when you do it” (P2)

This created panic about the level of harm being caused and regret about the ingestion, which resulted in patients *disclosing to staff*: **“I had to tell staff because I couldn’t breathe or anything, so I told staff” (P1).**

This loss of control was often associated with *swallowing impulsively*, during which patients ingested in the absence of any of their usual triggers to self-harm, *without thinking of the consequences*:

“if you can see something that’s there, you do that. I don’t think to myself, I’ll plan to use that later, just whatever’s there on the spur of the moment” (P4)

Staff regarded impulsive swallowing as indicative of patients *forming a habit* of ingestion, which patients discussed in terms of *becoming addicted* to ingesting:

“The feeling that you get when you do it just makes you want to do it again and again and again” (P2)

Therefore whilst regaining control of the self is an important function of swallowing, paradoxically at times it is an act which is utterly impulsive and out of control. Whilst patients seemed unaware of, or never articulated this paradox, staff demonstrated insight into the uncertainty about risk which underpins ingestion:

“but some of the things she swallowed, you kind of didn’t know what would happen. She might swallow a piece of china and...it could pass through and do no harm, but it was a bit like playing Russian Roulette” (S1)

Regaining Control: Of the Environment

Swallowing also served as a means of patients **regaining control over the environment**. Clear procedural responses to ingestion existed to manage the behaviour and ensure the patients' safety, thus the environment engaged in a *consistent response* to ingestion of which the patients were aware. Therefore the patients could manage the ward environment and staff behaviour by engaging in swallowing to elicit a pre-determined response:

“when this started happening when she was on ward, the reaction was always the same, so you know my feeling is that she went from sort of completely out of control scenario to stopping that scenario by doing something which then led into a different scenario” (S2)

Swallowing was also a means of patients exerting the ultimate control of *leaving the environment*:

“where people swallowed in order to get to the general hospital in order to potentially go AWOL...just getting out of this environment for a day, just get a break, see a new environment ” (S4)

Interestingly, all the patients denied having ever swallowed as a means of leaving the ward, and consistently reported negative experiences of their treatment whilst in hospital.

Swallowing also gave patients control over the interpersonal environment, by influencing the relationship between themselves and staff, who usually held **“all the other control...like PRN, IM's, the staff have more control over it than you” (P2)**. For some, it was this interpersonal function of circumventing the staffs' attempts to keep them safe, which was the primary motivator for ingestion:

“the satisfaction of having done something to yourself...without staff knowing...just getting one over on them” (P5)

Bringing about Care

Staff perceived swallowing to be a means of patients *expressing distress* that they were unable to articulate, and of eliciting support:

“that’s the way she kinds of tells you that she needs help, more than, she’s not good at actually coming and asking to have a chat with you” (S5)

Staff discussed their feelings that patients were competing for staff attention, and used swallowing as a means of *eliciting care*, as patients were aware that it was deemed serious enough to warrant intervention: **“to get care, she was swallowing to get attachment from people” (S3)**. The *extended time span* of swallowing also provided patients with a means of eliciting care for as long as the object remains inside them, in contrast to other forms of self-harm:

“probably the intention is to be looked after for as long as possible. To know that I’ve still got something in my stomach, that I can still go back to professionals and...be able to say I still have this, I still need care and treatment” (S6)

Staff also felt that patients *wanted medical staff attention* because it granted them a sustained period of individual interaction with staff who were not usually on the ward:

“they want us to do something about it, you know, take them to see the doctor. Because they love the doctor, they never see enough of the doctors... the doctors are hardly ever, you hardly ever get that one on one time. So if you’ve swallowed a battery and the doctor has to come and see you, it’s all about you with that doctor” (S5)

Interestingly, no patients discussed swallowing as a means of eliciting care, indeed some denied swallowing in order to gain attention, which they associated with being deemed ‘manipulative’:

“I felt like other people, like think you did it for attention, or whatever... but with me it wasn’t, I didn’t want the attention” (P6)

However several patients discussed wanting time with staff to explore how they were feeling and the reasons why they swallowed:

“probably just talking, asking the reasons why... I think it would have helped just a little bit knowing that they’re trying to get to know why” (P5)

Struggling with Swallowing

Struggling to Manage Risk

Staff felt that they were often *not fully aware of the risk* that patients would ingest, only becoming aware of the risk after the patient had swallowed, which was linked to the invisibility of ingestion and the infrequency of this phenomenon:

“and the risks, like I say, were really high, and we didn’t always know what the risks were. And at times, there were obviously risks and we hadn’t even noticed them” (S2)

This lack of awareness was particularly worrying for staff, due to both the *uncertainty* about the potential consequences, and *fearing the level of risk* to which patients may have exposed themselves. Whilst the patient could ingest and suffer no lasting consequences, staff were also aware that it could result in death:

“I mean if you swallow a battery and it passes through straight away, fine, no problem. If you swallow it and it leaks, you’re in a whole world of trouble...I mean that could kill her” (S5)

Facing this level of uncertainty about risk and the act of ingestion itself often left staff feeling afraid, panicked and in **“pure shock” (S6)**. From prevention to dealing with the aftermath, staff struggled to or felt *unable to manage* swallowing, and this anxiety was also underpinned by *feeling responsible* for the patients’ safety. Staff viewed part of their duty of care as keeping the patient safe from harm, even from themselves:

“some of the staff feel it’s their responsibility, that they could have stopped them. And it can affect them seriously... But not seeing that you can’t, you can’t altogether stop them from self-harming” (S6)

This burden of responsibility was made even heavier by the fact that staff were often *worrying about the repercussions* of failing to discharge their duty of care:

“the nurses worry because if it happens on their watch you know, what were they doing? So they’re fearful as well, because they’re perceived as not doing what they should be doing. But of course that’s not true, she’d do it in her room” (S3)

Dealing with the Impact

Staff discussed having to **deal with the impact** of ingestion, both in terms of the personal emotional impact, and the practical impact on the ward environment and other patients, which left them feeling **“frustration, anger, and just tiredness” (S2).**

“it makes things difficult...they had to put her on finger food...which means everything on the ward runs late and you then can’t have so much stuff out...it just has a knock on effect on everyone” (S5)

For some staff, these overwhelming demands and negative emotions made it difficult to keep sight of the fact that the patients’ behaviours were not directed at them. At times, they were left *feeling that it’s personal*, particularly when they lacked the necessary time and support to reflect on the patients’ behaviour:

“they just sort of panicked, and it did, it caused them significant stress...rather than her needing help, it was like why is she doing this to us?” (S1)

For others, this was experienced as the patient punishing staff or attempting to influence their behaviour:

“to punish you, to make you feel that it’s your fault, so next time you must listen. So next time when I say I want this, you will give it to me, and if you don’t, I’ll do the behaviour” (S6)

Interestingly, emotional responses of staff mirrored the emotions experienced by patients prior to swallowing or self-harming. Thus, key emotions for both staff

and patients were: frustration, anger, upset, out of control of their emotional responses and the people around them, and feelings of being punished or abused.

Staffs' complex emotional responses to this difficult situation often resulted in *challenges to their professional identity*. Staff discussed feeling that they were drawn into responding in ways which did not fit with their ideas of themselves as professionals:

“on the days when you get annoyed, you think, I’m not as caring as I think I am...she’d do things, and I’d think for God’s sake, not again, and then I’d kind of think, not quite who you thought you were, are you?...so it kind of challenges your view that you want to have, that you’re this wonderful caring professional all the time” (S2)

Becoming Inured to Self-harm

After initial shock and concern some staff discussed how repeated exposure to this behaviour resulted in them *becoming inured to self-harm*, in which the emotional impact was attenuated:

“I do sometimes worry about myself that I’ve become a little too acclimatised. The fact that I can see someone do something horrific and go ok, fine, it happens, deal with it.” (S5)

These factors could lead to the staff sometimes *minimising patients’ distress* and the potential risk:

“I’ve worked here for four years, you think, well, you’ve swallowed a battery, that’s not going to cause you any imminent harm.” (S5)

This process of minimising patients’ distress was sometimes contributed to by the staff *not feeling able to trust the patients’* report of their experience. This resulted in staff either implicitly minimising the patients’ distress – **“it’s psychosomatic, there’s not as much pain as what’s being described” (S4)** or more explicitly, by viewing patients’ expressions of pain as a means of eliciting care, in the absence of a real need for medical attention.

Being Forced to Respond in Unhelpful Ways

The burden of caring for patients engaging in such risky and unmanageable behaviours, and the concomitant emotional distress resulted in staff feeling forced into ways of responding which felt unhelpful.

Staff identified how the inpatient environment itself served to *unintentionally reinforce extreme behaviours*. Staff members discussed how they tried to manage patients' behaviour by reinforcing positive and ignoring negative behaviours, but acknowledged that this was nearly impossible within an inpatient environment, where people who self-harm **"got all the attention, out of necessity"** (S1). This was particularly salient given the level of risk posed by ingestion:

"But it's very difficult to get staff to behave that way, because they are responsible for this person staying alive" (S3)

Strategies such as separate meal times and increasing observation levels, designed to reduce the risk of further ingestion, were recognised by staff as potentially providing attention which the patients may have found reinforcing:

"And we were fussing around her a lot... we'd put her on finger food, she had to have separate dinner times and stuff. And I think you know, such a great big deal was made of it, that fed into it for weeks afterwards" (S5)

Staff were sometimes forced to provide ongoing monitoring and attention for long periods of time, as the extended time span of swallowing means that patients remain at ongoing risk often weeks or months later:

"But when swallowing something, they are all aware, all the nurses we panic, even the doctors do panic, because they can come back reporting the pain, the pain, severe pain. You can't weight the pain, you can't grade the pain, you can't see the pain. You go by what they tell you." (S6)

Conversely, interventions such as *further restricting the environment* and removing objects to *keep people safe* may have forced patients into further acts of

swallowing, as means of trying to regain control over an environment which feels increasingly beyond their control:

“so she wasn’t even allowed her own lighter, she wasn’t allowed anything, so the more you deprive someone, the more they’re gonna, the more innovative they are and the more they’re going to try and swallow things I think” (S3)

“I’m going to keep hurting myself then, I’m going to do it more, because I don’t want you to observe me. But it’s getting the clients to realise that actually then they’re going to want to observe you even more, if you keep doing it” (S2)

Some staff reported *feeling angry and critical* when patients continued to self-harm, which resulted in them acting towards the patients in ways which could be experienced as punitive:

“and you have a staff team who get very angry with this behaviour, who want to be punitive because they need to do that to deal with their own feelings” (S2)

Staff felt that this may have contributed to patients feeling unable to discuss openly the reasons why they were swallowing, which made it more difficult for staff to understand and effectively treat swallowing. Other staff discussed how critical or angry responses to patients resulted in increased emotional distress that precipitated another act of self-harm:

“if people were being unpleasant to her it would, we’d get into a cycle of you know, well you don’t care about me, so I’m just going to do this” (S2)

Patients also reported experiencing staff interventions, designed to keep them safe, as punitive, creating further distress:

“it’s like they’re punishing you for punishing yourself...once they’ve done that, you feel like even worse, so you punish yourself more” (P5)

Staff identified that at times, *minimising the patients’ distress* or self-harm resulted in the patient feeling that their communication of distress was not being

heard. This resulted in the patient escalating their level of self-harm, in an attempt to ensure that the staff heard, and thus responded to their need:

“Perhaps it had got to the point where we had gone, wow you’ve swallowed a battery, you’re just going to have to pass it, so she thought right well, if I swallow a spoon, that’s not going to come out is it, so they’re gonna have to do something about it maybe more” (S5)

Breaking Free

This phase of the journey will not be discussed in depth, as it is largely consistent with processes reported in stopping other forms of self-harm.

‘A Light bulb’s Clicked’

When discussing the end of their journey through swallowing, one patient described how realising that they no longer **“need to do it as much” (P1)** brought insight: **“but now it’s like a light bulb’s come on, I don’t need to do these behaviours” (P3)**. For many of the patients, this moment came when they prioritised other mutually incompatible goals above swallowing, a process which was also recognised by staff members:

“‘cause I want to get out, you have to do it if you want to get out, you have to stop” (P2).

Making Use of Support

Several factors were deemed important by patients and staff in helping patients to set goals to stop ingesting and progress towards them, which included improvements in mental state:

“when my mental state is better, like I’m on the right medication and stuff like that, just like, you don’t feel like you have to do it any more.” (P2)

Developing additional coping strategies to help manage emotional distress was key, and these ranged from simple techniques such as listening to music and

playing games, to techniques learned through psychological therapies, as well as accessing support from staff, friends and family:

“but now I’ve learned that ok, if I’m angry, if I’m frustrated, then I do stuff like doing a hobby I like doing, like cross stitch, or read a book or play games, and engage that way” (P3.2)

“my therapist has been very helpful, she listens to me, and she’ll tell me stuff to do and to try, which is good,” (P4)

Staff, in contrast to patients, also focused on the importance of the restricted environment in helping patients:

“the patient will reduce their level of self-harm because the environment is keeping them safe, not that they are keeping themselves safe” (S6)

However, staff were also aware that the inpatient environment could hinder as well as help patients:

“I think it makes them hard for them to stop in this environment as the ward can be very stressful and even if they are feeling more secure their co-patients can upset them” (S5).

Recovery isn’t a Smooth Path

There was recognition amongst staff and patients that the path out of swallowing was not a smooth one, and this stage of the journey was often characterised by relapses. However, whilst in the earlier stages of recovery, this lapse may trigger an extended period of self-harming, as patients moved further along the journey towards recovery, these occasional lapses remained isolated incidents:

“when I go through a bad patch I do it, but now if I have a blip, I don’t give up, I soon go back to where I am, before when I was doing it, I’d do it over and over again” (P1)

The patients’ stage of progression along this path also had an impact on staff. Those members of staff who worked solely with clients who had not reached this phase of the journey were left feeling that ingestion was an unmanageable behaviour,

which they had limited, if any, success in treating on acute psychiatric inpatient wards.

Discussion

Whilst patients' and staff accounts of their experiences of ingestion indicate similarities with literature concerning other forms of self-harm, this study has identified some processes and functions which are unique to swallowing.

Starting Swallowing

Patients almost exclusively began swallowing whilst on adolescent inpatient wards or in prison, although they all had previously self-harmed using multiple methods (Soong et al., 1990; Gitlin et al., 2007). What emerged as key to patients starting to ingest was being placed in a restricted environment which removed their previous means of self-harm, necessitating the development of new strategies. Whilst patients often reported thinking of ingestion independently, staff stressed the importance of modelling, which also occurs in adolescent inpatient settings (Taiminen, Kallio-Soukainen, Nokso-Koivisto, Kaljonen & Helenius, 1998) and within prisons (Losanoff & Kjossev 2005; Vassilev, Kazandziev, Losanoff, Kjossev & Yordanov, 1997). Whilst Losanoff and Kjossev (2005) suggest that prisoners imitate behaviour after observing the beneficial outcomes, different processes operate in adolescent units, in which acts of self-harm function as initiation rites or to strengthen group cohesion (Taiminen et al., 1998).

Discovering the Benefits

Patients widely viewed swallowing as a coping strategy which initially may have served to fulfil the functions of established methods of self-harm, although

patients reported functions which appear unique to ingestion. This may reflect primary and secondary functions, in which one self-harming behaviour can serve multiple, co-existing functions (Kleindienst et al., 2008).

The invisible and internal nature of swallowing gave patients the opportunity to self-harm without being detected and prevented staff being able to stop patients or remove the source of harm once they had ingested. This resulted in the patients engaging in a protracted act of self-harm, which removed the need to engage in any further acts of self-harm whilst the object remained inside. In contrast, staff experienced this as the patient prolonging their control over the environment, as they were forced to respond to the potential risk every time the patient reported pain. Gitlin et al. (2007) offered a similar conception of the ingested object as a 'time bomb' leading to prolonged anxiety for professionals.

Causing more damage was another key function of swallowing, which often occurred as a later stage in a hierarchy of self-harm methods. This appeared to be linked to both the internal and potentially fatal nature of the damage which was inflicted, and the fact that surgical interventions to manage this risk gave the patients further means of self-harming, such as interfering with wound healing (Favazza & Conterio, 1988). Staff also experienced swallowing as being a riskier form of self-harm, although treatment guidelines from the American Society for Gastrointestinal Endoscopy suggest that the mortality rate for ingestion is actually quite low, with only 1% requiring surgery (Eisen et al., 2002).

Interestingly, whilst patients wanted to inflict serious damage, they also discussed 'going too far', in which the unintended physical consequences of ingestion often sparked high levels of anxiety and regret. This forced patients into disclosing the ingestion to staff. This process has been explained in previous

literature as a ‘hypochondriacal cycle’ (Martinez, 1980), although the experiences reported by the participants in the current study indicates that this may be overly simplistic explanation. Martinez (1980) argues that during the hypochondriacal cycle patients become preoccupied after ingestion with the potential damage being caused, and the associated high levels of anxiety actually induce physical symptoms.

In contrast, in the current study both patients and staff noted that swallowing was often impulsive and triggered merely by the opportunity arising, with no prior consideration of the consequences. However, having time to reflect on the potential consequences of ingestion triggered anxiety in patients about the possible impact on their health. For some patients, this anxiety was only triggered when they started to experience abdominal pain, which they interpreted as an indication that physical damage was occurring. This anxiety may therefore reflect natural and appropriate worry about previously unconsidered damage, which may actually be occurring, particularly given the higher rates of complications subsequent to ingestion in psychiatric populations (Palta et al, 2009). Thus, to explain this as a hypochondriacal anxiety, as Martinez (1980) suggests, may be an overly simplistic explanation based on observations of the patients’ behaviour rather than their self-reported experience. Thus, further research focusing on patients’ experiences of anxiety subsequent to ingestion is required to clarify potential explanations.

Impulsivity is a recognised risk factor for self-harming (Herpertz et al., 2007) particularly high levels of Negative Urgency (the tendency to commit regrettable and rash acts whilst experiencing negative affect) and Lack of Premeditation (the inability to delay action in order to deliberate) which appropriately characterise the responses of patients in this study (Glenn & Klonsky 2010; Lynam, Miller, Miller, Bornovalova & Lejuez, 2011). This impulsivity may underpin the habitual or

addictive nature of the swallowing described by some patients and staff, which is also noted in other forms of self-harm (Nixon, Cloutier & Aggarwal, 2002). Nixon et al. (2002) propose that it is the release of endogenous opiates to regulate pain which positively reinforces self-harm by creating a sense of relief and wellbeing, thus forming the basis of addiction. However, whilst it is clear that this pathway may operate in forms of self-harm which inflict feelings of pain, such as cutting or burning the skin, it is less clear whether this pathway can explain the addictive quality of swallowing. Patients in the current study reported widely varying levels, if any, of pain on ingestion, and thus without experiencing pain, it is questionable whether endogenous opiates would be released. Further research will need to be conducted in order to ascertain whether the release of opiates does underpin the addictive nature of ingestion, or whether alternative processes are in operation.

Another key function of ingestion to emerge from the analysis was that of regaining control in an environment in which the patient is powerless. This included regaining control of the self and the body (Medina, 2011; Reece, 2005), often in relation to past experiences of abuse, as well as regaining control of the interpersonal environment (Gitlin et al., 2007). Regaining control is a function of self-harm which has been explored within prison settings (Kenning et al., 2010), although this function may generalise beyond those who are in physically restricted settings, to those who feel psychologically or emotionally restricted (Medina, 2011). In a community sample of people who self-harmed the third most commonly reported function of self-harm was to 'generate control' (Polk & Liss, 2009). Ingestion may potentially be a more effective means of regaining control than other methods of self-harm, given the invisible and internal nature which makes it difficult to prevent and impossible to end, once the object has been ingested.

Whilst staff and patient accounts were largely consistent, staff identified one function of ingestion which patients denied, which was swallowing to bring about care, a function consistently reported in other forms of self-harm (Kleindienst et al, 2008). Studies into cutting and burning etc have also noted differences between the functions reported by staff and patients (Thompson, Powis, & Carradice, 2008). This may be due to patients lacking awareness of the contingencies operating in the environment, and thus they are not consciously aware that ingestion serves the reinforcing function of eliciting care from staff. The pejorative labels used to describe this function, such as ‘attention seeking’ or ‘manipulative’, may also make it difficult for patients to admit that they self-harm as a way to communicate distress and obtain support. Alternatively, patients may feel ashamed of wanting help or of disclosing this need to staff.

Struggling with Swallowing

The attitudes towards and emotional reactions of staff to ingestion were consistent with those reported in literature regarding other forms of self-harm. These included struggling to understand the meaning or function of ingestion, making it harder for staff to empathise, which can hamper the provision of effective treatment (Bosman & van Meijel, 2008). Feeling unable to manage or control swallowing resulted in staff feeling helpless, deskilled, and that their professional identities were being challenged (Friedman et al., 2006; Rayner, Allen, & Johnson, 2004; Thompson et al., 2008). Staff felt highly anxious about risk, which stemmed in part from their feelings of responsibility for keeping the patients safe, and a fear of repercussions from management. At times, they also perceived patients’ self-harming as being personally directed, as a means of trying to control their behaviour, or to punish them (Charles & Matheson, 2007; Gallagher & Sheldon, 2010; Gitlin et al., 2007;

Thompson et al., 2008). The burden of these difficult emotions sometimes resulted in staff feeling frustrated and angry with patients, which spilled over into critical or punitive responses (Thompson et al., 2008; Wilstrand, Lindgren, Gilje, & Olofsson, 2007). One formulation of the strong emotions evoked in staff, which mirror the emotions of patients prior to self-harming, is that of a countertransference response. Rayner et al. (2004) discuss the idea of complementary projective identification, in which staff emotions complement those of the patient – so when the patient self injures in order to punish themselves, staff may experience anger and act towards the patient in a punitive way. Alternatively, feelings of being distressed or out of control may reflect a process of concordant projective identification, in which staff are empathising with the patients' own feelings of being out of control. Rather than acting on these negative emotions, staff can use them as information about the patients' experiences, facilitating empathy and guiding intervention.

Patterson, Whittington and Bogg (2007) warn of the dangers of allowing antipathy towards self-harm to develop, as this can alienate the patient, increasing the risk of further self-harm or suicide. Interestingly, in the current study more experienced staff reported that they become inured to self-harm over time. Whilst their reactions may not have been wholly negative, they suffered a loss of empathy which may have negatively impacted on the nature of the care they provided, to the detriment of the patients.

Whilst these findings are consistent with literature on the impact of other forms of self-harm, staff reported that many of these feelings were heightened due to the intrinsic nature of ingestion. Staff panicked more in response to ingestion, due to the perceived higher risk and feeling less able to manage this form of self-harm, in which they could not directly intervene once the object had been swallowed. The

rarity of ingestion, and the internal and therefore invisible nature of the damage it caused also resulted in staff feeling less able to understand and empathise with the patient.

Staff reactions were also influenced by the settings they worked in, and the patients' current stage of their journey through ingestion. Staff working on acute inpatient wards with clients who continued to ingest reported finding ingestion particularly challenging. This is potentially due their lack of training in and experience of working with serious self-harm, the acute nature of the setting and the limited resources and support available.

One of the key processes to emerge which is not as fully described in the literature is the complex interplay between the patient and the inpatient environment, which can serve to initiate, sustain and escalate ingestion. Martinez (1980) discusses the 'double bind' which swallowing creates for prison staff, who by managing the risk of ingestion actually reinforce the behaviour by providing exactly what the inmate was seeking – staff contact, analgesia or transfer to hospital. Staff in the current study were placed in a similar 'double bind'. Further restrictions and increased observation levels may simply reinforce the feeling of powerlessness which precipitated the patients' initial ingestion. Similarly, the demands of the inpatient environment mean that staff have to respond to extreme behaviours, in order to manage risk. These demands also mean that staff often lack the time and resources to consistently reinforce patients' positive behaviour, such as appropriate communication. This was particularly true for the acute inpatient wards, which were treating more patients with fewer resources, with staff who may have received less specialist training in self-harm, in comparison to medium-secure services.

Thus, the inpatient environment can inadvertently reinforce extreme behaviour such as ingestion over more appropriate ways of obtaining care, and thus the inpatient unit which is designed to heal may actually lead to an exacerbation of self-harm. The processes by which patients stop swallowing are consistent with those reported for other forms of self-harm including: improvements in psychological functioning, either through medication or the development of alternative coping strategies (Shaw, 2006); developing connections with others and directly expressing emotions (Kool, van Meijel & Bosman, 2009).

Limitations and Implications for Future Research

This is a qualitative study drawing on a constructivist Grounded Theory approach which aimed to develop an abstract theoretical understanding of staff and patients' experiences of ingestion, which was co-constructed by myself and the participants during the research process. As such, Grounded Theory does not aim to explain the experiences of those not included in the study. However, when trying to assess the potential applicability of the theory to the wider population of those who ingest, it is important to be aware of the context of the sample, and the methodological limitations which influenced this (Elliott et al., 1999).

Despite attempting to recruit from an NHS mental health trust, and from the community via national self-harm websites, all the patients were drawn from three secure wards within one independent sector provider of mental healthcare. The experiences of patients within NHS services may be different from those in independent sector healthcare, due to differences in staffing, resources, and treatment approach. In addition, referral pathways to the independent sector, who often provide

specialist services and out of area placements may influence both the type of patient they treat, and their experience of treatment.

Whilst staff participants were drawn from both the NHS and independent sector services, in contrast to the patients, it was not possible to recruit staff from all professional disciplines who may work with those who ingest. Therefore there are many potentially different experiences of working with ingestion which are not represented.

Only six of the twenty five patients approached agreed to participate, and patients who had ingested very recently or who had not swallowed for a substantial time period appeared more reluctant to be involved. Whilst those who had recently ingested stated that they felt it would be too destabilising to discuss their experiences of ingestion, those who had not ingested for a long time declined to participate without explanation. However, it could be hypothesised that they were concerned about jeopardising a long period of recovery by talking about their experiences in great detail. Alternatively, these patients may now view ingestion as ego-dystonic, and therefore have started to reinterpret their motivations for, and beliefs about ingestion. Further details about the earlier/later stages of the journey were therefore not available, and thus these stages of the model are unlikely to have reached saturation. Additional research, drawing on the experiences of those who are still ingesting, or have been in recovery for an extended period would therefore be helpful in enriching the model developed.

The sample obtained was also entirely female, predominantly White, and from a British cultural background. This is important, given the ethnic, cultural and religious differences which have been observed in other forms of self-harm (Boriril, Fox, & Roger, 2011), which may also influence the type of self-harm used. In

addition, the functions of ingestion reported in prisoners are based almost entirely on male-only samples, and therefore including male psychiatric inpatients in the research would allow not only the identification of any gender differences in ingestion, but also whether the functions reported in prisoners are connected to gender issues, or the pressures of prison environment itself.

This limited sample means it is unlikely that all categories reached saturation, particularly given the patients' difficulties with remembering their experiences. This may be due to the overly-general autobiographical memory in those with Borderline Personality Disorder (Startup et al., 2001), which prevents them recalling specific memories about ingestion. In addition, the high levels of emotional arousal present at the time of the ingestion may also have impeded hippocampal functioning, preventing the formation of a clear memory of the ingestion at the time (Brewin, 2001). Participants also struggled to verbalise their experiences of ingestion, which may be due to poor verbal communication skills found amongst self-harmers (Nock, 2010; Contario et al., 1998). The effects of an unknown researcher, anxieties about whom the information may be shared with, and what impact this may have, and a reluctance to discuss distressing experiences should also be considered.

Implications for Future Research

As this was an exploratory study replication is required with a larger and more diverse sample, preferably across NHS, independent sector providers and the community to consider the generalisability of findings to the wider population of those who ingest. Future research should include a more diverse sample in regards to the ethnicity, gender (men) and age (adolescents) of patients. Further diversity in regards to staff disciplines, the amount of experience they have in treating ingestion

and the type of inpatient setting they are working in should also be included, as these factors may influence how professionals are affected by, relate to, and ultimately respond to ingestion.

Difficulties recruiting from the community may reflect the rarity of ingestion, or it may be that those who self-harm by ingesting, which is higher up the risk hierarchy, are more likely to end up in secure units for treatment. Alternatively, it may indicate that ingestion is predominantly an inpatient phenomenon, which requires exploration through future research, as it has the potential to hugely impact how services prevent and treat ingestion. Other populations such as prisoners should also be included in future research. Whilst regaining control has been discussed as a function of self-harm in prisoners in some studies (Kenning et al., 2010; Martinez, 1980), most of the literature on ingestion in prison highlights secondary gain as the key function. Further research into the experiences of prisoners who ingest would clarify the similarities and differences in functions with those identified in the current study.

Methodological changes to any future research may be beneficial in avoiding some of the limitations outlined above. Spending more time on the ward prior to conducting the interviews may have resulted in patients becoming more comfortable with the researcher, thereby increasing both the numbers of those who agreed to participate, and their level of disclosure. Conducting follow-up interviews over the course of several months would also allow richer data to be collected, potentially across different stages in the patients' journey through ingestion. Alternatively, recruiting a former self-harmer by ingestion to conduct the interviews may be helpful, as this would minimise the power differential and potentially facilitate patients' disclosure (Smith, Monaghan, & Broad, 2002).

Alternative approaches to interviews should also be considered, given the patients' difficulties in remembering and disclosing discussed above. The difference between staff and patients' in regards to the functions of ingestion reported also highlights the importance of contingencies operating in the ward environment, which may shape the behaviour of the patients without their knowledge. Thus, observational studies of ingestion may allow for a direct assessment of any contingencies which motivate or reinforce ingestion, and are not reliant on patients being able to remember or verbalise their experiences, or choosing to disclose.

Large scale epidemiological studies, preferably over multiple sites may also be useful in helping to gather more demographic data, to identify potential distal and proximal risk factors for ingestion, and to establish prevalence, morbidity and mortality rates. This could be conducted either through sending questionnaires out to appropriate services, conducting retrospective reviews of hospital and prison records over extended time periods, or collecting incident reports of ingestions from multiple sites on an ongoing basis to obtain a prospective measure of ingestion.

Implications for Clinical Services

Despite the limitations outlined above, the findings generated do have important clinical implications which should be considered by services treating patients who ingest. Inpatient treatment for young people with an established history of self-harm may be detrimental, rather than helpful, as it may facilitate patients starting to ingest, and maintain or escalate this behaviour once established. Taiminen et al. (1998) recommend that adolescent females with BPD should not be treated in large groups on inpatient wards, or if this is unavoidable, then the length of hospitalisation should be limited to two weeks, to avoid the 'contagion' of self-harm.

Findings by Chiesa, Sharp and Fonagy (2011) support the lack of efficacy of inpatient treatment for those with BPD and self injurious behaviour, recommending long term community treatment in line with NICE Guidelines for BPD (NICE, 2009).

For those inpatient services already treating patients who ingest, the challenge is to find more effective treatment strategies. If staff perceptions of the function of swallowing as a means of eliciting care are correct, then inpatient wards need ways of managing ingestion without inadvertently reinforcing it via high levels of staff attention. Being more able to fully assess the risks of ingestion, for instance by having access to x-rays etc on site, would reduce contact with medical staff and the need to leave the ward, thus preventing unintentional reinforcement. Taking a stance of ‘involved neutrality’ (Charles & Matheson, 2007) in which all staff, including medics deal with the patient after ingestion in a business-like manner, with as little demonstration of affect as possible may serve to reduce the reinforcement obtained from staff reactions. However, this may be difficult for staff given the common emotional reactions of shock and panic reported.

Interestingly, patients in the current study denied swallowing as a means of eliciting care, instead focusing on ingestion as being a means of causing more severe and prolonged damage to the body, and regaining control over the self and environment. In light of the patients’ struggle to wrestle control from a restrictive environment in which they feel totally powerless, the current methods of restricting the environment and increasing observation levels are contraindicated, as they decrease the patients’ feelings of control, prompting an escalation of the behaviour (Jeglic, Vanderhoff, & Donovanick, 2005; Harrison, 1998).

As patients often started swallowing when the environment removed their previous means of self-harm, this may indicate the need for therapeutic risk taking in the form of allowing patients safe, supervised access to methods of self-harm which are less risky and easier to manage (Harrison, 1998). Allowing the patient to continue self-harming in a contained manner, whilst stabilising their mental state with medication, and developing alternative coping strategies through psychosocial interventions may therefore result in an attenuation of self-harm, without the patient necessarily having to make a commitment to stop (Shaw, 2006). However, Gough and Hawkins (2000) acknowledge the dilemmas inherent in allowing therapeutic risk taking in institutional settings.

Patients also reported wanting staff to spend time talking with them about their motivations and emotions after ingestion, which Shaw (2006) described as a “powerful yet underutilised intervention” (p.167). Other studies indicate that staff are reluctant to discuss patients’ reasons for ingestion due to beliefs that patients are not able to discuss it, or that talking about the behaviour will serve to reinforce it or ‘infect’ other patients (Bosman & van Meijel, 2008). Other treatment approaches may include ‘co-opting’ in which staff engage with patients as an expert on the dynamics of self-injury, discussing their self-harm from a position of calm neutrality and curiosity, which has been effective in reducing self-injury in adolescents (Charles & Matheson, 2007).

Staff members clearly articulated in the study that they struggle to understand swallowing, which results in them feeling confused, frustrated, or finding it difficult to empathise. Staff reported not receiving specific training in how to manage ingestion, which for some reflected a lack of in-depth training about self-harm. Staff require support in developing their understanding of and skills in dealing with

ingestion, as well as ongoing support and supervision to help them manage the complex practical and emotional demands of working with those who ingest.

Conclusions

This exploratory study identifies several unique features of ingestion, such as the invisible and internal damage it causes and the difficulties it poses for prevention and intervention, which in turn influences the functions it serves. These include allowing patients to prolong an act of risky self harm and regain control of the self and the environment. This study also highlights the importance of the interpersonal and systemic pressures of the inpatient environment which can influence the initiation and maintenance of ingestion in those patients already using self-harm as a coping strategy. Further research is required to develop a comprehensive understanding of ingestion, to inform the provision of effective interventions and treatment settings, and to ensure appropriate support for staff working with those at risk of this serious form of self-harm.

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PART 3:
CRITICAL APPRAISAL

This critical appraisal focuses on four areas: recruitment, the interview process, transcription and analysis and the integration of staff and patient perspectives. Recommendations for research and clinical services are offered in light of these discussions.

Recruitment Difficulties

Ethical approval was received in April 2010, but data collection did not begin until February 2011, due to considerable difficulties with recruitment. Whilst I had anticipated some difficulty, only four potential participants were identified from an entire NHS Mental Health Foundation Trust, including inpatient and community services. Of those, three did not wish to participate and one became too unwell to consent. Further avenues of recruitment were sought, including Gastroenterology departments, specialist personality disorder services within London and the UK and national self-harm websites. Whilst this identified a small number of participants, people chose not to be involved, or services declined access.

The scarcity of participants highlighted the relatively rare and severe nature of swallowing, given the entire sample was recruited from medium-secure and personality disorder services within an independent sector hospital. Difficulties recruiting from the community and the emerging importance of the interpersonal and systemic processes identified in this study indicate a role for the inpatient environment in triggering, sustaining and escalating ingestion. Thus there may not be large numbers of people who ingest in the community. However, it may also be that for those in the community, ingestion functions as an effective coping strategy, and thus they do not require support from mental health services. Alternatively, they may be quickly transferred to inpatient services, or the ingestion may be fatal. Should swallowing exist within the community, further research would be important, as it

may be underpinned by different processes and serve different functions to ingestion in inpatient environments.

Only six out of twenty-five participants approached felt able to participate. These six women had not self-harmed by swallowing for between four months and two years and therefore the study lacks participants who had more recently ingested or were still actively ingesting. Those who had swallowed within the past four months, as well as those who had not ingested for a period of several years all declined to take part. One patient who had recently ingested felt that it was “too raw, ‘cause I only did it a couple of weeks ago...I just don’t think it would be very beneficial to me to talk about it”. However, patients often declined to participate without explanation, even when asked directly about their reasons. Whilst the study did draw participants from the admission, rehabilitation wards, and Dialectical Behaviour Therapy Unit, who were at varying stages of their journey through ingestion, those who chose not to participate may shed light on additional, as yet unexplored stages of the journey, and helped to saturate the final category.

The sample was also predominantly White British, which is important considering that rates of self-harm and the types of method used are influenced by ethnic and religious background. South Asian women are at highest risk of self-harm, (Bhogal, Baldwin, Hartland, & Nair, 2006) followed by White and Mixed-ethnicity women, whilst those with religious beliefs reported reduced rates of repeated self-harm (Borril, Fox, & Roger, 2011). Whilst cutting the skin is common in European countries, self-immolation is frequent in the Middle East, Africa and South Asia (Ahmadi et al., 2009) and pesticide poisoning is common in African countries such as Uganda (Kinyanda, Hjelmeland, & Musisi, 2004).

Grounded Theory seeks to understand the experiences of those involved in the research and use this information to develop an “abstract theoretical understanding of the studied experience” (Charmaz, 2006, p.4). As such, it does not aim to represent the wider experiences of those not included in the sample, and therefore the fact that the populations discussed above were not included in the research is not a limitation of the theory per se. However, given the potential value of the experiences of these groups in enriching our understanding of ingestion, further research would allow an exploration of whether the theory generated can accurately capture experiences of ingestion in other groups or settings.

Interview Process

As a novice to qualitative research, several interesting factors emerged during the interviews which prompted me to reflect on the utility of interviews as a method of qualitative research, particularly with such vulnerable populations.

Remembering

Patients often struggled with recalling their experiences clearly, if at all, and the interview transcripts were littered with ‘don’t know’ and ‘can’t remember’. Patients particularly struggled with accessing affect and cognitions which preceded or followed ingestion, and thus potentially important information about the functions of ingestion was not obtained. When the patients could remember, relaying this experience was often hampered by a struggle to find the right words. These difficulties may themselves play a role in patients’ self-harm, which serves as a means of expressing emotions.

Several processes may have been influential, including the long time span since their last ingestion and poor verbal communication skills, which have been noted in those who self-harm in other ways (Nock, 2010). The effects of Borderline Personality Disorder (BPD) and high levels of emotional arousal on memory should also be considered. Research indicates those with BPD demonstrate an over-general autobiographical recall with reduced recall for specific memories, which protects them from recalling distressing memories which could trigger self-harm or suicide (Startup et al., 2001). Additionally, high levels of emotional arousal inhibit hippocampal functioning, impeding the formation of memory (Brewin, 2001). Therefore patients may not have formed detailed memories of ingestion due to high levels of emotional arousal at the time. Both of these processes would impact on patients' abilities to recall detailed memories of ingestion during interviews.

However, as Thomsen and Brinkmann (2009) discuss, specific autobiographical memories recalled in interviews are not as accurate a record of what 'actually' happened as previously assumed, even in those without memory deficits. Whilst recall of the 'gist' of the event remains relatively constant over time (although by no means an accurate representation of the event itself) the attributed meaning and affect are subject to change. These are often re-interpreted in the context of later experiences, emotions and shifts in meaning. This is key, given that the research focused on the meaning and function of ingestion, and what I was obtaining in interviews was perhaps not the functions and meaning patients held at the time, but rather 'what I think now about why I swallowed then'.

This strengthens the case for including patients who have recently ingested in future research, as they would have easier access to memories which have yet to be re-interpreted. Where this is not possible, Thomsen and Brinkmann (2009)

recommend eliciting peoples' memory of the event as it was then, and how they remember and feel about it now, in order to track changes in perception over time.

Disclosing

Thomsen and Brinkmann (2009) discuss how social processes operate in selecting memories to be discussed within interviews, particularly in regards to the interviewee's aims. Reflecting on why patients reported not being able to remember experiences raised potential additional reasons, such as impression management, or a desire to modulate their affect by not discussing distressing memories. The medium-secure setting, in which information is shared within the staff team may also have influenced patient disclosure. This is highly salient when researching self-harm, given the limits of confidentiality in regards to risk. I was left wondering whether patients would ever chose to disclose that they were contemplating or had recently ingested, knowing that I would have to pass this information to their clinical team.

Interestingly, some staff acknowledged that they were 'holding back' due to concerns that their professional viewpoint was not reflective of how things 'actually were', or commented that what they were saying would be viewed negatively, as it did not represent best practice. Others disclosed information hesitantly or waited until the audio recorder had been turned off, and the interview was officially over. Thus the data collected is likely to represent only a proportion of staffs' experiences and ideas. Observations of the ward environment and the process of the interviews, along with information from my reflective journal were included to strengthen the analysis. However, facilitating fuller disclosure from staff would be helpful in enriching the data further.

The participants' hesitation about full disclosure may have been influenced by the location of the interview, as Elwood and Martin (2010) note. All of the patients were interviewed in a quiet room on their ward, a decision determined largely by security requirements. However the fact that patients were being interviewed on a locked ward, by an interviewer who was free to enter and leave at will could have had a significant impact, exacerbating the existing power differential. Patients may not have felt comfortable discussing all aspects of their experience in an environment in which staff could enter at any time.

Elwood and Martin (2010) extend this idea further, suggesting that people enact different identities in different physical locations. For patients, being interviewed on the ward may mean they enact the identity of 'restricted patient', influencing what they discuss. Staff who are interviewed in their place of employment may feel more 'expert' and knowledgeable, and thus discuss the professional implications of ingestion or relay the 'party line', rather than the personal and emotional impact which may have been elicited if they had been interviewed at home. Interestingly, the first three staff interviewed were no longer employed in the service where they had encountered ingestion, and only one was interviewed at the site of their current employment. This may help to explain these three staff disclosing more about the negative emotions created by working with those who ingest, and being more critical about their own, and the environment's response to ingestion.

Whilst this makes a case for interviewing participants away from the ward environment, holding the interview in the environment within which the processes under study are occurring helps to generate a context for the explicit content of the interview, generating a richer understanding. It is unlikely that I would have been

able to connect so vividly with the feelings of powerless and being out of control which were central to the patients' accounts, without visiting the ward and seeing the many physical and relational restrictions in place.

Influence of the Researcher

Grounded Theory is an interactionist, constructivist approach, which acknowledges that I as the researcher would have exerted my own influence on the interview process. During the interviews it quickly became apparent that some participants had significant histories of abuse and trauma, which they acknowledged but did not explore in detail. I was struck by the fragility of some of the patients, which enhanced my awareness that I knew little about their background or whether they had discussed and started to process these experiences, for instance through therapy. I was also aware of feeling anxious about delving too deeply into patients' experiences of swallowing, in case it prompted a resurgence of the behaviour, a worry enhanced by some members of ward staff also feeling concerned. For some, talking about self-harming in detail can serve as a trigger for further self-harm, whilst for others, rekindling emotional states such as powerlessness, self-dislike and resentment which usually precede self-harm can also serve as triggers (Tantam & Huband, 2009). This needed to be considered given that for some their last ingestion was relatively recent.

The patients' vulnerability also raised the existing power differential very clearly, and I was aware that this position conferred ethical responsibility for ensuring that no harm befell participants (Brinkmann, 2007). These factors combined to make me feel less able to probe for more details about potentially distressing experiences, what Guillemin and Gillaim (2004) term 'ethically important moments'.

However, it should also be considered that whilst from a research perspective I felt there was much more left to explore, the participants may already have revealed more in the interview than they had necessarily planned or wished to. The risk of potentially exploiting participants to meet the needs of the research is an important ethical consideration which is particularly pressing when the research population is highly vulnerable.

These issues also made it difficult for me, at times, to balance my role as researcher with that of a trainee Clinical Psychologist, a conflict which often occurs for clinicians conducting research (Orb, Eisenhaur, & Wynaden, 2000). During certain interviews, I experienced a pull to enter into a more therapeutic dialogue with the client, as sticking to the research agenda felt un-empathic and unnatural. Reflecting on this during the interview itself allowed me remain aware that engaging in a more therapeutic dialogue would shape the course of the interview and the data which emerged. As Brinkmann (2007) notes, it would be unethical to enter into a more therapeutic interaction with the patient, who had consented only to taking part in a research interview, and not a therapeutic encounter. However, whilst transcribing the interviews I did notice that at these times my tone and speed of speech did alter, in order to more effectively convey my feelings of empathy and thus I did influence the participants' responses in some way. Recognising the interactions inherent in the research process, and the resulting co-construction of the theory between the researcher and the participant was one of the reasons for utilising a constructivist Grounded Theory methodology.

Interestingly, time emerged as another unanticipated influence on the interview process. Both the patients and staff had very busy days, making it difficult to schedule interview sessions of more than one hour. This at times felt as if it was

constraining the flow of the interview, and precluding the exploration of further areas of interest, as I was having to finish 'on time'. In other circumstances, I might have felt more able to sit with the participant, and allow time and silence to facilitate them sharing more of their experiences. Whilst with two participants I was able to schedule in additional interviews, this was not possible for all. I therefore had to tolerate not knowing what would have emerged from those minutes of the interview which the demands of the environment precluded.

Transcription

Transcribing all the interviews myself, whilst time consuming, meant that I became deeply immersed in the data, developing an intimacy which sparked comparisons, contrasts, and interesting questions to explore. I used a de-naturalised transcription style, consistent with the focus of Grounded Theory on the meaning of the content of the interview, rather than the process of the interview itself. However, the generated transcript, at times, bore little relation to my own experience of the interview, which had been full of hesitations, pregnant silences and expressions of strong emotion. Whilst I had attempted to capture this information, including by recording observations of the research and by keeping a reflective journal, I felt that much of the emotional richness of participants' descriptions was lost. This was particularly important given that many of the patients struggled to articulate their experiences with the richness and depth desired in qualitative research (Colaizzi, 1978). Oliver, Serovich and Mason (2005) note the importance of recording involuntary vocalisations (sniffing, laughing), response tokens (uh-huh, mmm) and non-verbal vocalisations (fidgeting, nodding) because of the important affective information it relays, which provides context for the meaning of the spoken, or

unspoken words. Many of the patients' responses to my reflections, rephrases or probes were in the form of response tokens or non-verbal vocalisations, which meant that much of this valuable, if highly co-created information was lost. This was partly due to the difficulties of coding and incorporating this type of information into the write up, given the standard presentation of quotations which focus solely on the participants' speech, rather than the preceding interaction with the interviewer, what Potter and Hepburn (2005) deem the 'deletion of the interviewer'.

I became increasingly aware that "transcription can powerfully affect the way participants are understood, the information they share, and the conclusions drawn" (Oliver, Serovich, & Mason, 2005, p.1) and therefore the importance of including paralinguistic and non-verbal features of participants' accounts (Willig, 2007). This would also require a more naturalised transcription style, such as Jeffersonian Transcription (Jefferson, 1984). The interviewer would also need to conduct the transcription themselves, to avoid misinterpreting often ambiguous involuntary vocalisations, or non-verbal responses which would not be recorded on the audio recording, which in itself suggests a move towards using video recordings for qualitative research (Smith, Flowers, & Larkin, 2009).

Analysis

Becoming immersed in the stages of analysis highlighted the subtleties of the phenomena, other interesting avenues of enquiry and alternative ways of formulating the data. This clearly indicated the importance of theoretical sampling, in which data is sought to elaborate and refine the categories which are emerging from the analysis, in order for the categories to become 'saturated'. This could be through identifying and interviewing new participants who have additional information about the

categories, or by re-interviewing previous participants to generate increased depth about the areas of interest (Charmaz, 2006). Whilst it was possible to re-interview two patients, the low incidence of swallowing and the high rejection rate made it unfeasible to conduct further theoretical sampling with patients. Interviews with the first three members of staff highlighted the importance of including staff with more experience of ingestion, as well as healthcare assistants and nursing staff, who may have very different experiences of ingestion. These staff were subsequently recruited from the medium-secure unit on which the patients were residing. However, whilst theoretical sampling was therefore attempted, it is unlikely that all categories would have reached theoretical saturation, shaping the analysis and pushing it towards certain directions, and away from others (Charmaz, 2006).

Accessing the Participants' Experiences

Reflecting on the limitations of the data obtained and the further limitations imposed by transcription prompted me to question whether we could ever actually access the participants' experiences of swallowing, in the way we wished. It is easy to assume that qualitative interviews allow us to ask a question, and get a response which accurately reflects the participants' experience of the phenomenon under investigation. As Kvale (1996) states, interviews draw upon "an implicit bodily and emotional mode of knowing that allows a privileged access to the subject's lived world" (p. 125). However, as Colaizzi (1978) acknowledges "there are many psychological phenomena which are either beyond human experiential awareness or which cannot be communicated," (p.65) which is often the case for corporeal phenomena (Willig, 2007). It may therefore be impossible for patients to fully understand or communicate their experience of swallowing, in any form.

In addition to difficulties knowing, remembering and disclosing experiences, there are also problems with qualitative interviews as a methodology which can prevent access to participants' experiences. Murphy, Dingwall, Greatbatch, Parker and Watson (1998) stress the transient nature of the unequal relationship between participants and researcher, which pushes participants to fabricate responses in line with the constraints of the interview context. Scott and Lyman (1968) reformulate interviews as 'accounts' which take the form of either excuses or justifications, when the participant feels, due to the questioning nature of the interview, that there is a suggestion they have acted in some untoward fashion. Through their accounts, participants attempt to refute this suggestion, by offering excuses which deny responsibility, or by justifying the behaviour as understandable. As self-harm is often perceived as 'challenging' behaviour (in contrast to the patients' 'justification' of it as a coping strategy) patients may have felt the need to justify ingestion to the researcher and ward staff. This will have undoubtedly shaped their accounts of the functions of swallowing.

Potter and Hepburn (2005) suggest that interviewers consider the footing of the participant, as well as their stake and interest; that is, what they are trying to achieve by the interview. Important questions such as: who are they talking as (individuals or members of a class such as 'patients' or 'staff'); and who are they talking to (the researcher as an individual, their family, community, or staff team) need to be considered when analysing the interviews.

Integrating Staff and Patients' Perspectives

Earlier stages of the analysis process indicated a significant overlap between the staff and patients' themes, which were therefore combined in later stages.

However, as noted in the results, there were areas in which staff and patient views conflicted, for instance, such as whether patients were engaging in swallowing as a means of eliciting care and attention (the staff view), which the patients adamantly denied as ‘attention seeking’.

Having conducted the majority of the patient interviews prior to the staff members’, I found myself feeling indignant on the patients’ behalf when staff later described their actions as attempts to punish, influence or manipulate staff behaviour. However, whilst writing up, I felt myself being pulled towards potentially privileging the staff view over that of the patients. This may have been due to staff views matching more closely to established understandings of self-harm prevalent in the literature, with which I am familiar and the fact that I am a clinician in a privileged position professionally closer to the staff members I interviewed. This shows the ongoing struggle of the clinician-researcher to ‘bracket’ their previous ‘sense-making’ of the phenomenon under investigation, which needs to be monitored at every stage of the research process (Chenail & Maione, 1997). I might have also been influenced by the richness and depth of staff answers, which fitted more naturally into the format of presenting a Grounded Theory, in contrast to the sometimes sparse accounts from patients. This raises the question of whether qualitative methods inherently privilege the voices of the articulate, as the capacity to intelligently describe experience is a pre-requisite for qualitative research (Colaizzi, 1978). Participants’ potential use of ingestion as a means of communicating their distress and need for help indicates a reduced ability to verbally articulate their experiences, which is ironically precisely what the qualitative methodology required.

Literature indicates that conflicts between staff and patient perceptions of the functions of self-harm are common. Staff often perceive self-harming behaviour as

manipulative, whilst patients view it as a means of coping, or an expression of distress (Thompson, Powis, & Carradice, 2008). However, little has been published about why staff and patients have such different conceptions of the same phenomena, and how this can be resolved, given the impact on the therapeutic relationship.

The pressure I felt during analysis was to identify the ‘right’ functions of swallowing, as it was difficult to accept that both groups could have equally valid, often contradictory ideas. However, Grounded Theory’s constructivist stance rejects the existence of an objective reality, acknowledging that the world “consists of multiple individual realities influenced by context” (Mills, Bonner, & Francis, p.26). By acknowledging the multiple subjective, co-constructed realities of individuals, we can avoid being drawn into an epistemological debate about who is ‘right’ (Larkin, Watts, & Clifton, 2006). Instead we are free to concentrate on finding ways in which staff and patients can co-create a shared understanding of ingestion to facilitate effective treatment, which is particularly important given the conflicting nature of the treatment approaches indicated by the different functions of swallowing. This shared understanding could underpin staff training, as interventions aimed at increasing staff knowledge about self-harm have been shown to be effective in improving attitudes towards self-harm, increasing feelings of competency and enhancing the care process (Patterson, Whittington, & Bogg, 2007).

Suggested Methodological Changes

The issues raised during the research, and my reflections on the process have identified several changes to the methodology which may be beneficial to future research. It should be acknowledged that this will be a difficult to recruit population in both community and inpatient settings, who may struggle for a myriad of reasons

to discuss their experiences of ingestion in depth. Spending time on the ward and getting to know the patients and staff may allow the development of a relationship which facilitates discussion of the more personal and distressing aspects of their experience. However, it would be important not to become perceived as part of the staff team, which may further restrict what patients disclose, or to enter into a more therapeutic relationship with patients in the pursuit of a personal goal such as a research project. Spending more time on the ward may also allow the direct observation of ingestion, granting researchers the chance to assess the existence of contingencies in the environment which influence ingestion.

Re-interviewing participants over the course of several months would allow researchers to follow up on earlier interviews, and track any changes in their views, which may be particularly important for phases of the journey such as ‘Breaking Free’. An alternative would be to recruit a former self-harmer by ingestion to conduct the interviews, as this would minimise the power differential and potentially facilitate patients’ disclosure because of increased empathy due to shared experience. This also has the potential to increase the richness of the data collected, and ground the findings more firmly in the patients’ reality (Smith, Monaghan, & Broad, 2002). However, the interviewer’s own experiences of ingestion may impact on the way they conducted the interview, and they would need to ‘bracket’ these assumptions whilst conducting the research.

Spending more time explicitly discussing with participants their anxieties about the interview, what the information would be used for, who would have access, and what they themselves were hoping to use the interview for, would provide important information about the participant’s role and stake. This may facilitate

disclosure, and would provide valuable information in contextualising the information during the analysis stage, enriching the final theory.

Ideally patient interviews should be held off the ward, where possible, to flatten the power hierarchy and reduce any concerns about confidentiality. Staff could be offered a choice of location, including their home, at work, or in a community setting which is as 'neutral' as possible. Interviews could also be video taped to capture important non-verbal communications. Using more naturalistic transcription methods such as Jeffersonian transcription would ensure this non-verbal contextualising information was retained during the analysis and write up. Altering the way the quotations are incorporated into the paper would highlight the influence of the researcher, and make it easier to incorporate participants' token responses.

Whilst patients and staff were sent written copies of the initial categories developed from the data analysis, time and resource constraints prevented me obtaining feedback about the final version of the theory. Holding meetings with participants to present the theory and obtain more detailed verbal feedback may generate further information to enrich the analysis, as well as strengthening the validity of the final theory. However, the demands of this on the participants should also be considered, as although some patients reported finding it helpful to discuss their experiences, research asks participants to engage in activities "not intended solely or even primarily for their direct benefit" (Orb et al., p.271). We must therefore be mindful of balancing the research demands with the wellbeing of participants.

Implications for Clinical Services

Whilst the implications of the research findings in relation to the inpatient environment and management strategies were discussed in the empirical paper, they

may also be useful in informing individual therapeutic work. Patients often reported not understanding their own reasons for ingestion, and therefore spending time within therapy developing a clear formulation of why the individual ingests may resolve this confusion and highlight areas of intervention (Shaw, 2006).

In 'Breaking Free' patients discussed stopping ingesting by focusing on more important and mutually contradictory goals, such as leaving the inpatient ward. Exploring the patients' longer term goals, and assessing whether these are compatible with continuing to ingest may help motivate patients to stop ingesting. As the patients also recognised the importance of being motivated to make use of the interventions being offered, increasing patients' motivation to engage in therapy and to replace self-harm with other coping strategies may be useful. Techniques such as Motivational Interviewing may be a helpful precursor or adjuncts to individual therapy in treating self-harm (Kamen, 2008).

One of the key functions of ingestion to emerge was that of regaining control, and therefore finding ways of reducing patients' feelings of powerlessness may reduce their need to ingest. Identifying opportunities within the inpatient environment which maximise choice, such as in their daily activities, leisure time, or the types of treatment options open to them may help patients feel more in control (Martinez, 1980). In addition, instruction in problem solving, such as Brief Problem-Solving therapy may also help patients find more adaptive ways of getting their needs within the constraints of the inpatient environment (Townsend et al., 2001).

As many patients reported ingesting impulsively, teaching strategies which help patients control their impulsivity may reduce the frequency of ingestion, as well as the subsequent emotional distress. Cognitive behavioural approaches, including problem-solving training may be of use in reducing impulsivity, although the

evidence for the effectiveness of these approaches are mixed (Moeller, Barratt, Dougherty, Schmitz, & Swann, 2001).

These strategies could be introduced alongside an effective medication regime, where appropriate, in order to stabilise mental state, which was reported as being key for patients in breaking free from ingestion. Therapeutic interventions such as Dialectical Behaviour Therapy (DBT) (Linehan, 1993) or Acceptance-Based Emotion Regulation therapy (Gratz, 2007), which facilitate the development of more adaptive emotion regulation strategies and communication would also serve to redress the use of self-harm as a means of coping with emotional distress. DBT has demonstrated efficacy in reducing psychopathology and self-harm when provided in inpatient (Bohus et al., 2004), outpatient (Linehan et al., 2006) and high-security settings (Low, Jones, Duggan, Power, & MacLeod, 2001).

Conclusions

Whilst the study was subject to difficulties and methodological limitations outlined in this paper, the qualitative, exploratory focus into an under-researched area generated some important insights. This included the identification of processes and functions which are potentially unique to ingestion; highlighting avenues for future research and challenges to using qualitative methodologies in this population, and raising some interesting questions about the nature of the treatment we should be providing for patients with serious self-harm behaviours.

My journey through this research has been challenging and ultimately rewarding and it has been a privilege to share the experiences of both staff and patients as they make their own journey through ingestion.

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APPENDIX I

DSM-IV-TR criteria for Pica

The diagnostic criteria for Pica, as defined by the American Psychiatric Association (DSM-IV-TR, 2000) are:

- A.** Persistent eating of non-nutritive substances for a period of at least 1 month.
- B.** The eating of non-nutritive substances is inappropriate to the developmental level (e.g. beyond the age of 18 months)
- C.** The eating behaviour is not part of a culturally sanctioned practice.
- D.** If the eating behaviour occurs exclusively during the course of another mental disorder (e.g., Mental Retardation, Pervasive Developmental Disorder, Schizophrenia), it is sufficiently severe to warrant independent clinical attention.

APPENDIX II

Local Ethics Committee

Documentation

East London REC 3

Board Room A
2nd Floor
Becketts House
2/14 Ilford Hill
Ilford
Essex
IG1 2QX

Telephone: 0208 9265025
Facsimile: 0208 926 5009

22 April 2010

Miss Abigail Pain
269 Woolwich Road
Charlton
SE7 7RB

Dear Miss Pain

Study Title: A Qualitative Study into the Functions and Processes of
Self Harming by Ingesting Non-Digestible Foreign
Bodies in Women
REC reference number: 10/H0701/25
Protocol number:

Thank you for your letter of 14 April 2010, responding to the Committee's request for further information on the above research [and submitting revised documentation].

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation [as revised], subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Covering Letter	1	22 February 2010
REC application	4	22 February 2010
Protocol		04 February 2010
Participant Information Sheet: Mental Health Staff	2	29 January 2010
Participant Information Sheet	3	04 February 2010
Participant Information Sheet: Website	1	04 February 2010
Participant Information Sheet: A&E Staff	2	29 January 2010
Participant Consent Form	2	29 January 2010
GP/Consultant Information Sheets	2	29 January 2010
Evidence of insurance or indemnity		17 February 2010
Referees or other scientific critique report		15 October 2009
Interview Schedules/Topic Guides	4	04 February 2010
Questionnaire: IPDE SCREENING QUESTIONNAIRE		
CV Janet Feigenbaum		18 February 2010
CV Dr. Marion Bates		18 February 2010
GPLETTER	1	03 February 2010
Self Harm Inventory		
Symptom checklist 90 R		
Investigator CV		18 February 2010
Participant demographic sheet	2	29 January 2010
list of sites		
Covering Letter	1	
Participant Information Sheet: website	3	14 April 2010
Participant Information Sheet: participant	5	14 April 2010
Participant Information Sheet: mental health staff	4	14 April 2010
Participant Information Sheet: A&E Staff	4	14 April 2010
Participant Consent Form	4	14 April 2010
GP/Consultant Information Sheets	4	14 April 2010
Response to Request for Further Information	1	14 April 2010

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0701/25

Please quote this number on all correspondence

Yours sincerely



Rev. Dr. Joyce Smith
Chair

Email: janet.carter@redbridge-pct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"
SL- AR2 for other studies]

Copy to: Dr Janet Feigenbaum, University College London / North East London
Foundation Trust
[R&D office for NHS care organisation at lead site]



National Research Ethics Service

East London 3 Research Ethics Committee

2nd Floor, Becketts House

2/14 Ilford Hill

Ilford IG1 2QX

Telephone: 020 8926 5025

Facsimile: 020 8926 5009

Email: Janett.Carter@redbridge.NHS.UK

29 July 2010

Miss Abigail Pain
269 Woolwich Road
Charlton
SE7 7RB

Dear Miss Pain

Study title: A Qualitative Study into the Functions and Processes of Self Harming by Ingesting Non-Digestible Foreign Bodies in Women
REC reference: 10/H0701/25
Protocol number:
Amendment number: 1
Amendment date: 19 July 2010

The above amendment was reviewed at the meeting of the Sub-Committee held on 29 July 2010].

Ethical opinion

Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Information Sheet: staff	5	08 July 2010
Participant Information Sheet	6	08 July 2010
Notice of Substantial Amendment (non-CTIMPs)	1	19 July 2010
Covering Letter	1	19 July 2010

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0701/25:

Please quote this number on all correspondence

Yours sincerely



Janett Carter
Committee Co-ordinator

E-mail: janet.carter@redbridge-pct.nhs.uk

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Dr Janet Feigenbaum, University College London
[R&D office for NHS care organisation at lead site]*



National Research Ethics Service

East London REC 3

Board Room A
2nd Floor
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2/14 Ilford Hill
Ilford
Essex
IG1 2QX

Telephone: 020 7794 0500 x34836

17 January 2011

Miss Abigail Pain
269 Woolwich Road
Charlton
SE7 7RB

Dear Miss Pain

Study title: A Qualitative Study into the Functions and Processes of Self Harming by Ingesting Non-Digestible Foreign Bodies in Women
REC reference number: 10/H0701/25
SSA reference number: 10/H0402/80

The REC gave a favourable ethical opinion to this study.

Notification(s) have been received from local assessor(s), following site-specific assessment. On behalf of the Committee, I am pleased to confirm the extension of the favourable opinion to the new site(s) and investigator(s) listed below:

Research Site	Principal Investigator / Local Collaborator
St Andrew's Healthcare, Billing Road, Northampton, NN1 5DG	Miss Abigail Pain

The favourable opinion is subject to management permission or approval being obtained from the host organisation prior to the start of the study at the site concerned.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0701/25

Please quote this number on all correspondence

Yours sincerely

Laura Keegan
Committee Co-ordinator
Email: laura.keegan@nhs.net

Copy to: Dr Janet Feigenbaum, University College London

This Research Ethics Committee is an advisory committee to the London Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within
the National Patient Safety Agency and Research Ethics Committees in England



National Research Ethics Service

East London REC 1

Room 24, 2nd Floor
Burdett House
Mile End Hospital
Bancroft Road
London
E1 4DG

Telephone: 020 8223 8602

23 February 2011

Miss Abigail Pain
269 Woolwich Road
Charlton
London
SE7 7RB

Dear Miss Pain

Study Title: Qualitative Research into the beliefs, concerns and experiences of NHS staff who work in services which support clients who self harm by ingesting solid objects

REC reference number: 11/H0703/6

Thank you for your letter of 02 February 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered [in correspondence] by a sub-committee of the REC 21st February 2011. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Response to Request for Further Information		02 February 2011
REC application		10 December 2010
Applicant's Checklist		10 December 2010
Research Protocol	3	02 December 2010
CV - Dr Marion Bates		
Confirmation of funding		06 April 2010
Focus Group - Prior Experience with Self Harm by Ingestion Prompts	1	26 November 2010
Staff Consent Form	2	02 February 2011
Evidence of insurance or indemnity		06 September 2010
Investigator CV		02 December 2010
Participant Consent Form	2	26 November 2010
Covering Letter		
CV - Dr Janet D Feigenbaum		
CV - Miss Abigail Pain		02 December 2010
Staff Information Sheet	2	26 November 2010
Peer Review		01 December 2010
Staff Interview Schedule	2	19 October 2010
Focus Group - No Prior Experience of Working with Clients who Self Harm by Ingestion Prompts	1	26 November 2010
Demographics Sheet		
Recruitment Information Sheet	1	26 November 2010
Staff Information Sheet	3	02 February 2011

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

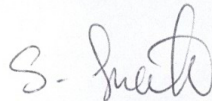
We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

11/H0703/6

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



 Dr Arthur T. Tucker
Chair

Email: sandra.grote@thpct.nhs.uk

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Dr. Janet Feigenbaum*
[R&D office for NHS care organisation at lead site]

APPENDIX III

Patient and Staff Information Sheets



St Andrew's Healthcare
PARTICIPANT INFORMATION SHEET
Version 6, 15/11/2010

Name of researcher: Abigail Pain

Qualitative Study into the Functions and Processes of Self Harming by Ingesting Non-Digestible Foreign Bodies

You are being invited to take part in a research study. Before you decide whether to take part, it is important that you read some more information about the study.

This sheet will give you some more information about why the study is being carried out, what you would be asked to do if you decided to take part, and how the study will be conducted.

Please take some time to read this sheet, and to discuss it with other people if you wish. You are also very welcome to ask me any further questions about the study, or if about anything on this sheet which is unclear.

Why am I conducting this study?

This study will form part of my Doctorate in Clinical Psychology training, at University College London.

The aim of the study is to understand the experiences of people who self harm by swallowing solid objects. I am also trying to understand the reasons why people self harm in this way, and the process by which they start to do this in order to help develop better psychological treatments.

Why have you been chosen?

You have been asked to take part in the study because you have self harmed by swallowing solid objects, either now, or in the past.

Do you have to take part?

No, you do not have to take part in the study. It is up to you to decide whether you wish to take part or not. Deciding not to take part in the study will not affect the care you receive from services either now or in the future.

If you do wish to take part in the study, you will be given this information sheet to keep, and asked to sign a consent form stating that you wish to take part.

If you do give consent to take part in the study, you are still free to leave the study at any point, without having to give a reason. If you choose to leave the study, this will not affect the care you are currently receiving, or will receive in the future. If you leave, any information that we have already collected from you will be destroyed.

If you do choose to take part in the study, what will happen to you?

If you would like to take part in the study, then please ask the member of staff who gave you this information sheet to ring me and pass on your contact details. I can then contact you to arrange a convenient time to meet. At this meeting, you can ask me any other questions you may have. I will then ask you to sign a consent form to say that you wish to take part in the study.

We can then arrange a time to meet again, or if you prefer, we can hold the interview in the same meeting. I will ask you to fill in a sheet with some basic information about yourself, and a short questionnaire about how you have been feeling over the past few weeks. We will then have an interview, which will last about an hour, although it may last up to two hours. This interview will be audio-recorded using a digital voice recorder. After the interview, I will ask you to fill in two more questionnaires, one about other types of self harm you may have used in the past, and another one about how you have been feeling recently.

After the interview, I will type up a transcript of what we discussed in the interview. When I have started to pull out some of the ideas from the interview, I will post this to you, and invite you to offer your comments, either by phone or by email/letter. This would be voluntary, and is to gain any additional information and your comments about my findings.

No part of the study is compulsory, and are not related to the care that you receive from your GP, hospital or other mental health professionals.

Who will know you are taking part in the study?

The audio recording of the interview will be destroyed after it has been typed up. All of the written information you provide will be anonymised, so that you cannot be identified. Any quotes that you provide which are used in the published research will also be anonymous.

All anonymised data will be securely destroyed within 20 years of the study in keeping with the Data Protection Act, 1998.

We will also inform the mental health professionals who are currently providing your care that you are taking part in the study.

What are the possible benefits of taking part in the study?

You may find it helpful or interesting to have time to talk about your experiences of self harming. The information gathered during this study will also help to inform our understanding of why people self harm by swallowing solid objects, which may hopefully help us improve treatment in the future.

What are the possible disadvantages or risks of taking part in the study?

Some people can find it upsetting to talk about their self harm, and they then be at a higher risk of self harming as a way of coping with these upsetting feelings. However, this is not the case for most people, and we will support you if you become upset, in order to reduce any risk of you self harming as a result of becoming distressed in the interview. If you feel at risk of self harming, then we will facilitate you accessing support from your care team.

What will happen to the results of the research study?

The results of the study will be printed as part of my doctoral thesis. The results of the study will also be published in a scientific journal and presented at a national or international conference. However, any identifying comments you make will be anonymised before any publication.

Who has reviewed the study?

This study has been given ethical approval by the University College London Ethics Committee and has been reviewed and approved by the East London Research Ethics Committee 3 on behalf of the NHS.

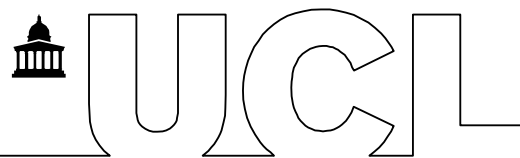
Contact Details

If you wish to discuss any of the information further, then please ask the member of staff who gave you this information sheet to contact me. I will then contact you, and will try to do my best to answer your questions.

If you feel that I have not addressed your concerns adequately or if you have any concerns about my conduct, then please ask a member of staff, or myself to contact Dr Janet Feigenbaum, who is the Strategic and Clinical Lead for Personality Disorder Services, North East London NHS Foundation Trust and Senior Lecturer, Research Department of Clinical, Educational and Health Psychology, University College London. Dr Janet Feigenbaum will then contact you to discuss your concerns.

Alternatively, you can contact the St Andrew's Healthcare Complaints Manager via your keyworker, on Extension 6417.

Thank you very much for taking the time to read this information sheet.



Staff Information Sheet
Version 3, 02.02.2011

Name of researcher: Abigail Pain

**Experiences of NHS Staff of working with Clients who
Ingest Non-Digestible Foreign Bodies
A qualitative study**

I am trying to identify suitable participants to take part in the above study, which I am conducting as part of my Doctorate in Clinical Psychology training, at University College London.

This study has been given ethical approval by the East London 1 Research Ethics Committee on behalf of the NHS. Abigail Pain is the identified contact person for the study.

Please take some time to read this sheet, which explains the aims of the study to determine if you would like to participate. You are very welcome to contact myself if you have any further questions about the study or if anything on this sheet is unclear.

Why am I conducting this study?

This study will form part of my Doctorate in Clinical Psychology training, at University College London. The aim of the study is to understand the experiences of staff members who work with people who self harm by ingesting non-digestible solid objects, as well as the concerns and emotions that this may evoke in staff members who have not seen this type of presentation before. It also aims to gather information about the possible functions this form of self harm serves for these clients.

It is hoped that the further understanding of why people engage in this form of self harm, and the experiences of the staff members who support them that is developed through this study may be used in the future to improve the treatment provided to those who self harm, and the education and support offered to staff.

Who is suitable to take part?

You are suitable to take part in the study if:

- You are under the age of 18
- You are a fluent English speaker
- You are currently employed in the NHS to provide care and treatment to service users
- You have an awareness of the general area of self harm, and are interested in talking about your opinions, emotions and concerns that come to mind when thinking about working with service users who self harm by ingesting solid objects.

You do NOT have to have previous experience of working directly with someone who self harms by ingesting solid objects. We are interested in gaining different perspectives from staff members, including the issues that this form of self harm may raise for people who have never worked with this presentation before.

What does taking part in the study involve?

You will be asked to sign a consent form to say that you wish to take part in the study. You will then be invited either to an individual interview, or to take part in a focus group with other staff members. Whether you are asked to take part in an individual interview or in a focus group will depend on your personal preference, and your previous experiences of working with people who self harm in this way.

Focus Groups

If you are invited to take part in a focus group, this will involve meeting with a small group of other staff members for about an hour, at a convenient location. At this meeting, staff will be invited to have a discussion about their experiences of working with people who self harm by ingesting objects, their ideas about why people engage in this form of self harm, and the concerns and emotions which are raised when thinking about this issue.

Individual Interview

If you are invited to take part in an individual interview, you will be asked to meet with me for between 60 to 90 minutes to discuss your experiences of working with people who self harm in this way in more detail.

The interviews and focus groups will be audio-recorded using a digital voice recorder. After the interview/focus group, I will type up a transcript of what we discussed in the interview. When I have started to pull out some of the ideas from the interview, I will post this to you, and invite you to offer your comments, either by phone or by email/letter. This would be voluntary, and is to gain any additional information and your comments about the findings.

Who will know you are taking part in the study?

The audio recording of the interview will be destroyed after it has been typed up. All of the written information you provide will be anonymised, so that you cannot be identified. Any quotes that you provide which are used in the published research will also be anonymous. All anonymised data will be securely destroyed within 20 years of the study in keeping with the Data Protection Act, 1998.

If information is revealed during the course of the research which indicates that any member of NHS is behaving in a manner deemed unprofessional, the researcher will pass this information on to the relevant line manager, in order to ensure the safety of staff and patients.

What are the possible benefits of taking part in the study?

You may find it helpful or interesting to have time to talk about your experiences of working with people who self harm in this way, or to have the space to think about some of the associated issues or concerns if you have not previously worked with this client group.

The information gathered during this study will also help to inform our understanding of why people self harm by swallowing solid objects, which may hopefully help us improve treatment in the future.

What are the possible disadvantages or risks of taking part in the study?

Some people can find it upsetting to talk about their experiences of working with clients who engage in serious self harm. However, this is not the case for most people, and we will support staff who become upset.

Do you have to take part in the study?

No, it is up to each individual to decide whether they wish to take part in the study. Participants are also free to withdraw from the study at which ever point they decide. You do not have to give a reason, and any data already collected will be destroyed if they wish.

What will happen to the results of the research study?

The results of the study will be printed as part of my doctoral thesis. The results of the study will also be published in a scientific journal and presented at a national or international

conference. However, any identifying comments you make will be anonymised before any publication.

Contact Details

If you wish to contact me to discuss any of the information further, then please do so on: (07806768992) or email abigail.pain@nhs.net

If you have any concerns about any aspect of this study, you should ask to speak with me on and I will do my best to answer your questions. If you feel that I have not addressed your concerns adequately or if you have any concerns about my conduct, then please contact:

Dr. Janet Feigenbaum, IMPART
Strategic and Clinical Lead for Personality Disorder Services, North East London NHS Foundation Trust and
Senior Lecturer, Research Department of Clinical, Educational and Health Psychology, University College London.

on janet.feigenbaum@nhs.net , Work Mobile: 07957919961 Work Office: 0844 600 1213

Thank you very much for taking the time to read this information sheet.

Abigail Pain

Research Department of Clinical, Educational and Health Psychology General Office -
Room 436, 4th Floor
1-19 Torrington Place, London WC1E 7HB

APPENDIX IV

Patient and Staff Consent Forms



Qualitative Study into the Functions and Processes of Self Harming by Ingesting Non-Digestible Foreign Bodies

St Andrew's Healthcare

CONSENT FORM

Version 6, 16/11/2010

Name of researcher: Abigail Pain

Participant Identification Number:

Please initial box

- 1 I confirm that I have read and understood the information sheet dated 16/11/2010 for the above study. I have had the opportunity to think about the information provided, ask the researcher questions about the study, and have had satisfactory answers to these questions
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. I understand that if I withdraw from the study, all of the information I have provided will be removed by the researcher.
3. I give my consent to take part in the above study.
4. I consent to the audio recording of the interview. I understand that the recording, any transcripts of the interview, and the questionnaires will be destroyed within the next 20 years in keeping with the Data Protection Act, 1998.
5. I understand that the mental health professionals involved in my care will be informed of my participation in the study.
6. I understand that the information that I provide will be included in the researcher's doctoral thesis, will be published in a scientific journal, and may be presented at a national or international conference. I understand that all information included will be anonymised to protect my identity.

☐☐☐☐☐☐

Name of Participant

Date

Signature

Researcher

Date

Signature



**Qualitative Study into the Experiences of NHS staff of working with Clients who Ingest
Non-Digestible Foreign Bodies**

CONSENT FORM

Version 2, 02/02/2011

Name of researcher: Abigail Pain

Participant Identification Number:

Please initial box

- 1 I confirm that I have read and understood the information sheet dated 02/02/2011 for the above study. I have had the opportunity to think about the information provided, ask the researcher questions about the study, and have had satisfactory answers to these questions
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. I understand that if I withdraw from the study, all of the information I have provided will be removed by the researcher.
3. I give my consent to take part in the above study.
4. I consent to the audio recording of the interview. I understand that the recording, any transcripts of the interview, and the questionnaires will be destroyed within the next 20 years in keeping with the Data Protection Act, 1998.
6. I understand that the information that I provide will be included in the researcher's doctoral thesis, will be published in a scientific journal, and may be presented at a national or international conference. I understand that all information included will be anonymised to protect my identity.

Name of Participant

Date

Signature

Researcher

Date

Signature

APPENDIX V

Interview Guides

Guidelines for Patient Interviews: Version 1

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?
b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
c)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?

d)	How did you manage to stop self harming by swallowing?
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Patient Interviews: Version 2

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
f)	Have you self harmed in other ways, or swallowed other objects whilst you already had something inside you?
g)	How do you feel about the objects after you have swallowed them?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?

b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
d)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?
e)	
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Patient Interviews: Version 3

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
f)	Did this have anything to do with access to certain methods?
g)	What method of self-harming do you find most helpful?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
f)	Have you self harmed in other ways, or swallowed other objects whilst you already had something inside you?
g)	How do you feel about the objects after you have swallowed them?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?

c)	Is there anything important about the object remaining inside you for a long time?
d)	Does swallowing affect how in control of things you feel?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?
b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
c)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?
d)	How did you manage to stop self harming by swallowing?
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Patient Interviews: Version 4

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
f)	Did this have anything to do with access to certain methods?
g)	What method of self-harming do you find most helpful?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
f)	Have you self harmed in other ways, or swallowed other objects whilst you already had something inside you?
g)	How do you feel about the objects after you have swallowed them?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?

c)	Is there anything important about the object remaining inside you for a long time?
d)	Does swallowing affect how in control of things you feel?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?
b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
c)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?
d)	How did you manage to stop self harming by swallowing?
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Patient Interviews: Version 5

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
f)	Did this have anything to do with access to certain methods?
g)	What method of self-harming do you find most helpful?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
f)	Have you self harmed in other ways, or swallowed other objects whilst you already had something inside you?
g)	How do you feel about the objects after you have swallowed them?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
f)	What impact did the way staff respond have in the short term?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?

c)	Is there anything important about the object remaining inside you for a long time?
d)	Does swallowing affect how in control of things you feel?
e)	Getting one over on Staff – did this play any role in you deciding to swallow something?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?
b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
c)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?
d)	How did you manage to stop self harming by swallowing?
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Patient Interviews: Version 6

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Timeline of Self Harm	
a)	Could you tell me a bit about the first time that you remember self harming?
b)	Have the ways in which you self harm changed since you first started?
c)	What was it about X which was helpful for you?
d)	Why did you change the way that you self harmed?
e)	How did you decide to self harm by swallowing objects?
f)	Did this have anything to do with access to certain methods?
g)	What method of self-harming do you find most helpful?
3. The Experience of Swallowing	
a)	Can you tell me about the last time you self harmed by swallowing an object?
b)	Are there other times or situations when you decide to swallow things?
c)	Are there other times when you have thought about swallowing something but didn't actually do it?
d)	Could you tell me about the types of objects you have swallowed?
e)	How did you decide what types of objects to swallow?
f)	Have you self harmed in other ways, or swallowed other objects whilst you already had something inside you?
g)	How do you feel about the objects after you have swallowed them?
4. Help Seeking Behaviour	
a)	Could you tell me what you did after you have swallowed something?
b)	How long was it before you told them that you have swallowed something?
c)	Can you describe what it is like in the time between swallowing something and telling someone what has happened?
d)	How did you decide when/whether to tell someone what you had done?
e)	Were there times when you did something different after swallowing something?
f)	What impact did the way staff respond have in the short term?
5. Functions of swallowing objects	
a)	Are you able to tell me a bit about why you swallowed things?
b)	Did swallowing things do the same thing as X e.g. cutting, burning, taking overdoses?

c)	Is there anything important about the object remaining inside you for a long time?
d)	Does swallowing affect how in control of things you feel?
e)	Getting one over on Staff – did this play any role in you deciding to swallow something?
f)	'Invisible form of self harm' – did this have any influence on you deciding to swallow something?
g)	What are your experiences of the way other people have responded to your self harming?
6. Treatment received	
a)	Could you describe what, if any, treatment you have received after swallowing an object?
b)	Have you ever had an operation to remove an object that you have swallowed? Or to deal with complications because of an object you have swallowed?
c)	Have you ever had any psychological therapy or treatment for your self-harming behaviour?
d)	How did you manage to stop self harming by swallowing?
7. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview
b)	Offer grounding and relaxation exercises
c)	Offer information about sources of support

Guidelines for Staff Interviews: Version 1

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
c)	How were these experiences different?
d)	How did other members of staff respond to your client who was ingesting objects?
e)	What kind of help or treatment did you offer to your client who was ingesting?
f)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	What ideas do you have about why people swallow objects?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self-harm?
b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?

6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
8. Debrief	
a)	Debrief from interview, offer information about sources of support.

Guidelines for Staff Interviews: Version 2

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	In what setting were you working with this client?
c)	How responsible were you for the safety of this client? What impact, if any, did this have on your feelings/responses?
d)	If you have worked with more than one client who has ingested, can you tell me about the similarities and differences?
e)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
f)	How were these experiences different?
g)	How did other members of staff respond to your client who was ingesting objects?
h)	What kind of help or treatment did you offer to your client who was ingesting?
i)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	What ideas do you have about why people swallow objects?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self- harm?

b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?
6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
7. Debrief	
a)	Debrief from interview, offer information about sources of support

Guidelines for Staff Interviews: Version 3

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	In what setting were you working with this client?
c)	How responsible were you for the safety of this client? What impact, if any, did this have on your feelings/responses?
d)	If you have worked with more than one client who has ingested, can you tell me about the similarities and differences?
e)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
f)	How were these experiences different?
g)	How did other members of staff respond to your client who was ingesting objects?
h)	Were there any differences among different staff disciplines about how they responded to your client who ingested?
i)	How did your client respond to staff from different disciplines?
h)	What kind of help or treatment did you offer to your client who was ingesting?
i)	Was this the general response from staff?
j)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	How did your client start swallowing?

c)	What ideas do you have about why people swallow objects?
d)	Do you think your client understood their own reasons for ingestion?
e)	Was your client able to articulate these reasons?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self- harm?
b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?
6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
7. Debrief	
a)	Debrief from interview, offer information about sources of support

Guidelines for Staff Interviews: Version 4

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	Do you think swallowing is more extreme than other forms of self-harm?
c)	Do you think swallowing is an understandable form of self-harm? Why?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	In what setting were you working with this client?
c)	How responsible were you for the safety of this client? What impact, if any, did this have on your feelings/responses?
d)	If you have worked with more than one client who has ingested, can you tell me about the similarities and differences?
e)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
f)	How were these experiences different?
g)	How did other members of staff respond to your client who was ingesting objects?
h)	Were there any differences among different staff disciplines about how they responded to your client who ingested?
i)	How did your client respond to staff from different disciplines?
h)	What kind of help or treatment did you offer to your client who was ingesting?
i)	Did you spend time talking with the client about why they ingested afterwards? If so, why?
j)	Did this differ at all from the help or treatment you offer to clients who self-harm in different ways?
k)	Did working with this client change the support you offered in any way?

l)	Was this the general response from staff?
m)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
n)	How did staff respond to the support that was offered?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	How did your client start swallowing?
c)	What impact do you think the environment had, if any, on your client ingesting?
d)	What ideas do you have about why people swallow objects?
e)	Were your ideas about the functions of swallowing the same as your clients or different?
f)	Do you think your client understood their own reasons for ingestion?
g)	Was your client able to articulate these reasons?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self-harm?
b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?
d)	Do you think existing theories of self-harm can be used to explain ingestion or not?
6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
7. Debrief	
a)	Debrief from interview, offer information about sources of support

Guidelines for Staff Interviews: Version 5

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	Do you think swallowing is more extreme than other forms of self-harm? Does this have anything to do with the damage being internal?
c)	Do you think swallowing is an understandable form of self-harm? Why? Does the invisibility of swallowing affect this in any way?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	In what setting were you working with this client? Did your client ever swallow in the community?
c)	How responsible were you for the safety of this client? What impact, if any, did this have on your feelings/responses?
d)	If you have worked with more than one client who has ingested, can you tell me about the similarities and differences?
e)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
f)	How were these experiences different?
g)	How did other members of staff respond to your client who was ingesting objects?
h)	Were there any differences among different staff disciplines about how they responded to your client who ingested?
i)	How did your client respond to staff from different disciplines?
j)	Did your client ever want contact with staff from particular disciplines, e.g. medical staff?
k)	What kind of help or treatment did you offer to your client who was ingesting?

l)	Did you spend time talking with the client about why they ingested afterwards? If so, why?
m)	Did this differ at all from the help or treatment you offer to clients who self-harm in different ways?
n)	Did working with this client change the support you offered in any way?
o)	Was this the general response from staff?
p)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
q)	How did staff respond to the support that was offered?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	How did your client start swallowing?
c)	What impact do you think the environment had, if any, on your client ingesting?
d)	What ideas do you have about why people swallow objects? <i>Leave the ward, get surgery, punish staff, get care and attention?</i>
e)	Were your ideas about the functions of swallowing the same as your clients or different?
f)	Do you think your client understood their own reasons for ingestion?
g)	Was your client able to articulate these reasons?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self-harm?
b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?
d)	Do you think existing theories of self-harm can be used to explain ingestion or not?
6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
7. Debrief	
a)	Debrief from interview, offer information about sources of support

Guidelines for Staff Interviews: Version 6

1. Introduction	
a)	Introduction and consent to the interview and recording, including the right to leave at any time. Aim of the research. Confidentiality limits.
2. Beliefs/Concerns about Working with People who Ingest	
a)	What comes into your mind when you think about working with someone who ingest solid objects?
b)	Do you think swallowing is more extreme than other forms of self-harm? Does this have anything to do with the damage being internal?
c)	Do you think swallowing is an understandable form of self-harm? Why? Does the invisibility of swallowing affect this in any way?
b)	What has influenced the way you think about people who ingest?
c)	What concerns or beliefs do you think other staff may have about working with people who ingest?
3. Experiences of Working with People who Ingest	
a)	Could you tell me about your experience of working with people who self harm by ingesting objects?
b)	In what setting were you working with this client? Did your client ever swallow in the community?
c)	How responsible were you for the safety of this client? What impact, if any, did this have on your feelings/responses?
d)	If you have worked with more than one client who has ingested, can you tell me about the similarities and differences?
e)	Can you tell about any experience you have had with working with people who self harm in other ways, such as cutting or burning?
f)	How were these experiences different?
g)	How did other members of staff respond to your client who was ingesting objects?
h)	Were there any differences among different staff disciplines about how they responded to your client who ingested?
i)	How did your client respond to staff from different disciplines?
j)	Did your client ever want contact with staff from particular disciplines, e.g. medical staff?
k)	What kind of help or treatment did you offer to your client who was ingesting?
l)	Did you spend time talking with the client about why they ingested afterwards? If so, why?
m)	Did this differ at all from the help or treatment you offer to clients who self-harm in different ways?
n)	Did working with this client change the support you offered in any way?
o)	Was this the general response from staff?
p)	What kind of support, if any, did you receive from the service whilst working with your client who ingested?
q)	How did staff respond to the support that was offered?
4. Functions of Ingesting Objects	
a)	What is your understanding of the experience of ingesting objects for the client?
b)	How did your client start swallowing? Why do you think other clients didn't start to ingest?
c)	What impact do you think the environment had, if any, on your client ingesting?
d)	What ideas do you have about why people swallow objects? Leave the ward, get surgery, punish staff, get care and attention? Do they want attachment, to specific team members?
e)	Were your ideas about the functions of swallowing the same as your clients or different?
f)	Do you think your client understood their own reasons for ingestion?
g)	Was your client able to articulate these reasons?
5. Education and Training	
a)	Could you tell me about the training, if any, you have received in working with people who self-harm?
b)	Did this training cover self-harming by ingestion?
c)	Do you feel that the level of training about self-harm you have received has been appropriate for the clients you have worked with?
d)	Do you think existing theories of self-harm can be used to explain ingestion or not?
6. Any other information	
a)	Is there anything else you think it would be important for me to know?
b)	How have you found the interview today?
7. Debrief	
a)	Debrief from interview, offer information about sources of support

APPENDIX VI

Questionnaires

(Removed due to Copyright)

Psychometric Information

Symptom Checklist 90-R (SCL-90-R)

The SCL-90-R renders scores for 9 factors, including psychoticism, as well as providing a Global Severity Index score. Internal consistency coefficient alphas for the nine symptom dimensions range from .77 for Psychoticism, to .90 for Depression, and Test-retest reliability coefficients range between .80 and .90 over a week period. The SCL-90-R is also normed on four gendered groups; adult psychiatric inpatients, adult psychiatric outpatients and adult non-patients.

International Personality Disorder Examination Screening Questionnaire: DSM IV Module (IPDE Screening Questionnaire) (Loranger, 1997).

This is a 77 true/false item self-report questionnaire, which screens for the 11 DSM-IV personality disorders (APA, 1994). Inter-rater agreement for the IPDE has been reported as .59 for definite diagnoses, and .70 for probable/definite diagnoses. Test-retest reliability coefficients range between .62 and .63 for definite and probable/definite diagnoses over a six month period (Loranger et al, 1994). The screening questionnaire can identify those who do not have a personality disorder, but cannot definitively establish a personality disorder diagnosis.

The Self-harm Inventory (SHI) (Sansone et al, 1998)

This is a 22 Yes/No response item self report questionnaire, which establishes the lifetime prevalence of deliberate self-harming behaviours. Internal consistency for the SHI has been reported to range from .80 to .90 depending upon the sample (Latimer, Covic, Cumming, & Tennant, 2009).

Demographics Sheet

A brief questionnaire collecting socio-demographic details was developed to describe the heterogeneity of both the patient and staff sample.



Staff Demographics Sheet

1. Please indicate your gender:

☐ Male

☐ Female

2. Please select the appropriate age range:

☐ 18-29

☐ 30-39

☐ 40-49

☐ 50-59

☐ 60+

3. Please select your ethnicity:

☐ White British

☐ Black British

☐ Mixed – Black/White British

☐ Asian British

☐ Chinese British

☐ White European

☐ Black African/ Caribbean

☐ Asian

☐ Chinese

☐ Other (please specify)

4. Please indicate your highest level of professional qualification:

.....

5. How many years have you worked in the NHS since qualifying?

.....

6. Please indicate your current job title

.....

7. How often, on average, do you work with a client who self harms *in any form*?

.....

8. How often, on average, do you work with a client who self harms by *swallowing objects*?

.....

9. Have you had any specific training in working with clients who self harm?

☐ YES

☐ NO

10. If YES, please specify how much training you have received e.g. in number of hours/days.

.....



PARTICIPANT DEMOGRAPHIC SHEET

Version 2, 29/01/2010

Qualitative Study into the Functions and Processes of Self Harming by Ingesting Non-Digestible Foreign Bodies in Women

Name of researcher: Abigail Pain

1) Participant Identification Number:

2) Age:

3) Ethnicity (Please tick the most appropriate)

- | | | |
|--|---|--|
| <input type="checkbox"/> White British | <input type="checkbox"/> Black British | <input type="checkbox"/> Mixed – Black/White |
| <input type="checkbox"/> Mixed – Asian/White | <input type="checkbox"/> Asian British | <input type="checkbox"/> Chinese British |
| <input type="checkbox"/> White European | <input type="checkbox"/> Asian | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Black African/Caribbean | <input type="checkbox"/> Other (please specify) | |

4) Marital Status:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Married/Civil Partnership | <input type="checkbox"/> Co-habiting | <input type="checkbox"/> In a relationship |
| <input type="checkbox"/> Separated/Divorced | <input type="checkbox"/> Widowed | <input type="checkbox"/> Single |

5) Employment Status:

- | | |
|--|---|
| <input type="checkbox"/> Full time employment | <input type="checkbox"/> Part-time employment |
| <input type="checkbox"/> Unemployed | <input type="checkbox"/> Full time education |
| <input type="checkbox"/> Part-time education | <input type="checkbox"/> Voluntary work |
| <input type="checkbox"/> Other (please specify)
..... | |

6. Education Status:

- | | |
|--|--|
| <input type="checkbox"/> Left school before taking GCSE's | <input type="checkbox"/> Obtained GCSE (or equivalent) |
| <input type="checkbox"/> Obtained A Levels, GNVQ's
or other post 16 qualification | <input type="checkbox"/> Obtained a University Degree |
| <input type="checkbox"/> Obtained Post Graduate degree e.g Masters, Phd | |

APPENDIX VII

Examples of Data Analysis

Examples of Data Analysis from a Patient Interview

Line by Line Coding	Interview Coding	Focused Coding
Experiencing pain Regretting Ingestion Attitudes changing over time/ Wanting to ingest	starts..then about, a week after or something and it really hurts and stuff like that you regret doing it but at that time you want to do it.. INT: <i>so it sounds like when you first swallow it you want to do that..</i>	<i>Experiencing Pain Regretting ingestion</i>
Wanting to ingest	P: yeah INT: <i>...and it feels good</i>	
Swallowing on impulse Identifying objects to swallow	P: sometimes it's like impulse, the wallowing...if you like see a pen or something you just like pick it up and swallow it. Just on impulse and everything INT: <i>let me just check out that I'm following you So sometimes you swallow something because you have a lot of bad feelings</i>	<i>Swallowing impulsively</i>
Feeling bad precipitating ingestion	P: Yeah INT: <i>and you feel really upset and want to do some damage. But then other times it was more just</i>	
Swallowing on impulse	P: on impulse INT: <i>seeing something you could swallow</i> P: yeah INT: <i>and you'd just pick it up and swallow it</i> P: yeah INT: <i>yeah...and what's that kind of week like where it's not hurting, it's not doing anything but you know it's inside you?...What's that time like?</i>	
Not needing to use other forms of self-harm Ingestion is a form of continuous harm Others lack control Others have control over other methods Controlling ingestion	P: it makes like...you don't need to like ...to do other self harming or that lot because you know that you've already got it... I can't explain it...but like you've got something which no one can do anything about...like if you were head banging or something they could stop you doing that, but if you've got something inside you they can't stop you. INT: <i>and what's that feeling like? That you know that they can't do anything? What does that feel like?</i>	<i>Not needing to use other forms of self-harm Regaining control Preventing Intervention</i>
Feeling good because of control	P: good... INT: <i>you said that if it's inside you, it kind of, it's still self harming</i> P: yeah INT: <i>cos you know it's in there...</i>	<i>Feeling good</i>
Continuing to damage Requiring medical intervention	P: it does stuff to you as well sometimes, like I've had stuff done because of it INT: <i>mmm can you tell me a bit more about that?</i>	
Requiring medical intervention	P: like when I swallowed a pen, it perforated my umm small intestine. I had to have like an emergency operation to get it out INT: <i>what was like that, when that happened?</i>	<i>Unintended physical consequences</i>
Feeling scared	P: scary INT: <i>umm, I can imagine, suddenly everything's out of control</i>	<i>Feeling scared</i>
Losing control	P: yeah	<i>Losing control</i>

Examples of Data Analysis from a Staff Interview

Line by Line Coding	Interview Transcript	Focused Coding
Not being able to assess risk	mouth, and you might just be getting some bleeding from her gums and the insides of her mouth, but actually this might be something far more serious...so there was kind of...there was all of that. There was the whole, oh my god, what has she done? How bad is this going to be? You know, we need to get her to A and E, er...so you've got that going on, you've got a busy ward, you've probably got no very many staff	
Feeling shocked Worrying about risk Juggling demands Being understaffed	INT: <i>mmm</i> P09: and I know on one level, that despite the fact that you're faced with great human distress, you're also thinking oh bloody hell, I really need this right now, you know? And...It's difficult for those feelings not to be translated to that person. Even if you don't say it, it's really difficult for them not to pick up on that...erm....and....in sort of, your non verbal or whatever, it just happens, doesn't it?	<i>Feeling unable to manage the risk</i>
Facing distress Feeling annoyed Struggling to hide feelings	INT: <i>mmm</i> P09: so you've got everything else happening, you've probably got a ward round going on, and now you've got her stood in the corridor, spitting up glass and blood, and a duty doctor saying, just get her an ambulance to A and E. So you've now got to find a member of staff to take her down to A and E. You've now got to deal with the A and E staff, who've already seen her four times this week, who are actually in a lot of cases saying to you...well, don't you look after these people? If you know that she does this, why couldn't you stop her? You know, and you've got them then saying to her you're just wasting our time. We've got people in here who are really ill, and you've done this to yourself So...you know...you know what I mean? So you take her to A and E, and your feeling annoyed, and all the rest of it, and then they're pissing you off, because they're telling you you haven't done your job properly and then they're telling her that she's a waste of time...so she's then sitting crying, and you're thinking oh thanks, I now need to deal with all of this	<i>Feeling annoyed</i>
Juggling demands		<i>Juggling demands</i>
Requiring Medical Intervention Being understaffed Repeated A&E trips		
Being criticised		<i>Being criticised</i>
A&E Staff criticising patient		<i>Being judged</i>
Feeling annoyed Feeling annoyed with A&E staff Being criticised A&E Staff criticising patient		<i>Being criticised</i> <i>Being judged</i>

APPENDIX VIII

Example of a Memo

Memo: Engaging in Cycles of Self-Harm

The role of the restricted environment is crucial in regards to both establishing the need to engage in self harm by different methods, and then in reinforcing these behaviours once they are established. Interactions between the staff and the patient often set up a cycle of self harm, in which the responses designed by staff to keep the patient safe and prevent further self harm paradoxically lead to an escalation of behaviour.

P01/228-231: *“If I tell the staff, and they take me down to A and E and take it out, I’m more likely to come back and self harm again”*

Patients self-harm because they feel powerless, stuck in a restricted environment in which the staff have all the control, and they have none. The only thing they can control, to some extent, is what happens to their body. Self-harming becomes a way in which they can re-gain some control, over their body, and over the environment. But the environment responds by becoming even stricter, objects are removed, and patients feel ultimately even more out of control. Thus, they are triggered to self-harm again, in another attempt to regain control.

P05 experiences the staff’s attempts of trying to keep her safe as being “like they’re punishing you for punishing yourself” (**P05/1116-7**). This causes her to feel ‘crap’ and in order to deal with these negative emotions, she engages in further self harm “because once they’ve done that, you feel like even worse, so you punish yourself more, and it will just go back and forth” (**P05/1120-2**) effectively setting up a cycle which escalates rather than ends self harm. For others, the intervention of staff to prevent their self harm or suicide attempt prevents them from achieving their goal, which engenders feelings of annoyance and anger. These negative feelings then trigger the need for further self harm, as **P04/389-97** recounts

“cos when they like stop me from doing stuff, like stopping me from self harming...that just pissed me off so then when I went into seclusion I cut all my arms...and they were like what have you done that for, and I was like cos I’m pissed off with you and they were like why, and I was like cos you’re trying to save me and I don’t like it, I don’t appreciate it.”

which staff then try and prevent, creating cycles of self harm. However, it is unclear as to whether P4 self harms again as a means of managing the feelings of anger or frustration, or whether this is a means of exerting some sort of control over a situation which is very much out of her control. Or is it means of expressing her anger at the staff for saving her, and punishing them in some way for her actions?

Staff members also identified the potentially negative impact that their responses had on the patient’s self harming behaviours. However, whilst the patient’s focused on the behaviour of staff, such as removing all items and placing them in seclusion, staff focused on the emotional tone of their responses. Both S2 and S3 recognised the impact that angry staff responses had on patients, which often resulted in patients becoming distressed, and therefore engaging in further acts of self harm as a means of managing this emotional distress.



APPENDIX IX

Example of a Reflective Journal Entry

Example of a Reflective Journal Entry

1st of March, 2011

Written immediately after a patient interview.

She seemed young looking, and appeared less anxious when she came in to the interview than she had on the ward. She talked very fast initially, due to anxiety maybe, which gradually started to calm down as the interview progressed.

She suggested starting with how she got the idea of ingestion and why she did it, commenting “you’re going to think it’s stupid though” and told me the story about her dog. She talked very matter of factly about her experiences and her wish to die. I think she was being open with me – she checked once whether I would tell the team, and I reminded her of the limits of confidentiality. She said at the end of the interview that it hadn’t made her think too much about swallowing. I called her out, and she admitted that it had made her think about it more. She denied that she would make plans to do it, as she wants to get her leave.

I felt very emotional when she talked about the self punishment function of self-harm. She said that she must have done something really bad in order to deserve that, and the self harm was in some way making up for that, and bringing feelings of relief. I felt pulled to tell her that this was how children make sense of bad things, that it’s their fault, but never, in my experience, was that the case. I felt very drawn into wanting to do something therapeutic in the interview, rather than just sticking to getting the data, more so than any other interview. I tried to reflect on this in the interview, to manage those feelings and remain in the role of the researcher. It felt unnatural, and I wondered what impact it had on her that I didn’t respond or challenge her views about the abuse? I wonder if it’s harder to do this kind of research if you are a clinician, rather than just being a researcher?

I noticed a very interesting contrast between her and the previous participant, who is very much towards the recovery side of her journey, whilst X is still fighting the battle. She clearly stated that she would self-harm or commit suicide if she was outside in the community. I felt very much like I wanted to reassure her that things would get better for her, but at the same time I was not sure that they would. Again I was torn between being a researcher and a clinician. It’s not ethical to enter into a therapeutic interaction with the participants during a research interview...but neither did it feel ethical to allow her self-blaming comments to go unnoticed or un-challenged.

APPENDIX X

Feedback Handouts

Experiences of Swallowing Objects – *‘it’s a way of coping’*

You may have started swallowing because:

- ☐ You used to self-harm in other ways, but you couldn’t do this in hospital because you didn’t have razors, lighters, medication etc
- ☐ You saw someone else swallow something
- ☐ You wanted to find a way of causing more damage to yourself
- ☐ It’s an easier form of self-harm to do in hospital, because staff can’t take away everything that you might swallow
- ☐ Staff can’t interfere once you have swallowed something
- ☐ It’s an invisible form of self-harm – so people can’t tell that you’ve done it, or judge you.

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Some things that might trigger you to swallow objects are:

- ☐ Flashbacks to horrible memories
- ☐ Distressing thoughts
- ☐ Feeling very upset
- ☐ Experiencing upsetting things like losing a loved one
- ☐ Hearing voices
- ☐ Feeling like you need to punish yourself
- ☐ Wanting to die
- ☐ Wanting to damage your body

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Swallowing objects might help by:

- ☐ Getting rid of horrible thoughts or memories
- ☐ Releasing tension and helping you feel relief
- ☐ Getting rid of upsetting emotions

- ☐ Feeling that you've punished yourself
- ☐ Feeling in control of the situation
- ☐ Experiencing pain
- ☐ Making you feel that the self-harm continues after you've swallowed
- ☐ Making you feel in control of staff
- ☐ Making sure that staff pay attention and notice that you are upset

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After swallowing an object, you may feel:

- ☐ Pleased that you've managed to do something to hurt yourself
- ☐ Satisfied that you've 'got on over' on staff
- ☐ More in control of the situation
- ☐ More in control of your own body
- ☐ Pleased about the damage the object might be doing
- ☐ Worried or scared about what damage the object might do
- ☐ Regret swallowing the object
- ☐ Upset that swallowing the object didn't kill you, or that staff saved you.

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Staff might respond by:

- ☐ Talking to you about how you feel
- ☐ Taking you to A and E
- ☐ Removing everything from your room that you could swallow
- ☐ Putting you on a higher level of observations
- ☐ Putting you in seclusion
- ☐ Being caring

- ☐ Being angry and upset

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You might try to stop swallowing objects by:

- ☐ Setting goals – such as to leave hospital
- ☐ Talking to staff about how you are feeling, rather than self-harming
- ☐ Developing new coping strategies
- ☐ Having therapy or attending groups
- ☐ Thinking about the consequences that swallowing has for you, staff, your friends and family
- ☐ Taking medication
- ☐ Carrying on trying, even when things are difficult, or if you self-harm again

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What might be different about swallowing objects compared to other forms of self-harm:

- ☐ You might have started swallowing objects because you didn't have any way of cutting, burning, overdosing, or using other methods of self-harm that you've used in the past
- ☐ It might be easier to swallow something than to do other forms of self-harm when you are in hospital
- ☐ Swallowing is invisible, so people can't tell you've self-harmed. This means they can't interfere with your self-harming, or judge you for what you've done.
- ☐ Once you've swallowed the object, people can't do anything to interfere, because it's inside you
- ☐ Swallowing might make you feel that you are self-harming the entire time the object is inside you, rather than the self-harming ending when you've made the cut or burnt your skin.

- ☐ You might get taken to hospital, to make sure that you are ok, or to have an operation
- ☐ Swallowing might cause more serious damage, particularly to the inside of your body
- ☐ Swallowing might get more of a response from staff than other forms of self-harm

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Thank you very much for all your help!

Staff Experiences of Working with Patients who Swallow Objects

Patients may have started swallowing objects because:

They had learned this behaviour from other patients whilst an inpatient	YES / NO
The environment removed their old forms of self-harm such as cutting, in order to keep them safe, so they had to find new methods	YES / NO
They had plenty of time to sit and think of alternative methods of self-harm whilst on the ward	YES / NO
They wanted to inflict more serious damage on themselves	YES / NO
It's an easier method of self-harm to use on an inpatient ward as there is always something which can be swallowed	YES / NO
Staff can't interfere once they have swallowed an object	YES / NO

.....

Patients may be triggered to swallow objects by:

They swallow impulsively when they see objects	YES / NO
They swallow due to forming a habit/ becoming addicted to swallowing	YES / NO
Hearing command hallucinations to self-harm/ commit suicide	YES / NO
Having distressing thoughts/ memories/ flashbacks	YES / NO
Experiencing overwhelming distressing emotions	YES / NO
Wanting to die	YES / NO
Feeling like they need to punish themselves	YES / NO

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Swallowing may serve the following functions for patients:

Help them to elicit care and support from staff, over an extended period of time	YES / NO
Communicating emotional distress and the need for support which they are not able to verbally express	YES / NO
Allow them to leave the ward environment by needing to go to the general hospital/ provide them with an opportunity to abscond	YES / NO
Allow them to have an operation, which gives them further opportunities for self-harming over a long period by interfering with the scar.	YES / NO
Provide them with a means of inflicting more serious forms of damage on themselves	YES / NO
Help them regain some control over the environment by eliciting a consistent response from staff	YES / NO
As a means of punishing staff members, or trying to influence staff behaviour	YES / NO
To help them regain some control over their bodies	YES / NO
As a form of suicide	YES / NO
As a means of regulating emotional distress and releasing tension	YES / NO
As a means of punishing themselves for perceived wrongs	YES / NO

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Ways in which you may try to manage patient's swallowing are:

Removing objects which can be swallowed from the ward environment	YES / NO
Increasing their level of observations	YES / NO
Placing them in seclusion	YES / NO
Calling the doctor for an assessment	YES / NO
Taking them to the A and E department for assessment	YES / NO
Talking to the patient about how they are feeling and why they swallowed the object	YES / NO

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Patients might stop swallowing by the following processes:

Deciding to stop swallowing to achieve another goal such as getting leave or returning to the community	YES / NO
Improvements in their mental state due to medication	YES / NO
Staff manage to remove most of the opportunities for them to ingest	YES / NO
Learning alternative coping strategies to manage and communicate distress	YES / NO
Using staff and family members as sources of support	YES / NO
Being able to control impulsivity and think of the consequences first	YES / NO

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Working with patients who swallow may affect you in the following ways:

It may make you feel anxious, frightened or shocked about the risk	YES / NO
You may feel responsible for stopping patients swallowing	YES / NO
You may worry about the repercussions for yourself, or for the patient if they manage to ingest	YES / NO
It may make you panic when a patient swallows something	YES / NO
It may feel more difficult to manage the risk and stop patients swallowing than other forms of self-harm	YES / NO
Swallowing may seem unfathomable	YES / NO
It may be more difficult to empathise with swallowing because it's invisible, you can't relate it to your own experiences or understand it.	YES / NO
It may feel more difficult to stop patients swallowing	YES / NO
You may feel frustrated, annoyed or angry when patients continue to swallow	YES / NO
It may challenge your professional identity, particularly when swallowing is difficult to control	YES / NO
You may minimise patient's distress, or assume the pain is	YES / NO

psychosomatic	
It may be difficult to trust that patients are telling you the truth about experiencing pain etc.	YES / NO
You may feel that you are forced into responding to swallowing in ways that actually reinforce the behaviour, such as having to take them to A and E, put them on higher levels of observations, or continually monitor whether the object has passed	YES / NO
You may feel that patients have swallowed things on purpose to punish you or influence your behaviour	YES / NO
You may become used to swallowing and no longer feel shocked by patients ingesting, particularly smaller objects such as batteries	YES / NO
You may feel exhausted by trying to manage swallowing and the impact it has on other patients and the ward environment	YES / NO

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Swallowing may be different from other forms of self-harm in the following ways:

Patients may have started swallowing because they could no longer use their old methods of self-harm whilst being an inpatient or because it is easier to swallow	YES / NO
Patients tend to only swallow whilst in an inpatient environment, not in the community	YES / NO
Swallowing is invisible, so it's harder to detect and manage	YES / NO
It's difficult to end the episode of self-harm when patients swallow objects, unlike cutting or burning	YES / NO
Swallowing means that patients often have to go to A and E, or have an operation	YES / NO
Staff have to continue to monitor ingestion and provide care for a much longer period than other forms of self-harm	YES / NO
Patients are continuing to self-harm the entire time the object remains inside them	YES / NO
Swallowing can be more risky than other forms of self-harm, although the patient has little control over how much damage the object inflicts.	YES / NO

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Thank you very much for all your help!

APPENDIX XI

Behavioural Chain Analysis

Behavioural Chain Analysis in DBT

Behavioural Chain Analyses are similar to Behavioural Analysis (Bandura & Goldman, 1995) but are conducted in much more detail, on one single chain of behaviour, rather than attempting to locate general patterns within behaviour. Behavioural Chain Analyses are conducted after the incidence of one of the 'target' behaviours in Dialectical Behaviour Therapy, which are: life-threatening behaviours, therapy-interfering behaviours, and quality of life interfering behaviours.

Behavioural Chain analyses are conducted to identify the antecedents to one of these target behaviours, which include the conditions which increased the likelihood that the behaviour would occur (vulnerability factors), the events which precipitated the events (proximal discriminative stimuli) and the consequences of the behaviour. They focus on changes which occur moment to moment, considering external changes in the environment, as well as changes in thoughts, emotions and behaviours.

1) Describe the specific target behaviour

This includes specific details about the behaviour itself, it's intensity, and what you did, said, thought and felt.

2) Describe the specific precipitating event which triggered the target behaviour

This includes what environment event started the chain of behaviours, how you were thinking and feeling at the time, what you were doing at the moment the event occurred, and why the event happened at that specific moment in time.

3) Identify the general vulnerability factors which were present before the precipitating event.

This includes physical illness or injury, changes to eating or sleeping patterns, substance or alcohol use, stressful events in the environment, or intense emotions

4) Describe in precise detail the chain of events which led from the precipitating event to the target behaviour.

This needs to focus on step by step changes in thoughts, feelings, sensations and actions. Try and break down each link or step into smaller steps.

5) Identify the consequences of the target behaviour

This includes other people's immediate reactions, and their reactions later on, your own emotional reaction immediately after the behaviour, and later on, and the effect the behaviour had on the environment.

Conducting a behavioural chain analysis means that clients have to focus on the specific details of the situation leading up to the behaviour occurring, which helps to strengthen the episode memory of this particular behaviour. This can help to counteract the over general memory deficits which are found in BPD. Helping clients to discriminate the triggers for their behaviours means they are more likely to recognise these patterns in the future, and engage in an alternative, more adaptive response.

The focus on the client's emotional responses during the Behavioural Chain Analysis also helps to expose clients to emotions which they would usually try and avoid or end, and this process may also reduce shame and increase problems solving abilities.

During the process of conducting the Behavioural Chain Analysis, assessment of the events leading up to the target behaviour and the associated consequences also open up discussion about alternative actions which could have been taken. Clients should identify at each stage of the chain where they could have done something else which would have averted the target behaviour. They should then identify what else they could have done at these points, and what coping strategies and skills they could have employed. This provides the opportunity to reinforce the interventions which are being taught as part of the DBT treatment package. Clients should also consider what they could do to reduce their vulnerability to the chain occurring again in the future, and what they could do to repair the consequences of the target behaviour which has already occurred.

See Lynch, Chapman, Rosenthal, Kuo and Linehan (2006) for further discussion.