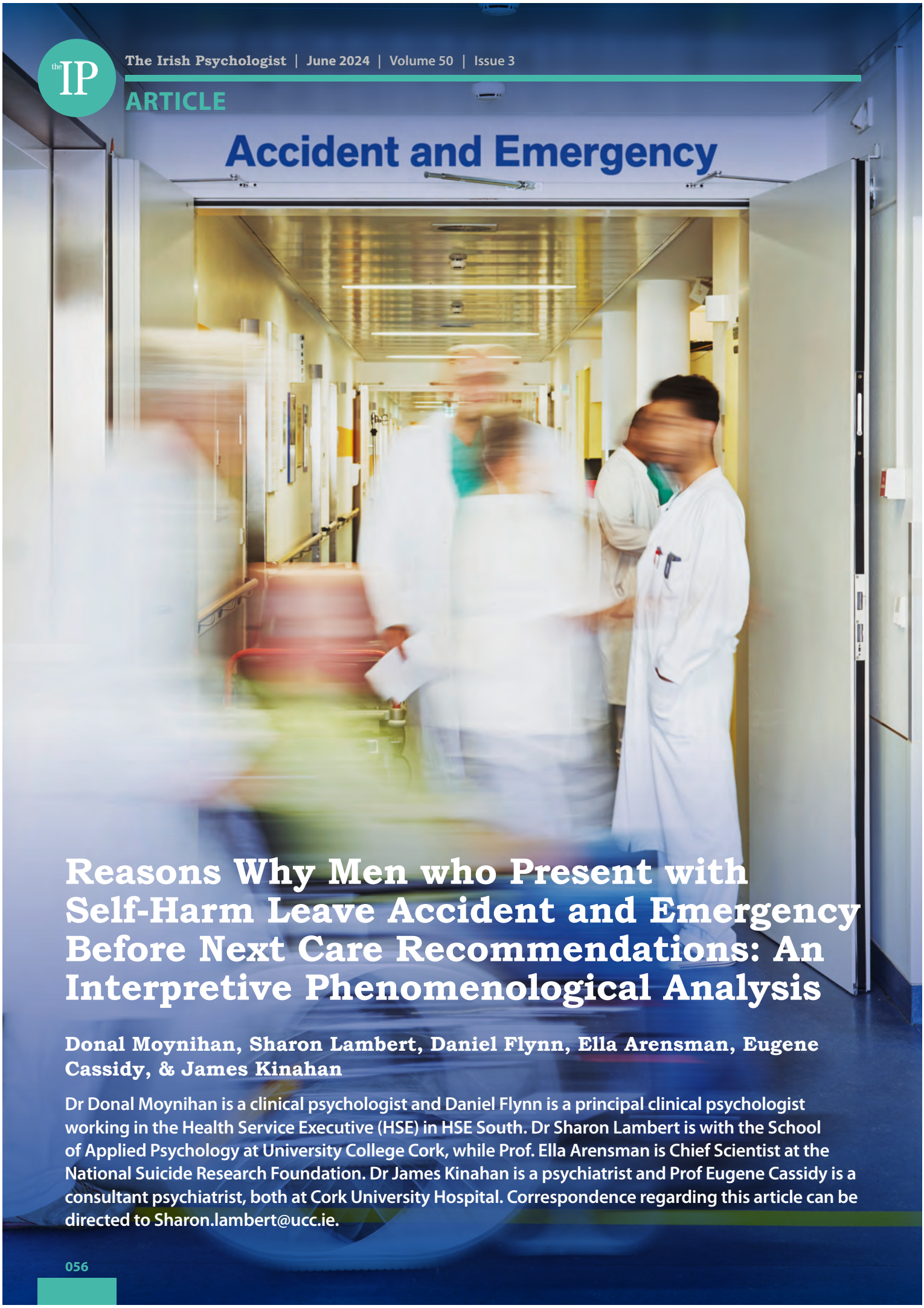
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ARTICLE



Reasons Why Men who Present with Self-Harm Leave Accident and Emergency Before Next Care Recommendations: An Interpretive Phenomenological Analysis

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Introduction

Self-harm is a major worldwide concern (Griffin et al., 2017), and research has demonstrated that 20-25% of individuals who die by suicide have engaged in an act of self-harm within the 12 months before their death (Bergen et al., 2010). Emergency departments (ED) are increasingly recognised as a significant location for the introduction of suicide and self-harm prevention measures (Boudreaux et al., 2013). In Ireland in 2019, the National Self-Harm Registry logged 12,465 presentations to hospital due to self-harm. The rate for males was 187 per 100,000, which is 5% higher than when economic recession hit in 2007. Cork city, where the current study was located, had the highest rate for males, 1.9 times higher than the national average (Joyce et al, 2020).

Guidance on clinical best practice (Isacsson & Rich, 2001; Royal College of Psychiatrists, 2004) recommend that psychosocial assessment in ED is a central component in the management and prevention of self-harm. The assessments are deemed to be of benefit on both a practical and therapeutic level. It may increase the likelihood of attending follow-up care (Barr et al., 2005) and the assessment itself can be therapeutic (Whitehead, 2002). In 2019, 72% of Irish patients received a psychosocial assessment after presenting to hospital, unchanged from the previous two years (Joyce et al., 2020).

Those who self-harm are a vulnerable client group who remain hidden for the most part, and an ED presentation is a significant occasion for engagement and deploying self-harm and suicide preventative measures (Hawton et al., 2002). However, despite national guidelines (College of Psychiatrists of Ireland, 2016) for the delivery of care to those who self-harm, challenges remain in optimising engagement with these patients. A significant proportion of those who attend ED with self-harm leave before the appropriate psychosocial assessment can be carried out and do not get next care recommendations (Arensman et al., 2018). Hickey et al. (2001) reported that these individuals are more likely to repeat an act of self-harm within 12 months and are also at a heightened risk of needing psychiatric interventions. Additionally, they are estimated to be three times more likely to engage in a repeat act of self-harm (Crowder et al., 2004). Several studies reported that psychosocial assessment may impact positively on attitudes to further help-seeking and thus reduce the impact of self-harm (Horrocks et al., 2005; Palmer et al., 2006). Failure to receive an assessment could be attributed to flaws in service design (Hughes et al., 1998). An Irish study (Arensman et al., 2018) reported that males aged between 25 and 44 years who presented after drug overdose or attempted drowning were at the greatest risk of leaving. They were inclined to attend ED at night-time, were more often city residents or people experiencing homelessness, and had previous episodes of self-harm. Males who leave before completing the psychosocial assessment are a group where there are gaps in our knowledge and warrants further research.

The aim of the current study is to explore the lived experience of males who self-harm and leave the ED before accessing a psychosocial assessment and receiving next care recommendations using interpretive phenomenological analysis (IPA). Insights into this process may offer potential opportunities for ED staff to engage differently with this client population.

Method

Participants

Eligible participants were males over 18 years of age who presented to ED in the study hospital following an act of self-harm and who left before next care recommendations. Service users were excluded if they could not be contacted on discharge or if they did not give consent to be further contacted by the researcher. There was a protocol in place to exclude participants if they were deemed to be significantly impacted by substances at the time of the interview, if they presented as severely emotionally dysregulated, or appeared to be in a dissociative or psychotic state. None of these issues arose.

Participants meeting inclusion criteria were identified by the suicide crisis assessment nurses and consultant psychiatrist in an urban teaching hospital in the south of Ireland by purposive sampling between May 2018 and January 2019. As part of routine clinical practice, individuals who leave ED before next care recommendations receive a follow-up phone call. As part of this phone call, the research project was explained, and individuals were asked for their consent to be contacted by the researcher. A letter of invitation, study information leaflet, and details of support services were sent, this was followed up via phone call. Those who wished to take part were scheduled for interview in a community psychology building. Overall, 12 people opted-in; four did not respond, one declined, and one person did not attend. In total, six Irish males aged 21 to 47 were interviewed following informed consent (Table 1). Pseudonyms have been used throughout to protect anonymity.

Table 1: *Participant demographics and method of self-harm*

Pseudonym	Age	Self-harm at presentation to ED	Previous self-harm	Living arrangements
Michael	21	Cutting	Multiple episodes	Lives with mother
Luke	46	Jumping from height	Multiple episodes	Lives alone
Maurice	22	Cutting	Multiple episodes	Lives with mother
Niall	44	Cutting	Multiple episodes	Lives alone
Terry	43	Attempted drowning	Multiple episodes	Homeless
Eoin	47	Overdose	Infrequently	Lives alone

Data Collection

Semi-structured interviews were carried out by the first author with six participants in the weeks following their presentation to the ED (average time to interview was three weeks). Smith et al. (2009) report that IPA is best carried out with a small homogenous sample. An interview schedule was developed in line with IPA guidance (Smith et al., 2009). Interviews were 50 minutes on average, with a range of 40 to 75 minutes. These were audio-recorded and transcribed verbatim and de-identified. Participants were offered an opportunity to receive the completed final write-up. Supervision was used to discuss observations, the process, and reactions after each interview, or to follow up on any immediate care needs for the participant.

Analysis

IPA (Smith & Osborn, 2008; Smith et al., 2009) was used to analyse the data. There is an emphasis on how individuals make meaning from their experience of a certain phenomenon. IPA recognises the impact of the researcher's orientation on the data collection process and final write-up (Smith et al., 2009). This idiographic method leads to a co-constructing of meaning between researcher and participant. IPA is favourable over more socially constructed methods such as discourse analysis (Gee, 2005), as it stays closer to individual's lived experience of the phenomenon. Conceptual, linguistic, and descriptive aspects of note were recorded in one margin and codes were developed in the other for each transcript. A line-by-line approach was utilised with multiple re-reads to increase familiarisation (Smith & Osborn, 2003). Themes were further examined to understand the connections between them, resulting in a set of superordinate themes. Notes were made where supporting extracts could be found within the data. This procedure was replicated for each transcript. Throughout this process there was constant referral to the original transcript to ensure the analysis was grounded in the data. Another researcher reviewed the themes for reliability and appropriate representation in the data.

Ethical Considerations

Important ethical considerations in this study included verifying informed consent, contacting participants in a non-coercive manner, ensuring confidentiality, and managing possible emotional distress at the time of interview. Ethical approval was sought and granted by the host institution. All participants were given an information sheet and a consent form. A risk management plan was in place for instances of participants presenting in crisis. Participants were fully debriefed after interview. A leaflet containing contact details of relevant support and treatment services was provided.

Results

Complete analysis of the data produced five superordinate themes: *Safety and other service users; Waiting in the shadows; A compounding of distress; Expectations from experience; and Client-clinician relationships.* These comprised of a further 11 subthemes (see Table 2).

Table 2: *Superordinate themes and subthemes*

Superordinate Themes	Subtheme
Safety and other service users	Putting others at risk
	Feeling exposed
	An element of fear
A compounding of distress	Like mental health is not an issue
	A monkey in a cage
Waiting in the shadows	A shadow in the background
	Risky thoughts: they'd eat you up
Expectations from experience	Inpatient; Not going down that road again
	ER; Knowing the procedure
Client-clinician relationships	Uncertainty without shared information
	A questionable questioning style

Safety and other service users

Other people in the waiting room had a range of effects on participants. Some were fearful of those waiting and what they might do to the participant, already feeling vulnerable. Others were worried for the other patrons of the hospital and how they might experience the participant's distressed behaviours. Shame was frequently the underlying emotion. This extract demonstrates the fears that Maurice had about becoming aggressive and lashing out at other service users ***(Putting others at risk):***

"I didn't feel one bit safe, do you know what I mean? I'm around these people and I could do anything… ED really should have a separate part for someone like myself. They didn't even ask if I felt like harming anyone else…When I was in that frame of mind, I could have felt like harming someone. If someone came in front of me, I probably would have hit them or something. And they were putting me next to old people and stuff, like. I was saying to myself 'if I blank out here now, there's an old man sitting next to me, and I could attack your man like" (Maurice).

Maurice experienced an unpredictability of the self that was exacerbated by not feeling safe in the ER. Self-preservation makes sense when feeling threatened. Maurice experienced these thoughts as almost intrusive in his heightened state of fear and. Similarly, to Stephen, he sees himself as separate and different from the others waiting. *'Someone like (himself)'* who was dangerous, volatile, and unpredictable which is in stark contrast to the elderly man. If he were to *'blank out'* it may indicate that he was not responsible for his own actions. He was a man presenting as hypervigilant of his own internal process due to heightened levels of emotional distress.

The theme of ***Putting others at risk*** highlights a fear of being unable to manage and consequent impact on others. There is a clear separation of self and others; it could be argued that this 'othering' is exacerbated by the stigma of mental illness. This links with the theme ***Feeling Exposed*** when seeing other Service users. Niall spoke about feeling exposed and on show *'sitting in the middle of the waiting room'* and the shame that this engendered:

"If someone needs to go in after cutting their arms,, it's not nice to be sitting in a waiting room with blood coming out of your hands and especially if there are young children sitting there, 'cause it would make the person themselves, they're already feeling like shit anyway, but I think that can make them feel that bit worse if your hand is open and there's bandages around it and children around the area, like do you know? It would make the patient themselves a bit more comfortable I think, not even a room like, I know that's not possible, but something that you could even pull a curtain across. Not to have them sitting in the middle of waiting room like, where young kids are looking…the embarrassment, and it wouldn't be just the kids either like. Just the embarrassment of it like. The last thing you need is someone looking at you" (Niall).

Niall struggled with identifying as the person who was sitting in the waiting room after cutting his arm. He moved from *'someone'* to *'I'*, but then reverted to using *'they'* and *'the person'*. He created a strong, visceral image of the blood coming out of his 'open' hands where he was both literally and figuratively exposed. This was in distinct contrast to the innocence of children. He reached out for empathy and validation by trying to engage the listener with *'like do you know?'* A compromise of his basic privacy using a *'curtain'* would have been sufficient for him. The repetition of *'embarrassment'* and the mentioning of children emphasises the shame he experienced after an already traumatic incident.

The analysis also captured ***An element of fear.*** In the busy environment, the autonomic stress system is activated, and Stephen must consider the options of whether to stay and to protect himself against the 'loads of people' or leave and reduce that risk. 'Next move' suggests the constructed moves of an elite fighter, depicting the hospital waiting room as like a war zone. Eoin describes another element of the fight or flight response, freeze:

"You're afraid of your life. Afraid to look left and right. You could see people talking over there and think they're talking about you. A fella might look at you for a few seconds and you're thinking, what the fuck is he looking at me for? What am I after doing to him? The paranoia comes in, the fear comes in. Anxiety comes in. Worry" (Eoin).

A compounding of distress

This theme describes the impact that the interpersonal style of hospital security had on their experience, with individuals feeling ***Like mental health is not an issue***. Body language and other nonverbals were enough to make some feel unwelcome at ER. Terry describes the *'pure arrogant security fuckers'* that he was monitored by. It presents an image of an *us versus them* atmosphere where one party was superior to the other. The use of the expletive is an effort to level the playing field:

"Am just pure arrogant security fuckers looking at you like you're a piece of shit like mental health is not an issue, the kind of 'would you not fucking cop on? There are people here who are having heart attacks and fucking strokes, and you want to fucking kill yourself! Don't be annoying us, we've fucking better things to be doing' you can see it in their faces like" (Terry)

The simile conveys the sense of worthlessness he experienced while being stripped of dignity with a judging look. He was under the impression that his concerns and difficulties were not valid, and that ED was not the place for him. It was as if the societal stigma was brought to life for him in a very tangible way. physical health difficulties were seen to be severe acute illnesses that are life threatening, and mental health presentations of self-harm and suicidality, were perceived to be illegitimate in the eyes of the those whose job it is to monitor security. The mental health difficulties could even be alleviated if they decided to *'cop on'*. All of this is interpreted from facial expressions; individuals in such high distress are very vulnerable to misinterpretations.

Being under observation by security while waiting for clinical input left some feeling imprisoned, like ***A monkey in a cage:***

"He was sitting in a chair, outside the room and how was I going to fall asleep? How was I going to relax? I was like a monkey in a cage. He sitting down in an armchair looking in at me. All I needed was someone to talk to. Like the ambulance driver did or the guards did. Do you know what I mean?" (Stephen).

Stephen found it difficult to remain calm and relaxed enough to fall asleep. The use of rhetorical questions demonstrates the answers were obvious. The metaphor brings to mind an animal on show in the zoo with people looking for their amusement. Monkeys in a cage are generally chaotic, loud and are often attempting to get out. Like other participants, he felt dehumanised by his treatment. In contrast to his agitated state, the security guard in an *'armchair'* seemed more comfortable and at ease. Stephen went on to describe the impact that observation and isolation had on him:

"You feel guilty enough about being in the situation in the first place, but you feel fucking ten times worse then and then you come in and you try to come back to normality if you can and you're put in this fucking place. Locked up. What the fuck is this about like? I'm being really…I felt like I was being…like it was a cry for help or whatever and then I felt like I was being fucking punished there" (Stephen).

Waiting in the shadows

A common experience for participants was to feel like they were not acknowledged. This lack of connection meant that some were vulnerable to further risky thoughts. The simile Maurice uses, conjures up images of something scary creeping around, ***A shadow in the background*** that is unworthy of care: '

You're only like a shadow in the background. They're just walking past you. Get up and walk out. They're not even making eye contact with you.' (Maurice).

Their shadow form would have no substance to them and be two dimensional in nature allowing them to blur in. Shadows tend to frighten people and it is the uncertainty of what might be lurking that can be unsettling. Perhaps Maurice is unsure of what form he takes, as

just like the shape shifting structure of a shadow, his volatile moods are ever changing and do not allow for a concrete sense of self. The lack of eye contact confirms his shadow like feelings by not being afforded basic courtesy. He knows that it is the very least he should be getting in terms of care If they were to *'even'* share a glance it might reaffirm his dignity.

Another participant shared this view on the need for someone to talk to:

"When a person is suicidal, right, they need to talk to someone. That's why Samaritans and all these crowds are there. They need to talk. Not to be isolated. Not to be isolated. You feel guilty enough after what's happened, right, everyone after knowing, but then you feel you're being punished more" (Stephen).

Stephen acknowledges the need to talk to someone, but then emotionally distances himself from the *'suicidal thoughts'* with the use of *'a person'* and *'they'*. The repetition of *'isolation'* brings it slightly closer to him with the impact of such seclusion. He recognises the *'need'* to talk through his difficulties and does not present this as simply a preference. However, the guilt he feels for harming himself is compounded by the experience of isolation.

Michael spoke about how a type of connection kept him from leaving the ED sooner:

"All the nurses that were like trying to keep me there had left at that point, so it had been early in the morning, and I'd been waiting so long. I was just saying to myself 'this is so awful', so I just left. I just walked out because anyone that was paying attention to me had left at that point because they were going home or something, but no one else even knew who I was" (Michael).

He built a link with the nursing staff while waiting, but then lost the connection and experienced it as quite distressing. This was made worse by the fact he had already been waiting for a significant period. By the nurses *'paying attention'* to him, he perceived himself to be *seen*, which is an important element in trauma informed care. It may be that the nursing staff understood him and helped him to *know* himself in some way. He felt contained when held in mind by the nurses and this changed when that connection was broken due to the changeover of staff.

Many of the participants spoke about how that lack of connection left them vulnerable to similar thoughts and behaviours that brought them to ED initially, captured as ***Risky thoughts: they'd eat you up.*** Maurice felt out of place and didn't know what to do while waiting and sat there *'twiddling'* his thumbs:

I was sitting there twiddling my thumbs... I stood there at one point banging my head off the wall hoping they'd come over to me. One nurse seen me. They kept walking past me and when I went in first, they were like 'you're next to be seen to see the psychiatrist' and then 4 hours later I was still sitting there. Then all those crazy thoughts came back, and I felt really anxious. Like 'what are they doing? They're not going to help you. Just leave. Go away and do it again' So then I left. (Maurice)

Banging his head off the wall is another externalisation of him looking for help. It displays the desperation he was feeling and demonstrates that he did have the language to engage staff effectively. The nurses walking past him when he expected to be seen, left him feeling invisible. By saying that the *'crazy thoughts came back'* it implies that he returned to the state of distress that he was in before attending. Maurice was suspicious and hopeless and believed the only alternative to sitting with intense anxiety was to leave and self-harm again.

Expectations from Experience

This theme captures the impact that previous attendances at ED and inpatient admissions had on the participant's decision to leave. They were keen to avoid repeating the past. Niall spoke of his journey of recovery and the theme ***Inpatient; Not going down that road again*** captures how he saw inpatient psychiatry as impeding his wellbeing and was keen to avoid it if possible:

*"I didn't want to go down that road again, like. I was down that road before with psychiatry you know. And I didn't like the way I felt when I was on tablets and that, so I made my choice that I was going to contact *local counselling service and that's how they came into it"* (Niall).

By being *'down that road before'* could it mean that he had to work to come back from it and recover from the *recovery system?* The repetition of *'down'* emphasises how he felt on that journey. He decided to leave the ED as he considered being on medication worse than experiencing the actual mental health symptoms.

Terry described what it was like for him when he was medicated and staying on the ward: *"I knew I wasn't going to kill myself, so I thought why am I hanging around now. They'll put me in a ward again, I'll be walking around like a fucking zombie"*. He felt that his basic safety was in check and perhaps saw ED as purely a life saving measure that could not offer more support other than admission to an inpatient ward Maybe the ED served the function he was looking for and therefore he left. He creates a strong image of being like the walking dead while on medication; there in body, able to walk around, but with no quality of life, purpose or meaning. It is evocative of rotting away slowly, while being stripped of humanity, and left as physical matter. It could be useful to provide some education as to the alternatives, given the perception he has of being turned into a monster on the ward.

As part of the theme, ***ER; knowing the procedure***, others detailed past experiences they had in ED itself and the impact that these had on their decision to leave. For one repeat attender there was a lot of embarrassment associated with looking for care:

"Here we go again. Doing doctor's thinking, doing nurse's thinking. I suppose I was thinking like, 'fuck it, they're sick of me'. I was doing their thinking like. I'd even be looking at nurses inside and I'd be hiding from them because I'm here again. It's like a merry go round, like a rollercoaster I was on" (Eoin).

The ED was all too familiar to Eoin, and he felt exasperated by it starting *'again'*. By *'doing'* the clinician's thinking it sounded like something automatic that he had little control over, however, he then takes ownership over thoughts with some hesitation. He recognised that he felt like a burden and assumed the staff believed the same. This led to shame related behaviour by *'hiding from them'* and getting caught in the cycle. It escalated from the gentle *'merry go round'* to the more severe twists and turns of a *'rollercoaster'*.

Stephen explained how fear from a previous presentation at the ED dominated his experience and caused him to be confronted with more distress on arrival:

"I know the procedure. They're going to put me in here and when I go in that door the security will be there. Boxed in. I was getting more agitated. I was getting worse actually…I was thinking, and I was thinking, and I was thinking. The secretary came out and said, 'she'll be down shortly'. And I said I went away home, I knew the procedure" (Stephen).

He prompts a claustrophobic image of being 'boxed in' and watched by security as if he had been arrested. He emphasises how much worse he was getting with the use of repetition and reveals that he took time to decide to leave *'I was thinking, and I was thinking, and I was thinking'.* He made up his mind that he'd seen enough of ED before and could not face being *'boxed in'* again.

Client-clinician relationships

Many participants mentioned difficulties they had with not receiving clear information, captured as ***Uncertainty without clear information.*** This led to confusion and uncertainty and did not foster an atmosphere of physical or emotional safety:

"I know they're busy and things, but it would only take two minutes to come over and even if it was every five minutes and say 'oh, someone else came in that's in a worse condition than you we have to deal with them'. That'd be fair enough like, but when I came in first, she told me I was next to be seen…maybe not even a separate room, but not leave a fella sitting in the corner. I went in and was told I was next so was thinking maybe 20 minutes, half an hour but none of that. I'd have said 'ya, no problem', if she actually told me I'd be waiting" (Maurice).

Maurice recognises the need for prioritising different emergencies, but still would like regular updates. Like other participants, being left *'sitting in the corner'* was more of an issue than the wait itself. It is suggestive of being put out of the way, forgotten about, or even punished.

Terry also would have preferred clearer information to help him feel safe:

"I fully understand that it's procedural and that they're busy and they need to get the information from to make you better and follow the next steps, but at the end of the day it's you that's lying there not knowing if you tried to commit suicide last night….just a few bits of information saying look you're ok now but we're going to have the psychiatrist have a look at you because you mentioned a few things about wanting to die. That would have kept me in [ED] on Christmas day. She was looking at me and I don't know, I was just after waking up (laughs), so I unhooked and ran" (Terry).

He realises that the staff have follow certain steps but would like if there was more recognition of the vulnerable position of the client after seriously harming themselves. There is inherent helplessness in lying down with people looking over you, and this would be exacerbated when you wake up in a hospital setting without knowing how you got there. An explanation of what is coming when they *'follow the next steps'* is important instead of assuming the individual knows. Clear communication would remove the possibility of *mind reading* and may facilitate a shared narrative of events.

When the participants were seen, some had concerns around how the clinicians gathered information, evident in the theme ***A questionable questioning style***. Terry described being treated like the suspect of a crime where the only goal of the interaction was to obtain information, to the detriment of building a relationship:

"Questioned very fucking procedurally and clinically. 'How are you feeling? Are you going to kill yourself tonight? Are you going to attempt suicide? We need to take your belt, we need to take your shoes. They question you like you're in a Garda [police] station" (Terry).

The expletive is used to express disapproval of such a perceived forceful questioning style. Risk management was a top priority for the clinician; however, little regard was given to the individual when he was stripped of his dignity by removing some of his clothes. He goes on to describe an alternative approach to the interview:

"so you have suicidal thoughts, yes. Why didn't you commit suicide?' and you kinda go, your first thought is 'fucking hell, I can't even get that right! (laughs)' I can see why they ask like… but it's compounding how useless you are and why would you want to be alive…so why didn't you kill yourself could be rephrased to why have you presented yourself here today and sought help instead of why didn't it fucking work for you (laughs)" (Terry).

Terry uses humour to deflect from the shame of feeling incompetent. He suggests that when the question is phrased negatively, it is more difficult to propose protective factors. '. This extract highlights the risk management nature of the work in crises and how a more therapeutic response can be forgotten about when under pressure and wanting to keep people alive.

In comparison to the direct questioning style, comes to focus purely on the physical injury and neglecting to treat the person as a whole:

"She wasn't even talking to me. She just cleaned them really., if she just had a small chat like that would have been, would have made it a bit less… if she just said 'oh, how are you?' small chat, you know" (Maurice).

Short pieces of conversation or general niceties when interacting with someone would put them at ease. Maurice could not find the word for how it made him feel *('would have made it a bit less…')* but he knows that he wanted something different. It may have helped him to see himself as a person separate to the wounds he was presenting with.

Michael had two contrasting styles of clinician interaction and was able to reflect on which one put him more at ease. He could get a feeling for when a clinician was genuinely engaged or just following procedure by asking 'generic questions':

"some were talking to me directly and trying to understand me, but others were asking me really generic questions that I just didn't want to answer. …just talking to me like a human being" (Michael).

The generic questions deindividualize the interaction to the person and give them the impression that the clinician is just gathering information instead of trying to 'understand'. It may feel like more of a tick the box exercise, devoid of empathy. This is contrasted with the genuineness and congruence in the other interaction where he was not being treated as a symptom of self-harm that needs to be measured, but as a 'human being' with emotions and fears. A reciprocal collaborative conversation instead of one-way questioning.

Discussion

While there has been much research on the experience of care at the ED for self-harm and some limited quantitative research examining the profile of those who leave before next care recommendations can be made, to the authors' knowledge this is the first study exploring the reasons for such self-discharge. The themes that emerged from the interviews demonstrate that there are a variety of reasons for leaving the ED without receiving next care recommendations. A combination of internal and external barriers prevented the men from staying in line with medical advice. Internal barriers included negative emotions such as fear, shame, and guilt, and the associated cognitive and behavioural processes that accompany such emotions. The aspects external to the person that lead them to leave early included the impact of other patients in the waiting room, the presence of security staff, and the style of interaction employed by the clinicians.

Our sample was representative of this population and in line with Arensman et al. (2018) study. The impact of alcohol and drug use on early self-discharge was also considered to be central in the process (Horrocks et al., 2005). While alcohol was present for some of the participants in this study, there were numerous other reasons cited for leaving. It is interesting to note that previous studies sought to explain the self-discharge with factors related to the patient and almost never with factors related to the service. The current study reveals a more complex interplay of person and the environment.

In relation to the superordinate theme of *Safety and other service users*, Cerel et al. (2006), and Owens et al. (2016) reported that other individuals in the waiting room negatively impacted on shame and guilt. There was a perceived divide between those that were there for self-harm and those with physical illnesses. lack of privacy compounding anxiety and shame has been reported in previous studies also (Horrocks et al., 2005; Suominen et al., 2004). However, fear of other service users and concern for them did not arise in previous literature Exposure to threat has long been understood to stimulate sympathetic hyperarousal and parasympathetic hypoarousal in the autonomic nervous system (LeDoux, 2002; Ogden et al., 2006; Van der Kolk, 1996). Therefore, threatening, and traumatic incidents can produce a wide range of physiological, emotional, and cognitive symptoms. With such dysregulation, individuals struggle to tolerate it without becoming overwhelmed (Ogden et al., 2006). In the current study, for many the decision to leave can be understood to be part of this process, as well as the continuing urges to self-harm. This overwhelm can lead to inhibition of cortical activity (LeDoux, 2002) associated with disinhibition and lack of impulse control.

For most of the participants there did not seem to be a consideration of what supports may be needed once they left ER. One participant also suggested to have volunteers, like The Samaritans, available in the ER. Service providers need to consider how we can offer instrumental support to those in emotional crisis to assist them in regulating emotion so they can access onward care. Trauma informed care (SAMHSA; 2014) is another perspective that could be used to foster safety and trustworthiness ER. A trauma informed service accommodates such dysregulation and views people as presenting with adaptive responses as opposed to 'challenging behaviour'. This facilitates environments of compassionate care and reduces stigma and bias (Huckshorn & LeBel, 2013). Almost all the participants who described both internal and external barriers to staying in the ED described experiences that were the opposite to the principles espoused by trauma informed care.

A lack of connection and a sense of isolation following presentations for self-harm has been a reported experience for many (Cerel et al., 2006; Horrocks et al., 2005). This disconnect served to increase emotional dysregulation and at times left the service user with urges to leave the ED. Perhaps the population who leave are those that cannot tolerate the isolation. Hunter et al. (2013) and Owens et al. (2016) described how regular check-ins by staff allowed individuals to believe they are worthy of care and created a positive experience of care (Palmer et al., 2006). Participants in this study also detailed how brief check-ins by staff would be beneficial. Although, this was often lacking and left them vulnerable to similarly risky urges that made their visit a necessity in the first place. Participants described how they took it into their own hands by leaving when they did not feel safe.

Previous experiences at the ED having an impact has been reported in previous research (e.g., MacDonald et al, 2020; Owens et al., 2016). However, there appears to be a significant finding in the current study, given that participants described the influence of negative inpatient admissions on their decision to leave. It would be interesting to examine the rates of previous inpatient admissions for a larger sample of this population. Participants in other studies have commented on a lack of control and a sense of being punished whilst being an inpatient for self-harm (Brophy, 2006). Similar to the participant who believed there to be little therapeutic input as an inpatient others held the same view that they did not get the opportunity to engage in therapy for self-harm on the ward (Rolfe, 2002). Psychoeducation on the other possible interventions for self-harm may be beneficial to Service users who may assume that an inpatient admission is always the next step.

Similar to findings on general experiences of care for self-harm at the ED (Hunter et al., 2013; Owens et al., 2016), the participants in this study described how their interactions with staff were often unsatisfactory due to a lack of clear shared information. It often led to confusion and uncertainty about what was going to happen next. In contrast to this style of interaction, participants in the current study reported that regular updates about wait times would have helped to decrease the anxiety brought about by uncertainty and facilitated them to stay. A systematic review (Rees et al., 2014) of the literature on ED staff's attitudes towards those who present with self-harm concluded that they held negative perceptions, and this was attributed to insufficient training and knowledge of how to manage their psychological needs. In addition, Arensman et al. (2020) are engaged in the implementation and evaluation of a training programme, entitled *Self-harm Assessment and Management Programme for General Hospitals in Ireland* (SAMAGH). SAMAGH aims to reduce hospital-based self-harm repetition rates and increase rates of mental health assessments being conducted with self-harm patients.

Limitations

As IPA is an interpretive process, it was important to maintain an audit trail of the analysis for transparency and validity (Yardley, 2000). knowledge developed through this study is not presented as absolute truth, rather an interpretation of the experiences of

the participants, using a recognised framework. The data relied on participants' recall of interactions and memory and perception can be faulty and are inevitably influenced by the passage of time. While there were recruitment difficulties in this hard-to-reach population, the homogenous sample allows for the findings to be theoretically generalised within this population (Smith et al., 2009).

Future Research and Clinical Implications

The feasibility of ED trauma informed service provision should be explored. Similar projects have been conducted in other settings (e.g. Barton et al., 2009). Under the current system, it would be beneficial to explore the perception of ED staff of those that leave and to examine if there are shared areas of misunderstanding. In a similar vein, exploring the views of females who leave before recommendations can be made would add further insight into this phenomenon. On a more practical level, implementing an initiative where voluntary services are given a small space near the waiting room to facilitate supportive listening may prove helpful in encouraging people to wait. Future re-design of the ED physical environment should allow for a move away from a common waiting room area following triage to designated treatment spaces. Giving choice regarding privacy and allowing the individual to decide if they want to wait in the general waiting room or in a more secluded area also seemed to be important for participants and may be something to consider in the future.

Conclusion

There are a significant number of men who self-harm that leave the ED every year before they can receive next care recommendations. It is impossible to stop every one of these, but there are certainly steps that can be taken to reduce the occurrence. Educating clinical and non-clinical staff on the reasons why emotionally distressed men struggle to wait in accident and emergency and trauma informed responses can increase awareness of the issues involved and changes to service delivery could help mitigate the current high levels of disengagement.

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