THE UNIVERSITY OF HULL

An Exploration of Families' Experiences of Young People's Self-Harm

being a Thesis submitted in partial fulfilment
of the requirements for the degree of Doctor of Clinical Psychology

in the University of Hull

by

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July 2021

Acknowledgements

Firstly, thank you to each of the participants who took part in the study. Thank you for taking the time to share your stories and for being so honest and open regarding your experiences. It was a privilege to be able to meet you all and listen to your stories first-hand. Like you, I hope that the sharing of your stories and experiences will be able to help many others.

I would also like to thank Dr Charlotte Cosquer and Andy Stephenson for their support with the development of the initial idea for the research. Further thanks to Charlotte for all your support with recruitment. It was not an easy or straightforward process, and the research would not have been possible without you.

To my research supervisors, Annette and Paul. Thank you for sharing with me your knowledge and wisdom alongside providing support and continued enthusiasm for the research. You have encouraged me to celebrate each movement forward no matter how big or small and I will continue to carry this teaching with me.

A big thank you to all my friends, family and fellow trainees for your compassion and support always. Particular thanks are given to my brother, Keir, and my closest friend, Alice, for always having the right words to say and helping me to find a smile even in times of stress.

Finally, thank you to my Mam and Dad. There are not enough words to express my gratitude to you both. Thank you for your never-ending understanding, support and love. Thank you for always believing in me even when I struggled to believe in myself.

Overview

This portfolio thesis consists of three parts. Part one is a systematic literature review and part two is an empirical paper. Taken together they provide a greater understanding of the experiences of young people's self-harm amongst parents and families. Part three forms the appendices.

Part One: A systematic literature review of parents' experiences and understandings of self-harm amongst young people in the United Kingdom. The review identified ten articles and completed a narrative synthesis, which identified six themes. The review demonstrated the impact of self-harm on parents and the potential influence of parents in supporting their child with self-harm. It emphasised the importance of thinking and working systemically with self-harm and highlighted the need to challenge negative societal discourses regarding self-harm.

Part Two: An empirical study exploring family experiences of adolescent self-harm within the context of having received a systemic family intervention. Four families (n = 8) completed non-directive interviews that were analysed using narrative analysis. The study found that significant life events precipitate self-harm, which is a significant cause of stress and difficulty amongst families. Different experiences of help-seeking were reported, but all families experienced a turning point associated with receiving a systemic family intervention and with changes within the family's wider context. Implications of the research and areas for future research are discussed.

Part Three: Appendices relating to the systematic literature review and empirical paper, including all relevant documentation, a reflective statement and an epistemological statement.

Total word count (including tables, figures, references and appendices): 32,825

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Part One: Systematic Literature Review

A Systematic Literature Review of Parents' Experiences and Understandings of Self-Harm Amongst Young People in the United Kingdom

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This paper is written in the format ready for submission to the journal

Journal of Family Studies

Please see Appendix A for submission guidelines

Word Count (including tables, figures and references): 8250

Abstract

Self-harm is a growing public health concern for young people. Previous research has implicated parents as being important to understanding young people's experiences of self-harm and access to support and treatment for mental health difficulties. This review aims to provide an up-to-date, systematic review of parents' experiences and understandings of self-harm amongst young people in the United Kingdom. A systematic search of the literature was conducted and ten articles met inclusion criteria. Narrative synthesis was used to synthesise the data. The synthesis indicated six themes that were interconnected and held different relationships with parents, young people, and self-harm. The six themes included: Discovering self-harm; Understanding self-harm; Longer-term emotional and psychological effects of self-harm; Effects on parents' behaviour and parents' responses to self-harm; Help-seeking; and Experiences of support and treatment. This review demonstrates the impact of self-harm on parents and the potential influence of parents in supporting their child with self-harm. The review highlights the importance of thinking and working systemically with families where self-harm is present. It also emphasises the negative impact societal discourses has regarding self-harm and the need for wider societal change to support young people.

Keywords: systematic literature review, self-harm, young people, parents

Introduction

There is no universally agreed upon definition for self-harm. However, the following definition of self-harm has been used within research and aligns with the definitions utilised by the studies included within this review: “Any form of non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, jumping from a height and running into traffic), regardless of the motivation of the degree of intention to die. This definition includes what in the USA would be described as non-suicidal self-injury (NSSI) and suicidal behaviour (Swannell et al., 2014)” (Cottrell et al., 2018, page one).

The definition has also been identified as being in line with United Kingdom (UK) clinical practice (Cottrell et al., 2018). Within the UK, self-harm support and interventions are predominantly delivered via Mental Health services. This suggests that self-harm is commonly conceptualised within UK practice as a mental health difficulty or is associated with a mental health difficulty. This review will adopt the same position to conceptualise self-harm.

Self-harm has become a growing public health concern for young people aged 10-24 years (World Health Organisation, 2021) as it can continue into adulthood and/or become a life-threatening behaviour (Bailey et al., 2017). It is difficult to ascertain definitive prevalence rates of self-harm because it is often unreported and fewer than one in five young people in the UK who self-harm seeks psychological help (Stallard et al., 2013). In addition, prevalence data relies on self-disclosure and young people have described a reluctance or inability to disclose self-harm reinforced by stigma (Klineberg et al., 2013).

Due to a lack of prevalence rates and the growing concern associated with self-harm, research has focussed on subjective experiences of self-harm amongst young people to develop understanding (e.g., Stänicke et al., 2018). Although this research is important for understanding the perspective of young people who self-harm and adapting individual support, it does not consider the wider systemic perspective and the interaction and effects of the systems that often surround a young person and their self-harm.

Families are often the key system in young people's lives. Research that has considered self-harm, young people and their family has predominantly focussed on the identification of risk and protective factors to the development of self-harm (Rubenstein et al., 1998; Borowsky et al., 2001; Ackard et al., 2006; Hawton & Fortune, 2008). These factors typically focus on the parent-child relationship and the family context, suggesting that this is important in understanding the development of self-harm amongst young people and it can influence the relationship between a young person and self-harm. Additional research has highlighted that adolescents report that their family, alongside friends and school, are the main source of support in preventing self-harm (Fortune et al., 2008). This supports the need to adopt a systemic perspective of self-harm.

As research has implicated the parent-child relationship, it seems important to further consider the role and experiences of parents with young people who self-harm. Previous research has explored parents' experiences when their child has other mental health difficulties and has suggested that this can be a significant source of stress for parents and negatively impact their well-being (Sloan et al., 2020). Furthermore, parents are influential in accessing mental healthcare for young people and are noted to be the first person to seek professional help (Boulter & Rickwood, 2013). Therefore, parental experiences could be

significant, and they could impact the experience of the young person, self-harm, and access to support. It seems crucial to understand this in the context of few young people seeking psychological help (Stallard et al., 2013).

Some research has begun to explore the role of parents in relation to young people's self-harm. Arbuthnott and Lewis (2015) synthesised the literature examining parents of young people who self-harm. Young people's self-harm may exacerbate typical parenting challenges, negatively affect parental mental health and wellbeing, and affect family dynamics. Parents of young people who self-harm need accurate information about self-harm, peer support, parenting resources and opportunities for self-care. However, this review was undertaken over five years ago and included samples from different countries. Scoping searches indicated that further literature has been published since then.

Therefore, it seems important to complete an up-to-date review explicitly focussed on parents in the UK. The current literature review aims to explore the experiences and understandings of young people's self-harm amongst parents in the UK. This review aims to expand upon previous research exploring experiences and understandings of self-harm from the perspective of the young person and previous research focusing on parental experiences of their child's mental health difficulties (i.e., not specific to self-harm). The review findings will help to develop understanding of the relationship between young people, self-harm, and parents. This has important clinical and service implications for support and treatment.

Method

Search Strategy

A systematic literature search, up to and including November 2020, was conducted using five electronic databases: APA PsycInfo, APA PsycArticles, MEDLINE, CINAHL Complete and Academic Search Premier. A range of databases were selected to increase the likelihood of finding all relevant literature.

Search Terms

An initial scoping search helped to identify key search terms and synonyms were also considered. The search terms were reviewed by a third party experienced in conducting systematic literature reviews. The search terms were as follows:

Parent* OR guardian* OR caregiver*

AND

Adolescen* OR child* OR youth* OR teen* OR "young person* OR "young adult*" OR juvenile*

AND

"Self harm" OR "self-harm" OR "self injur*" OR "self-injur*" OR self mutilat* OR self-mutilat* OR "self inflicted" OR "self-inflicted"

AND

Experience* OR understand* OR impact* OR attitude* OR belief* OR perception* OR thought* OR view*

Two search limiters were applied so that articles were from academic journals and were written in English. Firstly, this was to ensure the articles were of a higher quality and had

been peer reviewed. Secondly, the English language filter was selected for practical reasons, but because the systematic review focussed on UK-based samples this will not have significantly impacted the search findings.

Study Screening and Selection Strategy

All articles retrieved from the first search were screened by their title to assess their relevance. If relevance could not be ascertained from the title, then abstracts, or in some cases the full article, were reviewed. Articles identified following initial screening of title and abstract were then reviewed with the inclusion criteria applied. The inclusion criteria are outlined in Table 1 below.

Table 1

Inclusion Criteria for Articles to be Included in the Review

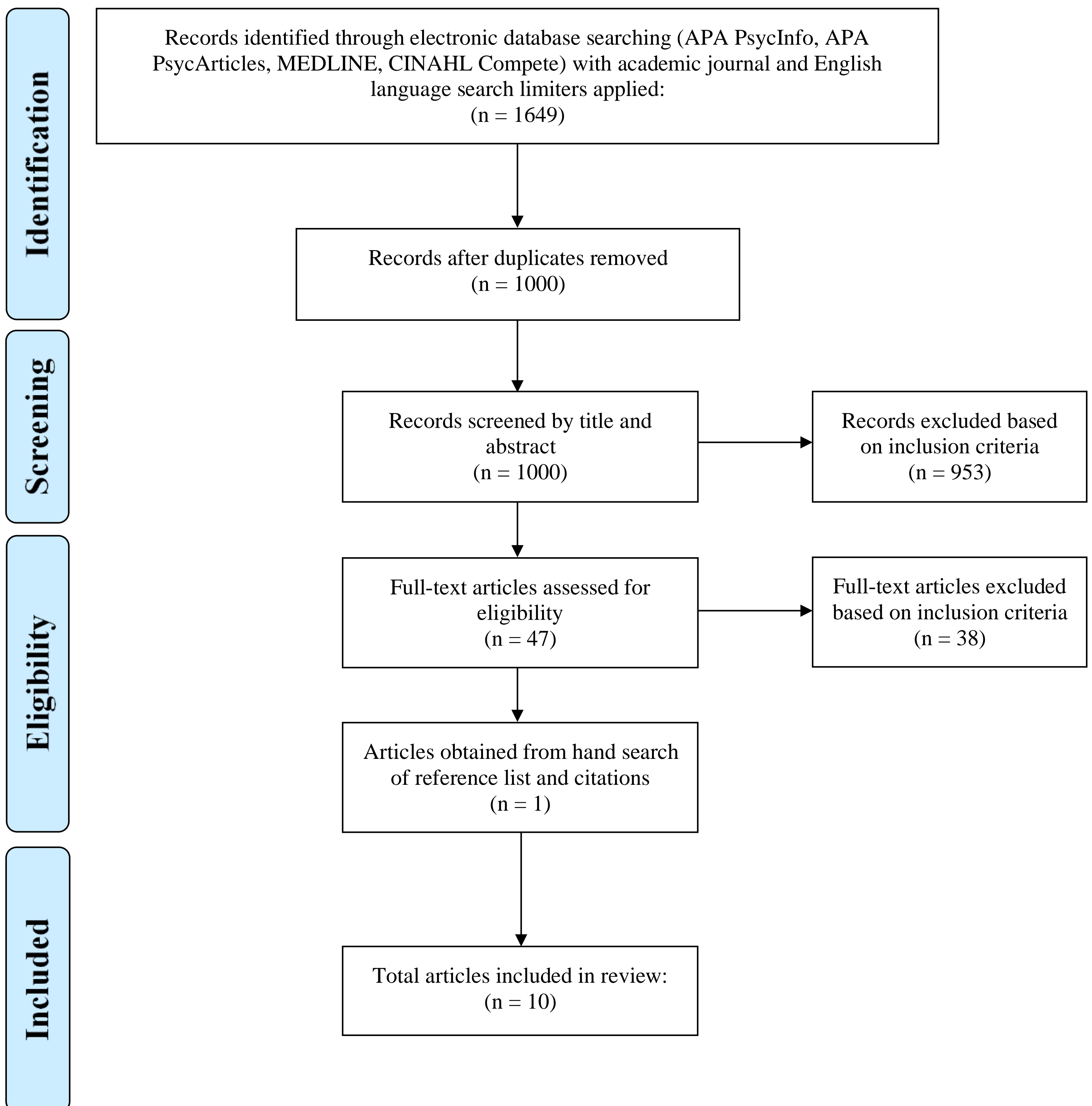
Inclusion criteria	Rationale
Published in an academic journal	To ensure articles had sufficient scientific rigour.
Study recruited parents of young people and data is provided by the parents	To ensure articles focussed on the parents' experiences and understanding and not those of the young person or other family members and to ensure that recruited participants were parents of the targeted age population (i.e., young people aged 10-24 years old).
Study does not include parents who have a child with another diagnosis that is not related to mental health (for example, Intellectual Disability)	Parents of children with different diagnoses may have different understandings of their child's self-harm behaviour because they understand this within the context of their child's diagnosis.
Study used a UK-based sample	To ensure articles were relevant to the research question and the location of the research.

After initial screening, full text articles were accessed and further reviewed with the inclusion criteria applied. 38 papers were excluded at this stage. A hand search of reference lists of all included papers and a citation search (whereby papers that had cited the including paper were screened) were completed. The same inclusion criteria were applied to papers identified

through these searches and one additional paper was included. Figure 1 demonstrates a summary of the screening and selection process.

Figure 1

PRISMA Flow Diagram Demonstrating a Summary of the Article Screening and Selection Process



Data Extraction and Quality Assessment

After article selection, key data were extracted from each article. This included: study aim(s), participant characteristics, design and analysis, key findings and limitations as outlined by the study. Tables 2 and 3 contain full details of data extraction.

Two checklists were used to assess the quality of each study included in the review. Firstly, for qualitative studies the National Institute for Health and Care Excellence (NICE, 2012; See Appendix D) quality appraisal checklist for qualitative studies was used. This is designed for assessing qualitative studies and questions are framed so that it can be applied to a wide variety of qualitative research. Secondly, for quantitative studies the Downs and Black (1998) quality appraisal checklist was employed. This can be applied to a variety of quantitative research including randomised controlled trials and non-randomised control trials. The NICE quality appraisal checklist for qualitative studies and the Downs and Black (1998; See Appendix E) checklist were selected because they are both established checklists and provide adequate depth to cover all relevant aspects of methodological quality. To establish inter-rater reliability, three studies (two qualitative and one quantitative) were randomly selected and rated by another researcher. Any discrepancies in quality assessment were discussed until an agreement was formed.

A summary table displaying the results of the quality assessment can be found in Appendices F and G. Due to a limited number of studies, quality assessment was not utilised as a method to exclude studies from the analysis, but it did provide important information considered within the synthesis.

Data Analysis

The extracted data was analysed using Narrative Synthesis. As the review only included two quantitative studies which employed different measures it was not possible to conduct a meta-analysis. Narrative Synthesis uses words and texts to summarise quantitative and/or qualitative data and it focuses on 'telling the story' of the findings from the included studies (Popay et al., 2006), which was deemed most appropriate for the research question that focussed on experiences. Popay et al.'s (2006) guidelines on conducting Narrative Synthesis were consulted throughout the process. Each paper was read several times and a detailed data extraction procedure was completed. An initial thematic analysis was completed whereby the extracted findings across all papers were grouped together based on similarities. Following this an Ecomap (see Appendix H) was developed to explore the relationships between the themes.

Results

Overview of Included Studies

In total, ten studies were included in the current review (see Tables 2 and 3 for an overview of included studies). Of the included studies, eight were qualitative and two were quantitative. The quantitative studies (Gilliland, 1990; Mojtabai & Olfson, 2008) utilised different methods of analysis. Gilliland (1990) utilised descriptive statistics and analysis involved either Chi squared using Yates' correction or Fisher Exact Probabilities Test. Mojtabai and Olfson (2008) analysed the accuracy of parents' reports using Receiver Operating Curve analyses and the association of parental detection of self-harm behaviour with professional help-seeking was assessed using multivariate logistic regression models. Three of the qualitative studies utilised a phenomenological approach (Raphael et al., 2006;

Oldershaw et al., 2008; Rose et al., 2011) and five utilised thematic analysis (Ferrey et al., 2015; Ferrey et al., 2016a; Ferrey et al., 2016b; Hughes et al., 2017; Stewart et al., 2018).

Five of the studies utilised the same dataset to explore different aspects of parents' understandings and experiences of young people's self-harm (Ferrey et al., 2015; Ferrey et al., 2016a; Ferrey et al., 2016b; Hughes et al., 2017; Stewart et al., 2018). Interviews began with an open-ended section where participants explained their experiences of caring for a young person who self-harmed. Semi-structured prompts were then used for the second half of the interview, so the method was seen as appropriate to obtain rich qualitative data.

All studies focussed on the experiences and understandings of parents; they recruited the parents of young people aged under 25 years old from the UK.

Quality of Included Studies

Overall, most qualitative studies were of good quality (Raphael et al., 2006; Oldershaw et al., 2008; Rose et al., 2011; Ferrey et al., 2016a; Ferrey et al., 2016b; Hughes et al., 2017; Stewart et al., 2018) and were given ratings of "++". In general, research designs were defensible, analyses were rigorous and well-described, and the studies presented rich data with convincing findings. Where studies were rated lower (a rating of "+" was ascribed to Rose et al. (2011) and a rating of "-" was ascribed to Ferrey et al. (2015)) this was due to a lack of information. It was unclear as to whether studies had or had not fulfilled items on the checklist. As the Ferrey et al. (2015) study was part of a larger group of studies it could be presumed that areas such as the design and analyses were appropriate as the other studies had met these criteria (Ferrey et al., 2016a; Ferrey et al., 2016b; Hughes et al., 2017; Stewart et al., 2018).

With regards to the quantitative studies, Mojtabai and Olfson's (2008) paper received a rating of 11 out of 14 (79%) whereas Gilliland's (1990) paper received a rating of 7 out of 17 (41%). Like the qualitative papers, Gilliland's (1990) failure to meet criteria was due to a lack of detail reported by the study. It was therefore difficult to determine whether criteria were met. Due to the small number of papers relevant to the review question it was not appropriate to exclude a paper based solely on its quality assessment rating, instead the rating of each paper was considered during the analysis and interpretation.

Table 2

Summary of Quantitative Studies

Reference	Study Aims	Participant Characteristics	Measures	Design and Analysis	Key Findings	Quality Assessment Rating
Gilliland (1990)	To explore whether a previous finding, of no differences between children who are referred to hospital for self-harm and a "psychiatric control" population, would be replicated.	Twenty-five parents of young people (aged between 13-16 years old). Control group: Forty-five parents of young people (aged between 13-16 years old).	Questionnaire designed specifically for this study.	Questionnaire yielding descriptive statistics. Chi squared using Yates' correction or Fisher Exact Probabilities Test.	Main reasons for self-harm were: Row with friends (40%), row with parents (20%) and marital row (12%). However, for 16% there was no evident precipitating factor. Parents of experimental group were significantly less likely to be concerned about their child's mental state. Parents were significantly more likely to drink alcohol excessively in the experimental group.	41% (7/17)
Mojtabai and Olfson (2008)	To examine correlates of parental detection of children's self-harm and to examine the association of parental detection of children's self-harm with	7036 parent-child dyads. Young people were aged over 11 years old.	Development and Well-Being Assessment structured interview (child and parent version) (DAWBA; Ford et al., 2003).	Survey completed across two time points (1999 and 2004).	Less than one in four parents knew about their children's history of self-harm behaviour. Parents who perceived their children as suffering from definite or severe emotional	79% (11/14)

	professional help-seeking.		One question from the Strengths and Difficulties Questionnaire parent version (SDQ; Goodman, 1999; Green et al., 2005). SDQ child version. Five questions from the General Functioning Scale of the MacMaster Family Activity Device (FAD; Byles et al., 1988).	The accuracy of parent's reports was assessed using Receiver Operating Curve analyses. Association of parental detection of self-harm behaviour with professional help-seeking was assessed using multivariate logistic regression models.	and behavioural problems were more likely to detect self-harm. Parental psychological distress was associated with improved detection of self-harm. Parental knowledge of children's self-harm behaviour was closely linked to help-seeking.

Table 3

Summary of Qualitative Studies

Reference	Study Aim(s)	Participant Characteristics	Design and Analysis	Key Findings	Quality Assessment Rating
Raphael, Clarke & Kumar (2006)	To explore parents' responses to self-harm by their child to understand their concerns, experiences and support needs in order to inform education and training about self-harm for health professionals.	Nine parents of seven young people (aged 16-24 years old). Two instances where mother and father were interviewed together, three mothers interviewed alone, and two fathers interviewed alone.	Qualitative study using a phenomenological approach.	Three themes: (1) Emotional responses (2) What to do next? Where to find information and support (3) Health professionals	++
Oldershaw, Richards, Simic & Schmidt (2008)	To investigate the continuing effects of a child's repeated self-harm and to establish parents' perspectives on their role in seeking or maintaining help.	Twelve parents of twelve young people (aged 13-18 years old). Nine mothers, two fathers and one grandmother with a maternal role.	Qualitative study using an interpretative phenomenological analysis.	Four themes: (1) The process of discovery (2) Making sense of self-harm (3) Psychological impact on parents (4) Effect of self-harm on parenting and family	++
Rose, Cohen & Kinney (2011)	To explore how parents experience their relationship with services following an episode of their child's self-harm.	Five mothers of five young people (aged 15-16 years old).	Qualitative study using an interpretative phenomenological analysis.	Three themes: (1) The Unknown ('What lies beneath') (2) Shame and Blame ('Are we that sort of family?')	++

				(3) Knowledge ('Knowledge is power')	
Ferrey, Hawton, Simkin, Hughes, Stewart & Locock (2015)*	None clearly stated.	Thirty-nine participants related to thirty-seven young people (aged up to 25 years old). Thirty of the young people were daughters, six were sons and one was a husband.	Qualitative study using thematic analysis (?).	Five main topic areas: (1) Why do young people self-harm? (2) Finding out that a young person in your family is self-harming (3) Living with self-harm (4) Experiences of support and treatment (5) Looking ahead	-
Ferrey, Hughes, Simkin, Locock, Stewartm Kapur, Gunnell & Hawton (2016a)*	To explore how the discovery of a child's self-harm affects parenting behaviour, including working with their child's other parent/s and parenting the child's siblings.	Thirty-seven parents of thirty-five young people (aged under 25 years old).	Qualitative study using thematic analysis (?).	Six Themes: (1) Changes in parenting strategies after the discovery of self-harm (2) The effect of parents' conceptions of self-harm on how they parented (3) The effect of differing views on parenting between parents (4) Parenting siblings (5) Long-term effects of self-harm on parenting (6) Parents suggestions for other parents	++
Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell & Hawton (2016b)*	To investigate the practical impact of self-harm on the lives of families and how this affects parenting strategies.	Thirty-seven parents of thirty-five young people (aged between 14-24 years old).	Qualitative study using thematic analysis.	Eight Themes: (1) Immediate impact (2) Ongoing impact on parents' emotional state and mental health (3) Impact on partners (4) Impact on siblings (5) Impact on wider family (6) Social isolation and social support (7) Impact on work and finances (8) Parent's conception of the future	++

Hughes, Locock, Simkin, Stewart, Ferrey, Gunnell, Kapur & Hawton (2017)*	To explore how parents make sense of their child's self-harm behaviour.	Thirty-seven parents of thirty-five young people (aged between 14-24 years old).	Qualitative study using thematic analysis.	Three themes that describe processes that underpinned parents' attempts to make sense of self-harm: (1) Their initial reactions of bewilderment and confusion (2) The search for information (3) Their attempts to build a new way of seeing	+
Stewart, Hughes, Simkin, Locock, Ferrey, Kapur, Gunnell & Hawton (2018)*	To explore how parents of young people who self-harmed experienced support and treatment both for their child and for themselves.	Thirty-seven parents of thirty-five young people (aged between 14-24 years old).	Qualitative study using a grounded theory approach to thematic analysis.	Three themes: (1) Attitudes towards the young person (2) Practical aspects of help (3) Involving parents	++

Note. * denotes studies that utilised the same participant sample

Narrative Synthesis

Findings from the selected papers were synthesised and six themes were identified. To develop an understanding of these themes, their relationship to one another and their relationship to parents, young people and self-harm, an ecomap was developed (see Appendix H). The following section provides a description of the six themes and a narrative of the ecomap.

Discovering Self-Harm

The first theme connected parents with their experience of discovering self-harm. The first stage of discovery seemed to be an initial detection of the behaviour, but overall, there seemed to be a weak relationship between parents and the detection of self-harm whereby fewer than one in four parents knew about their child's self-harm (Mojtabai & Olfson, 2008). There were some factors that influenced parents' detection of self-harm, for example, parents with a child with an existing mental health diagnosis or parents who perceived their child as experiencing a "definite or severe emotional and behavioural problem" were more likely to detect self-harm (Gilliland, 1990; Mojtabai & Olfson, 2008).

Some research indicated that when parents did detect self-harm and attempted to speak to their children about this, they were met with denial or refusal or inability to talk about it (Oldershaw et al., 2008; Hughes et al., 2017):

"So, I sat [her down] and, [said] "Oh, my God, explain." And she was really dismissive – "I don't want to discuss this" – completely gave me the cold shoulder."

(Hughes et al., 2017, page 219)

After the initial detection parents often took a “wait and see” approach and hoped that the suspected self-harming behaviour would resolve itself (Oldershaw et al., 2008).

Furthermore, parents commonly had strong emotional reactions to the discovery (Raphael et al., 2006; Rose et al., 2011; Ferrey et al., 2015; Ferrey et al., 2016b; Hughes et al., 2017). Parents’ reactions were commonly categorised by shock (Raphael et al., 2006; Rose et al., 2011; Ferrey et al., 2015; Ferrey et al., 2016b; Hughes et al., 2017) as well as feelings of panic and horror (Rose et al., 2011; Ferrey et al., 2016b):

“At first, when you see these marks on your child’s beautiful skin, you’re just filled with every emotion that you can possibly think of—fear, anxiety, disbelief, anger and just not knowing what to do.”

(Ferrey et al., 2016b, page 3)

Understanding Self-Harm

Overall, parents described that developing an understanding of self-harm was a gradual and ongoing process (Oldershaw et al., 2008) and involved ruminating on the reasons for self-harm and searching for information to gain knowledge (Hughes et al., 2017). Over time, some parents were able to gain an understanding of self-harm from their child (Oldershaw et al., 2008; Hughes et al., 2017):

“I learned the reasons why it was effective. Even though I hated it and couldn’t condone it, with my thinking and my understanding of it [I] made some kind of sense to it.”

(Hughes et al., 2017, page 220)

However, this was not generalisable to all parents (Oldershaw et al., 2008; Hughes et al., 2017).

In addition, parents were able to develop reasons why their child had self-harmed which shaped their understanding of this behaviour. Parents conceptualised self-harm as either normal and/or part of a mental health difficulty or as “bad” behaviour (Ferrey et al., 2016a). Other studies provided more detail. Parents in Oldershaw et al.’s (2008) study identified three categories of causal factors that they thought underpinned the development of their child’s self-harm, which include: emotional difficulties (for example, self-harm as a method of easing pain and worry), situational difficulties (for example, self-harm occurring due to the experience of bullying) and personality factors (for example, experiencing low self-esteem). Parents in other studies also highlighted situational difficulties (Gilliland, 1990; Hughes et al., 2017) and emotional difficulties (Hughes et al., 2017) in their understanding of self-harm.

Longer-Term Emotional and Psychological Effects of Self-Harm on Parents

As well as strong emotional reactions to the discovery of self-harm, there were several longer-term emotional and psychological effects on parents which were shared across samples. Parents commonly experienced guilt (Oldershaw et al., 2008; Ferrey et al., 2016b; Hughes et al., 2017) and fear (Raphael et al., 2006; Oldershaw et al., 2008) and there was evidence of feelings of helplessness and confusion (Raphael et al., 2006; Hughes et al., 2017), disappointment, sadness, and loss (Oldershaw et al., 2008) and stress and anxiety (Ferrey et al., 2016b):

"It's confusing. I felt angry. I felt sad. I didn't know what to do. Mums and Dads are supposed to know everything aren't they, but we don't. We didn't have the answers and we didn't know why she was doing this to herself."

(Hughes et al., 2006, page 218)

Shame was also commonly experienced among parents (Rose et al., 2011; Ferrey et al., 2016b) but shame seemed somewhat separate from other emotional and psychological effects as there are additional factors that interact with parents' experience of shame. Societal discourses regarding self-harm directly influenced parents experience of shame (Rose et al., 2011) and also influenced stigma, which further exacerbated the experience of shame (Rose et al., 2011):

"'Cause you don't know, you've never used this service before…you have an image of mental health services, you do, 'cause you see it on telly!"

(Rose et al., 2011, page 199)

Effects on Parents' Behaviour and Parents' Responses to Self-Harm

The discovery of self-harm had a strong and influential impact on changes in parents' behaviour (Oldershaw et al., 2008; Rose et al., 2011; Ferrey et al., 2015; Ferrey et al., 2016a; Ferrey et al., 2016b). In addition, the emotional and psychological effects influenced changes as several parental responses (for example, searching through information, trying to access the right care via GP and anxiously ruminating) were driven by parental feelings (Rose et al., 2011; Ferrey et al., 2015):

"How can I have…not realised…how can I make sure that I don't 'not realise' in the future? And what…measure can I put in place to be more in tune with how she's feeling, you know, if that's possible to do."

(Rose et al. 2011, page 200)

Furthermore, the understanding of self-harm strongly influenced behavioural responses whereby parents who conceptualised self-harm as normal behaviour or as part of their child's mental health difficulty were more likely to adopt supportive strategies whereas parents who conceptualised self-harm as "bad" behaviour were more likely to increase monitoring and control of the child (Ferrey et al., 2016a). Changes in parental behaviour were therefore linked with the young person and their self-harm. Supportive strategies were deemed to be more helpful whereas monitoring and control created more of a stressful relationship with young people (Ferrey et al., 2016a).

Another notable change in parents' behaviour following the discovery of self-harm was that parents ruminated on the reasons for self-harm, including what they might have or not have done to contribute to the behaviour (Hughes et al., 2017), often leading them to believe that they should have known and been able to prevent or intervene to stop their child's self-harm (Rose et al., 2011). There was a strong relationship between rumination and parents' experiences of guilt, shame, and blame (Rose et al., 2011; Hughes at al., 2017):

"From the very beginning, when I was pregnant with her, what did I do wrong? Did I eat the wrong things? Did I get too stressed? When [she] was young, did I feed her properly? Did I interact with her? When she was older, did I praise her enough? Did I criticise her too

much?...I know that she's an adult now and she takes responsibility for her choices and I can only be supporting her but that was very, very difficult, the blame, the guilt."

(Hughes et al., 2017, page 218)

The papers also indicated contradictory findings on how parents changed their responses to their own needs. Some parents felt that only by taking care of themselves could they help their child (Ferrey et al., 2016b). Alternatively, other parents felt that they had to deny their own needs (Oldershaw et al., 2008). Ferrey et al.(2016b) supported this, reporting that parents found it difficult to maintain a full-time job due to a desire to be available when their child needed them. Parents were also significantly more likely to drink alcohol when they parented a child who self-harmed compared to parents of children with other mental health difficulties (Gilliland, 1990). However, Gilliland (1990) did not explore whether there was a causation between these two factors.

Help-Seeking for Self-Harm

Several papers commented on how parental help-seeking for self-harm was triggered (Mojtabai & Olfson, 2008; Oldershaw et al., 2008; Hughes et al., 2017). Parental knowledge of self-harm was closely linked to help-seeking behaviours (Mojtabai & Olfson, 2008; Oldershaw et al., 2008). In addition, help-seeking was triggered by a deterioration or an accumulation of problems (Oldershaw et al., 2008):

"Things just gradually accumulated to the point where we realised we actually needed some external help."

(Oldershaw et al., 2008, page 141)

Furthermore, there were barriers to parental help-seeking for self-harm. Stigma and blame strongly influenced help-seeking behaviour as a fear of this prevented parents from talking to others to access help (Raphael et al., 2006; Rose et al., 2011; Ferrey et al., 2015; Ferrey et al., 2016b):

"As a parent, you're just not equipped. You don't know where to go or who to speak to – you blame yourself."

(Ferrey et al., 2015, page 2)

Experiences of Support and Treatment

Parents had a strong relationship with support and treatment which they viewed as crucial and beneficial (Oldershaw et al., 2008; Stewart et al., 2018). Parents reflected positively on a range of interventions such as early intensive support, practical strategies, psychological interventions, and parent groups (Ferrey et al., 2015; Ferrey et al., 2016b; Stewart et al., 2018). The importance of parent groups was further emphasised by the findings that hearing the experiences of others could function as both a source of information and support for parents (Ferrey et al., 2015). Parents were also able to provide advice and strategies for other parents of young people who self-harm (Ferrey et al., 2015; Ferrey et al., 2016a).

There was a strong relationship between support and treatment and the services which provided this. Parents reflected on their relationships with services, which could be either strong or weak. For example, in one study, parents emphasised the importance of professionals having a positive attitude towards their child but had mixed experiences of whether their child's self-harm was taken seriously (Stewart et al., 2018). Services offering support within the United Kingdom are closely connected to the wider NHS context, but the

relationship between this context and the services and between this context and parents was stressful. Parents reported that it was distressing to perceive services as pressed when they were receiving support (Stewart et al., 2018).

Furthermore, there was a strong relationship between services and knowledge of the young person and their self-harm, but this had an impact on the relationship between parents and their knowledge of the young person and their self-harm. Parents experienced difficulties when they felt excluded from their child's care (Rose et al., 2011; Stewart et al., 2018). It was stressful for parents when they had a sense that services controlled the knowledge as this diminished their role and left parents feeling disempowered and inadequate as well as angry and frustrated (Rose et al., 2011). Parents understood the dilemma of confidentiality, but this did not influence their feelings towards not having the knowledge of their child and their self-harm (Stewart et al., 2018). Regular updates were viewed as an essential part of support and treatment (Stewart et al., 2018) and when information was shared with parents, they felt included and empowered (Rose et al., 2011) which is represented in the strong relationship between parents and knowledge of the young person and their self-harm:

> *"Clinicians, please talk to carers. Don't exclude us. We're part of the solution. We may be part of the problem. I think often clinicians' perception, certainly in my experience, can be that you're part of the problem. Well, I may be but actually, if you help me out I can maybe be part of the solution too."*
>
> *(Stewart et al., 2018, page 82)*

Discussion

The aim of the review was to explore parents' experiences and understandings of young people's self-harm. The narrative synthesis indicated six themes across studies that revealed different aspects of parents' experiences and understandings. The themes, and components of these, were organised into an ecomap. Ecomaps (Hartman, 1978) were developed as a tool to develop an understanding of a family within its social, cultural, and political environment. Ecomaps have been utilised within systemic practice (McCormick et al., 2008) and its application in the review highlights the experiences of parents within the contexts of self-harm, young people, mental health services, and society.

The results indicated that the discovery of self-harm was characterised by strong emotional reactions from parents and self-harm had short and long-term impacts on parent's emotional and psychological well-being. This replicates the finding from Arbuthnott and Lewis's (2015) review that indicated young people's self-harm had a negative impact on parental mental health. This also suggests that parenting a child who self-harms is characterised by similar experiences as parenting a child with other mental health difficulties, as existing literature has highlighted that this can be a significant source of stress for parents and can negatively impact their wellbeing (Sloan et al., 2020). The strong psychological and emotional effects of self-harm on parents supports the need to adopt a systemic perspective in understanding and treating self-harm. This is because it highlights the experience of mutual distress amongst young people who self-harm (Stänicke et al., 2018) and their parents suggesting that self-harm and its effects envelops the whole family. Furthermore, the review highlights patterns of interpersonal interaction between parents and their children who self-harm which are influential in shaping the young person's experience of self-harm and support (for example, the emotional and psychological effects of self-harm impact parental responses

and behaviours such as adopting controlling or supportive strategies and help-seeking). Therefore, there is a need for self-harm support and treatment to consider the experiences and interactions of the whole family which is akin to systemic practice.

In addition, the review highlighted that parents can have different understandings of self-harm. The variety of conceptualisations could be explained by social constructionism, which is a is a theory of knowledge that has been influential in systemic theory and practice (Boston, 2000). Social constructionism proposes that knowledge is constructed through social processes and interactions between people (Burr, 2015). Therefore, knowledge of self-harm can be regarded as historically and culturally specific (Burr, 2015). As parents within the studies were from different social, cultural, and political contexts this explains the variability in their understandings of self-harm. Furthermore, social constructionism highlights the role of societal discourses in influencing parents' understandings and experiences of young people's self-harm. Therefore, the differing stories parents tell about self-harm relate to the societal discourse around self-harm available to them and their own unique experience of and interaction with these stories. Previous research has identified that society within the UK holds unfavourable views of individuals with mental health difficulties (Crisp et al., 2000), and self-harm is a highly stigmatised behaviour (Staniland et al., 2020). If parents have been exposed to these discourses, then this could negatively influence their understanding of self-harm. Therefore, it is important to consider how these wider societal discourses can be challenged and replaced with non-stigmatising discourses to allow parents to develop more compassionate understandings of self-harm that might support their own and their child's experience of this behaviour.

Furthermore, the importance of developing an awareness of parental understandings of self-harm is influenced by the finding that parent's responses were in part driven by their understandings. Parents were the help-seekers for young people's self-harm, which aligns with previous literature that has suggested parents are influential in young people accessing mental healthcare (Boulter & Rickwood, 2013). However, even with support of parents', previous literature has indicated that few young people access help for self-harm in the UK (Stallard et al., 2013). The review indicated that stigma and blame, influenced by societal discourses, can be barriers to help-seeking for self-harm. Dallos and Draper (2010) consider societal discourses in systemic theory and practice and summarise Foucault's (1975) position that discourses can be replicated and changed and have influence in daily interactions and conversations. Thus, they are influential in shaping and developing understandings of self-harm, which can affect parental behaviours and responses. This review strengthens Rose et al.'s (2011) conclusion that acknowledging and understanding the experiences of parents and the impact of stigma, blame and shame could help professionals and wider society to develop an understanding and empathy for family experiences of self-harm and challenge the existing societal discourses. Current literature has indicated that negative attitudes exist amongst laypeople, healthcare professionals and teachers towards self-harm (Law et al., 2009; Timson et al., 2012) which is both influenced by and perpetuating of negative societal discourses that function as a barrier to accessing help. Therefore, intervention at a wider societal level to challenge and dismantle these stigmatising discourses of self-harm is needed to ensure young people receive support and treatment for self-harm. Challenging discourses could be supported by targeted training focused on developing compassionate, non-stigmatising understandings of self-harm to groups of people such as parents of young people, healthcare staff and teachers who are more likely to encounter this behaviour.

Assessment of Strength of the Review

Overall, quality assessment indicated that most studies were high quality. The quality score was affected for some studies due to a lack of detail. Five of the studies shared the same sample of 37 parents. Therefore, the review is based on a limited sample of parents, and it is unclear whether these findings would represent the experiences of parents from a range of social, cultural, and political backgrounds within the UK. Furthermore, except for Mojtabai and Olfson's (2008) study, due to the nature of recruitment only parents explicitly aware of their child's self-harm were included in the studies. Therefore, there may be differences in experiences and understandings of self-harm between parents who are acutely aware of their child's self-harm and those who are unaware or uncertain of the presence of this behaviour.

Only two of the qualitative studies considered the role of the researcher. NICE (2012) highlight that the role of the researcher can affect and influence the data and conclusions drawn. In several studies it was unclear whether the method was reliable as it was not stated how many researchers were involved in data analysis and whether triangulation of datasets occurred. This creates uncertainty regarding the impact of researcher influence and bias on the presented conclusions. However, themes were identified across studies which suggests that there were shared experiences across different participant samples.

Wider Implications

The review has a number of implications. Firstly, it emphasises the importance of thinking and working systemically with young people who self-harm. Parents are strongly affected by their child's self-harm and their responses are influential as there are long-term behavioural changes for parents and they are crucial in help-seeking. Including parents in services supporting young people who self-harm could not only improve the well-being of parents but

also influence their understanding and responses to self-harm, which would help the young person. It is important to note that there are differences amongst parents in their experiences, understandings, and responses to self-harm. Therefore, clinicians should work with families in a person-centred way.

There is also a need to consider the impact of wider societal discourses on self-harm. Societal discourses currently develop blame, shame and stigma amongst parents which operates as a barrier to accessing support for self-harm and negatively impacts upon parental wellbeing. Existing literature suggests further effects of negative discourses of self-harm, including reduced treatment options for young people and the development of self-stigma (Aggarwal et al., 2021). Referencing Foucault (1975), Dallos and Draper (2010) suggest a 'bottom-up' understanding of discourses whereby they are continually transforming and changing waves of meaning, which suggests that they can be influenced and changed. Providing non-stigmatising education regarding self-harm on a wider societal level could challenge current negative discourses. Future research could continually focus on identifying views within society to target and tailor education and to monitor discourse changes.

Conclusion

It is important to adopt a systemic perspective when understanding and treating young people's self-harm as it has a significant emotional, psychological, and behavioural impact on parents which, one could argue, will have a direct influence on the young people's coping and management of the self-harm as well as access to treatment, with parents often acting as the 'help-seekers' in such instances. Adopting a systemic perspective also enables consideration of the effects of societal discourses that surround and influence young people's

self-harm, enabling families to deconstruct (Dallos and Draper, 2010) the influence of these discourses on their understandings and actions.

Interventions are needed to provide education on a wider societal level to reduce stigma and remove barriers to help-seeking. In turn this could have a positive effect on the wellbeing of both the young person and their parents. It is important to note that there are a limited number of studies within this review and caution should be taken to not overgeneralise the findings to parents of young people who self-harm from different social, cultural, and political contexts. It is recommended that clinicians work with families in a person-centred way but are aware of the possible systemic factors that influence self-harm and the systemic effects of young people's self-harm.

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Part Two: Empirical Paper

An Exploration of Family Experiences of Adolescent Self-Harm Within the Context of Having Received a Systemic Family Intervention

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This paper is written in the format ready for submission to the journal

Journal of Family Studies

Please see Appendix A for submission guidelines

Word Count (including tables, figures and references): 10,234

Abstract

Self-harm is a public health issue amongst adolescents, but there is limited evidence supporting the effectiveness of specific interventions for adolescents who self-harm. A family-centred approach is indicated as a shared component amongst more efficacious interventions, but to date only one study has evaluated the effectiveness of systemic family therapy for adolescent self-harm. The current study explores families' experiences, meanings and narratives associated with self-harm within the context of having received a systemic family intervention. Four families (n = 8) completed non-directive joint interviews that were analysed using narrative analysis. The results indicated that significant life events precipitate self-harm, which is a significant cause of stress and difficulties amongst families. Different experiences of help-seeking are reported, but all families experienced a turning point associated with receiving a systemic family intervention and with changes within the family's wider context. The study supports the delivery of systemic interventions for adolescent self-harm and emphasises the importance of maintaining a wider systemic perspective when working with this difficulty.

Key words: self-harm, adolescent, family, experience

Introduction

The current study builds upon previous research exploring adolescent self-harm and systemic family interventions. Therefore, it adopts the same definition of self-harm used previously within this area of research in line with UK clinical practice (Cottrell et al., 2018). Self-harm is defined as: "Any form of non-fatal self-poisoning or self-injury (such as cutting, taking an overdose, hanging, self-strangulation, jumping from a height and running into traffic), regardless of the motivation or the degree of intention to die. This definition includes what in the USA would be described as non-suicidal self-injury (NSSI) and suicidal behaviour (Swannell et al., 2014)" (Cottrell et al., 2018, p. 1).

The lifetime prevalence of self-reported self-harm is around 6.4% (McManus et al., 2019). Data suggests that in 2018/19 0.44% of young people (444 per 100,000 aged 10-24 years old) were admitted to hospital following self-harm in England (Hospital Episode Statistics, 2020). However, this figure does not include young people who attended A&E following self-harm or young people who do not present at hospital, which suggests that self-harm is more prevalent amongst young people than what the data represents. Definitive prevalence rates amongst adolescents are hard to ascertain as self-harm is reliant on self-disclosure and young people feel reluctant or unable to disclose self-harm reinforced by stigma (Klineberg et al., 2013). Nevertheless, self-harm has become a public health issue amongst adolescents. Self-harm has been linked with an increased risk of mortality (Hawton et al., 2012) as the risk of suicide following self-harm is 49 times greater than the general population risk (Hawton et al., 2015).

As an attempt to develop a greater understanding of adolescent self-harm and in response to concerning statistics, research has focussed on the subjective experiences of adolescents who

self-harm. A meta-synthesis (Stänicke et al., 2018) indicated that adolescents could provide an understanding of their own self-harm and shared experiences were reported across different samples as participants' understandings were organised into the following themes: to obtain release; to control difficult feelings; to represent unaccepted feelings; and to connect with others. In addition, adolescents who self-harm, compared to adolescents who do not, are more likely to feel a need for help but do not try to obtain this (Evans et al., 2005).

Adolescents understand their self-harm but often struggle to speak about this and seek support (Stänicke et al., 2018; Evans et al., 2005). Despite this knowledge, there is limited evidence that support the effectiveness of specific interventions for young people who self-harm (Cottrell et al., 2018). This is particularly concerning in the context of high prevalence rates. NICE guidelines regarding the long-term management of self-harm amongst young people (National Institute for Health and Care Excellence [NICE], 2012) are particularly vague for professionals to act upon. A recent systematic literature review concluded that only Dialectical Behaviour Therapy for Adolescents (DBT-A) could currently be classified as a 'well-established' treatment for self-harm (Glenn et al., 2019). Treatments were classified as 'well-established' when found in at least two independent research settings by two independent research teams to be either statistically significantly superior or equivalent to placebo or another treatment. Interestingly, the review highlighted that a family-centred approach is one of the shared components of more efficacious interventions.

It is perhaps unsurprising that a family-centred approach is a shared component of efficacious interventions, as previous research has highlighted the systemic nature of self-harm. Factors relating to family history and the parent-child relationship are implicated as risk factors for the development of self-harm when associated with stress and difficulty (Ackard et al., 2000)

and protective factors when associated with cohesiveness and connectedness (Rubenstein et al., 1998; Borowsky et al., 2001). In addition, adolescents report that their family, alongside friends and school, are the main source of support in preventing self-harm (Fortune et al., 2008). Furthermore, the systemic nature of self-harm was demonstrated through qualitative research focused on parents' experiences of young people's self-harm. Parents often report strong emotional reactions to discovering self-harm (Ferrey et al., 2016), seek help for their child (Oldershaw et al., 2008; Rose et al., 2011) and reflect on wider systemic impacts of self-harm e.g. on siblings (Ferrey et al., 2016).

As research has implicated the adolescent's family as important in understanding and protecting against self-harm, highlighted the effectiveness of family-centred interventions and demonstrated that self-harm has an impact on family members, it seems important to explore systemic family interventions for self-harm. Generally, systemic family interventions are effective for a range of child-focused difficulties such as eating disorders and first episode psychosis (Carr, 2018). Systemic family interventions emphasise the importance of understanding difficulties in the context of social interactions and relationships (Boston, 2000). Influenced by the social constructionist perspective (Boston, 2000) they do not focus on causal explanations of the individual's difficulties, but on the experiences, meanings and narratives that have been attributed to, and consequently shape and maintain, an individual's difficulties (Cottrell et al., 2018). To date, one study has evaluated the effectiveness of systemic family therapy for adolescent self-harm (SHIFT trial; Cottrell et al., 2018), which concluded that there was no statistically significant difference in self-harm repetition rates between individuals who had family therapy and those who received treatment as usual (Cottrell et al., 2018).

Despite the limited evidence-base, Child and Adolescent Mental Health Services (CAMHS) deliver systemic family interventions for adolescent self-harm. These interventions use the approach and technique outlined by the SHIFT trial (Cottrell et al., 2018), but can employ a different method of delivery. Therefore, it is important to evaluate the SHIFT trial to determine whether its findings are representative of clinical practice and whether there remains a rationale for working systemically with self-harm.

Ougrin and Asarnow (2018) noted that the SHIFT trial used hospital attendance as the primary outcome measure but increased contact with family therapists might have led to the detection of more high-risk self-harm episodes amongst adolescents, which would lead to increased hospital presentations. In addition, the SHIFT trial sees hospital admission as a negative outcome, but admission could represent positive changes within the family system. For example, following family therapy, families may be more able to respond appropriately to self-harm, which could include supporting hospital attendance.

Therefore, positive change may occur in family systems in relation to adolescent self-harm following a systemic family intervention, but this has not been explored in detail. There was some evidence from the SHIFT trial that family therapy elicits change in the adolescent and their caregiver (Cottrell et al., 2018). Family therapy had a statistically significant positive impact on adolescents' suicidal ideation and on emotional and behavioural difficulties for both the adolescent and caregiver (Cottrell et al., 2018). Further research following SHIFT explored changes in families' understandings of self-harm following a systemic family intervention. Rogers and Schmidt (2016) reflected that during family therapy families often had different and opposing understandings of adolescent self-harm, but during therapy family members became more able to hold multiple, different understandings. This suggests that

changes in families' experiences and understandings of adolescent self-harm might occur within the context of receiving a systemic family intervention, but to date no research has interviewed families and relies on outcome measures and therapists' perspectives (Cottrell et al., 2018; Rogers & Schmidt, 2016; Amoss et al., 2016).

One study explored adolescents' experiences and understandings of self-harm following systemic family therapy, using first-hand accounts (Holliday et al., 2018). Findings suggested an effect on adolescents' experiences of self-harm as there was a theme of "moving forward" post-intervention. However, the study does not represent the systemic nature of self-harm and the systemic impact of the intervention.

Currently, adolescent self-harm is a growing public health concern with a limited evidence base for interventions. Families are considered important risk and protection mechanisms in self-harm and family-centred approaches are universally reported in efficacious interventions, supporting the need to work systemically with adolescent self-harm. There is little evidence for systemic family interventions for adolescent self-harm and existing evidence has limitations. Research indicates that there are some changes in experiences, meanings and narratives associated with adolescent self-harm following systemic family interventions. However, this research, like other studies exploring experiences of adolescent self-harm, explored self-harm from the perspective of therapists or a specific family member (for example, adolescents). Therefore, the current study proposes to explore families' experiences, meanings and narratives associated with adolescent self-harm within the context of the family having received a systemic family intervention in current UK clinical practice. To explore these, the following research questions were developed:

1. What are families' experiences, meanings and narratives, associated with self-harm, following completion of a systemic family intervention?

2. Do families' experiences, meanings and narratives, associated with self-harm, change during and/or after receiving a systemic family intervention?
3. If so, in what ways do experiences, meanings and narratives associated with self-harm change?
4. Do families' associate identified change with having received a systemic family intervention for self-harm?

This research will develop the knowledge base as it aims to discover the experiences of families in relation to self-harm. This knowledge might help other families with their experience of self-harm as it could normalise their experiences, provide support and understanding for the experience of self-harm and/or provide hope for the future. It could also help develop professionals' understandings of self-harm, which is important as professional attitudes towards self-harm can be negative (Karman et al., 2015). This could in turn lead to better experiences for families with self-harm. Exploring how families talk about their experiences in the context of a systemic family intervention could also add to the evidence-base for this as families might share their experiences of the intervention and whether this shaped their experiences and/or understandings of adolescent self-harm.

Method

Design

The study utilised a qualitative methodology and a narrative approach to explore families' experiences, meanings, and narratives associated with self-harm within the context of receiving a systemic family intervention. Narrative inquiry considers that stories drawn from participants reflect how people view and understand their experiences (Josselson, 2011). Narratives are understood within their context, which includes how they were obtained and how this could have impacted the content and narration of the story (Josselson, 2011).

Recruitment and Participants

Ethical approval was given by the Faculty of Health Sciences Ethics Committee (University of Hull) and the Health Research Authority (See Appendix I). A field supervisor within the local Child and Adolescent Mental Health Services (CAMHS) identified potential families to take part in the study. The inclusion criteria included:

- Family member/s who attended and completed a systemic family intervention for adolescent self-harm within the last twenty-four months.
- Participants must have attended at least three sessions of a systemic family intervention for adolescent self-harm.
- Families received the intervention from CAMHS practitioners who were either systemic practitioners qualified at intermediate level of systemic practice or CYIAPT systemic trained or fully qualified MSc level systemic practitioners.
- Participants must be English speaking and must have completed their systemic family intervention without the support of a translator.

Exclusion criteria were as follows:

- Participants currently receiving treatment from CAMHS.
- Participants with safeguarding, police investigations or social care concerns as identified by CAMHS workers.

Recruitment took place from February 2021 to May 2021. In total twenty-three families were identified as being eligible by the field supervisor. Twelve families provided consent to be directly contacted by the researcher, six families declined, and five families were not reachable. Once participants had provided consent to be contacted by the researcher, they were telephoned, sent text message and/or email and further details of the research and information sheets were provided (See Appendices J, K and L). Of the twelve families who provided consent to be contacted, four later declined, four were not reachable, and four

families (n = 8 participants) agreed to participate. The sample size was deemed sufficient and appropriate for narrative analysis as the quality (i.e., the richness) of the data is more important than the quantity (Lieblich et al., 1998) and the study will add to the growing findings that narrative research methods can be implemented within groups of people as opposed to with individuals, which has been more common (Lieblich et al., 1998).

Three families consisted of a mother and a young person who had self-harmed, and one family consisted of a mother and a father of a young person who had self-harmed. Further demographic data is not reported to protect the anonymity of the participants because participants were recruited from a specific time frame across two small services within one NHS Trust and so could be easily identifiable.

Procedure

Interviews were arranged directly with participants and were held via videocall. Joint interviews were conducted to obtain family narratives. Joint interviews are considered an appropriate technique when researchers aim to explore experiences and their shared nature amongst participants (Morris, 2001; Radcliffe, Lowton & Morgan, 2013). Informed consent was obtained from each participant (See Appendix M). One participant was under the age of 16 years old and so they provided their assent, and their parent provided consent for participation (See Appendices N and O).

Non-directive interviews were conducted to reduce the researchers' influence on the narratives obtained in line with the aim of narrative research, which is to obtain stories as unobtrusively as possible (Josselson, 2011). Research has indicated that participants may struggle to initiate the telling of their story (McCance et al., 2001). To help orientate

participants to narration the following statement was read aloud prior to them telling their story:

"I would like to ask you to tell me about your experience of self-harm before, during and after attending family therapy. I would like you to think about your experience as a story. Each story has a beginning, a middle and an end. You may start and end your story wherever you like."

Once participants had finished their story questions were only asked for clarification purposes and to ensure that the participants had finished telling their story. Participants' stories lasted between 7 minutes 57 seconds and 28 minutes and 36 seconds (average length of time = 15 minutes 56 seconds). Afterwards, participants were emailed a sources of support sheet (See Appendix P) should they require support after interview. Interviews were transcribed, transcripts were anonymised, and any given names were replaced with randomly generated pseudonyms.

Analysis

Narrative analysis was completed using the Lieblich et al. (1998) model, which has a four-cell design (see Figure 1). Lieblich et al. (1998) recommend utilising more than one cell during analysis. A holistic-form approach was used to analyse the narratives as a whole by focusing on the structure and telling of the stories (Lieblich et al., 1998). A categorical-content approach was implemented to analyse the content of the narratives (Lieblich et al., 1998).

Figure 1

Lieblich et al's (1998) Four Cell Design

Holistic-Content	Holistic-Form
Categorical-Content	Categorical-Form

Holistic-Form Analysis

The holistic-form analysis was carried out as follows (Lieblich et al. 1998). Firstly, each recording was listened to several times to understand the key themes and events in the narrative as well as the emotion, tone, and expression. This was influential in identifying the plot axis within each narrative. A guide by Gergen and Gergen (1988) was employed to further assist with identifying plot axes. This guide is characterised by stages of: understanding the development of the story from the beginning to the end; identifying significant events and characters that contribute to the end point; re-writing the events of the narrative in chronological order; developing an understanding of how events are linked; and identifying demarcation signs to inform understanding of the narrative such as how one event finished and another began.

The next stage focused on identifying the form of the narrative. Frye (1957) outlined that narratives can take one of four forms: comedy, romance, tragedy or satire. Once the plot axis and the form of the narrative was identified, an individual graph was constructed for each narrative. The researcher also utilised their reflections on each interview and the emotions within the narrative to construct the plots (Gergen and Gergen, 1988; Lieblich et al., 1998). Finally, the graphs were compared to establish commonalities and combined to create a prototypical graph (Lieblich et al. 1998).

Categorical-Content Analysis

The categorical-content analysis was also based on Lieblich et al.'s (1998) method. The first stage is to select the relevant subtext, but as the interview prompt asked participants to reflect on their experiences of self-harm in the context of attending a systemic family intervention the entire transcript was utilised. The transcripts were read as openly as possible whereby categories were not predetermined but emerged from the reading (Lieblich et al., 1998). For categories to emerge the researcher identified the principal sentences that expressed new and meaningful information. Sentences were used to determine minor categories using an inductive approach (Elo & Kyngäs, 2008) and to identify major categories that represented the content of the narratives (Lieblich et al., 1998).

Researcher Influence

The primary researcher (LT) was a 23-year-old, White-British, female trainee clinical psychologist. The researcher had no personal or family experiences of self-harm. However, the researcher had professional experience of working with people who self-harm and held a particular interest in systemic family interventions which could influence the interpretation of narratives. Following each interview, the researcher utilised a reflective diary to consider the process of the interview, any emotive or stand out points in the interview and the feelings that were evoked during the story. Throughout the research process, the primary researcher had regular research supervision with two qualified and research experienced clinical psychologists (one of whom is also a qualified systemic family therapist) and attended a reflective practice group with fellow trainee psychologists. Appendix C contains a reflective statement with further reflections on the primary researcher's position and influence on the research.

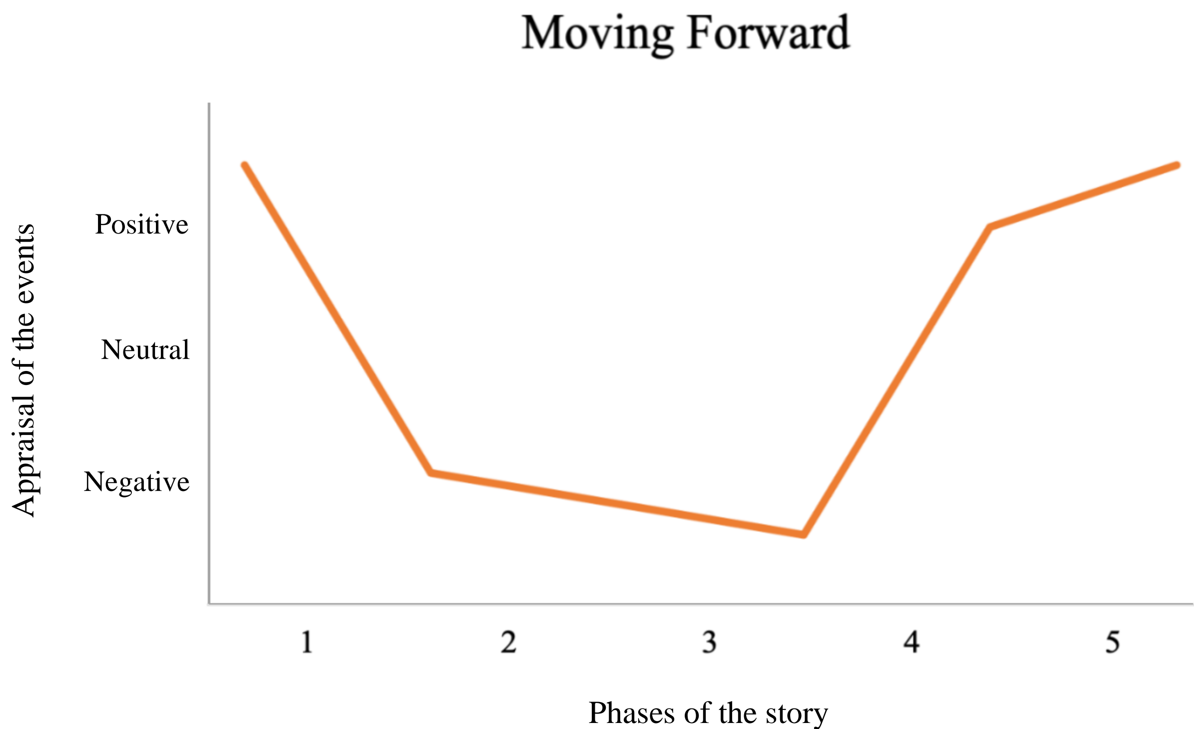
Results

Holistic-Form Analysis

All four narratives had a plot axis that involved the family encountering and then overcoming difficulties in relation to adolescent self-harm. One overall plot theme was identified: "Moving Forward". The plots were consistent with a plot form of "romance" (Frye, 1957) in which characters face a series of challenges which are overcome to achieve an end goal. Three plots had five phases and one plot had four phases. Phases were defined as specific events, actions, experiences, or emotions that occurred throughout the narrative and moved the course of events. The plot with four phases was consistent with phases 2-5 amongst the other plots so one prototypical graph was created (see Figure 2).

Figure 2

Prototypical Graph Reflecting the Phases of the Family Narrative and the Appraisal of Events Within Each Phase



Phase 1: The Difficulties

The first phase reflected difficulties emerging within families. Difficulties, such as bullying and an increase in stress associated with college, initiated a sharp decline in the well-being of young people. One family did not discuss their situation prior to the difficulties emerging and started with a stable trajectory. However, this phase was similarly characterised by difficulties in the young person's life and negative emotions.

> *"For the first year and a half, two years it was all going really well. Real good friends and then it started to get a little bit out of hand…And people are different and I think Bailey's quite sensitive, so I think she really took that to heart"* (Interview 1, page 1)

"I think she was at…high school and then college, but and the work got very intense and she had major deadlines to meet and. Just other things started getting very stressful." (Interview 3, page 2)

Phase 2: The Struggle

Amongst three families, there was a second notable change in their experiences. After the difficulties had emerged young people began self-harming and parents either noticed this or the young person disclosed it to them. This led to a further decline in the plot trajectory and parents reflected on the significant effect that this discovery had on them and their wellbeing.

"And obviously I was worried about Bailey, so I was waking up in the middle of the night and going in her bedroom making sure that she didn't have anything in there that she could do it with and an- I just. From my point of view, it was difficult" (Interview 1, page 2)

"I found it totally devastating…my world crumbled at that point" (Interview 2, page 3)

"It was hard. Really is hard when you know that your child's struggling. And the only way they can cope with what they're going through is to hurt themselves." (Interview 3, page 5)

For the parent dyad, the first phase of their narrative was characteristic of phase two, as depicted in the prototypical graph (see figure 2). The discovery of their child's suicide note meant that the family did not notice difficulties emerging and they experienced a steeper decline in their plot trajectory as they were initially in a positive place where they were unaware that anything was wrong. The family did not discover that their child was self-

harming until phase three, but the trajectory of their story and emotionality associated with the discovery of their child's distress was a similar experience to the discovery of self-harm in the other narratives.

"This suicide note just totally floored us coz we hadn't known how unhappy she was. To all intents and purposes we thought she was happy." (Interview 4, page 6)

Phase 3: Help-Seeking

The start of this phase was characterised by parents expressing that they did not know what to do to help their child.

"From a parents' point of view you wanna help but you don't really know how to." (Interview 1, page 5)

"It's really, really difficult to just to know what to do for the best…it is, yeah, pretty devastating…not knowing what to do. How to help." (Interview 3, page 5)

Despite this feeling of not knowing, parents sought help for their children through GPs, taking advice of friends or self-referrals to CAMHS. Two families' plots had a steadier trajectory through phase three as they accessed the help that they needed, but there were no significant changes in experiences or emotions at the point of accessing help. The other two families experienced a decline in wellbeing during phase three and their experiences were increasingly negatively appraised as initial attempts to seek help from school and CAMHS led to an increase in stress.

"We felt she [CAMHS practitioner] was very dismissive of us. She was focussing more on Morgan's, what they called 'bad behaviour' at the time. And not really, so much of the self-harm was she? She just said 'oh well, why do you do it? Why do you need to do it?'. It was a very negative experience that one." (Interview 2, page 1)

Phase 4: The Changes

The next phase began after families had received help. Phase four was characterised by a clear turning point in narratives and a change to a positive trajectory and appraisal of their experiences. During this phase families were either receiving or nearing the end of the systemic family intervention and acknowledged the role that this intervention played in the turning point.

"We went to a few appointments, didn't we, that really helped I think." (Interview 1, page 3)

"It finished before she started University and she was a different person after the family therapy" (Interview 3, page 2)

"I mean CAMHS really helped us in the fact that they gave us some guidance on what we could do as parents" (Interview 4, page 16)

Participants commonly reported feeling supported and understood during this phase and seemed to have developed an understanding that made sense of the young person's self-harm.

"Michelle my therapist she erm helped with sort of understanding myself. And in a way understanding why I self-harmed. And I think that, overall helped me to understand it more than anything." (Interview 3, page 2)

"You know with CAMHS they helped us erm-" "Put it straight in our minds" "Yeah put it straight in our minds" (Interview 4, page 16)

The change in trajectory during this phase was also characterised by wider contextual changes for families. Alongside the changes linked to receiving the systemic family intervention other factors such as moving to a more supportive school, receiving a diagnosis of ADHD and a change in the young person's life stage as they became eighteen were also important.

"I think with the advice from CAMHS as well as the support from school was really helpful. And I think that's, that's the biggest thing for us." (Interview 1, page 5)

"I'd always said that I thought she had ADHD or something similar, and the school then started to agree with me so they got involved, the doctors got involved" (Interview 2, page 2)

"But we think all that [young person getting their own car] sorta helped her in a way because in a way she got her own independence…And I think in a lot of ways it's maybe helped us all coz she likes having the independence." (Interview 4, page 17)

Phase 5: A Better Place

The final phase demonstrated a continued positive trajectory where the family situation continued to improve and then stabilise. Families spoke positively about their current position.

"She's not doing it [self-harm] now are ya?" "No" "She's in a much better place than what she was. Which is really good." (Interview 2, page 3)

"So as it stands now, she is probably doing all the lessons back in school, which is great and we've had no more erm incidents of the self-harm." (Interview 1, page 5)

"She was a different person after the family therapy. I think just talking through everything and being able to open up about everything that's happened, but, it just sort of helped her as a person. Just come to term with things and, and thus because of that, there isn't really the need to harm herself any further." (Interview 3, page 2)

Two families reported no further incidents of self-harm following the intervention. Two families reported that self-harm still occurs, but that this is less frequent, and it was not associated with the same level of emotionality as previously. It seemed that families were more able to manage self-harm and accept its infrequent presence.

"You feel more in control. Then there's still times you'll slip. I don't know if it ever leaves you for good. But, it's a minority rather than the majority." (Interview 3, page 4)

Categorical-Content Analysis

Major and minor categories around family experiences, meanings and narratives associated with self-harm were obtained from the narratives. Table 1 outlines the major and minor categories.

Table 1

Major and Minor Categories Derived from Inductive Categorical-Content Analysis

Major Categories	Minor Categories	Number of primary sentences in category
Understanding Self-Harm	The Precipitating Events	23
	Meanings Ascribed to Self-Harm	25
Experience of Self-Harm	Parent Experiences	29
	Young People's Experiences	8
	Education Systems	29
Experience of Systemic Family Intervention	Appraisal of Intervention	24
	The Technique	28
	The Therapist and Process	15
Reflection on Experiences	What Has Been Learnt	3
	Recommendations	12

Understanding Self-Harm

Families expressed how they understood self-harm with regards to its development and maintenance.

The Precipitating Events. Families reflected on key life events that they believed precipitated self-harm. This included the young person being subjected to bullying, school-based behaviour difficulties and stress in managing an intense college workload. One family was not aware of precipitating events at the time but had developed an awareness since. They could also acknowledge that their understanding of the development of self-harm might be different to their child's.

"The things that she highlighted which had like obviously really upset us was she has a sibling. And she said…that she always feels second best to her sibling, and she always has done. Doesn't she? … And that we've treat them differently. Which-" "We never have." "In our eyes we never have but she obviously…felt that didn't she?" (Interview 4, page 4)

Meanings Ascribed to Self-Harm. Families ascribed different meanings to self-harm that were sometimes related to the events involved in the development of self-harm. For example, one family viewed self-harm as part of a mental health difficulty that had been triggered by bullying. Another family viewed self-harm as a way to seek attention but acknowledged that it also might be used as a form of release from difficult feelings. The idea of self-harm being used as a coping mechanism was further echoed by families who viewed self-harm as a response to the young person feeling lonely and low or without control.

"I think I sort of realised…I didn't have much control with everything going on…I sort of did it [self-harm] just [for] control of something" (Interview 3, page 3)

One family acknowledged the influence of the systemic family intervention in shaping their understanding of self-harm, but for the other families it was unclear as to where their understandings had come from and how the intervention might have changed or shaped these.

Experience of Self-Harm

Parent Experiences. Parents spoke more than young people about their experiences of self-harm. Parents commonly reported strong emotional reactions linked to the discovery of their child's self-harm that were characterised by strong emotional reactions including worry.

"Pretty devastating is apparent" (Interview 3, page 5)

"My world crumbled at that point…for her to hide that from me and feel she had to hide it was quite heart-breaking." (Interview 2, page 4)

Parents commonly reported that they did not know what to do to help their child, but in all families the parents sought help from wider systems.

"We really just didn't know what to do, totally come out the blue…But we knew from that point we needed some professional help. So we rung our doctors didn't we?" (Interview 4, page 2)

The families who did not receive adequate support when they first reached out had further experiences of stress associated with self-harm. They reflected on the challenges in balancing life without support and feeling like they were fighting to get help.

"From my point of view, it was difficult because I was trying to sort it out. I'm trying to balance work. I'm trying to support Bailey. I'm trying to work with the school I've got, you know, a million different things going on but at the top of that list is Bailey, obviously, so it was really hard." (Interview 1, page 1)

"At the same time I was fighting her behaviours myself, and I was fighting the school to understand her behaviours and acknowledge that there was something wrong that she wasn't attention seeking or being "bad" as what they called her." (Interview 2, pages 3-4)

Young People's Experiences. Young people reflected on their experiences of self-harm less so than parents. Nevertheless, their experience of self-harm was characterised by negative emotions and difficulty.

"I struggled with self-harm on quite a regular basis." (Interview 3, page 1)

"I just felt real lonely" "Yeah. She felt real lonely and low" (Interview 2, page 2)

Education Systems. All families reflected on their experience of self-harm in relation to their experiences of the young person's school or college. Difficulties at school prior to and during self-harming episodes were common for young people and included bullying, difficulties with behaviour or workload pressures.

"She was very unhappy at college…she got two A distinctions at the end of the first year." "Then she burnt herself out in that time doing that"* (Interview 4, page 11)

Families attempted to work with school to help the young person at the time of their self-harm, but one family found the school had a different and unhelpful understanding of the young person's difficulties and two families felt school/college were only focused on attendance figures, which maintained the family's distress and difficulties.

"It just made it worse, erm, coz I was trying to get her to school coz they was on about fining me and stuff like that." (Interview 1, page 2)

"I think if she'd been a bad attender and things they would've been more interested in her problems but I went in with her two or three times to see them to sort of explain how badly she was feeling…in a way they didn't listen" (Interview 4, page 11)

Two young people ended up moving schools and one dropped out of college to pursue an apprenticeship instead. The two families who moved schools found their new schools to be more understanding and supportive which was influential in positively changing their experiences of self-harm.

"The [new] school is massively supportive and I think that really makes a big difference" (Interview 1, page 4)

Experiences of Systemic Family Intervention

Appraisal of Intervention. Families commented on their experience of the intervention. All families valued the intervention as positive, helpful and as part of the turning point within their story.

"She [the therapist] was a great support, 'cause she knew it was an overall thing. It wasn't just, it was like a tree with lots of branches, w- one was self-harm you know, there was there was behaviours, there was lots of other things so, that basically was the most help we got wasn't got? We we didn't we haven't had any other meetings about anything other than her ADHD which Meredith also sorted that out for us." (Interview 2, page 2)

"She was a different person. After the family therapy, I think just talking through everything and being able to open up about everything that's happened, but, it just sort of helped her as a person. Just come to terms with things" (Interview 3, pages 1-2)

The Technique. Families were able to reflect on the helpful aspects of the intervention. The explorative stance of therapists around families' experiences and contexts was useful in helping families to develop an understanding of self-harm and to reduce its occurrence.

"And so the lady [the therapist] was just going more or less into just how we were and just things that would help Jordan. In general, things that could help her at college, things that could help her at home and just to try and improve herself and make herself feel better about herself. And in doing so, that then helped her feel better so that she wasn't needing to self-harm as much." (Interview 3, page 1)

As well as an exploratory approach, families also reflected on the helpfulness of being given practical advice around safety and protective strategies.

"We continued with the CAMHS an- and kind of working with the gentleman and an-figuring ways out to help you, wasn't it? How you dealt with different situations and when you feel like you're going to do it look at those reasons and look at what kind of would happen going forward if you continued to do that and what kind of strategies you could, we could use for her to not get to that point." (Interview 1, page 4)

The Therapist/Process. In addition, the support of a therapist was deemed important in changing family experiences of self-harm. Families found having a therapist who was independent from the family and the difficulties was important.

"It was just more the support and having somebody outside that wasn't pushing against what you was trying to do they was trying to help the situation." (Interview 1, page 3)

"I mean CAMHS really helped us in the fact that they gave us some guidance on what we could do as parents." "And they gave us someone to talk to about it all basically that was independent." (Interview 4, pages 15-16)

Families acknowledged that young people might have found it difficult to open up and talk to the therapist, but this process was made easier when the therapist was non-judgmental, and when families felt listened to and heard.

"It was just nice to talk to someone that obviously I didn't know. And like they're not there to judge or anything." (Interview 1, page 5)

"She [the therapist] listened, she understood some of the reasons behind it and she was just fabulous…I think it cause she she finds it hard to talk and connect with people that she doesn't know and I don't know Meredith was just so- she was lovely wasn't she." (Interview 2, pages 3-5)

Reflection on Experiences

Families provided an evaluation of their experiences. This involved either discussing what they had learnt or providing recommendations to help other families with self-harm.

What Has Been Learnt. Families reflected on what they learnt following their experiences of self-harm and receiving intervention. In one family, the parent acknowledged that they had learned the importance of ensuring that their child was safe and that safety needed to be established prior to therapy.

"Knowing that up first and foremost is just safety…I've gotta just keep you safe one way or another and then we'll look at trying to help thereafter." (Interview 3, page 5)

Other parents felt that they had learned during the intervention how to helpfully manage their child's self-harm.

"For us…that lady [the therapist] told us things to do to get round- you know do- don't play up to Taylor…not highlight it, f- for us coz we found if you made a thing about it, she does it more...it works better for us to…lean ourselves away." "And I think we've got a lot better at doing that." (Interview 4, pages 13-14)

Recommendations. Two families provided recommendations directly linked to their own experiences. One family explained they had never heard of CAMHS, so expressed that it would have been helpful if services were more widely known. The parent also acknowledged their fear of social services which provided a barrier in talking to people. They recommended people spoke more about their experiences, to help reduce other people's fears and enable families to access support for self-harm.

"If things were known more widely, like CAMHS for instance and places that you can access, I think. And if if people kind of share their experiences of using the service. Other people might feel more comfortable accessing it 'cause I think sometimes as well, even though, you know they're trying to help, I think you have that. Because she's a child and you always get the social services thing. It it kind of goes well. If I go to them, they might. They might want to take her away or they might want to." (Interview 1, page 5)

Another family considered their first experience of an initial assessment at CAMHS stressful and unhelpful, but on the other hand they reported a positive experience with the therapist delivering the systemic family intervention. They discussed that more consistency across practitioners and more options for family support would be helpful.

"From our experience moving forward I think it's more…consistency across all of the counsellors. They all need to be singing off the same hymn sheet. I know every single person young person you see is different story but I think if they're all following the same guidelines etcetera, but I do think there needs to be more help-" "Yeah there do" "-for self-harm without a shadow of a doubt because that was literally the only option that we were given. Go to CAMHS." (Interview 2, pages 4-5)

Discussion

The research questions were concerned with whether families' experiences, meanings, and narratives, associated with self-harm, changed within the context of receiving a systemic family intervention and if so, what those are.

Firstly, prior to receiving intervention, families experienced difficulties within the lives of the adolescent, precipitating the experience of self-harm. Previous research had implicated a range of risk factors in the development of self-harm (Hawton & Fortune, 2008) and this was reflected in the current study as families had different experiences, suggesting that self-harm is not precipitated by a specific event. Families highlighted bullying, difficulties at school with behaviour and difficulties managing an intense college workload, which aligns with literature that indicated bullying, intrapersonal and interpersonal emotional turmoil, and school problems as precipitating factors in adolescent self-harm (Roose & John, 2003; McAndrew & Warne, 2014). The experiences before self-harm shaped how families understood this behaviour. Families understanding of self-harm was varied but included as a response to difficult feelings or a lack of control, a release, and a way to seek attention/connection suggesting that family understandings are like those of individual adolescents (Stänicke et al., 2018).

Families initially struggled with difficult and negative emotions regarding self-harm. Previous research has not considered the experiences of families, but separately young people report distressing emotions when feeling the urge to self-harm (Pascoe et al., 2020) and parents report experiencing sadness, stress, and anxiety as they discover and attempt to manage their child's self-harm (Oldershaw et al., 2008; Ferrey et al., 2016). The current study

connects these two findings by demonstrating that self-harm is distressing for the family which further highlights the systemic effects of self-harm.

The importance of adopting a systemic perspective of self-harm is further emphasised by the finding that parents initiate help-seeking. In line with existing literature, adolescents do not try to obtain help from external services (Evans et al., 2005) but parents are influential in accessing mental healthcare (Boulter & Rickwood, 2013). However, for some families, attempts to access help increased stress. This occurred when families felt dismissed and that their concerns about their child's wellbeing and self-harm were not understood. Parents of young people who self-harm have previously emphasised the unhelpfulness of professionals not listening to their perspectives (Stewart et al., 2018) suggesting that for help-seeking to be effective, professionals need to listen to and understand the experiences of the parent as well as those of the adolescent, suggesting the benefits of a family, rather than individual, focus.

All families expressed a turning point in their experiences of adolescent self-harm, which was partly associated with receiving the systemic family intervention. The findings support the claim that a family-centred approach is characteristic of efficacious interventions for adolescent self-harm (Glenn et al., 2019), as all parents reflected on how the intervention had helped their experiences and understandings of self-harm as well as those of the adolescents. One adolescent also reflected on the importance of having their parent present during the intervention to help them find their voice in therapy.

In addition, the findings expand on the SHIFT trial (Cottrell et al., 2018) which measured the effectiveness of a systemic intervention by quantitative outcome measures. The current study highlights the effectiveness of systemic interventions for adolescent self-harm as families

outlined how this intervention positively changed their experiences of self-harm. The current research aligns with Holliday et al. (2018) who identified a theme of "moving forward" amongst adolescents' experiences and understandings of self-harm during the SHIFT trial and expands on this finding by suggesting that this is representative of the whole family experience. Holliday et al.'s (2018) theme of moving forward was partly characterised by participants being able to move forward and resist or abstain from self-harm and within the current study the experience of self-harm had not disappeared from all families. The presence of self-harm within families could account for the findings in the SHIFT trial that systemic interventions were not significantly more effective than other interventions. However, the current study delves deeper into experiences and suggests that although self-harm is still present, it occurs less frequently and families are better prepared to manage self-harm, so it is not associated with the same level of distress.

Despite the role the intervention played in positively changing family experiences of self-harm, the study also highlighted the importance of other systems and contextual factors (for example, schools, healthcare services and a change in life stage) in this turning point. Bronfenbrenner's (1979) ecological systems model highlights the influence of the exosystem and how social structures can indirectly influence individual's experiences. For example, government law permits young people more freedoms when they turn 18 years old. This enabled one family's child to access their own car, which helped with their independence. In turn, the family dynamic and their experience of self-harm was altered.

The systemic nature of self-harm was further emphasised by the finding that educational settings were referenced by all families as either a source of support or stress in relation to their experiences of self-harm. When schools listened to families and worked alongside them,

their experiences of self-harm as child and parental distress reduced. School is thought to be an important source of support with regards to self-harm (Fortune et al., 2008). However, families reflected that educational settings could be unhelpful. Young people have a high workload, schools seemed focussed on attendance figures and/or schools did not understand and mislabelled the young person's behaviour. This is indicative of the wider pressures that are placed upon schools and colleges, which hamper a focus on family wellbeing. The Department for Education's (DfE) statutory guidance (Department for Education, 2016) outlines that schools should monitor attendance closely and address poor and irregular attendance. Furthermore, the DfE publishes school/college performance tables where schools rank highly with high attendance figures and pupils attain high level grades. The measure and ranking of school performance could understandably lead to pressures within the school system, which leads staff to focus on academic achievement and attendance rather than pupil wellbeing and difficulties such as self-harm. This argument is supported by research where schools have outlined that a lack of time (due to the curriculum and teaching job demands) and resources is a barrier to addressing adolescent self-harm (Evans et al., 2019).

The Unsaid

Families indicated that some things were left unsaid within the interviews. Two of the young people spoke significantly less than their parents and one parent acknowledged that she could only start the story from where she knew it, not from where it began. Another family reflected that there were things they did not want to speak about in the interview, and another referenced that their child might have different experiences and understandings to them, but that they did not wish to participate. The nature of narrative interviews allows participants to control what they do and do not say (Corbin & Morse, 2003), but there are different possibilities regarding why some things were unsaid. Firstly, families were asked to tell their

story up to 24 months after the intervention. For all families they reflected on being in a better place now, which is indicative of recovery. The CHIME framework (Leamy et al., 2011) conceptualises recovery and has been applied to experiences of mental health difficulties (Brijnath, 2015). It outlines that empowerment, which is characterised by a focus on strengths, is an element of recovery. For families who have seemingly recovered from self-harm there may be challenges in talking about difficulty, conflict, and distress especially when they are in a position of focussing on their personal strengths and achievements.

Secondly, the reason for the unsaid may be linked to the topic of the research. Self-harm has been associated with feelings of shame and therapists reflected that they encountered powerful feelings of shame amongst families in the SHIFT trial (Amoss et al., 2016), suggesting it is likely that this was present amongst families participating in the current study. However, shame was not identified within the stories. Shame may have prevented families from discussing all aspects of their experiences related to self-harm as it has been found to be a barrier to individuals disclosing their experiences of trauma (Cummings & Baumann, 2021). The decision to leave elements of stories unsaid could have been further strengthened by the experience and/or fear of stigma because young people report this prevents them from speaking about self-harm (Klineberg et al., 2003). Josselson et al. (2011) emphasises the importance of interpreting the data within the context that it was obtained. Participants were asked to share their story with a researcher whom they had not met prior, and their experiences and/or fear of shame and stigma could have led to leaving aspects of their stories unsaid.

Strengths, Limitations and Future Research

This unique study explored for the first-time shared family experiences, meanings and narratives associated with adolescent self-harm within the context of having received a systemic family intervention. Hearing the voices of families who have experienced adolescent self-harm is a key strength of the study. The discussion has aforementioned the challenges and barriers that young people and their families experience when talking about self-harm, so to present the voices of families within this research is rare but of high importance to understand people's experiences.

The study aimed to be exploratory as narrative research does not focus on generating generalisable data (Josselson, 2011). Interestingly, families' narratives shared similar form and content suggesting that there were significant shared experiences within the sample. The stories identified within this research might be representative of one group of families who experience adolescent self-harm, but it is likely that there are other stories that were not captured by this research. The recruitment strategy could have influenced the narratives collected. The study was designed to recruit participants post-intervention and consequently CAMHS staff approached potential participants. Participants with negative experiences of CAMHS or the intervention might have been less likely to take part in the study and the study was not open to families who dropped out of intervention. Future research should aim to hear family experiences where families have not completed intervention and to address the barriers to participation for those who have had negative experiences with CAMHS and/or therapy. For example, a neutral individual not associated with CAMHS could be employed to contact and interview potential participants. In addition, all parents reported that they initiated contact with helping services and this could reflect that the current parents and families were already supportive. Future research could focus on speaking with families

where there have been referrals through external sources and/or where young people have self-referred to capture whether there are different narratives within families when parents have not sought help.

Thirdly, families focussed on their experiences of self-harm and provided less information on their meanings and understanding of this. Families spoke about their present understanding of self-harm, but it was not clear whether this had changed from before the intervention and, if so, how. Families spoke broadly about developing an understanding of self-harm throughout therapy and parents sometimes reflected that they did not understand all the reasons behind their child's self-harm but seemed to appreciate that their understandings might differ. This could suggest that intervention did have some influence on families' understandings and meanings. Rogers and Schmidt (2016) noted that at the beginning of the SHIFT trial family members often had different and opposing views of self-harm, but because of therapist techniques family members became more able to hold multiple, different understandings of self-harm. However, Rogers and Schmidt (2016) reported this from the perspective of therapists and families might not experience or notice changes in their understandings in the same way. The current study was designed to be non-directive as no previous research had explored this area. However, future research should now focus on families' meanings and understandings that are ascribed to self-harm within the context of receiving a systemic intervention. It would be important to establish whether families reflect on the same changes as therapists (Rogers & Schmidt, 2016) and how their understandings of self-harm interact with their experiences of this behaviour (for example, how do families understand self-harm when it first presents? And how does this understanding change when families experience a turning point?).

Finally, the study focussed on obtaining family stories from one context (i.e., experience of a systemic family intervention), as it did not aim to evaluate the effectiveness of systemic interventions but to explore family experiences and situate these within a specific context. However, families identified that the intervention was influential in their turning point. The SHIFT trail (Cottrell et al., 2018) compared family therapy to other interventions and therefore to develop a wider evidence base future research could explore family experiences of self-harm within different intervention contexts. For example, what are family experiences of self-harm when the adolescent receives an individual intervention? How does not being a part of a therapeutic intervention influence the experiences of the whole family in relation to self-harm?

Implications and Conclusions

The current study has implications for clinical practice. Firstly, families reflect positively on systemic family interventions for adolescent self-harm, and they have a positive effect on the experiences of the adolescent who self-harms and their parents. This study supports the delivery of systemic interventions for adolescent self-harm within CAMHS. Secondly, the study emphasises the importance of maintaining a wider systemic perspective when working with self-harm to develop an in-depth understanding of its development and maintenance. To positively change families' experiences of self-harm practitioners should consider wider system changes as it is not the therapeutic intervention alone that influences families' turning points.

Wider implications for the study include the importance of schools understanding self-harm and an ability to support students and their families. It is important for schools to work with parents, and this seems to be most effective when there is a shared understanding of the

child's distress and a plan of support from school. When schools are influenced by external policy pressures such as attendance and curriculum delivery, they are less able to attend to the needs of adolescents who self-harm. Young people's wellbeing should also be enshrined in policy as an educational priority.

Furthermore, the study was designed due to the growing public health concern regarding self-harm. It demonstrates that there are a variety of precipitating life events involved in the development of self-harm, but these events are identifiable. Future research should explore support for families during the initial decline before self-harm begins to prevent its occurrence and protect families from further difficult experiences.

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Part Three: Appendices

Appendix A. Submission Guidelines for Journal of Family Studies

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Updated 14th April 2021

Appendix B. Epistemological Statement

The epistemological stance of the researcher underpins the researchers' approach, methodology and interpretation of the data. Therefore, this statement has been written to summarise the position of the researcher and how this influenced the stages of the research.

One epistemological position is positivism. Positivism is based on the belief that there are identifiable truths (Willig, 2013) and this stance generally underpins quantitative research that employs methods of experimentation and observation to test and establish reality. This stance was rejected by the researcher as the assumption that there is one experience of self-harm amongst families does not align with previous literature or the researchers experience of clinical practice. Previous literature has highlighted that there are a range of factors that underlie the development of self-harm (Hawton & Fortune, 2008); young people have described different experiences and ascribed different meanings to their self-harm (Stänicke at al., 2018); and parents have also reported different experiences and understandings of their child's self-harm (Oldershaw et al., 2008; Ferrey et al., 2016). Although there may be similarities in experiences there is not one universal experience that can be viewed as the truth.

In contrast to a positivist position, social constructionism proposes that knowledge is constructed through social processes and interactions between people and knowledge can be regarded as being historically and culturally specific (Burr, 2015). Consequently, social constructionism acknowledges the possibility of the existence of multiple truths. This stance enabled the researcher to work in line with the exploratory aims of the research as well as to acknowledge that the different stories told by participants were equally valid constructions of events intended for the audience of the researcher and their research (Mishler, 2004).

Moreover, social constructionism has been influential in informing systemic approaches to working with families (Boston, 2000). As the research aimed to explore experiences of self-harm within the context of receiving a systemic intervention it seemed most appropriate to adopt to epistemological stance of social constructionism, as this underpins the work of systemic practice.

The social constructionist position influenced the researcher in selecting a qualitative methodology, which was also in line with the exploratory aims of the research. Several qualitative methodologies were considered, but the methodology that was deemed to be most in line with the epistemological stance was Narrative Analysis. Narrative research proposes that people live and understand their lives in storied forms and emphasises that narratives should be understood in terms of context and as influenced by the circumstances under which they were obtained (Josselson, 2011). This aligns with the social constructionist viewpoint that knowledge is co-constructed and influenced by various contextual factors (Burr, 2015).

A narrative approach was also deemed an appropriate method to explore family's experiences and due to a lack of previous research it seemed important utilise an exploratory method. Furthermore, a narrative approach was preferred over other qualitative methodologies as it emphasises the use of non-directive interviews. This allowed families control in what was and was not included in their story and therefore what was or was not spoken about with the researcher. This was deemed as important as previous research has highlighted the stigma associated with self-harm (Staniland et al., 2020) and the difficulties people might experience regarding talking about this (Klineberg et al., 2013). The researcher acknowledged that having to answer specific questions about their personal experiences and understandings of

self-harm could have been distressing for participants and/or functioned as a barrier to participation.

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Appendix C. Reflective Statement

Throughout this process I have frequently been envisioning a mountain in front of me and the completed thesis somewhere at the top. Facing this mountain has at times been overwhelming and exhausting, but also rewarding. Perhaps I have spent too long engrossed in narrative methods, but the easiest way for me to share my reflections on the research are to consider my experiences like a story. Like all stories there are significant characters, events, and a beginning, a middle and an end.

Choosing the research

The beginning of this process was marked by a feeling of "I don't know where to start." Prior to starting the course, I did a wide variety of work and volunteering and was always keen to try new things. When I started training, I was, and to some extent still am, open and interested in every opportunity I was offered. However, when faced with the decision to choose one research topic I did not know where to start. I listened as my peers spoke about their original research ideas that they had thought of and felt incompetent by comparison. I have learnt throughout this process the unhelpfulness of comparing myself and my research journey to others as no joy or progress is made whilst comparisons are. As Iyanla Vanzant once said: "Comparison is an act of violence against the self".

At the research fair there was one conversation that I was particularly drawn to. I spoke with Charlotte Cosquer and Andy Stephenson about an idea for a project exploring family experiences in relation to systemic interventions for self-harm. Coming from a close family I was drawn to systemic ways of thinking and working. I reflected on my own family system and how this had been influential in shaping my experiences and understandings throughout my life. Although I had little knowledge on systemic practice at the time the reasoning

behind working with families to create difference in the lives of multiple people rather than just the individual made sense to me. Over the course of training my passion for systemic practice has grown immensely. I have seen first-hand its impact, importance, and value and this has been crucial in re-energising and re-engaging me with my research.

Moreover, I was interested in research that would explore experiences of self-harm. I had noticed that despite not having personal experience of self-harm it has occupied an often silent presence in my relationships with others. I have seen the significance self-harm has played in lives surrounding mine, but I can count on my hands the number of conversations I have had about self-harm with others (prior to completing this research). I wondered whether this lack of conversation reflected the influence of wider societal discourses commonly presented in the media about self-harm, which interestingly was an area highlighted by the systematic literature review. The possibility of creating opportunities to speak with people about their experiences of self-harm and to provide a space to amplify people's voices felt incredibly important to me. This inspired me to speak further with Charlotte and Andy and consider how we could develop the idea into a research project.

Designing the research

One decision I was certain on was that I wanted to complete a piece of qualitative research. I was drawn to the idea of speaking directly with people to understand their experiences, even though this type of research stood in stark contrast to my undergraduate study that was predominantly focussed on quantitative methods. As the research was designed to be exploratory qualitative methods were an appropriate fit, but it still felt like a brave decision to pursue this due to my perceived lack of experience and knowledge. However, the advice

from trainees and course staff was clear in stating the importance of choosing research that you are interested in, and I was passionate about hearing people's voices and stories.

As no research had explored this area before I felt it was important to hear directly from people about their experiences in as unobtrusive manner as possible. I did not want to restrict participants to questionnaire-based measures or structured interviews. I considered semi-structured interviews but reflected on the lack of previous research into this area and feeling like devising topic guides would be driven by my personal interests rather than giving space for families to talk about the experiences, meanings and narratives that were important for them. This led me to explore a narrative approach to research and a quote by Josselson (2011, page 226) affirmed my decision to pursue this: "It is not the parts that are significant in human life, but how the parts are integrated to create a whole – which is meaning." I felt this quote emphasised the importance of hearing people's unrestricted stories and emphasised that it is not sections of extracted content that are important, but that meaning can be found from the whole and how this is told.

Decisions about participants and inclusion and exclusion criteria were also made at this point. I understood the importance of designing research that was inclusive but that would also protect potential participants. For example, it did not seem appropriate to interview families for whom intervention was ongoing or those with social care concerns in place. The research was also focussed on family experiences in the context of systemic interventions and so the decision to complete joint interviews with at least two family members was made. This was because families had attended the intervention together and I therefore did not want to speak to parents or adolescents separately as I felt this would exclude voices from the research. I was questioned during a research presentation when designing the project whether attempts

could be made to recruit a more "homogenous" sample. I had conversations in supervision around what is a family and whether homogeneity could even be applied to thinking about families. If I focussed on parents but a child was seen with a grandparent did this make the grandparent ineligible or eligible? Or if I focussed on a separate parent group and an adolescent group would this imply that the voices of siblings were of less importance? Due to not wanting to marginalise the voices of family members I chose to allow inclusion of any family member who had attended at least three sessions of intervention.

Initially I chose to complete joint interviews with participants. My passion for systemic practice meant that I was hopeful the intervention would have helped families in being together and I did not want to split families up within the research and interview people individually when they had been together for intervention. I wondered if this decision had also been influenced by my own views of families. When thinking of family words such as "connectedness" come to my mind. I now understand that this is shaped by my life experiences and led me to view "family experiences" as those which are shared between people. However, what I later considered was that family experiences and experiences of systemic intervention might not be in line with my own positive views and it might be incredibly challenging for families to come together again to talk in front of one another about their experiences. Individual contributions to the research could have still been in line with expressing family experiences and therefore not giving people the option to interview individually might have excluded valuable voices. After reflection and some initial difficulties with recruitment I reconsidered my decision and had an amendment approved to interview people individually. However, no participants opted to be interviewed alone which perhaps revealed that being interviewed with a family member was not the main barrier to participation.

Conducting the research

Ethics Application

The most frustrating part of the research was applying to ethics. I was aware that the ethics process would be long, but I did not foresee that this would take almost a year. There were various contextual delays (for example, changes due to Covid-19) on top of an already lengthy process. Throughout this point I learned how to be persistent and patient. It was difficult to not lose hope and I frequently tried to reconnect myself with the research topic and why I was doing this.

Recruitment

I perhaps naïvely thought that once ethical approval had been granted recruitment would be a straightforward procedure. Unfortunately, this was not the case and therefore not the end of completing ethics applications. I had hoped and intended to recruit more than eight participants, but there were significant unforeseen contextual changes that influenced recruitment. The study originally proposed to recruit families who had been discharged in the last twelve months. However, in March 2020 the Covid-19 pandemic was declared and government restrictions had a massive impact on practice in CAMHS. Very little was offered in terms of intervention for a significant period from March 2020 as clinicians were instructed to focus on covering urgent cases, crisis, or the inpatient unit. Therefore, by the time ethical approval was granted in late January 2021 there were very few families who had received intervention and been discharged within the last 12 months. Consequently, an amendment was approved by the ethics committee to extend the recruitment period to 24 months. However, this did very little to aid recruitment as many families initially contacted by Charlotte (my field supervisor) who had been discharged over 12 months ago stated that they had put this experience behind them and were reluctant to re-open it so long after.

Multiple avenues were explored by myself, Charlotte and my supervisors and everything we could have tried to identify participants and boost recruitment was attempted.

In total, twenty-two families were identified as being eligible. Although some of these were not reachable or chose to decline, twelve consented to be contacted by myself. Numerous attempts were made to contact potential participants and arrange convenient times to talk about the research. Even when some people confirmed and arranged participation, they then cancelled the interview and withdrew from the study. I found this stage of the journey incredibly disheartening. I still maintained that this research was needed and could have important clinical implications, but I also knew it could not happen unless people were willing and able to speak with me. However, I understood people's reluctance to interview. We were one year into a global pandemic and living life under everchanging restrictions, which at the beginning of 2021 were hardly different to those we had lived through in March 2020. Media reports at this time expressed concerns about the impact of lockdown on people's wellbeing and so I understood when families explained that they did not want to reopen their difficult past at this point in their lives. At the point of designing and planning the research I did not anticipate that we would have to recruit participants from beyond the last 12 months nor could I have been prepared to overcome such significant and understandable barriers to people's willingness to engage.

Interviews

It was a privilege to be able to meet with and interview the eight participants. The difficulties with recruitment made me realise this more so by understanding how rare and unique it was to get families together post-intervention to speak about self-harm. Although some may deem it to be a small sample size it is a privilege to have amplified the voices of the families within

this research. To not conduct research based on sample size would marginalise stories, which I feel were so rich, important, and impactful. Informal conversations with participants pre- and post-interview reminded me of the importance and passion I had for this research. Each family reflected on the value that they perceived the project to have and their hopes that their contribution would make a positive difference for the lives of others.

With regards to practically completing interviews, I often felt uncertain about what I was doing. My understanding of a narrative approach was that questions were only asked for clarification purposes, and I noticed that I was hesitant to ask any questions in case I did it "wrong" and influenced someone's story, which was a behaviour that I viewed as being negative and against the "rules" of the method. What I came to realise was that the researcher can never be fully separate from their research and narrative analysis owns a position of subjectivity as the data is understood not as being an exact telling of reality or truth, but as a construction of events that has been created in a specific setting (i.e. the interview), for a specific purpose (i.e. the research project) and for a specific audience (i.e. the researcher) (Mishler, 2004).

Data Analysis

After transcription of the interviews, I was met with the familiar feeling "I don't know where to start". I realised that if I wanted to analyse the data then a good place to begin would be by immersing myself in it. I listened to each story numerous times and read through the transcripts. I was incredibly moved by the stories that families had shared, and it felt like such a privilege to be able to hear and hold these stories.

With regards to completing the analysis, I found a creative approach to this process to be greatly helpful and it was refreshing to step away from the laptop screen and actively engage with the data. At times I hit a wobble in analysis where I was caught by my previous view that research should be objective. I found reassurance in Lieblich et al.'s (1998) description of narrative analysis: "The work that is carried out is interpretive, and an interpretation is always personal, partial, and dynamic. Therefore, narrative research is suitable for scholars who are, to a certain degree, comfortable with ambiguity." (Lieblich et al., 1998, page 9). I found that through reflection and self-reflexivity I became more comfortable with ambiguity.

Writing Up

One of the best pieces of advice I received during this process was from one of my research supervisors, Paul, who told me to just start writing. For someone who is an over-planner this was a very daunting and alien concept to me. How was I going to make sure that I'd written things right if I hadn't planned out exactly how I was going to write them? Nevertheless, I sat myself down and I wrote some words. Surprisingly to me quite a few of them made the final edits, but importantly they reduced that feeling of being stuck and made me realise that when I feel like I don't know where to start it's probably because there isn't a right or wrong starting point.

Systematic Literature Review

There were times when I felt I had no control over my empirical project. It felt stuck waiting for ethical approval or stuck waiting for recruitment. During these times I found control in writing my systematic literature review. I was pleased I started this early and that I chose a topic particularly close to my research area. Considering parents experiences emphasised the systemic nature of self-harm. This kept me motivated to complete my empirical project. To

hear family experiences and to consider these in the context of having received a systemic intervention for self-harm felt even more of an important gap in literature to address after completing the review.

Final Reflections

I feel immensely proud of not only what I have achieved, but what I have learned. Alongside the academic learning and developing my research skills I feel I have grown and learnt so much about myself. I have a much deeper understanding of my own views, biases and assumptions and this awareness will be crucial in my career and everyday life. I understand more about how I manage and respond in various difficult situations and how to remain focussed and hold onto my passion and sense of determination. It is important for me to focus on what I can control and to not compare myself and my journey to others.

As I write this reflective statement now, I consider that I have made it to the summit of that mountain. I realise that I spent so much time focussing on the end that I did not always pause and appreciate the journey. I have gradually learned through my supervisors how to celebrate each step forward no matter how big or how small and I will continue to encourage myself and others to do the same throughout my professional career and my personal life.

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Mishler, E. G. (2004). Historians of the self: Restorying lives, revising identities. *Research in Human Development, 1*(1-2), 101-121.

Appendix D. NICE Quality Appraisal Checklist for Qualitative Studies

<table>
<tr><td>Study identification: Include author, title, reference, year of publication</td><td colspan="2"></td></tr>
<tr><td>Guidance topic:</td><td colspan="2">Key research question/aim:</td></tr>
<tr><td>Checklist completed by:</td><td colspan="2"></td></tr>
<tr><td colspan="3">Theoretical approach</td></tr>
<tr><td>1. Is a qualitative approach appropriate?
For example:
• Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings?
• Could a quantitative approach better have addressed the research question?</td><td>Appropriate
Inappropriate
Not sure</td><td>Comments:</td></tr>
<tr><td>2. Is the study clear in what it seeks to do?</td><td>Clear</td><td>Comments:</td></tr>
</table>

For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Unclear Mixed	
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		

4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		
5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described?	Clear	Comments:

For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Unclear Not sure	
7. Were the methods reliable? For example: • Was data collected by more than 1 method? • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous? For example:	Rigorous Not rigorous	Comments:

• Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Not sure/not reported	
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data?	Reliable Unreliable	Comments:

• If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Not sure/not reported	
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:

<table>
<tr><td>13. Conclusions
For example:
How clear are the links between data, interpretation and conclusions?
Are the conclusions plausible and coherent?
Have alternative explanations been explored and discounted?
Does this enhance understanding of the research topic?
Are the implications of the research clearly defined?
Is there adequate discussion of any limitations encountered?</td><td>Adequate
Inadequate
Not sure</td><td>Comments:</td></tr>
<tr><td colspan="3">Ethics</td></tr>
<tr><td>14. How clear and coherent is the reporting of ethics?
For example:
Have ethical issues been taken into consideration?
Are they adequately discussed e.g. do they address consent and anonymity?</td><td>Appropriate
Inappropriate
Not sure/not reported</td><td>Comments:</td></tr>
</table>

• Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?		
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix E. Downs and Black (1998) Quality Appraisal Checklist for Quantitative Studies

Item	Criteria	Possible Answers	Comments
	Reporting		
1	Is the hypothesis/aim/objective of the study clearly described?	Yes = 1 No = 0	
2	Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.	Yes = 1 No = 0	
3	Are the characteristics of the patients included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.	Yes = 1 No = 0	
4	Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described	Yes = 1 No = 0	
5	Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided.	Yes = 2 Partially = 1 No = 0	
6	Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).	Yes = 1 No = 0	
7	Does the study provide estimates of the random variability in the data for the main outcomes? In non-normally distributed data, the interquartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	Yes = 1 No = 0	
8	Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).	Yes = 1 No = 0	
9	Have the characteristics of patients lost to follow-up been described? This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered	Yes = 1 No = 0	

	no where a study does not report the number of patients lost to follow-up.		
10	Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?	Yes = 1 No = 0	
	External validity		
11	Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.	Yes = 1 No = 0 Unable to determine = 0	
12	Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.	Yes = 1 No = 0 Unable to determine = 0	
13	Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.	Yes = 1 No = 0 Unable to determine = 0	
	Internal validity - bias		
14	Was an attempt made to blind study subjects to the intervention they have received? For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.	Yes = 1 No = 0 Unable to determine = 0	
15	Was an attempt made to blind those measuring the main outcomes of the intervention?	Yes = 1 No = 0 Unable to determine = 0	
16	If any of the results of the study were based on “data dredging”, was this made clear? Any analyses that had not been planned at the outset of the study should be	Yes = 1 No = 0 Unable to determine = 0	

	clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.		
17	In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? Where follow-up was the same for all study patients the answer should be yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.	Yes = 1 No = 0 Unable to determine = 0	
18	Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. For example, nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	Yes = 1 No = 0 Unable to determine = 0	
19	Was compliance with the intervention/s reliable? Where there was noncompliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.	Yes = 1 No = 0 Unable to determine = 0	
20	Were the main outcome measures used accurate (valid and reliable)? For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.	Yes = 1 No = 0 Unable to determine = 0	
	Internal validity – confounding (selection bias)		
21	Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case-control studies where there is no information concerning the source of patients included in the study.	Yes = 1 No = 0 Unable to determine = 0	
22	Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same	Yes = 1 No = 0 Unable to determine = 0	

	period of time? For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.		
23	Were study subjects randomized to intervention groups? Studies which state that subjects were randomized should be answered yes except where method of randomization would not ensure random allocation. For example, alternate allocation would score no because it is predictable.	Yes = 1 No = 0 Unable to determine = 0	
24	Was the randomized intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All nonrandomized studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.	Yes = 1 No = 0 Unable to determine = 0	
25	Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomized studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.	Yes = 1 No = 0 Unable to determine = 0	
26	Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.	Yes = 1 No = 0 Unable to determine = 0	
	Power		
27	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%? Sample sizes have been calculated to detect a difference of x% and y%.	Yes = 1 No = 0 Unable to determine = 0	

Appendix F. Qualitative Studies Quality Assessment

Paper	Checklist Score Item													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	Rating
Raphael et al. (2006)	Appropriate	Clear	Defensible	Not sure	Clearly described	Unclear	Reliable	Rigorous	Not sure	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Oldershaw et al. (2008)	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Rose et al. (2011)	Appropriate	Clear	Defensible	Appropriately	Clearly described	Clear	Not sure	Rigorous	Rich	Not sure	Convincing	Partially relevant	Adequate	Not reported	++
Ferrey et al. (2015)	Not sure	Mixed	Not sure	Not sure	Not described	Unclear	Not sure	Not sure	Poor	Not sure	Not sure	N/A	Inadequate	Not reported	-
Ferrey et al. (2016a)	Appropriate	Clear	Defensible	Appropriately	Not described	Not sure	Not sure	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	++
Ferrey et al. (2016b)	Appropriate	Clear	Defensible	Appropriately	Unclear	Clear	Not sure	Rigorous	Rich	Reliable	Convincing	Partially relevant	Not sure	Appropriate	++
Hughes et al. (2017)	Not sure	Mixed	Defensible	Not sure	Unclear	Unclear	Not sure	Rigorous	Rich	Reliable	Convincing	Partially relevant	Adequate	Appropriate	+

Stewart et al. (2018)	Appropri ate	Clea r	Defensi ble	Appropria tely	Unclea r	Clear	Not sure	Rigoro us	Rich	Relia ble	Convinc ing	Relev ant	Adequat e	Appropri ate	++

Appendix G. Quantitative Studies Quality Assessment

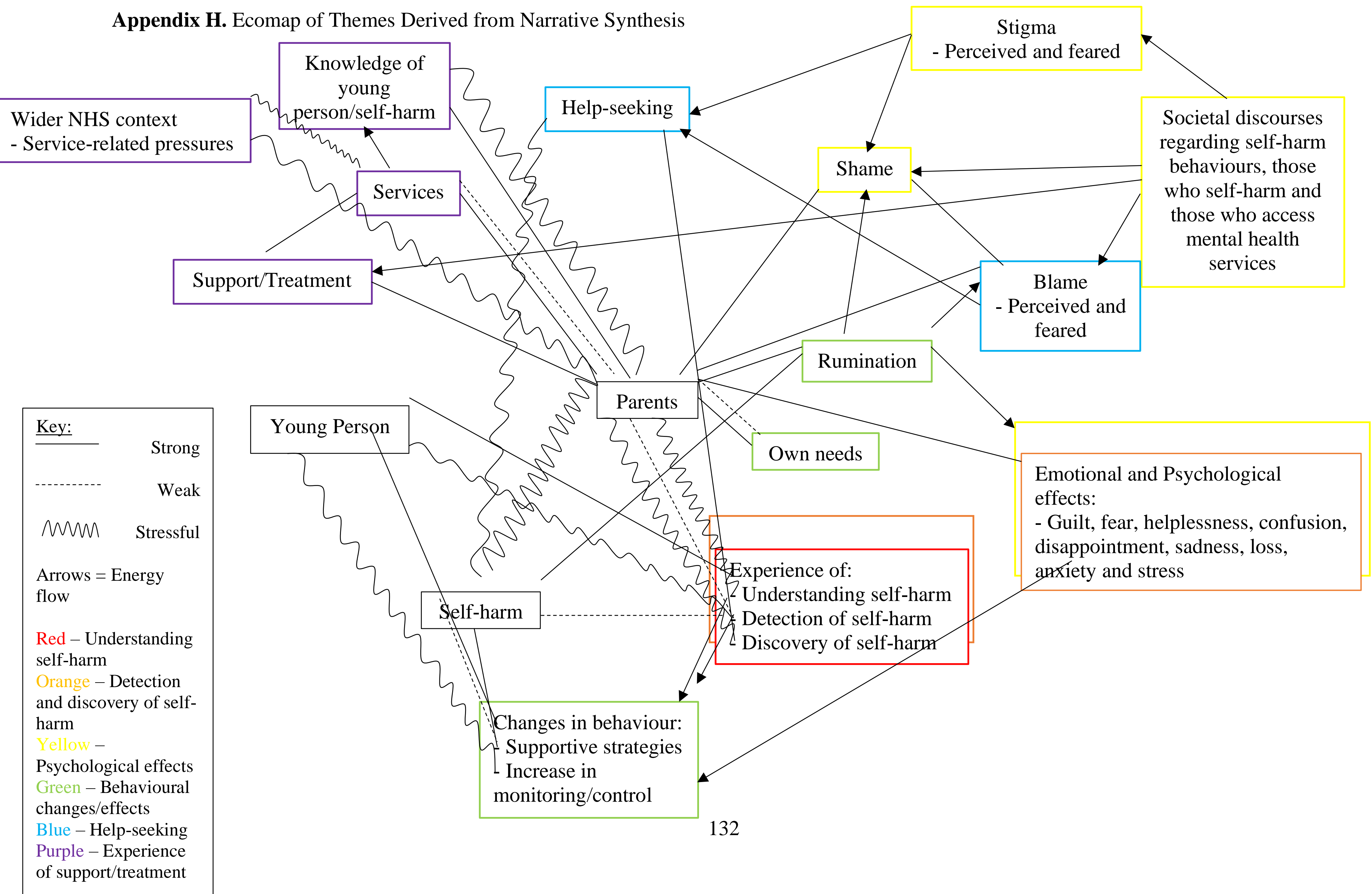
		Checklist Score	
Item	**Criteria**	**Gilliland (1990)**	**Mojtabai & Olfson (2008)**
	Reporting		
1	Is the hypothesis/aim/objective of the study clearly described?	Yes = 1	Yes = 1
2	Are the main outcomes to be measured clearly described in the Introduction or Methods section? If the main outcomes are first mentioned in the Results section, the question should be answered no.	No = 0	Yes = 1
3	Are the characteristics of the patients included in the study clearly described? In cohort studies and trials, inclusion and/or exclusion criteria should be given. In case-control studies, a case-definition and the source for controls should be given.	Yes = 1	Yes = 1
4	Are the interventions of interest clearly described? Treatments and placebo (where relevant) that are to be compared should be clearly described	N/A	N/A
5	Are the distributions of principal confounders in each group of subjects to be compared clearly described? A list of principal confounders is provided.	No = 0	No = 0
6	Are the main findings of the study clearly described? Simple outcome data (including denominators and numerators) should be reported for all major findings so that the reader can check the major analyses and conclusions. (This question does not cover statistical tests which are considered below).	Yes = 1	Yes = 1
7	Does the study provide estimates of the random variability in the data for the main outcomes? In non-normally distributed data, the interquartile range of results should be reported. In normally distributed data the standard error, standard deviation or confidence intervals should be reported. If the distribution of the data is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	No = 0	Yes = 1
8	Have all important adverse events that may be a consequence of the intervention been reported? This should be answered yes if the study demonstrates that there was a comprehensive attempt to measure adverse events. (A list of possible adverse events is provided).	N/A	N/A
9	Have the characteristics of patients lost to follow-up been described? This should be answered yes where there were no losses to follow-up or where losses to follow-up were so small that findings would be unaffected by their inclusion. This should be answered	N/A	N/A

	no where a study does not report the number of patients lost to follow-up.		
10	Have actual probability values been reported (e.g. 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?	No = 0	No = 0
	External validity		
11	Were the subjects asked to participate in the study representative of the entire population from which they were recruited? The study must identify the source population for patients and describe how the patients were selected. Patients would be representative if they comprised the entire source population, an unselected sample of consecutive patients, or a random sample. Random sampling is only feasible where a list of all members of the relevant population exists. Where a study does not report the proportion of the source population from which the patients are derived, the question should be answered as unable to determine.	Unable to determine = 0	Yes = 1
12	Were those subjects who were prepared to participate representative of the entire population from which they were recruited? The proportion of those asked who agreed should be stated. Validation that the sample was representative would include demonstrating that the distribution of the main confounding factors was the same in the study sample and the source population.	Unable to determine = 0	Yes = 1
13	Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of patients receive? For the question to be answered yes the study should demonstrate that the intervention was representative of that in use in the source population. The question should be answered no if, for example, the intervention was undertaken in a specialist centre unrepresentative of the hospitals most of the source population would attend.	Yes = 1	N/A
	Internal validity - bias		
14	Was an attempt made to blind study subjects to the intervention they have received? For studies where the patients would have no way of knowing which intervention they received, this should be answered yes.	Unable to determine = 0	N/A
15	Was an attempt made to blind those measuring the main outcomes of the intervention?	No = 0	N/A
16	If any of the results of the study were based on “data dredging”, was this made clear? Any analyses that had not been planned at the outset of the study should be clearly indicated. If no retrospective unplanned subgroup analyses were reported, then answer yes.	Unable to determine = 0	Yes = 1

17	In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls? Where follow-up was the same for all study patients the answer should be yes. If different lengths of follow-up were adjusted for by, for example, survival analysis the answer should be yes. Studies where differences in follow-up are ignored should be answered no.	N/A	N/A
18	Were the statistical tests used to assess the main outcomes appropriate? The statistical techniques used must be appropriate to the data. For example, nonparametric methods should be used for small sample sizes. Where little statistical analysis has been undertaken but where there is no evidence of bias, the question should be answered yes. If the distribution of the data (normal or not) is not described, it must be assumed that the estimates used were appropriate and the question should be answered yes.	Yes = 1	Yes = 1
19	Was compliance with the intervention/s reliable? Where there was noncompliance with the allocated treatment or where there was contamination of one group, the question should be answered no. For studies where the effect of any misclassification was likely to bias any association to the null, the question should be answered yes.	N/A	N/A
20	Were the main outcome measures used accurate (valid and reliable)? For studies where the outcome measures are clearly described, the question should be answered yes. For studies which refer to other work or that demonstrates the outcome measures are accurate, the question should be answered as yes.	No = 0	Yes = 1
	Internal validity – confounding (selection bias)		
21	Were the patients in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited from the same population? For example, patients for all comparison groups should be selected from the same hospital. The question should be answered unable to determine for cohort and case-control studies where there is no information concerning the source of patients included in the study.	Yes = 1	N/A
22	Were study subjects in different intervention groups (trials and cohort studies) or were the cases and controls (case-control studies) recruited over the same period of time? For a study which does not specify the time period over which patients were recruited, the question should be answered as unable to determine.	N/A	N/A

23	Were study subjects randomized to intervention groups? Studies which state that subjects were randomized should be answered yes except where method of randomization would not ensure random allocation. For example, alternate allocation would score no because it is predictable.	N/A	N/A
24	Was the randomized intervention assignment concealed from both patients and health care staff until recruitment was complete and irrevocable? All nonrandomized studies should be answered no. If assignment was concealed from patients but not from staff, it should be answered no.	N/A	N/A
25	Was there adequate adjustment for confounding in the analyses from which the main findings were drawn? This question should be answered no for trials if: the main conclusions of the study were based on analyses of treatment rather than intention to treat; the distribution of known confounders in the different treatment groups was not described; or the distribution of known confounders differed between the treatment groups but was not taken into account in the analyses. In non-randomized studies if the effect of the main confounders was not investigated or confounding was demonstrated but no adjustment was made in the final analyses the question should be answered as no.	No = 0	Yes = 1
26	Were losses of patients to follow-up taken into account? If the numbers of patients lost to follow-up are not reported, the question should be answered as unable to determine. If the proportion lost to follow-up was too small to affect the main findings, the question should be answered yes.	N/A	N/A
	Power		
27	Did the study have sufficient power to detect a clinically important effect where the probability value for a difference being due to chance is less than 5%? Sample sizes have been calculated to detect a difference of x% and y%.	Yes = 1	Unable to determine = 0
	Total Score	7/16 (41%)	11/14 (79%)

Appendix H. Ecomap of Themes Derived from Narrative Synthesis



Appendix I. Confirmation of Ethical Approvals

UNIVERSITY OF HULL

University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | E: e.walker@hull.ac.uk
w: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Lucy Tattersdill
Faculty of Health Sciences
University of Hull
Via email

22 July 2020

Dear Lucy

REF FHS274 - An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

Liz Walker | Professor of Health and Social Work Research |
Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
e.walker@hull.ac.uk | 01482 463336
@UniOfHull /UniversityOfHull universityofhull

UNIVERSITY OF HULL

Dr David Richards
Pro-Vice-Chancellor (Research & Enterprise)
University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 466732 | E: David.Richards@hull.ac.uk
w: www.hull.ac.uk

24 September 2020

Lucy Tattersdill
Clinical Psychology

Dear Lucy,

FHS274 An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

I am writing to confirm that the University of Hull has agreed to act as sponsor, subject to approval being granted in accordance with the Department of Health Research Governance Framework for the project "An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention".

Yours sincerely,

Dr David Richards
Pro-Vice-Chancellor (Research & Enterprise)
(Chair of University Research and Enterprise Committee)

cc Dean
Research Governance

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Miss Lucy Tattersdill
Trainee Clinical Psychologist
Humber Teaching NHS Foundation Trust
University of Hull
Cottingham Road
Hull
HU6 7RX

20 January 2021

Dear Miss Tattersdill

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention**
IRAS project ID:	**278441**
Protocol number:	**N/A**
REC reference:	**20/YH/0318**
Sponsor	**University of Hull**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **278441**. Please quote this on all correspondence.

Yours sincerely,
Alex Thorpe

Approvals Manager

Email: approvals@hra.nhs.uk

Copy to: *Ms Katie Skilton, Sponsor's Representative*

Appendix J. Study Information Sheet

Version number 4

Date: 27/03/2021

IRAS ID: 278441

INFORMATION SHEET FOR PARTICIPANTS (ADULT VERSION)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

I would like to invite you to participate in a research project which forms part of my doctorate research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

We know little about systemic family interventions for adolescent self-harm and family's experiences of self-harm when they have had systemic family interventions. This study aims to explore family's experiences of adolescent self-harm before, during and after they have received a systemic family intervention.

Why have I been invited to take part?

You are being invited to participate because you attended at least three sessions of systemic family interventions for adolescent self-harm and completed this intervention within the last twenty-four months.

What will happen if I take part?

If you choose to take part in the study, you will be asked to attend an interview on your own or a joint interview with at least one other family member who also attended at least three sessions of systemic family interventions with you. Participation will take place at either a health centre local to you, the University of Hull, your home address or via a video call (for example, Skype or Zoom). For the interview you will be asked to share your experiences of adolescent self-harm before, during and after attending family therapy. It is estimated that an interview may take between 25-90 minutes. Interviews will be audio recorded. There are no right or wrong answers and I am only interested in your family's experiences of self-harm and attending a family therapy intervention for this.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in any way. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part. If you decide to take part, I will ask you to sign a

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consent form and you will be given a copy of this consent form to keep. If you are under 16 years old, I will ask you to sign an assent form and for your parent/guardian to sign a consent form for you to participate.

What are the possible risks of taking part?

Participating in the study will require between 25-90 minutes of your time and this may be inconvenient for you. Some people may experience emotional distress when they talk about self-harm and attending therapy because it may bring to mind difficult issues and memories that are related to self-harm and attending therapy. If this happens to you the researcher will offer support and help signpost you to where you can gain access to further help from services, if needed.

What are the possible benefits of taking part?

I cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the information you give will help us to understand more about family experiences of adolescent self-harm and attending family interventions for this. Sometimes people find it useful to have the opportunity to talk about their experiences.

Data handling and confidentiality

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

All of the personal information that you provide will be kept strictly confidential. Any information that could be used to identify you will not be used in the research. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these. To protect your anonymity, you will be assigned a code or pseudonym. This will ensure it will not be possible to identify you from the information you provide. To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an on-line storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact appropriate authorities to ensure that you and other people are safe. It is unlikely that this will happen, and the researcher will try to discuss this with you.

Your contact details will be held securely for the duration of the research but then destroyed when the research is complete.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal

basis for processing your personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until your data has been transcribed, after which withdrawal of your data will no longer be possible because the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study, we will not retain the information you have given thus far.

What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk. The research may also be published in academic journals and/or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by The Faculty of Health Sciences Ethics Committee, University of Hull; The Health Research Authority; and Humber Teaching NHS Foundation Trust Research and Development Office.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Lucy Tattersdill
Clinical Psychology

Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel:
E-mail: L.R.Tattersdill-2018@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Annette Schlösser
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: +44 (0)1482 464094
Email: A.Schlosser@hull.ac.uk

Dr Paul Walton
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: p.p.walton@hull.ac.uk

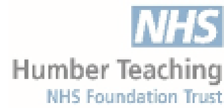
Thank you for reading this information sheet and for considering taking part in this research.

Appendix K. Study Information Sheet for Adolescents (Under 16 years old)

Version number 4

Date: 27/03/2021

IRAS ID: 278441



INFORMATION SHEET FOR PARTICIPANTS (ADOLESCENT VERSION)

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

I would like to invite you to take part in research being conducted as part of a Doctorate in Clinical Psychology. It is important that you know about the research before you decide whether to take part. Please read the following information carefully and you could speak about this information with your family or friends to help you decide. If you have any questions you can ask me (Lucy Tattersdill, Researcher)

Why is the research being done?

We want to know more about family's experiences of self-harm when they have had a systemic family intervention, because we currently only know little about this.

Why have I been invited to take part?

You can take part if you have been to at least three sessions of a systemic family intervention for adolescent self-harm within the last 12 months.

What will happen if I do take part?

If you choose to take part, you will be asked to have an interview on your own or a joint interview with at least one of your family members who also went to a systemic family intervention with you. The interview will happen at either a health centre local to you, the University of Hull, your home or on a video call. For the interview you and, if included, your family member/s will be asked to talk about your experiences of self-harm before, during and after going to the systemic family intervention. I think the interview might take between 25-90 minutes. Interviews will be audio recorded. There are no right or wrong answers and I am only interested in your family's experiences of self-harm and attending a systemic family intervention for this.

1

Do I have to take part?

You do not have to take part. It is your choice. After you have read this information sheet you can ask me any questions that might help you decide if you want to take part. If you want to take part and you are under 16 years old, you will have to sign an 'assent form for adolescents' and your parent/guardian will have to sign a 'parent consent form'.

Could there be bad points to taking part?

Some people might become upset when they talk about self-harm and attending therapy because they might be reminded of difficult memories. If you become upset the researcher will help by telling you about services where you could get further help from, if needed.

Could there be good points to taking part?

Your answers could help us to understand more about family experiences of self-harm and attending therapy, which might help other people in the future. Sometimes people find it helpful to talk about their experiences.

What will happen to my answers?

Everybody's answers will be looked at together and put into a report.

Will the interview and all information about me be kept private?

All of the information you give will be kept private. Any information that could be used to identify you (for example, your name) will be changed so that it is anonymous. The recording of the interview and all information about you will be stored securely.

The only time that information would have to be told to someone is if you said something that made me think you or someone else could be harmed. If this happened, I may need to speak to the appropriate authorities.

What will happen to the results of this study?

The results of the study will be written into a report that will be looked at by staff at the University of Hull and will be put on-line. The results may also be put into a scientific journal and/or put into a presentation that is then given to other people.

Who has looked at this study before it started?

This study has been looked at by a group of people called a Research Ethics Committee. They said that this study could happen.

Who can I contact?

If you have any questions or would like some more information about this study, please contact me using the following details:

Lucy Tattersdill
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel:
E-mail: L.R.Tattersdill-2018@hull.ac.uk

If you are not happy with the study, you can contact the University of Hull using the research supervisors' details:

Dr Annette Schlösser
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX

Tel: +44 (0)1482 464094
Email: A.Schlosser@hull.ac.uk

Dr Paul Walton
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: p.p.walton@hull.ac.uk

Thank you for reading this information sheet and for thinking about taking part in this research.

Appendix L. Study Information Sheet for Parents

Version number 4

Date: 27/03/2021

IRAS ID: 278441

INFORMATION SHEET FOR PARENTS/GUARDIANS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study: An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

I would like to invite your child to participate in a research project which forms part of my doctorate research. Before you decide whether you want your child to take part, it is important for you to understand why the research is being done and what your child's participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

We know little about systemic family interventions for adolescent self-harm and family's experiences of self-harm when they have had a systemic family intervention. This study aims to explore family's experiences of adolescent self-harm before, during and after they have received a systemic family intervention.

Why has my child been invited to take part?

Your child has been invited to participate because they attended at least three sessions of a systemic family intervention for adolescent self-harm and completed this intervention within the last twenty-four months.

What will happen if my child takes part?

If you choose for your child to take part in the study, they will be asked to attend an interview on their own or a joint interview with at least one other family member who also attended at least three sessions of a systemic family intervention with them. Participation will take place at either a health centre local to you, the University of Hull, your home address or via a video call (for example, Skype or Zoom). For the interview your child and the other participant/s will be asked to share their experiences of adolescent self-harm before, during and after attending a systemic family intervention. It is estimated that an interview may take between 25-90 minutes. Interviews will be audio recorded. There are no right or wrong answers and I am only interested in family's experiences of self-harm and attending a systemic family intervention for this.

Does my child have to take part?

Participation is completely voluntary. You should only consent to your child taking part if you want to choose for your child not to take part will not disadvantage you or your child in any way. Once you have read the information sheet, please contact me

1

if you have any questions that will help you make a decision about your child taking part. If you decide to consent to your child taking part, I will ask you to sign a consent form and you will be given a copy of this consent form to keep. Your child will then be asked to sign an assent form in order for them to participate.

What are the possible risks of my child taking part?

Participating in the study will require between 25-90 minutes of your child's time and this may be inconvenient for you and/or your child. Some people may experience emotional distress when they talk about self-harm and attending therapy because it may bring to mind difficult issues and memories that are related to self-harm and attending therapy. If this happens to your child the researcher will offer support and help signpost them and you to where you can gain access to further help from services, if needed.

What are the possible benefits of my child taking part?

I cannot promise that your child will have any direct benefits from taking part in the study. However, it is hoped that the information your child gives will help us to understand more about family experiences of adolescent self-harm and attending a systemic family intervention for this. Sometimes people find it useful to have the opportunity to talk about their experiences.

Data handling and confidentiality

Your child's data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

All of the personal information that you or your child provide will be kept strictly confidential. Any information that could be used to identify your child will not be used in the research. Direct quotes from the discussion may be used in research publications and presentations but your child will not be identified in these. To protect your child's anonymity, your child will be assigned a code or pseudonym. This will ensure it will not be possible to identify your child from the information you or your child provides. To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all of the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an on-line storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if your child or you disclose something that suggests that you, your child or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact appropriate authorities to ensure that you, your child and other people are safe. It is unlikely that this will happen, and the researcher will try to discuss this with you.

Your contact details will be held securely for the duration of the research but then destroyed when the research is complete.

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your child's personal data for the purpose of the research outlined above. The legal basis for processing your child's personal data for research purposes under GDPR is a 'task in the public interest' You can provide your consent for the use of your child's personal data in this study by completing the consent form that has been provided to you. Information about how the University of Hull processes your data can be found at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx

You have the right to access information held about your child. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have other rights including rights of correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the University of Hull Information Compliance Manager [dataprotection@hull.ac.uk]. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about my child taking part?

You are free to withdraw your child without having to give a reason. Withdrawing your child from the study will not affect you or your child in any way. You are able to withdraw your child's data from the study up until your child's data has been transcribed, after which withdrawal of your child's data will no longer be possible because the data will have been anonymised and/or committed to the final report. If you choose to withdraw your child from the study, we will not retain the information you or your child have given thus far.

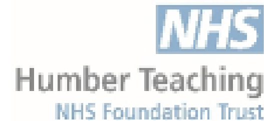
What will happen to the results of the study?

The results of the study will be summarised in a written thesis as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk. The research may also be published in academic journals and/or presented at conferences.

Who has reviewed this study?

Research studies are reviewed by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and been given a favourable opinion by The Faculty of Health Sciences Ethics Committee, University of Hull; The Health Research Authority; and Humber Teaching NHS Foundation Trust Research and Development Office.

Who should I contact for further information?



If you have any questions or require more information about this study, please contact me using the following contact details:

Lucy Tattersdill
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel:
E-mail: L.R.Tattersdill-2018@hull.ac.uk

What if I have further questions, or if something goes wrong?

If you wish to make a complaint about the conduct of the study, you can contact the University of Hull using the research supervisor's details below for further advice and information:

Dr Annette Schlösser
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: +44 (0)1482 464094
Email: A.Schlosser@hull.ac.uk

Dr Paul Walton
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email: p.p.walton@hull.ac.uk

Thank you for reading this information sheet and for considering for

Appendix M. Participant Consent Form

Version number 3

Date: 27/03/2021

IRAS ID: 278441

CONSENT FORM

Title of study: An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

Name of Researcher: Lucy Tattersdill

Please initial box

1. I confirm that I have read the information sheet dated 27/03/2021 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up until the point where my data has been transcribed without giving any reason, without my legal rights being affected. ☐

3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐

4. I agree to take part in the above study. ☐

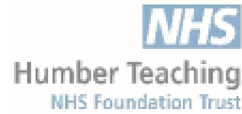
Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix N. Assent Form (for adolescents aged under 16 years old)

Version number 1.1

Date: 28/04/2020

IRAS ID: 278441



Assent form for adolescents

An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

Please circle an answer for each question:

Have you read (or had read to you) about this project?	Yes/No
Do you understand what this project is about?	Yes/No
Do you understand that if you want to stop taking part in the project you can tell the researcher?	Yes/No
Do you understand that you can stop taking part in the project at any point before the interview is written up by the researcher?	Yes/No
Have all your questions been answered?	Yes/No
Have you asked all the questions you want?	Yes/No
Are you happy to take part?	Yes/No

If you would like to take part, you can write you name below

Your name ....

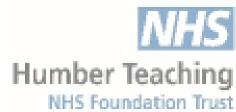
Date...

Appendix O. Parental/Guardian Consent Form

Version number 3

Date: 27/03/2021

IRAS ID: 278441



PARENT/GUARDIAN CONSENT FORM

Title of study: An exploration of family experiences of adolescent self-harm within the context of having received a systemic family therapy intervention

Name of Researcher: Lucy Tattersdill

Please initial box

1. I confirm that I have read the information sheet dated 27/03/2021 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my child's participation is voluntary and that I am free to withdraw my child at any time up until the point where my child's data has been transcribed without giving any reason, without my legal rights being affected. ☐

3. I understand that the research interview will be audio recorded and that my child's anonymised verbatim quotes may be used in research reports and conference presentations. ☐

4. I agree for my child to take part in the above study. ☐

____

Name of Participant (Child's name)

____________	____________	____________
Name of Parent/Guardian	Date	Signature
Name of Person taking consent	Date	Signature

Appendix P. Sources of Support Sheet

Version number 2

Date: 27/01/2021

IRAS ID: 278441

Sources of support and information regarding adolescent self-harm

Mind offers information and advice regarding self-harm for those who self-harm and their family on its website:

https://www.mind.org.uk/information-support/types-of-mental-health-problems/self-harm/about-self-harm/

HeadStart Hull offers information regarding services available for young people who are experiencing difficulties and their parents and carers on its website:

For young people: https://www.howareyoufeeling.org.uk/youngpersons

For parents and carers: https://www.howareyoufeeling.org.uk/parents-carers

You can also seek advice from your GP

If you are an adult and require urgent support, you can contact the Mental Health Response Service (Hull and East Riding). Tel: 01482 301701 (option 1).

If you are a child or young person and require urgent support or if you are seeking urgent support for a child or young person, you can contact the CAMHS Crisis Team. Tel: 01482 301701 (option 2).

Appendix Q. Example of a Holistic-Form Analysis

Plot Axis Trajectory	**Transcript**	**Phase/Appraisal of Events**
	Erm, so I think I picked up on, Bailey, I think I'd seen it and it was probably a couple of months after you'd started doing it I suppose.	Phase 2 – Notices self-harm a couple of months after it had occurred.
Negative	Er. But I was aware that she was having issues at school that I was trying to sort out, but the school she was at at that point were not very forthcoming with help. So, they were more bothered about Bailey's attendance at school whereas I just wanted to try and sort the issue out.	Phase 1 – Aware of issues in school, but school unhelpful
Downward trajectory (negative decline)	It was surrounding a bullying situation where she was with a large group of friends and and for the first year and a half, two years it was all going really well. Real good friends and then it started to get a little bit out of hand where, erm, they kinda ganged up on each other, I suppose, erm. And people are different and I think Bailey's quite sensitive, so I think she really took that to heart when when it was like, coz they go from one to another having a go at each other pushing someone out the group an- and that's kinda where it started. It was just little things like, erm, pushing her out the group chat or saying stuff about her on the group chat an- and then you know surrounding social media, which I think is a major problem with stuff like this these days. Coz it's so easy to get at somebody, erm, whereas when I was younger it was a case of you have to ac- actually see the person or go ask them to come out. You couldn't do it like you can now.	Details on issues in school, things had previously been going well Difficult/emotional time for young person Difficulties are the start of the story
Downward trajectory (negative decline)	Erm, so it started like that an- and I'd kinda noticed it and tried to work with the school to, find some kind of common ground where we could support Bailey, together, but, as I say they were more about attendance so it was more like "Bailey needs to be in school, Bailey needs to be in school." But she didn't want to go coz it was a large group of girls and there was picking on her an-. [Inhale] It just made it worse, erm, coz I was trying to get her to school coz they was on about fining me and stuff like that. [pause, inhale] m. And I was like look, I really your need help with this and it was like "yeah but we want Bailey in school" and I'm like but I'm trying to work with ya. You need to give me something because at the end of the day my daughter's mental health is my priority. Not your attendance figures.	Indicates that the bullying is the beginning of the story Phase 3 – Following noticing self-harm and bullying attempts to work with school Stress for parent re threats of being fined whilst trying to help child
	Erm, so this kinda spanned over a good few months and it was actually one of my friends at a school that I was working at the time [inhale] that said to me "have you thought about CAMHS?" And I said "I don't even know what that is. Never heard of it before. Never come across it. And, she basically	

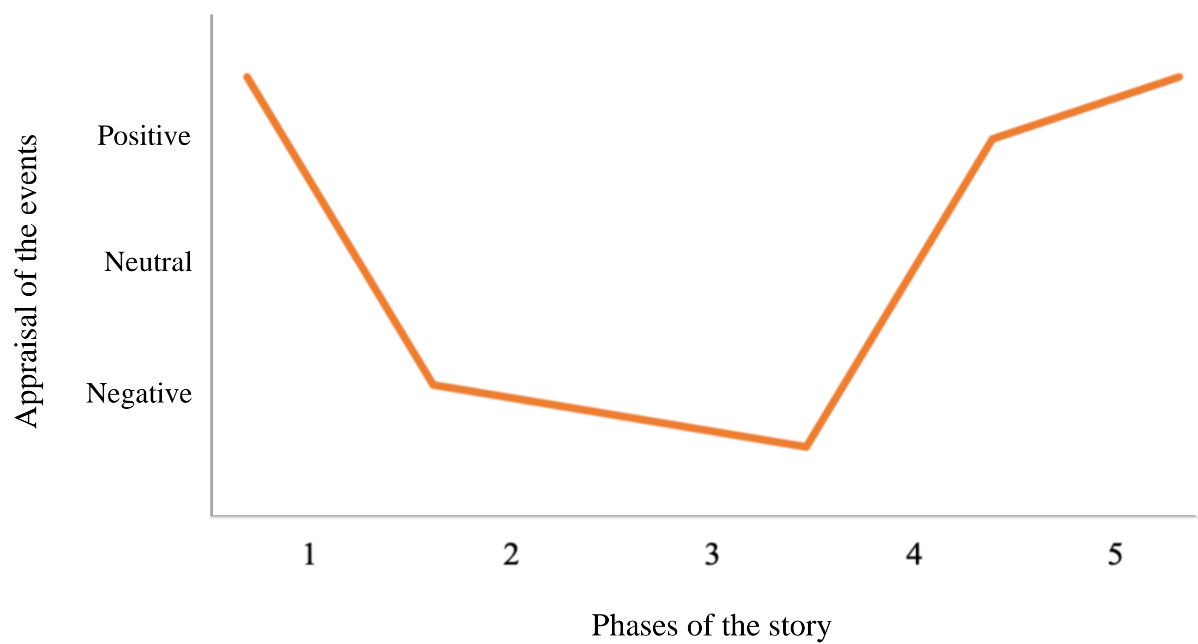
	said it's definitely worth, making a referral and seeing kind of what they say. And obviously I was worried about Bailey, so I was waking up in the middle of the night and going in her bedroom making sure that she didn't have anything in there that she could do it with and an- I just. From my point of view, it was difficult because I was trying to sort it out. I'm trying to balance work. I'm trying to support Bailey. I'm trying to work with the school I've got [laugh], you know, a million different things going on, erm, but at the top of that list is Bailey, obviously, so it was really hard. To, to kind of figure something out. [Pause, crackle in tape]	Parental stress and worry
Turning point, upward trajectory (positive incline)	So it was like a right explain to me what's what we'll we'll take the referral in and then they pass on to the next part of the team, I believe it goes like that if I remember rightly. Erm, I spoke to Bailey openly about it that I was doing the referral and made sure she was fully aware. Erm, and that she was supportive of that coz at the end of the day she's got to be the one that has to talk about it and and work her way through it. So, they took the referral and, we got an appointment, erm, with the gentleman. And we went to a few appointments, didn't we, that that really helped I think. It was just more the support and having somebody outside that wasn't pushing against what you was trying to do they was trying to help the situation. And they erm, did did a few groups didn't we together, an- and thought of some ways where you felt comfortable. Erm, like for example, when she was at school it was just dropping me an emoji on her phone just to say how she was feeling at certain points of the day. Coz I was worried at work that she wasn't happy and. Obviously, she was probably worried as well, erm.	Phase 4 – Attending appointments, turning point as support helped
Turning point, upward trajectory (positive incline)	Coz by that stage I had managed to get get higher up in the school and speak to somebody [inhale] and they finally offered, erm, for her to go in a a group called [school group name], which is a group of students that [pause] are not necessarily in the right setting for mainstream as such. So like not just Bailey's situation but other situations that children have. And they start after I think, was it nine o'clock? And you finished at half two so she could get to school before they got there and sh- well after they got there and she could leave before they left, so she had that piece of mind and she didn't have to sit in the classroom with them or go and have lunch with them. Or, you know, that type of thing so, that that was one of the things that was was good in the end that we got to was there. They did start to work with us a little bit, but I'd	Phase 4 – Turning point as support from school also helped

	already put in for a transfer to another school. Which I knew was a really good school coz my other daughter went there and they they were very supportive. Erm, so we continued with the CAMHS an- and kind of working with the gentleman and an- figuring ways out to to help you, wasn't it? How how P2: Yeah P1: You dealt with different situations and and when you feel like you're going to do it look at those reasons and look at [pause]. What what, what kind of would happen going forward if you continued to do that and what kind of strategies you could, we could use for her to not get to that point. So whether that be, she comes and speaks to me. But then, I think children aren't always comfortable going to speak to the parents because I think they find it hard that they're letting him down or something like there's always a kind of barrier coz you're very close. So I think it's always good to have other people so you did like a spidergram didn't ya? P2: Yeah P1: Of people she could talk to. So for example, my sister or a cousin or even a friend or a Nanna, d'ya know just erm different different people other than those that are really close and kind of living within that situation. So that that was really helpful. And then when we moved schools which you got your place at your new school where you're at now didn't ya? P2: Yeah	
Upward trajectory (positive incline)	P1: Erm, the school is massively supportive and I think that really makes a big difference so. They have something called [school group name], which is similar to [previous school group name], but what they do is they work with the student to [pause] integrate them back into the school slowly and at their pace, and they're not pushing for. You know th- that the first school was just attendance, attendance, attendance, and and nothing else. But this school was, erm, "What can we do to help Bailey? What, what's the first thing we can do? Right we'll keep her in [school group name] so she'll have all her lessons in [school group name] and she'll get used to the children that are in there. Get used to the, erm, the way it works an- and the teachers and things.	Phase 4 – Continuing the changes, moved to a different school
Upward trajectory (positive incline)	And then slowly integrate her slowly into school where it be a couple of lessons a week that she's happy to sit in, erm and then obviously integrated more so as it stands now, she is probably doing all the lessons back in school, which is great and we've had no more erm incidents of of the self-harm as it	Phase 5 – How things are in the present. After therapy and movement to new school things have gotten better as YP has

Turning point	stands. Erm, but I think with the advice and the stuff from CAMHS as well as the support from school was really helpful. And I think that's, that's the biggest thing for us.	integrated into school and stopped self-harm Phase 4 - CAMHS support and school support influential in turning point

Phase	**Event and Brief Summary**	**Plot Trajectory**
1	Previously "it was all going really well" then issues with a bullying incident at school and online ("that's kinda where it started") <u>Emotions:</u> Sadness	Downward trajectory, rapid negative decline
2	Parent notices young person's self-harm. Is concerned about the safety of the young person and concerned about seeking help due to fear of social services. <u>Emotions:</u> Worry, fear, stress	Downward trajectory, negative decline
3	Parent tries to seek help from school but finds them not forthcoming with this and more focussed on attendance rates which results in threat of family being fined. Parent trying to balance multiple stressors, seek help for young person and keep the young person's mental health a priority. <u>Emotions:</u> Worry, stress, frustration	Downward trajectory, negative decline
4	Simultaneous events: Referral into CAMHS and therapy begins (reflect on helpfulness of sessions), school start to offer more support but a transfer to another school has already been approved. New school is a lot more supportive. <u>Emotions:</u> Feeling connected, supported, and heard	Turning point Upward trajectory, positive incline
5	Young person has been fully integrated into the new school, no further incidents of self-harm and family are able to reflect on their experiences (what was helpful and what could help others).	Slight upward trajectory, positive incline

Interview 1



Appendix R. Example of a Categorical-Content Analysis

Transcript (Principle sentences underlined)	**Initial Commentary**	**Initial Open Coding** (prior to development of major and minor categories)
Erm, so I think I picked up on, Bailey, I think I'd seen it and it was probably a couple of months after you'd started doing it I suppose.	Parent notices YP self-harm after it started	Parent experiences, discovering self-harm
Er. But I was aware that she was having issues at school that I was trying to sort out, but the school she was at at that point were not very forthcoming with help. So, they were more bothered about Bailey's attendance at school whereas I just wanted to try and sort the issue out.	Bullying at school precipitates self-harm School are unhelpful	Precipitating events Difficulties with school
It was surrounding a bullying situation where she was with a large group of friends and and for the first year and a half, two years it was all going really well. Real good friends and then it started to get a little bit out of hand where, erm, they kinda ganged up on each other, I suppose, erm. And people are different and I think Bailey's quite sensitive, so I think she really took that to heart when when it was like, coz they go from one to another having a go at each other pushing someone out the group an- and that's kinda where it started. It was just little things like, erm, pushing her out the group chat or saying stuff about her on the group chat an- and then you know surrounding social media, which I think is a major problem with stuff like this these days. Coz it's so easy to get at somebody, erm, whereas when I was younger it was a case of you have to ac- actually see the person or go ask them to come out. You couldn't do it like you can now.	Things were going well before the bullying started, but then the bullying begins and gets out of hand YP upset by the bullying incidents Social media is an issues these days as it makes people more accessible, which provides more opportunities for bullying to occur	Precipitating events Young persons' experiences, precipitating events Issues with social media Parent experiences, discovering self-harm

Erm, so it started like that an- and I'd kinda noticed it and tried to work with the school to, find some kind of common ground where we could support Bailey, together, but, as I say they were more about attendance so it was more like "Bailey needs to be in school, Bailey needs to be in school." But she didn't want to go coz it was a large group of girls and there was picking on her an-. [Inhale] It just made it worse, erm, coz I was trying to get her to school coz they was on about fining me and stuff like that. [pause, inhale] m. And I was like look, I really your need help with this and it was like "yeah but we want Bailey in school" and I'm like but I'm trying to work with ya. You need to give me something because at the end of the day my daughter's mental health is my priority. Not your attendance figures.	Parent notices self-harm and bullying Parent attempts to work with school to support young person, but school is focused on attendance which is difficult as the young person is being bullied at school Parent has daughter's mental health as priority	Help-seeking from school Difficulties with school Parent priorities
Erm, so this kinda spanned over a good few months and it was actually one of my friends at a school that I was working at the time [inhale] that said to me "have you thought about CAMHS?" And I said "I don't even know what that is. Never heard of it before. Never come across it. And, she basically said it's definitely worth, making a referral and seeing kind of what they say.	CAMHS suggested by family friend. Parent had never heard of CAMHS before, but takes advice of friend	Help-seeking Parent experiences
And obviously I was worried about Bailey, so I was waking up in the middle of the night and going in her bedroom making sure that she didn't have anything in there that she could do it with and an- I just. From my point of view, it was difficult because I was trying to sort it out. I'm trying to balance work. I'm trying to support Bailey. I'm trying to work with the school I've got [laugh], you know, a million different things going on, erm, but at the top of that list	Parental worry about self-harm Parent has a lot to manage, but is prioritising the needs of the young person	Parent experiences

is Bailey, obviously, so it was really hard. To, to kind of figure something out. [Pause, crackle in tape] So it was like a right explain to me what's what we'll we'll take the referral in and then they pass on to the next part of the team, I believe it goes like that if I remember rightly. Erm, I spoke to Bailey openly about it that I was doing the referral and made sure she was fully aware. Erm, and that she was supportive of that coz at the end of the day she's got to be the one that has to talk about it and and work her way through it. So, they took the referral and, we got an appointment, erm, with the gentleman. And we went to a few appointments, didn't we, that that really helped I think. It was just more the support and having somebody outside that wasn't pushing against what you was trying to do they was trying to help the situation. And they erm, did did a few groups didn't we together, an- and thought of some ways where you felt comfortable. Erm, like for example, when she was at school it was just dropping me an emoji on her phone just to say how she was feeling at certain points of the day. Coz I was worried at work that she wasn't happy and. Obviously, she was probably worried as well, erm. Coz by that stage I had managed to get get higher up in the school and speak to somebody [inhale] and they finally offered, erm, for her to go in a a group called [school group name], which is a group of students that [pause] are not necessarily in the right setting for mainstream as such. So like not just Bailey's situation but other situations that	Referral process into CAMHS Importance of young people agreeing to access help Start of systemic family intervention. Attendance at a few appointments which are helpful Importance of having support of someone who is independent to the situation and understanding of it so they are not fighting against but alongside the family Developed practical strategies to help family School started to be more helpful for the family and offer different support	Help-seeking, accessing CAMHS Help-seeking, accessing CAMHS Appraisal of systemic family intervention Importance of the role of the therapist Helpful practical strategies School as more supportive

children have. And they start after I think, was it nine o'clock? And you finished at half two so she could get to school before they got there and sh- well after they got there and she could leave before they left, so she had that piece of mind and she didn’t have to sit in the classroom with them or go and have lunch with them. Or, you know, that type of thing so, that that was one of the things that was was good in the end that we got to was there. They did start to work with us a little bit, but I'd already put in for a transfer to another school. Which I knew was a really good school coz my other daughter went there and they they were very supportive. Erm, so we continued with the CAMHS an- and kind of working with the gentleman and an- figuring ways out to to help you, wasn't it? How how	Parent had already approved transfer to new school on the basis that it would be more supportive to the family	Need for school to be more supportive Content of systemic family intervention
P2: Yeah		
P1: You dealt with different situations and and when you feel like you’re going to do it look at those reasons and look at [pause]. What what, what kind of would happen going forward if you continued to do that and what kind of strategies you could, we could use for her to not get to that point. So whether that be, she comes and speaks to me. But then, I think children aren’t always comfortable going to speak to the parents because I think they find it hard that they’re letting him down or something like there's always a kind of barrier coz you’re very close. So I think it's always good to have other people so you did like a spidergram didn’t ya?	Exploratory approach with therapist considering why self-harm occurs, the risks associated with self-harm and safety and protective strategies Examples of activities during therapy	Appraisal of intervention
P2: Yeah		

P1: Of people she could talk to. So for example, my sister or a cousin or even a friend or a Nanna, d'ya know just erm different different people other than those that are really close and kind of living within that situation. So that that was really helpful. And then when we moved schools which you got your place at your new school where you're at now didn't ya?	Appraisal of activity as being helpful	Helpfulness of systemic family intervention technique
P2: Yeah		
P1: Erm, the school is massively supportive and I think that really makes a big difference so. They have something called [school group name], which is similar to [previous school group name] but what they do is they work with the student to [pause] integrate them back into the school slowly and at their pace, and they're not pushing for. You know th- that the first school was just attendance, attendance, attendance, and and nothing else. But this school was, erm, "What can we do to help Bailey? What, what's the first thing we can do? Right we'll keep her in [school group name] so she'll have all her lessons in [school group name] and she'll get used to the children that are in there. Get used to the, erm, the way it works an- and the teachers and things. And then slowly integrate her slowly into school where it be a couple of lessons a week that she's happy to sit in, erm and then obviously integrated more so as it stands now, she is probably doing all the lessons back in school, which is great and we've had no more erm incidents of of the self-harm as it stands. Erm, but I think with the advice and the stuff from CAMHS as well as the support from school was really helpful. And I think that's, that's the biggest thing for us.	New school is supportive which has made a big difference Young person able to integrate at own pace and feeling that the school is there to support the young person Self-harm is no longer occurring and this is suggested to be due to supportive school and support from CAMHS	Importance of school being more supportive Reflection on experiences Importance of school support Helpfulness/effectiveness of CAMHS support and systemic family intervention

Example of principle sentences from interview 1 that contributed to the minor category 'Precipitating Events':

- *"But I was aware that she was having issues at school that I was trying to sort out"*
- *"It was surrounding a bullying situation where she was with a large group of friends"*
- *"it started to get a little bit out of hand where, erm, they kinda ganged up on each other, I suppose, erm."*
- *"And people are different, and I think Bailey's quite sensitive, so I think she really took that to heart when when it was like, coz they go from one to another having a go at each other pushing someone out the group an- and that's kinda where it started."*
- *"It was just little things like, erm, pushing her out the group chat or saying stuff about her on the group chat an- and then you know surrounding social media,"*
- *"But she didn't want to go coz it was a large group of girls and there was picking on her an-"*