THE UNIVERSITY OF HULL

Making sense of self-harm: the context of austerity and drawing on stories of CAMHS clinicians.

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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June 2021

Acknowledgements

I would like to say a big thank you to the clinicians that took part in my study, for taking time out of your busy schedules to share your stories so openly and with such depth of feeling, it was a privilege to hear them. Thank you to those who acted as contacts for me within the services I recruited from – you made this possible! Particular thanks go to Dr Charlotte Cosquer for your support throughout this process.

I would also like to thank my research supervisors, Dr Annette Schlösser and Dr Paul Walton for sharing your knowledge and experience. Your belief in me and unwavering enthusiasm for my research revived me at times of difficulty, thank you for your patience with this.

Thank you to my family for your continued support, encouragement, and treats in the post. To Stephen for always being there whether I needed to laugh, cry, or escape to the seaside.

Finally, to the friends I have had the privilege of sharing this journey with, you continue to inspire me with your compassion and dedication. As we near the end of our training, I hold hope in the knowledge that you are the people alongside me as we begin our next adventures.

Overview

Self-harm is a growing concern within society and is often understood as reflecting mental 'illness'. However, attending to the 'bigger picture' when thinking about self-harm is helpful for making sense of self-harm, both for individuals and ecologically. This thesis includes a systematic literature review and an empirical study exploring self-harm within the context of austerity, and through hearing stories from Child and Adolescent Mental Health Services (CAMHS) clinicians.

The systematic literature review examined the relationship between self-harm and austerity in the UK and Ireland. The relationships between self-harm and suicide, and suicide and austerity are well established and highlight the need to also understand the relationship between austerity and self-harm. As such, a systematic literature review of research based in the UK and Ireland spanning 2008-2020 was conducted. A narrative synthesis identified three themes: 'Increases in self-harm rates from 2008', 'Economic Distress', and 'Support'. Findings highlight that increases in rates of self-harm could be understood in the context of austerity and point to support prioritising social issues, with clear service pathways as well as addressing need associated with contextual vulnerabilities.

The empirical study explores the experiences of CAMHS practitioners through hearing the stories and meanings they have generated from their experiences of working with young people who self-harm. Nine clinicians from across four CAMHS services in England took part in non-directive interviews. Narrative analysis found distinctions between experiences clinicians faced in relation to themselves as individuals and challenges associated with wider systems. Key challenges faced by clinicians suggest the need for a cultural shift in how we make sense of distress with corresponding changes to service design and provision.

Total word count (including appendices): 29,458

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Part one: Systematic Literature Review

Understanding the relationship between austerity and self-harm in the UK and Ireland.

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This Paper is written in the format ready for submission to the Journal of Social and Political Psychology

(See Appendix A for submission guidelines.)

Total word count: 8917 (Including abstract, tables, figures and references)

Abstract

The relationships between self-harm and suicide (Bergen et al., 2012; Owens, Horrocks, & House, 2002), and suicide and austerity (Coope et al., 2014; Mills, 2018; O'Hara, 2015) are well established. Increasing rates of self-harm highlight the need to also understand the relationship between austerity and self-harm. A systematic literature review of research based in the UK and Ireland spanning 2008-2020 was conducted. A narrative synthesis identified three themes: 'Increases in self-harm rates from 2008', 'Economic Distress', and 'Support'. The theme of 'Economic Distress' had subthemes of 'housing', 'employment' and 'finances'. 'Support' consisted of three subthemes: 'Services', 'Addressing Contextual Vulnerabilities' and 'Support Networks'. Findings highlight that increases in rates of self-harm could be understood in the context of austerity and point to support prioritising social issues, with clear service pathways as well as addressing need associated with contextual vulnerabilities.

Keywords: systemic literature review; self-harm; austerity.

Introduction

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 (Wright-Hughes et al., 2015). Increasing rates of self-harm are a concern within society (Griffin et al., 2018; McManus et al., 2019). Well established relationships between self-harm and suicide (Bergen et al., 2012; Owens et al., 2002), and suicide and austerity (Coope et al., 2014; Mills, 2018; O'Hara, 2015) draw attention to understanding the relationship between self-harm and austerity.

Since austerity measures, policies to cut public spending and increasing taxes, were introduced in the UK in 2010 (McGrath, Griffin, & Mundy, 2016) and Ireland in 2009 (Hardiman & Regan, 2013), there have been steep increases in rates of completed suicides (Barr, Ben, Taylor-Robinson, Scott-Samuel, McKee, & Stuckler, 2012; Coulter & Nagle, 2015). The literature-base exploring the links between suicide, economic recession and austerity is considerable and describes the harmful and often fatal impact of financial, employment and housing insecurity caused by austerity (Haw, Hawton, Gunnell, & Platt, 2015; O'Hara, 2015). These deaths, although presented by the media as depoliticised and pathologised outcomes of 'mental illness', were the consequence of distress caused by benefit cuts and welfare reform (Mills, 2018). The medicalisation and pathologisation of distress in the context of austerity has been discussed more broadly and highlights that understanding distress in the face of deprivation as 'mental illness' assumes blame on the individual, reinforcing narratives about 'scroungers' and 'skivers' (Mills, 2018), and allows society to respond to them within a "disempowering apolitical vacuum" (Thomas et al., 2018, page 3), thus shifting attention away from the impact of restricted welfare support dictated by neo-liberal oriented governments (Thomas et al., 2018).

As highlighted by Bambra (Bambra, 2016), a contextual approach demonstrates the contribution of economic, social and physical environment of a place to area-level health, including suicidal behaviour and there is convincing evidence that increased socio-economic disadvantage is associated with increased risk of both suicide and self-harm, particularly for men (Cairns, Graham, & Bambra, 2017).

Research evidencing the relationship between self-harm, unemployment and socio-economic deprivation adds further weight to the rationale for understanding the relationship between austerity and self-harm. Areas with higher levels of socioeconomic deprivation experience higher rates of self-harm, particularly by males (Hawton, Harriss, Hodder, Simkin, & Gunnell, 2001). Unemployment has also been demonstrated to contribute to increased risk of use of self-harm (Cunningham et al., 2021).

Rationale for question

The above-described evidence indicating the significant contribution of austerity to distress that often leads to suicidal behaviour highlights the importance of understanding how such policies impact people's need to use self-harm. Unlike when researching suicide, researchers are able to interview people who have used self-harm after the event to understand factors that prompted the event. This is the first review to examine the impact of austerity with a focus on self-harm and aims to give insight into possible points for prevention and intervention, both for future self-harm and suicide, due to close relationship between the two (Owens et al., 2002). Therefore, the current review aims to examine existing literature to offer a contextualised understanding of self-harm in relation to economic recession and austerity using the research question: What understanding does current research offer about the relationship between austerity and self-harm in the UK and Ireland?

Method

Search Strategy

A search of the literature was conducted using the electronic databases PsychINFO, PsychARTICLES, CINAHL, Academic Search Premier, MEDLINE and Business Source Premier for relevant articles. Despite not being a health journal, Business Source Premier was included due to the economic and social impact of austerity being a focus of the search. A date limiter, 2008 to June 2020, was applied to reflect the onset of the economic recession.

A search of existing systematic literature review papers to ensure originality of the review did not identify any previously published systematic literature reviews investigating the relationship between austerity and self-harm in the UK and Ireland.

The search terms used were;

("self harm" or "self mutilation" or "self injur*" or "non-suicidal self*")

AND

(austerity OR "welfare reform*" OR Recession OR government OR econom* OR unemploy* OR depriv*)

Articles that featured these terms in their title, abstract or keywords and met the inclusion criteria were identified. Search terms were developed from clinical knowledge, discussions with supervisors with knowledge of the subject and a search of key words and terms used in scoping searches. Inclusion and exclusion criteria are presented in Table 1.

Subsequent searches were limited to include peer-reviewed journals in the English language. A title search assessed initial relevancy; abstracts and full texts were then reviewed to ensure the inclusion criteria were met. A search of reference lists and citations of included articles was also completed.

Key authors identified from the retrieved articles were contacted to investigate whether any relevant articles were soon to be published and to identify any additional relevant articles which had not been identified from the existing search. Responses provided no new articles that met review criteria.

Table 1

Inclusion and Exclusion Criteria

Inclusion Criteria	***Rationale***
Study focuses on self-harm	Will only include papers that focus on self-harm, and not suicide, as existing literature has already investigated the suicide-recession link (Haw et al., 2015; Barr et al., 2012; Coope et al., 2014).
Conducted between 2008-2020	Reflects time period impacted by recession & austerity. Onset of the recession defined in literature as end of 2007/beginning of 2008 (Hawton et al., 2016; Barr et al., 2012; Chang et al., 2013; Coope et al., 2014).
Study carried out in UK or Ireland	UK and Ireland were both impacted by austerity measures (Haw et al., 2015; O'Hara, 2015; Coulter & Nagle, 2015) which were introduced in October 2009 (Life on the Breadline, 2018), and December 2010, respectively (Hardiman & Regan, 2013). UK and Ireland are island economies and both English speaking. Ireland forms another major British isle not included in UK and has a direct border with UK.
Study cites relationship between austerity or recession and self-harm within findings	Papers may exist that investigate self-harm over the time period relevant to the period of austerity in which the authors do not cite or mention recession or austerity as a factor – such papers have not been included as any relationship would be correlational.

Exclusion Criteria	***Rationale***
Studies which include specific populations (prison populations, refugees, inpatients, specific physical illness)	Circumstances of specific populations impacted differently by recession/austerity. Not representative of general population.

Literature reviews and resources which are not peer-reviewed research studies	Highest quality research findings included only.
Studies not available in English	Only papers discussing austerity and self-harm in UK and Ireland are included, so there is no need to conduct a search in other languages.

Article Selection

The search produced 1803 results. After the application of academic journal and language limiters and the removal of duplicates, the titles and abstracts of 1038 articles were assessed using the inclusion and exclusion criteria. Eight articles were considered to meet the criteria and were included in the review. Figure 1 depicts the Prisma (Moher, Liberati Tetzlaff & Altman, 2009). flow diagram outlining the process of article selection.

Data Analysis

Narrative synthesis was used for data analysis using guidelines outlined by Popay and colleagues (2006); this involved repeatedly reading the papers and developing a primary synthesis in the form of tabulated summaries using data extraction and quality assessment. Data were then grouped and mapped to illustrate relationship between findings which were then translated into themes and subthemes (Popay et al., 2006). Narrative synthesis allows the integration of qualitative and quantitative research findings as well as evaluation of methodological quality (Popay et al., 2006).

Data Extraction

A data extraction form was created in order to extract key information from the included studies. Data were extracted into a summary table (Appendix B); the following information was extracted from the studies: authors, year, aims, participant sample, method/design, inclusion/exclusion criteria, measurement tools, method of analysis, key findings.

Quality Assessment

A quality assessment of the selected articles was completed. The checklist (Appendix C) was adapted from the *Mixed methods appraisal tool* (MMAT), which is designed for the appraisal stage of systematic mixed studies reviews (Hong et al., 2018). The quality criteria items for studies that are randomised controlled trials and non-randomised trials were removed as there are no studies included using these designs. Items from a measure for assessing quality of interrupted time series (ITS) designs were included (Cochrane, 1998) apart from two items; one which questioned the use of ANOVA modelling, which was not used in the studies included, and one which questioned whether the assessment of primary outcome was blinded. The latter item was not included as the primary outcome for the included ITS studies is self-harm rates, an outcome that is not randomly allocated meaning the blinding of assessment is irrelevant. Inter-rater checks for quality assessment involved consultation with a statistician to discuss quality criteria assessing quantitative studies, specifically those questioning the appropriateness of the statistical analyses used. Further checks were carried out by a separate researcher who rated a sample of three studies. Differences in ratings occurred on three questions across two studies. Item 3.2 Geulayov et al., (2016) described their target population to be England; inter-rater checks highlighted that the study only includes data from three cities and the rating was therefore changed from ‘Yes’ to ‘No’ to reflect that the sample is not representative of the target population. Corcoran et al., (2016) Item 1.2 rating was changed from ‘No’ to ‘Unclear’ to reflect that based upon the data available it is not possible to assess whether the intervention (onset of recession) was independent of other changes. Item 1.5 rating remained the same despite being rated differently due to the study stating that the dataset was incomplete.

As the MMAT is not designed to result in a calculation of an overall quality score for each study (Hong et al., 2018), the ratings of each criterion are summarised in Table 2. All included articles were clear in their research questions and collected data to enable these questions to be answered, thus meeting the screening criterion of the MMAT (not presented in Table 2).

Figure 1: *Article Selection Process (Moher, Liberati, Tetzlaff, & Altman, 2010)*

Identification

Records identified through database searching
(n = 1803)

- Academic Search Premier (n = 546)
- MEDLINE (n = 553)
- CINAHL (n = 296)
- PsychINFO (n = 346)
- Psych-ARTICLES (n = 9)
- Business Source Premier (n = 53)

Records after non-academic journal (1672) and non-English language removed
(n = 1621)

Records after exact duplicates removed
(n = 1038)

Screening

Records screened by Title
(n = 1038)

Records excluded
(n =1005)

Records screened by Abstract
(n = 33)

Records excluded
(n = 26)

Eligibility

Full-text articles assessed for eligibility
(n = 7)

Full-text articles excluded
(n = 0)

Studies obtained from hand search of reference lists
(n = 1)

Included

Studies included in synthesis
(n = 8)

Table 2
Adapted MMAT Quality Assessment Criteria Ratings

Study Design & Quality Assessment Questions

Interrupted Time Series

First Author & Year	1.1. Is there a clearly defined point in time when the intervention occurred?	1.12. Are there at least 3 data points before and after the intervention?	1.2. Is the intervention independent of other changes?	1.3. Are there sufficient data points to enable reliable statistical inference?	1.4. Was the intervention unlikely to affect data collection?	1.5 Was the data set complete?	1.6 Were there reliable primary outcome measures?
Hawton (2016)	Yes	Yes	Unclear	Yes	Yes	Yes	Yes
Corcoran (2016)	Yes	Yes	Unclear	Yes	Yes	No	Yes

Qualitative Studies

First Author & Year	2.1. Is the qualitative approach appropriate to answer the research question?	2.2. Are the qualitative data collection methods adequate to address the research question?	2.3. Are the findings adequately derived from the data?	2.4. Is the interpretation of results sufficiently substantiated by data?	2.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?
Barnes (2016)	Yes	Yes	Yes	Yes	Yes
Barnes (2017)	Yes	Yes	Yes	Yes	Yes

Quantitative Descriptive Studies

First Author & Year	3.1. Is the sampling strategy relevant to address the research question?	3.2. Is the sample representative of the target population?	3.3. Are the measurements appropriate?	3.4. Is the risk of nonresponse bias low?	3.5. Is the statistical analysis appropriate to answer the research question?
Perry (2012)	Yes	Yes	Yes	Yes	Yes
Geulayov (2016)	Yes	No	Yes	Yes	Yes
Clements (2019)	Yes	Yes	Yes	Yes	Yes

Mixed Methods

First Author & Year	4.1. Is there an adequate rationale for using a mixed methods design to address the research question?	4.2. Are the different components of the study effectively integrated to answer the research question?	4.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	4.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	4.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?
Barnes (2018)	Yes	Yes	Yes	Unclear	Unclear

Results

Characteristics of included studies.

Table 3 summarises the methodological details and key findings of the eight studies included in the review relevant to the research question. Six studies were conducted in the United Kingdom (UK) and two were conducted in Ireland. The designs for the studies were: quantitative descriptive (N=3), interrupted time series (N=2), qualitative (N=2) and mixed method design (N=1). Three of the studies used data from the Multicentre Study of Self-harm in England (Clements et al., 2019; Geulayov et al., 2016; Hawton et al., 2015).

Table 3
Summary of the articles included in the review.

Author(s) & Year of Publication & Country	Research Aims	Participant Characteristics	Design	Outcomes, measures and method of analysis	Key Relevant Findings
Geulayov, G., Kapur, N., Turnbull, P., Clements, C., Waters, K., Ness, J., Townsend, E. and Hawton, K. (2016) UK	To examine trends in non-fatal self-harm in England in 2000-2012 using data from the Multicentre Study of Self-harm	Data from Multicentre study of self-harm (hospital presentations for self-harm in Oxford, Manchester & Derby from 2000-2010).	Face to face assessments or scrutiny of ED electronic databases. Dataset included: o Rates of self-harm o Methods of self-harm o Psychiatric history o Repetition of self-harm o Provision of psychosocial assessment of self-harm o Gender o Age	Negative Binomial Regression to assess trends in rates of self-harm. Logistic regression models to assess binary outcomes.	Rates of self-harm (2000-2012): Males: 362 per 100 000 Females: 441 per 100 000 During 2000-2012 84378 episodes of self-harm (41.4% by males, 58.6% by females, 25 sex unknown). Episodes involved 47048 people (43.1% males, 56.8% females). Trends were examined by period (2000-2007 vs 2008-2012). Rates declined until 2008 followed by an increase thereafter, particularly by males. Average rates were considerably higher in Manchester and Derby than in Oxford which reflected differences in socioeconomic characteristics of the centres.
Clements, C., Hawton, K., Geulayov, G., Waters, K., Ness, J., Rehman, M., Townsend, E.,	Describe incidence rates and trends in self-harm over time in men & women aged 40-59, using data from the Multicentre study of self-harm.	Data from people aged 40-59 years* from the Multicentre study of self-harm. N= 12601 (n=5886 men; n=6715 women)	Observational data from the Multicentre study of self-harm (hospital presentations for self-harm in Oxford, Manchester & Derby from	Negative Binomial Regression to assess trends in rates of self-harm. Single-variable logistic regression to	Rates of self-harm (2000-2013): Males: 363 per 100 000 Females: 449 per 100 000 Small increase in rates over time in men which increased more rapidly after 2008.

Appleby, L. and Kapur, N, (2019). UK	Compare key characteristics & explore outcomes (repetition, mortality by suicide), identify possible differences in subgroups of those who self-harm in midlife.	Subgroup comparisons for those who first presented 2002-2007 compared with those who first presented 2008-2013. Cohorts were chosen to reflect equal time periods before and after the economic recession in 2008. o *Age group defined to match age groups with highest suicide rates in men & woman.	01/01/2000 – 31/12/2013). Data included details on: o Mental state o Psychiatric history o Risk o Needs o Age o Gender o Date & method of self-harm	assess binary outcomes.	Men: self-harm more often characterised by alcohol use, unemployment and precipitating problems relating to finances and housing. Women: self-harm more often associated with indicators of mental ill health. Socioeconomic & mental health related factors became more common antecedents over time. In 2008-2013 cohort, self-harm was more often associated with economic distress (high unemployment, problems with finances & housing). Self-harm for the first time in midlife seems to be influenced by situational factors such as socioeconomic factors & relationship difficulties.
Perry, I. J., Corcoran, P., Fitzgerald, A. P., Keeley, H. S., Reulbach, U., & Arensman, E. (2012). Ireland	The development of a national deliberate self-harm (DSH) registry in the Republic of Ireland to determine and monitor the incidence and repetition of DSH, to identify high-incidence groups and areas and to inform services and practitioners	People who presented to hospitals with DSH in the Republic of Ireland 2003-2009.	Dataset included: o Encrypted patient initials o Gender o Date of birth o Area of residence o Date & hour of attendance at hospital o Method(s) of self-harm o Drugs taken (if applicable) o Recommended next care.	Conditional risk set analysis – risk of repetition of self-harm.	Average annual rate of persons presenting with DSH: Total: 198 per 100 000 Male: 173 per 100 000 Female: 224 per 100 000 Most notable annual changes were two successive 10% increases in male rate of DSH in 2007 from 162 to 179 per 100,000 in 2008, and to 197 per 100,000 in 2009. Authors noted that these changes coincided with the advent of the economic recession in Ireland.

	concerned with the prevention of suicidal behaviour.				Sex difference reduced in recent years; female rate was higher by 13% in 2009 (down from 38% in 2005). Highest rates of DSH by females was those aged 15-19 years (17-years particularly). Highest rates for males were among 20-24 years.
Corcoran, P., Griffin, E., Arensman, E., Fitzgerald, A. P., & Perry, I. J. (2015). Ireland	To assess the impact of economic recession and austerity in Ireland over the 5 years 2008-2012 on national rates of both suicide and self-harm.	○ Data on self-harm presentations to all hospital emergency departments in Ireland in 2004-2012 from the Irish National Registry of Deliberate Self-harm. ○ Data relating to suicide deaths and deaths of undetermined intent occurring in Ireland in 1980-2012 from the Irish Central Statistics Office. ○ *January 2008 defined as advent of recession. Unit of time used in analyses for self-harm was month (period 2004-2012 provided 108 months); quarterly for suicides.	Dataset included: ○ Gender ○ Age ○ *hospital-treated self-harm.	Interrupted time series analysis.	Advent of recession associated with an increase in self-harm (men: 40.5 per 100 000; women: 21.2 per 100 000) By end of 2012, self-harm rates were estimated as 31% higher for males, and 22% higher for females than if pre-recession trends continued. Men aged 25-64 years were most affected in terms of suicide and self-harm. Increase in self-harm by women was among 15–24-year-olds.

Hawton, K., Bergen, H., Geulayov, G., Waters, K., Ness, J., Cooper, J., & Kapur, N, (2016). UK	To investigate the impact of the 2008 recession on rates of self-harm in England, which gender and age groups were most affected, how any effects were related to local changes in rates of unemployment and the nature of participants' characteristics & problems which might explain any associations found.	○ People who self-harmed during 2005-2007 were compared to those who self-harmed during 2008-2010*. ○ Data from Multicentre study of self-harm (hospital presentations for self-harm in Oxford, Manchester & Derby from 2000-2010). * end of 2007/beginning of 2008 defined as the onset of recession.	Data analysed included: ○ Gender (binary M/F) ○ Employment (for those aged 15-64 years) (employed, unemployed, sick/disabled) Problems precipitating self-harm (any current difficulty reported by patient or identified by clinician as being related to self-harm).	Interrupted time series analysis.	Significant increases in rates of self-harm in 2008-2010 compared to those expected based on pre-recession trends, in males and females in Derby, and males in Manchester. Trend not seen in Oxford, or for females in Manchester. For those who received psychosocial assessment, no significant overall decreases in the proportion employed following onset of recession but increases in both genders in those who were unemployed and marked decreases who were registered sick or disabled. Changes occurred in Derby & Manchester but not Oxford. Marked increases in proportions of assessed patients who were identified as having problems at the time of self-harm related to employment, finances and, in females only, housing. For those who were employed, there was an increase in proportion of males with problems related to employment, and of females with employment, financial and housing problems in 2008-2010 compared with 2005-2007.

Barnes, M. C., Gunnell, D., Davies, R., Hawton, K., Kapur, N., Potokar, J., & Donovan, J. L. (2016). UK	To understand events and experiences leading to the episode of self-harm and to identify opportunities for prevention or mitigation of distress.	○ N=19 ○ 9 male; 10 female ○ Aged 19-56 ○ Had attended hospital following self-harm in 2 UK cities and specifically cited job loss, economic hardship or the impact of austerity measures as a causal or contributory factor ○ Purposive sampling	○ Semi-structured, in-depth, face to face interviews exploring participants' narratives leading up to the self-harm episode.	Grounded theory constant comparison method. Beck Suicide Intent Scale - (low 0-6, moderate 7-12, high 13-20, very high >20) Self-completed VAS to monitor for distress pre-interview & post-interview	Key themes *Circumstances that led to the SH episode* – employment difficulties, debt & benefits, housing difficulties *Co-existing or historical contextual vulnerabilities* – salient source of despair, justification for feelings of despair and worthlessness. Included abusive or neglectful childhoods, bullying, sexual identity issues, abusive adult relationships, significant bereavements and long-standing MH problems. *Perceptions of available help and support* - Need for clear practical help for economic difficulties and counselling or therapeutic support for co-existing or historical problems.
Barnes, M.C., Donovan, J.L., Wilson, C., Chatwin, J., Davies, R., Potokar, J., Kapur, N., Hawton, K., O'Connor, R. and Gunnell, D., (2017). UK	To understand and describe the experiences of people with financial, employment and benefit difficulties as they sought help for their problems and the consequences of their difficulties on mental health.	○ Three groups of people in two UK cities ○ 'self-harm' n=19 (people who had self-harmed due to employment, financial or benefit concern) ○ 'community' n=22 (people who were struggling financially) ○ 'service providers' n=25 (frontline staff from voluntary and statutory sector organisations	Individual face to face interviews (all groups) Focus groups ○ Service providers – staff from debt advice centre n=5 & Samaritan's outreach team n=7 ○ Community – Young parents support centre n=5)	Grounded theory constant comparison method. Beck Suicide Intent Scale - (low 0-6, moderate 7-12, high 13-20, very high >20)	Key Themes & subthemes *Service Provision* ○ Employment & benefit agencies ○ Independent/charity services ○ Health services Accessing services difficult. Free debt advice considered most useful. Community sample reported more knowledge of how to access debt advice than self-harm group. *Informal support*

		providing support services to the groups) Targeted sampling			Self-harm group reported fewer sources of support, less supportive networks and more difficult circumstances than community sample. *Unmet Need* o Practical guidance through system o Benefit & debt information o Co-ordinated services All groups indicated that practical help for financial & benefit issues would help and they wanted clear information about services available and how to access them. Help for current and past mental, emotional and physical difficulties was necessary. *Mental Health* Participants in the self-harm group reported a stronger belief that they should be self-reliant in the face of economic and mental health difficulties than the community group.
Barnes, M.C., Haase, A.M., Scott, L.J., Linton, M.J., Bard, A.M., Donovan, J.L., Davies, R., Dursley, S., Williams, S., Elliott, D. and	To determine the feasibility and acceptability of a brief psychosocial intervention (the 'HOPE' service) for people presenting to hospital emergency departments (ED) following self-	N=19 Intervention n=13 (up to 6 sessions of 1:1 support provided by community support staff trained in Motivational Interviewing) Control n=6 (one-off session signposting to relevant support organisations) Characteristics	Mixed methods. Questionnaires (standardised outcome measures & questions about debt, employment, benefits & self-harm) Qualitative interviews (participants and HOPE workers).	o PHQ-9 (depression severity) o GAD-7 (anxiety severity) o EQ5D-5 L (health related quality of life) o FSES (financial self-efficacy)	Interviews indicated benefits of intervention including resolution of specific financial problems, provision of support at a time when it was needed most, insight into coping behaviours. Reduction in mean PHQ-9 scores from baseline (n=19) to 3-month follow up (n=13).

Potokar, J., (2018). UK	harm or in acute distress because of financial, employment or welfare (benefit) difficulties	○ Mean age= 44years (SD=9) ○ 58% male ○ 95% white ○ 84% lived in rental accommodation.		Interviews analysed as case studies.	Randomisation and outcome measures used were acceptable to most, but HOPE workers will need to be prepared and sensitive to clarify, explain and reassure about the process. There are potential adaptations to be made for the full trial including flexibility in approach.

Quality Assessment

Overall, studies were of good quality, had clear research aims and used appropriate methods to collect and analyse data to answer the research questions. A particular strength of the included studies was their sampling; studies gathered data from large samples which included people from several locations with different socioeconomic variables.

One study scored lower on the assessment due to incomplete datasets, however these were adjusted for within calculations (Corcoran, Griffin, Arensman, Fitzgerald, & Perry, 2015). For interrupted time series design studies, it was unclear whether the intervention, which was onset of recession, was independent of other changes (Corcoran et al., 2015; Hawton et al., 2015). It could not be determined whether the study aiming to establish the feasibility and acceptability of the HOPE intervention (Barnes et al., 2018), had adequately addressed inconsistencies between qualitative and quantitative data, and whether these different components met quality criteria of each tradition due to the quantitative element of the study being included to establish acceptability of outcome measures for individuals receiving the intervention and therefore limited to descriptive statistical analyses.

Synthesis

A narrative synthesis of relevant findings identified three themes: 'Increases in self-harm rates from 2008', 'Economic Distress', and 'Support'. The theme of 'Economic Distress' had subthemes of 'housing', 'employment' and 'finances'. 'Support' consisted of three subthemes: 'Services', 'Addressing Contextual Vulnerabilities' and 'Support Networks'.

A conceptual map of the themes and subthemes is presented at Figure 2.

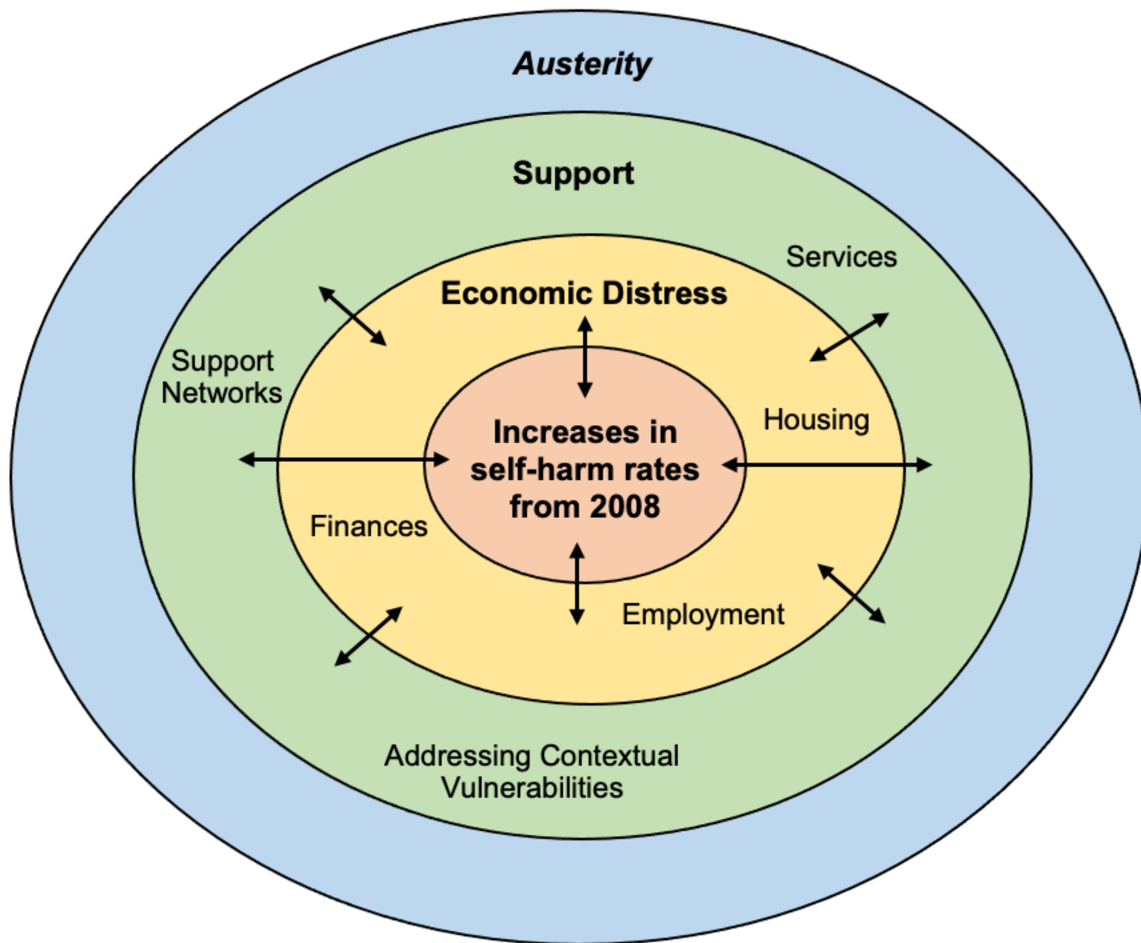

Figure 2. Conceptual ecological map illustrating the relationships between themes and subthemes in the context of austerity.

Increases in self-harm rates from 2008

Five studies examined trends in rates of self-harm over varying periods from 2000-2012 and evidenced increases in rates of self-harm from 2008, whilst overall rates generally declined before 2008 (Clements et al., 2019; Corcoran et al., 2015; Geulayov et al., 2016; Hawton et al., 2015; Perry et al., 2012).

Increases in rates of self-harm by males was supported by findings of all five studies; rates of self-harm by men declined 2000-2007 (incidence rate ratio [IRR] 0.96, 95%CI 0.95-0.98,

$p<0.0001$) and then steadily increased after 2008 (2008-2012; IRR 1.05, 95%CI 1.02-1.09, $p=0.002$) (Geulayov et al., 2016). This increase was more rapid for males in midlife (before 2008 IRR 0.98, 95%CI 0.95-1.00, $P=0.05$; after 2008 IRR 1.07, 95%CI 1.02-1.12, $P<0.01$). Developing a national deliberate self-harm registry in Ireland from 2003-2009, Perry (Perry et al., 2012) noted 10% annual increases in male self-harm rates from 2007-2008 and 2008-2009 (2007 - 162 [95% CI 157-168] per 100 000; 2008 – 179 [95% CI 173-185] per 100 000; 2009 – 197 [95% CI 191-203] per 100 000).

Using interrupted time series designs, two studies further investigated these trends with the aim of assessing the impact of recession and austerity on rates of self-harm in Ireland and England, respectively (Corcoran et al., 2015; Hawton et al., 2015). In Ireland, by the end of 2012, compared with if pre-recession trends had continued, self-harm rates by men were 31% higher, those aged 25-64 being most impacted. Comparably, female rates were 22% higher than expected based on pre-recession rates and a narrower age group was affected (15-24 years) (Corcoran et al., 2015). Investigating rates in three cities in England, Hawton also evidenced increases in rates of self-harm compared to those expected based upon pre-recession trends. In Manchester and Derby, male rates were 22% (167 individuals) and 22% (368 individuals) higher, respectively, in 2008-2010 than compared to rates in 2001-2007 (Hawton et al., 2015). Increased rates of self-harm were evident for males of all age groups in Manchester, and 15-24 years and 35-54 years in Derby (Hawton et al, 2015), supporting findings from Ireland (Corcoran et al., 2015) which also suggested a wide age group were affected. This contrasts with findings that rates primarily increased for those in midlife (Clements et al., 2019; Geulayov et al., 2016). Female rates were impacted in Derby only, where rates were 30% (708 individuals) higher than expected based upon pre-recession trends. There was relatively little effect in Oxford; authors related this to the socioeconomic variables of each city which are explored under the theme of ‘economic distress’.

There were inconsistencies in reported rates by women; two studies reported that generally rates decreased or did not change (Clements et al., 2019; Geulayov et al., 2016), while two reported rates for females increased (Corcoran et al., 2015; Hawton et al., 2015), but only for certain areas (Hawton et al., 2015). These differences may be explained by differences in study design and analysis; the two former studies used negative binomial regression models whilst the latter two used interrupted time series designs.

Economic Distress

The theme of 'economic distress' was closely linked to 'increases in self-harm rates from 2008' and despite some not exploring this directly (Clements et al., 2019; Geulayov et al., 2016; Perry et al., 2012), all studies noted the advent of the economic recession as a possible related factor in increases in self-harm rates (Barnes et al., 2016; Barnes et al., 2017; Barnes et al., 2018; Clements et al., 2019; Corcoran et al., 2015; Geulayov et al., 2016; Hawton et al., 2015; Perry et al., 2012).

Studies that compared contributory factors for self-harm between pre- and post-recession cohorts indicated that, after 2008, a greater proportion of people who presented with self-harm described problems relating to employment, finances and housing (Clements et al., 2019; Corcoran et al., 2015; Hawton et al., 2015). These three aspects of economic distress formed the subthemes described below, which were further supported by the findings from qualitative interviews of people who had self-harmed, a community sample and service providers (Barnes et al., 2016; Barnes et al., 2017). People commonly described depression, stress and anxiety related to economic difficulties when accessing help from their GP in relation to self-harm (Barnes et al., 2017).

Employment

Problems with employment, whether employed or not, were described as contributing to circumstances that led to self-harm for a greater proportion of people after 2008. Levels of unemployment were higher (Clements et al., 2019; Hawton et al., 2015), although in England, the overall proportion of people in employment did not decrease; this was explained by a considerable reduction in the number of people registered as sick or disabled (Hawton et al., 2015).

Unemployment and job loss were associated with feelings of despair and worthlessness, particularly for young people who described a lack of hope associated with difficulties finding work once leaving education, which contributed to self-harm.

This was illustrated by 'Paul, 23':

"*There's only so many times you can be defeated before you start to defeat yourself and eventually, I think I just got to the point where I'd had enough"* (page 4) (Barnes et al., 2016).

These difficult feelings were amplified when seeking employment support, particularly when signing on at Job Centres (Barnes et al., 2017). For those who self-harmed for the first time in midlife, unemployment was highlighted as a precipitating factor; men were more likely to be unemployed, a finding in line with those of the theme 'increases in self-harm from 2008' (Clements et al., 2019).

Finances

The impact of financial difficulties was also apparent in understanding the relationship between austerity and self-harm, with several of the studies reporting problems relating to finances as present at the time of self-harm (Barnes et al., 2016; Barnes et al., 2017; Barnes et al., 2018; Clements et al., 2019; Corcoran et al., 2015; Hawton et al., 2015).

Participants in the HOPE study who had presented to hospital following self-harm described financial hardship, and scores from PHQ-9 suggested that 61% would be categorised as severely depressed based upon their responses (Barnes et al., 2018).

In another study, 16 of the 19 participants interviewed about their experiences leading to self-harm described difficulties with finances (Barnes et al., 2016). Participants expressed fear about not being able to pay essential bills in the context of mounting debts which were difficult to pay due to restricted budgets. These pressures and anxieties, which often led to distress and self-harm, were intensified by fears about and experiences of changes to benefits (Barnes et al., 2016). During the study period (2012-2014) there were substantial changes to benefits in the UK, most notably 'bedroom tax' (2013) (Moffatt et al., 2016), Work Capability Assessment (2010) (Barr, Ben et al., 2016), and benefit sanctions (Barnes et al., 2017; Department for Work and Pensions, 2021) which provide important context to the difficulties described. Moreover, those who had self-harmed were more likely to have experienced being moved from Employment Support Allowance to Jobseekers Support Allowance through the Work Capability Assessment (2010) (Barnes et al., 2017; Barr et al., 2016). This move, when participants expressed that they did not feel mentally or physically able to look for jobs, caused further distress which contributed to self-harm (Barnes et al., 2017).

The impact of the work capability assessment and subsequent changes to income were highlighted by another study which described decreases in those who self-harmed who were registered as sick or disabled in 2008-2010, compared to 2005-2007 (Hawton et al., 2015).

Housing

People's descriptions of difficulties with employment and finances being a factor in the occurrence of self-harm often also had problems with housing (Barnes et al., 2016; Barnes et

al., 2017; Clements et al., 2019; Hawton et al., 2015), which included eviction or house repossession (Barnes et al., 2016; Barnes et al., 2017).

A quote from a service provider 'Penny' exemplifies how the above-described difficulties with employment and finances accumulate to impact people's housing, and the sense of despair and helplessness associated with this:

"We're getting people all the time, even men coming crying and saying 'look we're going to lose our house, what can we do?' and there's nothing, you know." (page 6) (Barnes et al., 2017).

Again, there was an effect of geography on the difficulties described; increases in levels of unemployment and decreases in those registered as sick or disabled were apparent in Manchester and Derby but not Oxford (Hawton et al., 2015).

The role of co-existing or historical contextual vulnerabilities was also highlighted following interviews with people who had self-harmed due to economic distress. These factors, which included known risk factors for self-harm including adverse childhood experiences (Cleare et al., 2018), sexual identity issues, abusive adult relationships and mental health difficulties, were described as a salient source of despair upon which economic distress grew (Barnes et al., 2016).

Support

Different forms of support and experiences of accessing these were explored in the literature as well as areas of need where support was lacking or could improve (Barnes et al., 2016; Barnes et al., 2017). There appeared to be an interaction between 'Support' and the other two themes; where experiences of accessing support were negative or support was absent, this contributed to further distress and self-harm whereas more positive experiences of accessing

help, whether from services or informal networks, seemingly negated some of the economic distress and related self-harm. One study piloted a support intervention involving up to 6 sessions with community support staff trained in Motivational Interviewing, the lessons and benefits from which are explored within the subthemes (Barnes et al., 2018).

Services

Studies exploring people's experiences of accessing services in relation to economic distress found that people wanted or appeared to benefit from timely clear and practical help for economic difficulties and a coordinated approach from services (Barnes et al., 2016; Barnes et al., 2017; Barnes et al., 2018). Alongside health services, job centres, benefit agencies and money advice-related services were most frequently accessed. Experiences of accessing services often contributed to distress as staff were considered rude and unhelpful. Accessing services was also difficult due to confusing and unclear referral pathways, waiting lists, delayed responses from services and overlapping service provision (Barnes et al., 2017; Barnes et al., 2018). Staff working within services shared challenges associated with pressures to meet quotas and inflexibility of the system. These pressures were illustrated using this quote from an employee at a Job Centre 'Penny':

> *"I think in this sort of work you get people – not that they aren't sympathetic – but they're 'it's black and white, he hasn't looked for a job, we're stopping the money' but then you'll get other people that will look a little bit further and say, 'well is there an underlying problem?' And try and signpost people but again for signing on they've [staff] got four minutes per person to check their job search, make sure they're doing everything they're doing, put notes on the system."* (page 5) (Barnes et al., 2017).

The HOPE intervention was described to benefit participants due to practical support with accessing organisations and services and communicating with creditors. The relationship with the HOPE worker provided participants with a 'nudge' to achieve small goals and provided

support when participants most needed it. The intervention appeared to meet unmet needs described in earlier studies (Barnes et al., 2016; Barnes et al., 2017) and highlighted the value of flexible approaches (Barnes et al., 2018).

Awareness of available support for economic difficulties was also raised as a factor linking economic distress with self-harm; compared to the community sample, those who self-harmed were often not aware of services until after they had self-harmed (Barnes et al., 2017).

Addressing Contextual Vulnerabilities

Several papers highlighted the role of contextual vulnerabilities in the use of self-harm when people were experiencing economic distress, and that support to address these was important (Barnes et al., 2016; Barnes et al., 2017; Clements et al., 2019; Geulayov et al., 2016; Perry et al., 2012).

One paper reported that 31.3% of people were in contact with MH services at time of self-harm (Geulayov et al., 2016) and risk of repetition of self-harm was associated with history of self-harm (Perry et al., 2012). For those who self-harmed a theme of self-reliance was highlighted, particularly in relation to accessing services (Barnes et al., 2017). When exploring unmet need, people noted the need for these to be addressed as well as the practical help to address economic distress (Barnes et al., 2016; Barnes et al., 2017).

Support Networks

One study highlighted that the self-harm group had smaller and/or less supportive support networks and generally described feeling isolated and having difficult family relationships. Support networks were valuable for the community sample providing emotional support and practical help in the forms of assistance with meals, paying bills and having social connection (Barnes et al., 2017)

Discussion

Studies investigating the relationship between austerity and self-harm were limited however, offer important implications for understanding the harmful impact of austerity. Increases in rates of self-harm were evidenced across multiple studies, particularly for males (Clements et al., 2019; Corcoran et al., 2015; Geulayov et al., 2016; Hawton et al., 2015; Perry et al., 2012), findings in line with existing research evidencing increased rates of self-harm in areas of increased socio-economic disadvantage (Cairns et al., 2017), as well as increases in rates of completed suicides in the context of austerity (Barr et al., 2012; Coulter & Nagle, 2015). The more significant and clearer findings related to male rates, as compared to female, which raises questions about males' position within society, and the impact of constructs about gender, masculinity and how males perform as gendered subjects (Ridge, Emslie, & White, 2011).

Although increases were seen in both England and Ireland, an effect of geography was seen on a more local level and appeared to reflect levels of unemployment and socio-economic disadvantage (Hawton et al., 2015), supporting existing research (Cairns et al., 2017).

The themes 'economic distress' and 'support' appeared to offer explanations for why rates of self-harm had increased; in the face of challenges of mounting financial, employment and housing insecurity which caused understandable distress; further distress was experienced when attempting to access support. These findings illuminated the layers of context that have been negatively impacted by austerity measures and exemplified concerns shared in the literature that people are responded to within 'apolitical vacuums' (Thomas et al., 2018) which the findings of the current review suggest were disempowering for both service-users and providers.

Fear about changes to benefits particularly in relation to the Work Capability Assessment and the introduction of benefit sanctions appeared significant for those who self-harmed, and in the context of existing contextual vulnerabilities. The assessment has received substantial criticism due to failing to accurately reflect the impact of mental health related difficulties on people's ability to work, has failed to increase the likelihood that people are in employment whilst being associated with increases in distress due to resulting in people being moved from disability benefits to unemployment benefits (Barr, et al., 2016).

Ideas about what it means to be 'fit to work' discussed above and the belief about having to be self-reliant described by those who self-harmed raise questions about their roots. Narratives spread by the media about those who receive welfare support being 'scroungers' and 'skivers' (Mills, 2018) go hand-in-hand with ideas of being a 'burden', which when in positions of needing to ask for support create an additional dilemma; people do not access support due to the internalisation of this idea, or if they do seek help are faced with negative experiences which serve to confirm such narratives.

The findings of the current study also highlight the importance of holding in mind the contextual vulnerabilities experienced by people who use self-harm in the context of austerity-related distress; support for these vulnerabilities was discussed as important within the literature.

Key implications also included clear and practical support for people when accessing services to offer support and advice around debt, benefits, and employment. Services need to increase awareness of the support available, particularly for people with existing contextual vulnerabilities. For example, awareness could be increased by improving signposting from

GPs or other health service settings. Attention should also be given to service design, with increases in funding as service providers discussed the pressures they had as contributing to "black and white" responses to people seeking support. Interventions such as social prescribing (Bickerdike, Booth, Wilson, Farley, & Wright, 2017) to improve and expand people's informal social support networks may also increase people's awareness of available support and the likelihood that they access this. More broadly, sustained spending on welfare has been found as a protective factor (Haw et al., 2015) and would likely remove much of the distress described in the current findings. It is the responsibility of clinical psychologists to take a political stance within their work to attend to these issues and highlight to commissioners and those in charge of service policy and design that the distress described in these findings and which they see and hear in their practice is a political issue, and not a reflection pathology.

Limitations

Three of the studies used data from a multi-centre study of self-harm (Clements et al., 2019; Geulayov et al., 2016; Hawton et al., 2015), thus limiting the generalisability of conclusions due to data being from the same sample.

Findings are also limited as analyses were confined to binary genders which do not reflect the numerous genders people may identify with; it is important for future research to include all genders as there is evidence indicating transgender people experience higher rates of self-harm and difficulties related to mental health, particularly before transition (McNeil, Bailey, Ellis, Morton, & Regan, 2012).

Furthermore, the search was potentially limited by the search strategy as other terms may have generated further literature and the initial search was completed by one researcher which may have biased paper selection.

Conclusions

The lack of literature examining the relationship between austerity and self-harm perhaps reflects the taken-for-granted ideas that self-harm is a reflection of pathology, rather than understood within context. However, similar to suicide literature, the findings of this review highlight that increases in rates of self-harm could be understood in the context of austerity and the intolerable circumstances people face because of welfare reform. Clinical implications point to support prioritising social issues, with clear service pathways as well as addressing need associated with contextual vulnerabilities.

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Part 2: Empirical Paper

A narrative exploration of CAMHS staff experiences and meaning-making of working with children & adolescents who self-harm.

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This paper is written in the format ready for submission to the journal of Social Science and Medicine
(see Appendix A for submission guidelines)

Word Count: 8999 (including abstract, tables, figures, references)

Abstract

Increasing numbers of children and young people attend services for support regarding self-harm (Hawton et al., 2012; McManus et al., 2019); service design has led to mental health staff's roles becoming increasingly focussed on risk management (Wolpert et al., 2014). Exploration into the experiences of young people who self-harm and their families suggest young people often feel treated as problems and families feel unable to cope and struggle to understand self-harm (Lindgren, et al, 2004; Rogers & Schmidt, 2016). Literature exploring clinicians' experiences of working with self-harm is scarce. The current study used a narrative approach to analyse non-directive interviews with Child and Adolescent Mental Health Services (CAMHS) clinicians from across four CAMHS services in England to explore their experiences of working with self-harm. Holistic-form analysis (Lieblich et al., 1998) found distinctions between experiences clinicians faced in relation to themselves as individuals, exemplified by the plot axis '*learning curve*', and challenges associated with wider systems, exemplified by plot axis *'facing systemic challenges'*. This distinction was also present in findings from categorical-content analysis. Key challenges faced by clinicians suggest the need for a cultural shift in how we understand distress with corresponding changes to service design and provision.

Introduction

Self-harm is currently a concern within society as self-harm behaviours are reported in increasingly younger populations at increased rates (Hawton et al., 2012; McManus et al., 2019). Reports from individuals who have been in contact with services emphasise the importance of staff spending time hearing their stories and understanding the meanings they have created from their experiences (Smith, 2002). Currently, services in England are set up in tiers that respond to diagnosis and severity; reductions in funding and resources which are reported to be up to 25% in some areas (Young Minds, 2013) paired with the risk associated with self-harm has led to mental health staff's roles becoming increasingly focussed on risk management, rather than prevention or intervention (Wolpert et al., 2014). However, there is little evidence exploring the experiences of staff in working with and co-creating meaning about experiences of self-harm, or the impact on them of managing risk (Gibb, Beautrais & Surgenor, 2010; Wilstrand, Lindgren, Gilje & Olofsson, 2007; Thompson, Powis & Carradice, 2008). This research aims to explore self-harm through a social constructionist lens to explore the experiences of Child and Adolescent Mental Health Service (CAMHS) staff to hear the stories and meanings they have generated from their experiences of working with young people who self-harm.

Social Constructionism is concerned with questioning the 'taken-for-granted' knowledge that people use to ascribe meaning to actions, ourselves and the world and takes the position that meanings or truths are "products of that culture and history" (Burr, 1995, p. 4). One theoretical expression of the 'nuts and bolts' of social constructionism is the Coordinated Management of Meaning (Pearce & Cronen, 1980; Pearce, 2005). This highlights that it is contexts that create the meaning of action and there is a hierarchy of which level of context (speech act, episode, relationship, self-concept, culture) is most inclusive for creating meaning (Pearce, 2005).

When applying this to an adolescent who has self-harmed, it is therefore important to take into account their self-concept, constructed from internalised stories about ourselves and others, and whether self-harm has become part of their 'script', and what their relationship is with self-harm. The language available from an individual's culture to be able to name the episode determines what meaning is created for the episode (Holmgren, 2004).

Systemic approaches to working with young people who self-harm attend to the meaning of self-harm as co-constructed within family systems and create space for members to explore meanings and construct new narratives in which individuals are more aware of the different meanings of self-harm and how these contribute to the problem being 'stuck' within the system (Boston, Eisler & Cottrell, 2009). However, when exiting the safety of the therapy room, beliefs about self-harm held by other members of the micro- and mesosystems (Bronfenbrenner, 1992) will interact with narratives created by the family. It is therefore important to understand what these belief systems are to understand what barriers to the adolescent and family creating new meanings for self-harm and how to manage events and emotions around it.

More positivist approaches view self-harm as a means of emotional regulation or avoidance which is developed and maintained through negative reinforcement (Messer & Fremouw, 2008; Chapman, Gratz & Brown, 2006). This is supported by reports by those who engage in self-harm that it is commonly used to relieve emotional arousal (Brown, Comtois, & Linehan, 2002). These may reflect the 'taken-for-granted' ideas about self-harm in society as they are easily accessible and therefore likely represent ideas available to staff working with individuals who self-harm. This provides further justification for qualitative social constructionist research to explore experiences and narratives of those working in the field other than the taken-for-granted truths.

Narratives of Self-Harm

Several studies have explored the experiences and perspectives of parents of children who self-harm (Byrne et al., 2008; Rogers & Schmidt, 2016; Amoss et al., 2016). These have demonstrated that parents feel they do not understand self-harm, feel unable to cope (Byrne et al., 2008), feel helpless, and avoid talking about emotions due to fear of provoking or worsening self-harm (Rogers & Schmidt, 2016). Parental beliefs around their lack of understanding of self-harm act as a barrier to open conversation and therefore self-harm goes unaddressed for long periods of time (Amoss, et al., 2016).

Perspectives and experiences of young people who self-harm is that they feel objectified, primarily treated as people with problems, without assets. Other findings were that professional caregivers are more likely to offer medication as treatment rather than conversation and highlighted how invaluable conversation and being treated as a human being are for people who self-harm (Lindgren, Wilstrand, Gilje & Olofsson, 2004; Smith, 2002).

Literature investigating beliefs about self-harm among professionals who meet young people is limited. The above literature highlights the importance of systems around the individual having the knowledge and understanding of self-harm in order that they do not position themselves around self-harm in a way that is detrimental to the young person and any intervention with which they are engaging.

Studies investigating attitudes of healthcare staff using the 'Attitudes Towards Deliberate Self-Harm Questionnaire' revealed concerns including their perceived confidence when working with individuals who self-harm (Gibb et al., 2010; McAllister, Creedy, Moyle & Farrugia, 2002) and their ability to cope with legal and hospital regulations (McAllister, et al., 2002). Some believed that their training was inadequate but perceived their contact to be helpful and outcomes to be positive (Gibb et al., 2010). One study reported feelings of helplessness and

negative attitudes towards working with people who self-harm (McAllister, et al., 2002). The apparent contradictions in results purporting to optimism whilst lacking confidence potentially highlight firstly, the limitations of using such scales which do not explore the complicated staff experiences, and secondly, the difficulties that staff face when working with people whom they do not feel fully equipped to help.

Wilstrand, Lindgren, Gilje & Olofsson (2007) examined narrative interviews about experiences of caring for people who self-harm with six psychiatric nurses. The theme 'being burdened with feelings' contained subthemes 'fearing for the patient's life-threatening actions', 'feeling overwhelmed with frustration' and 'feeling abandoned by co-workers and management'. One may propose that some of these experiences may reflect those of family members of individuals who self-harm. 'Balancing professional boundaries' had subthemes of 'maintaining professional boundaries between self and patient', 'managing personal feelings', 'feeling confirmed by co-workers' and 'imagining better ways of care'. These again highlight a sense of difficulty for nurses in balancing wanting to understand the patient and needing to manage the situation and their own emotions in a professional manner.

Thompson, Powis & Carradice (2008) investigated the experiences of 8 community psychiatric nurses of working with people who self-harm. Results demonstrated that these nurses struggled to conceptualise self-harm, found working with self-harm stressful particularly in relation to managing their own emotions and professional boundaries regarding risk. They reported that they managed these experiences by using coping strategies learnt 'on the job' and working on their relationship with the patient which they viewed as 'crucial'.

This literature highlights potential beliefs and attitudes of staff who work with patients who self-harm; the implications of these on patient experience is unclear, however one could predict that negative attitudes would be associated with less positive experiences of care for the patient,

with better outcomes being the consequence of positive attitudes. Future research should consider examining this.

This literature has important implications regarding the impact on staff. Reports of feeling helpless and difficulty managing the emotional burden associated with self-harm may reflect reports from parents of children and adolescents who self-harm (Byrne et al., 2008; Rogers & Schmidt, 2016; Amoss, Lynch & Bratley, 2016). It is important to consider how staff interact with young people and whether staff experiences reported lead them to relate to young people in ways that are isomorphic to relating within the family system.

Notable methodological limitations of the literature are the lack of heterogeneity of staff interviewed; the literature relies greatly on the experiences and reports of nurses, mostly in Emergency Department (ED) and inpatient settings, failing to consider the other professions that will meet an adolescent who self-harms. It is important that other staff are heard regarding their experiences of working with young people who self-harm to understand the impact on staff and how this may interact with the use of self-harm for adolescents.

There are many relevant people to contribute to the understanding of the system around young people such as schoolteachers and peer groups. CAMHS clinical staff were chosen as these teams interact with adolescents directly in relation to self-harm and so beliefs and perceptions of self-harm are in the forefront of interactions. Two local CAMHS clinicians were consulted during the developmental stages of the research during which they expressed a belief that there were unheard stories from CAMHS clinicians about their experiences of working with young people who self-harm. These came in relation to general practice and alongside the development of a different research study which focussed on exploring the experiences of young people and families who had engaged with a systemic intervention for self-harm.

Aims and rationale

The aim of this study is to explore the experiences of CAMHS practitioners working with young people who self-harm and the narratives they have constructed in making sense of these experiences. Existing research has suggested that staff members' need to keep people safe takes precedent in staff-patient interactions and can create a sense of powerlessness for the patient which can lead to self-harm (Thompson et al., 2008). This research is curious about how staff members' professional identities and wider policies influence how staff interact with adolescents who self-harm. Regarding clinical practice, the research hopes that providing an insight into the experiences of clinical staff may inform training needs and policies regarding what we offer children and young people in distress and how we support staff in offering this.
Research question:

- What are clinical staff member's experiences of working with children and adolescents who self-harm and how have their professional identities and wider policies shaped how they make sense of these experiences?

Method

Design

A qualitative design, using a narrative approach to analyse non-directive interviews with CAMHS clinicians was used to ask participants to think about their experiences of working with children and young people who self-harm.

Recruitment

Ethical approval was gained from the University of Hull Faculty of Health Sciences (Appendix B). Participants were recruited from within four CAMHS services in the Yorkshire region of England. Recruitment contacts from within each of the four CAMHS services advertised the

study by posters (Appendix C) and the participant information sheet (Appendix D) to clinicians within their service. Potential participants then either contacted the researcher directly or consented for their email addresses to be given to the researcher via the identified contact within their team. Once potential participants expressed interest, an email was sent containing further information about the study including the participant information sheet and consent form (Appendix E).

Study inclusion criteria included:

- Staff are from any clinical professional backgrounds. This was to safeguard the value of the research in offering something new (not a homogenous sample) as well as ensuring people are not interviewed unnecessarily.
- Worked clinically within CAMHS for 6-months or more to ensure a broad experience of working with young people who self-harm.
- Have experience of working with self-harm within a CAMHS setting.

Exclusion Criteria included:

- Have personal experience of self-harm (self or close relative).
- Individuals who may find the process too distressing. This can be determined by the individual or researcher, for example during briefing or the interview process.

Recruitment took place from February to April 2021. Twelve potential participants contacted the researcher, however three ceased contact. Overall, nine clinicians participated in the study from across four different CAMHS services in England. Participants came from various roles including Clinical Psychology, Mental Health Nursing, Systemic Therapy, and Counselling; experience of working within CAMHS ranged from 7-months to 22-years.

Data collection

Non-directive interviews were chosen to facilitate a non-judgemental stance and avoid the telling of narratives being overly influenced by the context of the interview and pre-planned questions (Josselson, 2011). The interview began with the researcher reading out the following statement to ask the participant to tell their story:

"I would like to ask you about your experiences of working clinically with children and young people who self-harm in the context of your professional identity. I'd like you to think of the entire experience as a story. The story can be as long or as short as you want it to be, and you can start and end your story wherever you like. It is your choice what you include in your story. Some areas you could include might be a recent or particularly salient experience of working with a young person who has self-harmed, how you understand self-harm, feelings towards self-harm."

Once the participant had finished telling their story, the researcher asked follow-up questions to gain further details or clarification of the participant's story.

Procedure

Electronic written consent for participation and audio recording of the interview was obtained for all participants prior to interview. Interviews were conducted via a video meeting platform, Microsoft Teams. At the beginning of the interview, it was confirmed that participants had read the participant information sheet and consent form and verbal consent for participation in, and audio recording of the interview was obtained. Participants were also reminded not to disclose any confidential information of any young people and families that they work with. Participants were asked to choose a pseudonym for themselves. Notes were

made by the researcher throughout and following the interviews, including reflections on interview process, the interviewee, and the researcher's emotional response to the story.

Analysis

Narrative analysis was conducted using a model describing four modes of reading a narrative (Figure 1) a combination of which was used to guide analysis of interviews as suggested by Lieblich, Tuval-Mashiach and Zilber (1998); a holistic-form approach to analyse the structure of entire stories, and a categorical-content approach to analyse story content.

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

Figure 1.

Four cell design (Lieblich et al., 1998).

Holistic Form

Holistic-form analysis was used to understand how the stories were told (Lieblich et al., 1988); narratives were transcribed verbatim, then listened to and read several times with attention to emotional expression and tone of voice to analyse each interview as a whole in relation to story parts.

The first stage is to define the plot axis of each story by understanding important events, emotions, actions, and issues in how stories were told (Lieblich et al., 1988). Development of plot axes was conducted using guidance by Gergen and Gergen (1988) which outlines stages of establishing an end point, identifying events that lead to the end point, ordering events in chronological sequence, and determination of causal links and demarcation signs.

Secondly, analysis of story dynamics was used to determine narrative form. Frye (1957) identified four basic narrative forms (comedy, romance, tragedy, and satire) which informed this analysis.

Graphs for each narrative were then constructed, derived from descriptions of events, evaluative comments, and emotional expression within the stories (Gergen & Gergen 1988; Lieblich et al., 1988).

Finally, prototypical narrative structures, were devised by comparing individual graphs to examine similarities and differences in narrative form and identify plot themes (Lieblich et al., 1988).

Categorical Content

Narratives were analysed following the procedure of categorical-content analysis described by Lieblich et al. (1998); (1) selection of subtext, (2) definition of the content categories, (3) sorting the materials into categories, and (4) drawing conclusions from the results.

(1) As the researcher had asked participants to talk about their experiences of working with young people who self-harm, all interview data was regarded as relevant material for the analysis.

(2) Category definition emerged from reading the transcripts as openly as possible to identify 'principal sentences' (units of meaning expressing new or distinct ideas) within each narrative.

(3) Principal sentences were assigned to relevant categories. Minor categories with similar content were then grouped to form major categories.

(4) Frequency of principal sentences for each category, depicting narrative content, were counted and tabulated.

Researcher Influence

Narrative research recognises the active role of the researcher and the influence of the relationship between the researcher and participants on the stories that participants choose to tell (Silver, 2013). The primary researcher (AG) was a 24-year-old white-British female trainee clinical psychologist with no personal experience of self-harm. Clinical experience was limited to working with adult populations. The primary researcher received regular research supervision with two qualified clinical psychologists with experience of working in CAMHS and research experience. The primary researcher engaged in self-reflexivity through use of a reflexive journal.

Results

Interview duration ranged from 14 to 45 minutes; average interview duration was 28.5 minutes. In total, 256.54 minutes of data were collected.

Holistic analysis of form

Analysis of plot progression revealed two plot axes: '*learning curve*' and '*facing systemic challenges'*.

Four participants described a story which matched the plot axis of '*learning curve'*. The title of 'learning curve' came from one of the stories and related to the development understanding of self-harm, supporting young people and professional teams with this, and managing risk in line with this understanding. Events in these stories began with participants facing challenges which they learn to overcome, leaving them with a positive sense of present which some related to ideas about the future.

Five of the participants' narratives presented with the plot theme '*facing systemic challenges*.' Events within these stories mostly began in a similar way to those fitting the 'learning curve', however participants then described further challenges which, due to their wider systemic nature, resulted in a sense of frustration and despair.

Comparing Plots

Learning Curve

Narratives with the plot axis of '*learning curve'* aligned with the plot form of 'romance' (Figure 2; Frye, 1957). This is represented in the graphs as an initial decline whilst the clinician faces challenges, followed by an incline as challenges are overcome (Gergen & Gergen, 1988). For all graphs there were three phases which stories progressed through (Table 1).

Figure 2.

Plot Axis Learning Curve.

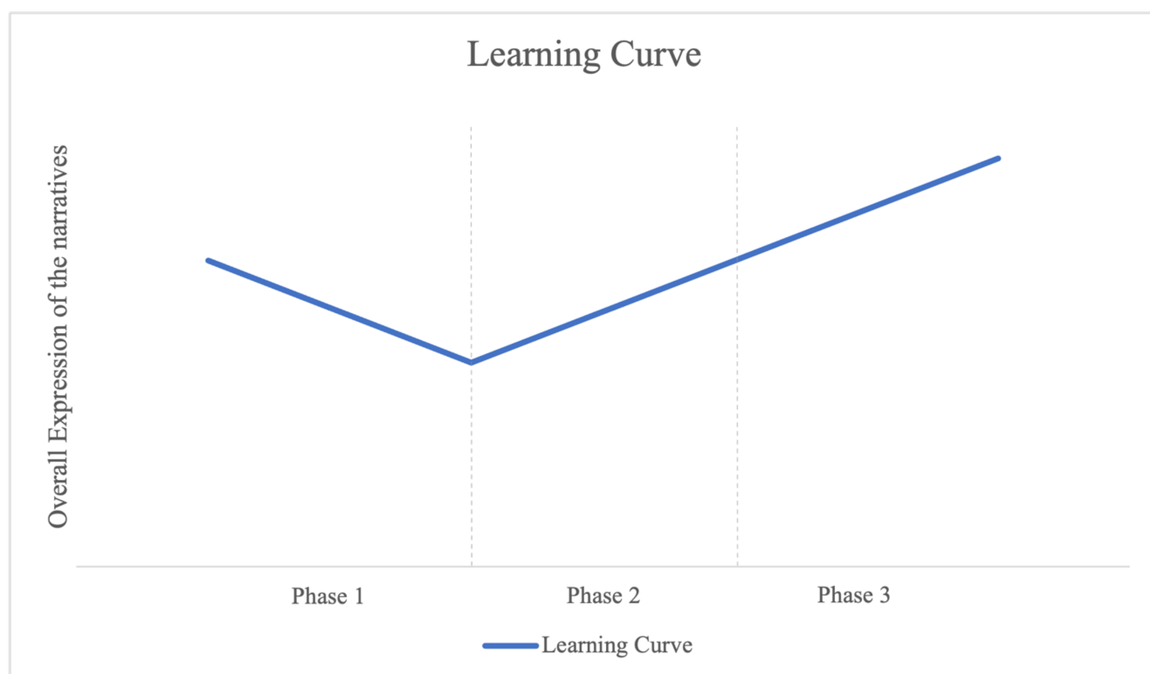


Table 1.

Phases of Learning Curve.

Phase	Theme
1	“Challenge”
2	“Learning”
3	“Sense of Mastery”

Facing Systemic Challenges

The plot form of ‘tragedy’ (Frye, 1957) characterised the axis of ‘*facing systemic challenges*’ (Figure 3); stories involving rapid downfall from a point of achievement (Gergen & Gergen, 1988). Graphs representing these narratives begin with a decline (clinicians describing challenging events) followed by an incline (clinicians defeat such challenges) but end with a second steeper decline as facing further challenges which they do not overcome. Out of the five graphs, three progressed through four phases (Table 2) whilst two had three phases; however, both remained consistent overall with the plot axis.

Figure 3.

Plot axis of Facing systemic challenges.

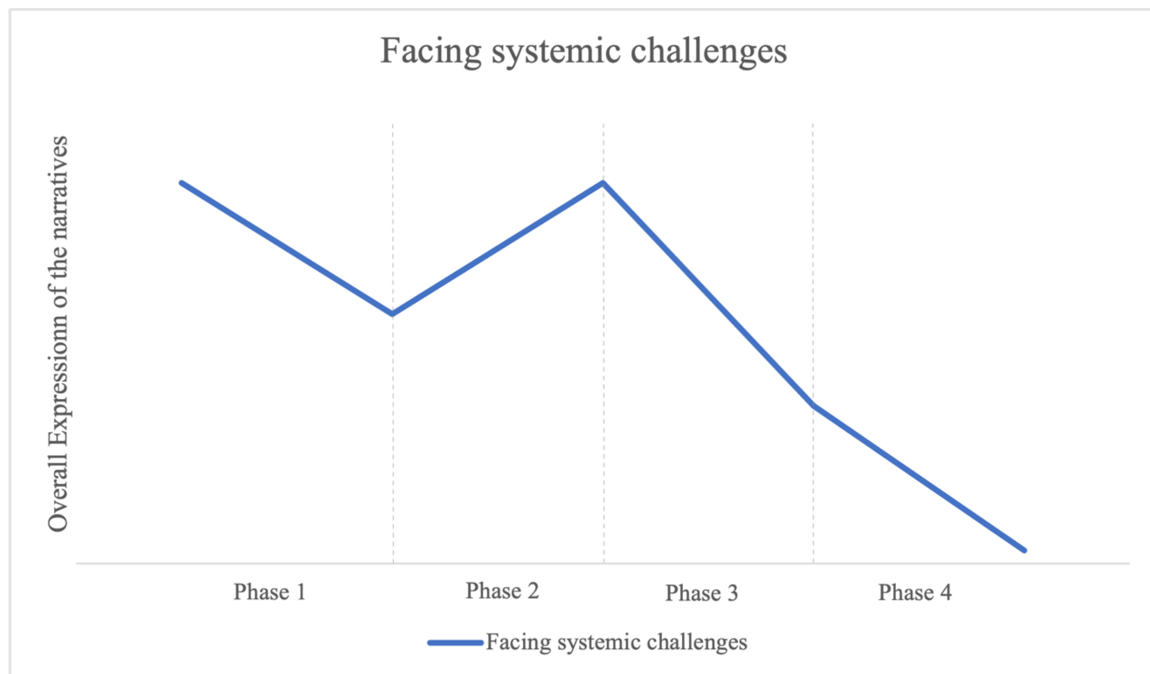


Table 2.

Phases of Facing Systemic Challenge

Phase	Theme
1	"Challenge"
2	"Working it out"
3	"Concern and frustration in relation to systems"
4	"Context of covid"

Phases of Clinician Narratives

Graphs consisted of three or four phases, represented by turning points in the narratives (Lieblich et al., 1988). Phases 1 and 2 followed similar trajectories between plot axes; trajectories split at Phase 3 (Figure 4).

Phase 1

Phase 1 for both axes was characterised by clinicians facing challenges. For those that fitted the '*learning curve'* challenges were associated with having limited understanding about self-harm or bringing prior experiences, both professional and personal, which clinicians experienced as being unhelpful in supporting young people who use self-harm. For example:

"Before I worked in this role, I worked in a secure children's home as a support worker and the young people used self-harm as a coping mechanism, but they were prevented from doing that, which I really, I now understand wasn't the right way to approach how children and young people self-harm at all" – Zebra (page 1, 16-19).

Challenges within '*facing systemic challenges'* reflected clinicians' difficulties in getting other systems to engage in the same approach and understanding as them.

"Sometimes that can feel unsettling 'cause you kind of think right, well, the young person doesn't particularly want to talk about self-harm, it feels like there's more useful things to talk about, but this is a self-harm clinic and the expectation is that you know I should know in order to manage risk.

Hmm, yeah, but I kind of push that to the side really because I work in an organisation where I regularly feel that the expectations on me, the boundaries around what's problematic and

how distress is resolved, don't fit with my clinical experience, so I'm constantly working within this, these kind of weird tensions that don't quite fit.” – Martha (page 2, 15-21)

“I take it extremely seriously and it really frustrates me if I ever hear people saying oh it's manipulative, or because I think those words are used quite a lot in in services or its attention seeking or. I don't see it as that all, I see it as an expression of, of distress.” - Jenny (page 2, 1-3)

For some, limited knowledge was a concern.
“when I was a trainee, I think self-harm was something that I, I felt really worried about working with and it made me feel really anxious” - Olive (page 3, 6-7)

Phase 2

For both groups, phase 2 involved overcoming their challenges in some way. Those with plot axis ‘*learning curve’* shared experiences of their “learning” journey to their current understandings and approaches to supporting young people who use self-harm.
“five years ago my understanding of self-harm was very limited. I feel now it's developed a lot in terms of how I can understand that and how, how to manage that I suppose helpfully for young people. How to risk manage that as well, quite, you know, in an effective way. And work with other professionals in supporting these young people by formulating and understanding self-harm in a different way I suppose to, to what I would have done before. So yeah, it's been a big learning curve for me really.” – Lottie (page 4, 3-8).

For the group '*facing systemic challenges'* this phase was characterised by "working out" how to work effectively with young people within organisational and service structures which did not match their clinical experiences, and experience value in this.

"And the other interesting thing that I found is that it's very possible to sort of talk about self-harm without talking about self-harm if you know what I mean. Like it's easier to talk about how it's spoken about or not spoken about, how it's responded to or not responded to. So that feels helpful sometimes." – Martha, (page 3, 1-3).

Phase 3

Phase 3 was characterised by the theme "sense of mastery" for those with plot axis *'learning curve'*.

"Yes, I feel like we give quite a good package and we give quite a high standard of very good quality care to families and children and young people. I'm proud of that to be honest because the team we're really good with it. We don't judge, we talk about it freely and we get families to start opening up communications and talk about it freely more, so the child, it doesn't become a secret anymore." - Betty (page 6, 9-13)

For the '*facing systemic challenges'* group, this phase was characterised by "concern and frustration in relation to systems" which related to systems of families, services, organisations, and society.

"We actually, as a service, categorise self-harm into something that is covered, called routine and something that is called urgent and that that doesn't sit very, very comfortably with me. Yeah. And just the idea that self-harm is even has its own pathway. Self-harm never exists in isolation" – Olive (page 9, 12-15)

“The service I work in I think has about a fifth the size of team that it would do according to the Royal College of Psychiatry and I, over the time I've worked with them and it's not that long in the current role it's reduced further, so it's gone from a small thing to a smaller team with an increasing demand. They’re sort of looking at what is the evidence base and the structures and intervention that we should provide. And doesn't seem to inform commissioning or service design. It seems to be just in response to crisis” – Betsy-May (page 3, 23-28)

Phase 4 (Facing systemic challenge – context of covid)

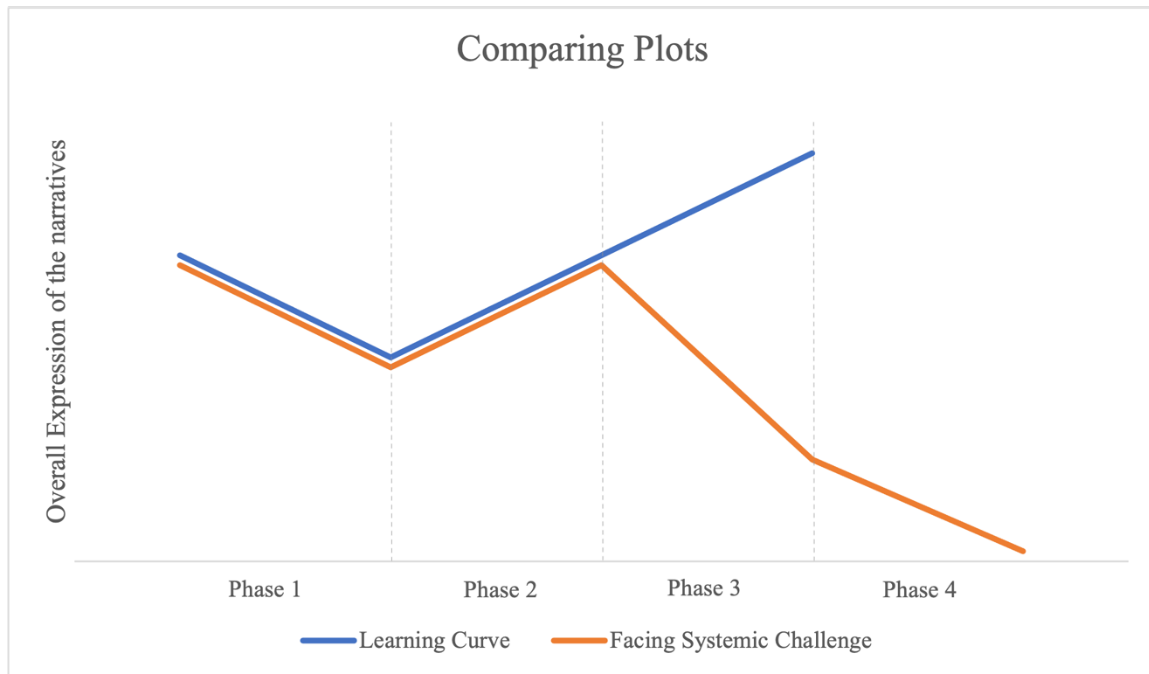
‘Facing systemic challenge’ had a fourth phase during which three of the clinicians described the “context of covid” and the impact of associated lockdowns.

“people being out of school for two months and having really, really broken education before that. This sort of increased anxiety, frustration and stress in parents, schools, children who need sort of security that schools might provide, through their routine or through their pastoral care in families where there isn't food or safety. That's been disrupted.” – Betsy-May (page 7, 3-7)

One narrative from ‘*facing systemic challenges’* deviated from the plot axis at phase 2 and moved directly to the phase characterised by “concern and frustration in relation to systems”, also shifting their phase characterised by “context of covid” to a phase earlier than the others with this plot axis. This was to allow for their phase 4 which described the context of them being at the end of their career and the hopes they had for what younger clinicians may do to change systems.

Figure 4.

Comparison of Plot Axes of Learning Curve and Facing Systemic Challenges.



Categorical Content

Content categories determined from analysis of the narratives are presented in Table 3.

Table 3.

Major and minor categories.

Major Category	**Minor Category**	**Number of Principal Sentences in Major Category**
The bigger picture	Societal Context	39
	Service/Organisational Context	47
	Model of understanding distress	20
	Personal position	7
Responding to self-harm	Sense / meaning making	37

	Communication within and between systems	23
	Risk-focussed	25
	Anxiety	13

The bigger picture

Participants discussed the impact of layers of context that influenced people's understanding of and responses to self-harm.

Societal Context

Many participants shared concerns about the position society takes on children's mental health and the role this plays in perpetuating distress.

"Mental health we can, we can help people, but it's just not as valued as as other modalities of of care... I think that needs addressing at a probably national international level." – Jenny, (page 3, 19-20, 24-25)

"Whether they feel bad for themselves or whether they feel bad 'cause other people are telling them to, or because society is telling them it's wrong, you know, they've got enough bad feelings going on. If I can, not reinforce but just, you know, not tell them off, then it, it's something." – Seren (page 6, 20-22)

Participants talked about the impact of social issues on the young people that they work with. For example, two participants talked about difficulties in getting others to recognise the difficult social circumstances young people are facing.

"I think we're working with the services that try and pathologise people when they are in really difficult circumstances and sometimes services are set up in the way that people have the sort of fewest resources will have the most difficulties to access them." – Betsy-May (page 4, 1-3)

"we call it a social mess in our office 'cause we do get a lot of social services going 'oh it's mental health' and we're like 'it's really not', you know it's a social aspect" – Person A (page 5, 18-19)

Pressure from education was also highlighted as an important factor:
"I think it's a much wider issue. I think we need to really try and think. I think education doesn't help young people. I think we put so much pressure and stress on young people through education". – Jenny (page 2, 19-20)

Concerns about increasing rates of self-harm were also expressed including a need for this to be attended to on a societal level. For example:
"you kind of feel like something more needs to be thought about, like you know how come we are in a culture and a society where these difficulties are becoming more pronounced." – Martha (page 4, 17-19)
"I think over the years I've noticed that we see more self-harm, more distress, more serious self-harm." – Jenny (page 1, 17-18)

Five participants commented on the impact of coronavirus and associated lockdowns on the distress experienced by young people and their capacity to respond as clinicians.
For example, talking in relation to rates of self-harm one participant said:

"with lockdown and with not being able to access school and not being able to access friends or kind of anybody that matters, I would expect that that's increased" – Seren (page 10, 15-16)

Attending to how services respond was also important:

"we're in coronavirus and have an increased need and apparently a reduced service. I find that concerning that we. We aren't sort of taking a step back to reflect on what would be the safest way of working in this context". – Betsy-May (page 6, 33-34 - page 7, 1-2)

Service/Organisational context

Participants described difficulties in being able to meet the needs of the young people that present to the services they are in due to lack of resourcing.

"And I feel as clinicians that we're often left dealing with completely unmanageable situations that.

I think as a manager, and I think as a clinician that we're not resourced. We just don't have enough resources to support the really complex young people that we seem to be coming across." – Jenny (page 2, 11-13)

One participant shared how they have to prioritise certain young people over others:

*"because of the pressures from the system and service that I have to make some of those decisions that are equally sh*tty when we get lots and lots of referrals and we have a limited amount of availability to respond. Then yeah, of course we prioritise. So even yeah we prioritise the, prioritise the severity"* – Olive (page 7, 20-23)

Two participants linked lack of resources with inappropriate organisational or service design:

"I think there's kind of a disconnect between commissioning and service that's available and population need." – Betsy-May (page 5, 30-31)

"I think the NHS has become too much of a business" – Jenny (page 4, 34)

These ideas were shared by participants who highlighted that how services are set up and function are often unhelpful. For example:

"if children and young people need to self-harm, there's a reason for it and they shouldn't be prevented from doing so. But the policy and procedure of the place where I used to work was that you prevented it, if you saw a young person self-harming you prevented it, even if that meant getting into a physical restraint with that young person." – Zebra (page 1, 19-20, page 2, 1-3)

"a lot of kids they call up and they've been like 'arrgh I've had a bad day at school', but they feel like they have to say that they want to hurt themselves in order for us to be involved. But that's not the case." – Person A (page 6, 22-24)

For some, use of humour was described as a way of coping with problematic service contexts:

"The really dark part of dark humour in my so profession is working with the children and their families is the best bit and the most manageable bit It's the service that doesn't make so much sense at times or the services around the young people families. The sort of chaotic interagency responses." – Betsy-May (page 6, 2-5)

Model of understanding distress

Several participants highlighted challenges associated with the model of understanding distress that pathologises emotions.

“we've got teenagers mums calling up going ‘oh my child's really anxious because it's exam time’ they’ve got anxiety so automatically, instead of it being an emotion, it's a label. D’you know we’re trying as a team to help kids self-soothe, to go ‘it's OK to have a bad day’”– Person A (page 6, 4-6)

“And it's because we live in a culture that supports that. You know, utterly, that view of distress. It's so unhelpful. It's the biggest challenge in my job is to try de-pathologise peoples understanding.

…they come into a mental health service and what I spend most of my time doing is trying to convince people they're not mentally ill” – Martha (page 8, 20-24)

One participant emphasised how this model dictates how clinicians are able to respond, which often don’t fit with their clinical experiences of what is helpful.

“I don't think a diagnostic model of mental health and emotional pain and distress is fundamentally helpful. But that's what we’re in mental health services, and that's what dictates policy. And that's what dictates how we manage risk. And that's what dictates our pathways and the fact that I have a self-harm clinic.” – Martha (page 8, 33-34 , page 9, 1-3)

Personal position

Many participants acknowledged how their personal circumstances shape their role as a professional and ability to connect with the difficult experiences of young people and their families.

“A big reason that I kind of went into nursing was probably the people that I used to know that self-harmed and had mental health difficulties” – Seren (page 7, 11-12)

“as a parent if my child came to me and said she was self-harming, I’d be completely devastated and distraught and I’d experience all those parent feelings.” – Zebra (page 2, 11-13)

Responding to self-harm

All participants discussed issues around different responses to self-harm, including, based on their experiences, which were helpful when working with young people who self-harm.

Sense/ meaning making

Several participants shared the sense they had made of self-harm and that it is understandable and often not ‘the problem’.

“when self-harm is happening, my experience is that. That's the kind of the consequences of something, rather than what's problematic” – Martha (page 1, 24-25)

“that's a normal reaction to a really abnormal situation… that is a coping strategy that that’s risky and not good for them, but it's understandable.” – Jenny (page 6, 16-17)

Many participants talked about the harm that can occur from preventing self-harm and highlighted that use of self-harm as a way of coping is often what is keeping the young people alive.

“if a child self-harms, it's probably a life, life life. What’s the word I'm looking for? Not life limiting, the complete opposite of that? Life maintaining strategy, that if we don't allow some

level of self-harm, if that is their only coping mechanism and will prevent that, actually are we doing them more harm than good." - Zebra (page 4, 23-26)

Participants commented that their role as professionals was often to support the young person and the people within their wider systems in making sense of self-harm within the young person's context.

"helping them make sense of not necessarily the self-harm, but the context of what's going on for them" – Betsy-May (page 2, 16-17)

"it was about then helping her to understand, and the professionals around her actually, what she was, what she was trying to communicate, and perhaps the impact of trauma and how, you know, it didn't necessarily mean she had a mental health diagnosis that actually this was. This was what was coming out with, from a build up of lots of different things in a nutshell, really." – Lottie (page 3, 10-13)

Communication within & between systems

Several participants highlighted that communication around self-harm as a significant factor. For example:

"sometimes it's, it's the response or lack of response that can keep things feeling difficult. So that's why it's really helpful, I think, to have families together rather than the young person on their own, because I think the response to it is often what can make the difference between it continuing or reducing as a kind of you know strategy, or as an outlet or as a way of communicating" – Martha (page 3, 12-16)

Having and taking the time to listen and try to understand the young person was something many participants recognised as important.

"what most people need when they feel like harming themselves is just somebody to listen" – Olive (page 6, 14-15)

"it is a way of communicating, and I think of you as you can start to understand that a little bit more by giving young people the time to you know and listening and formulating with them." – Lottie (page 3, 27-29)

Some participants talked about their role often being around opening up communication.

"We make sure that they understand that we have to make them safe around that so parents are aware so they can keep their child safe as well and open up that communication." – Betty (page 3, 4-6)

Risk-focussed

Most participants mentioned questions they ask to assess risk within interactions with young people.

"it's always a question that we ask about at the start with our assessments, we always obviously have to ask about whether they're doing it now, what they used to do. I personally like quite, I like to try and be quite specific with it and be very like, okay, so you've said that you used to hurt yourself. Do you cut? Do you burn? Do you take tablets and be very like direct with it." – Seren (page 1, 15-19)

Some participants commented that too much attention on risk was often unhelpful when working with young people.

"just check in on risk and then move on. And that's been something that has really helped me with young people that are regularly self-harming where I'm sort of containing whilst they wait for therapy, is actually, the focus doesn't always have to be on the self-harm." – Lottie (page 7, 16-19)

Other participants shared experiences of attempts to reduce risk which made things more dangerous. For example:
"we'll say, you know, you should have a lockable box and you should be locking away kitchen knives and razors. As though if you reduce the means, that that's it, the self-harm will just stop. And my experience is that that virtually never works. All that happens is that a young person uses something actually less safe than a clean razor blade or clean knife." – Olive (page 12, 17-21)

Anxiety

Participants' own anxiety and how this could get in the way of being able to connect with the young people in a helpful way was acknowledged by some. For example:
"it was only, as I've begun to manage my own anxiety and started listening more as opposed to trying to do, that I was able to get a clearer sense and understanding of why people would turn to that" – Olive (page 6, 3-5)

Participants described how anxiety within professional teams and family systems often had a significant impact when working with young people.
"the anxiety around us as a professional team around these young people is really high because they are risky" – Lottie (page 2, 26, page 3, 1)

“A game of sort of interagency pass potato, hot potato just avoiding any role, any responsibility or any holding of the case.” – Betsy-May (page 1, 24-25)

“just families ringing, ‘we don't know what to do’. Clinicians feeling like they don't know what to do cause we don't have capacity to respond so we put it back to the parents and then give them that advice, so we've done what we need to do and then parents feel uncontained so they feel like they need to do what they need to do, which is ring us and be like I need help and it's just this constant passing of. Yeah, just, just anxiety isn’t it, I’ve talked a lot about anxiety. But yeah, passing of responsibility.” – Olive (page 13, 18-24)

Discussion

Clinical staff members shared their stories of experiences of working with children and young people who self-harm in the context their professional identities and wider policies. Of note across analyses of both narrative form and content was the distinction between experiences clinicians faced in relation to themselves as individuals, and challenges associated with wider systems.

The plot axis of ‘learning curve’ appeared to represent clinicians’ own journeys to reaching a ‘sense of mastery’ in working with young people who use self-harm. Minor categories of ‘anxiety’, being ‘risk-focussed’, and challenges associated with ‘communication within and between systems’ may reflect steps in clinicians’ journeys to ‘sense-making’ about self-harm. Clinicians shared that their experiences had taught them the value of spending time with young people and their families and learning to listen and understand why a person may need to use self-harm, findings which resonate with existing literature (Smith, 2002).

Clinicians described how their own and team anxiety, limited understanding, and the organisational risk-focussed approach often meant that they initially worked with young people with aims of risk prevention. As illustrated by phase 2 and 3 of '*learning curve'* and findings within categories of 'responding to self-harm', clinicians were able to overcome problems associated with their own skills and anxiety, to work effectively with young people.

However, many reflected that risk-focussed ways of working were unhelpful and could lead to risk increasing due to young people harming in ways which were less safe or being physically restrained. This highlighted a mismatch between what clinicians experienced as helpful and what policies allowed them to do.

Clinicians discussed the importance of attending to context when working with young people to make sense of self-harm and supporting communication with and between systems around the adolescent. However, clinicians were met with barriers which were based within different layers of systems. This was illustrated by the plot axis of 'facing systemic challenge' and the major category of 'the bigger picture'. Clinicians shared frustration at having to de-pathologise peoples' understanding when meeting them in settings called 'mental health services'. Using ideas from CMM (Pearce, 2005), it seemed that for many families the highest context marker for making meaning of self-harm was the cultural 'model of understanding distress'; mental and emotional distress are understood as pathological, diagnosable 'illness' rather than part of social variation in responses to human problems (Conrad, 2007; Thomas et al., 2018). As exemplified in the minor categories of 'model of understanding distress' and 'service/organisational context' clinicians discussed their concerns about our societal understanding of distress and the often-harmful impact it can have when dictating service policy and design.

Moreover, a lack of resources was highlighted as a barrier to supporting young people as clinicians did not have time to spend with young people and felt pressure to rush them through systems with a focus on maintaining safety rather than addressing root cause, further evidencing existing concerns (Wolpert et al., 2014).

Clinicians shared their distress at being among those who responded in ways which were unhelpful due to service design and policy, and lack of resource. Although these feelings may echo those of helplessness described elsewhere (McAllister, et al., 2002), these findings offer some understanding that it may not be the clinician's individual feelings that prompt them to respond in ways which they consider to be unhelpful, but the context of service setting in which they work.

Discussing 'Societal context' clinicians talked about the impact of the meaning of self-harm held by society, for example language around a sense of 'badness', on the meaning created by young people about themselves (self-scripts) and episodes of self-harm (Pearce, 2005; Holmgren, 2004). As discussed in existing literature (Hawton et al., 2012; McManus et al., 2019), concerns were shared in relation to self-harm 'growing' which clinicians related to how we understand and respond to distress, as well as pressures on young people related to education. Clinicians also highlighted the need for our understanding of distress and how we create services to respond to things such as self-harm to be attended to on a national level or international level.

As highlighted by clinicians' narratives, the 'context of covid' was important when considering the context in which narratives were constructed. Clinicians shared concerns about the impact of restrictions on service capacity at a time when young people were losing

important resources in their lives including school and friends as well as further reductions in service provision. However, despite the pandemic and as illustrated by the plot axis ‘facing systemic challenge’, working in the context of under-resourced services were important parts of clinicians’ experiences and what clinicians discussed as the ‘problem’ within their narratives, rather than focussing on self-harm.

Limitations

Clinicians told their stories in the context of the covid-19 pandemic, during England’s third national lockdown. It is important to consider how this context will have influenced experiences of working with young people who used self-harm and subsequently, the stories constructed about these experiences. The influence of restrictions on the process of being recruited and being interviewed, for example, interviews taking place using online video calling, will have shaped how storied were constructed. Due to many clinicians working from home, participants perhaps missed out on experiencing the interview as something separate to their working day and therefore did not have the space to reflect on the interview question before telling their stories as they might have been able to if interviews were in person. This may have impacted on the length and depth of the interview, particularly if they had other commitments following the interview.

This study used a small and self-selecting group of clinicians from one region of the north of England. The self-selecting nature of the sample may mean that stories told were over representative of particularly positive or negative experiences. However, the aim of narrative research is not to create representative or generalisable findings but offer rich reflections of experience.

Clinical Implications and Conclusions

Clinicians told stories of working with young people which were perceived to be helpful and overcoming personal anxieties were often involved in the process of making meaningful sense of self-harm. However, these individual developments occurred within the context of a system which provides significant challenges regarding the benefit of this work. The plot axis of 'facing systemic challenges' suggested that for many of the clinicians, the highest context marker in the construction of their narratives of working clinically with young people who use self-harm, was culture (Pearce, 2005); clinicians were not always able to respond how they ideally would or were constrained by services which were dictated by cultural understandings of distress that pathologise emotional experience. This suggests the need for a cultural shift in how we make sense of distress and emotional experience with corresponding changes to service design and provision. A first step in this shift may involve attending to the language used to describe and express distress to enable young people and families to move beyond barriers created by language that pathologises these experiences (Holmgren, 2004). Initiatives such as the THRIVE model claim to offer "a radical shift in the way that services are conceptualised and potentially delivered" (page 4, Wolpert et al., 2014). Although taking a positive shift towards a more needs-led service design, the language used when describing who they expected to require the different levels of input continued to be based upon diagnostic labels, for example 'emerging personality disorder'. Similarly, the NHS long term plan (NHS, 2019) proposes increases in funding to allow more young people who have a 'mental disorder' to access 'treatment' thus continuing to use language which sends a message to the young person that there is something wrong with them, and perpetuating the problems described by clinicians.

At a service level, an increase in service provision and resource, and change in design is also needed to allow clinicians time to spend with families to explore why a young person may be needing to use self-harm, as well as the context surrounding their use of self-harm, as clinicians have highlighted the negative impact, on both themselves and young people, of a focus on risk and pressures to rush people through the system. This was in-keeping with clinicians' perspectives of the dangers and limitations borne from failing to consider the social and contextual contributors to the use of self-harm. Further research to understand the impact that distress experienced by clinicians in relation to having to work at odds with their values, and experiences of vicarious trauma is required.

Policy and guidelines, particularly around preventing young people using self-harm also require attention. Experiences from clinicians highlight that these policies appear to often attend to the needs of anxious professionals or organisations rather than the needs of the young people at those times and that preventing the use of self-harm often caused further distress.

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Appendix A - Author Guidelines

Submissions can reflect different epistemological, methodological, theoretical, and cultural perspectives. Work using the dominant hypothetico-deductive method of scientific inquiry and quantitative methodology is as welcome as work adopting alternative approaches (i.e., inductive or abductive methods of science, qualitative and mixed methods research). Submissions should contribute to innovation, questioning of assumptions, and controversy and debate. They should give creative impetuses for academic scholarship and, where appropriate, for applications in education, policymaking, professional practice, or advocacy and social action.

JSPP operates a rigorous and transparent peer-review process that focuses on a broad range of criteria. The overarching purpose of the peer-review process is to help achieve the highest possible quality for JSPP's manuscripts. Its aims are (1) to ensure that the research is technically sound; and (2) to offer guidance to support authors in making their manuscript as strong as possible, in line with JSPP's profile. JSPP uses a broad range of review criteria, some of which are less prominently considered in other journals. Depending on the type of article (see below), this may include:

- Societal importance and noteworthiness of the problem or topic
- Thoroughness of foundation, as documented in a comprehensive, fair, and critical review of the theoretical and empirical literature that situates the research meaningfully in relevant contexts
- Consistency of research goals and objectives, rationale and purpose, and research questions
- Suitability and creativity of the methodological approach in light of the research questions
- Quality and rigour of research design, sampling, data generation or measurement, and analysis
- Consistency of inferences and interpretation, insightfulness of discussion, adequacy of conclusions
- Degree of contribution to the literature, including potential to open up new avenues
- Interest and accessibility to a broad audience
- Sensitivity to ethical issues, including potential political and societal consequences of the research
- Clarity of presentation, including quality of writing and parsimony of tables and figures

Further information on quality criteria for quantitative, qualitative, and mixed methods research can be found in, for example, Dellinger and Leech (2007), Elliot, Fischer, and Rennie (1999), and Teddlie and Tashakkori (2009).

Manuscript length

We have two general categories of word limits. Exceptions to these limits are possible only if very well justified and when discussed before submission and/or publication with the editors. The word limits include everything in the article (with the exception of the non-technical summary): Abstract, main text, figures, tables, references, appendices. To be able to meet the word limit, we encourage creating online supplementary materials for lengthier appendices and additional materials or descriptions you wish to include in your article. Despite the word limits,

we expect transparent and detailed methodological reporting and a sufficient contextualization and elaboration of theoretical background of the research.

8000 words: for quantitative papers reporting one study or two studies with a similar design, and commentaries (which, however, typically are much shorter)

10,000 words: for qualitative papers, multi-study quantitative papers and quantitative papers with more complicated methods or analyses, review and theoretical papers

A) First submissions

For first submissions authors are requested to provide:

1. Your manuscript in one of the following formats: doc/docx (recommended), rtf, pdf, odt. Maximum file size: 5MB. Usage of our JSPP First-Submission Template is recommended: Download JSPP First-Submission Template. *Note:* You may embed low-resolution (< 100 ppi), screen-optimized versions of your figures within the text at the appropriate positions, or the end of the manuscript. For accepted articles a separate, high-resolution (300 ppi) image file for each figure is required – see (B-3) below.
2. Any further digital content of relevance for the review process but not embedded in your manuscript (like charts, images, appendices). Submit these additional items as supplementary files at step 4 of the online submission process. Maximum file size: 8MB each.

Please make sure that all personal information (including in the file properties) has been removed from the manuscript, and that the instructions in Ensuring a Blind Review have been observed.

B) Accepted manuscripts

If your manuscript has been accepted for publication, you are requested to provide:

1. The final version of your manuscript, including all revisions, in Microsoft Word format (if you use another program, e.g. OpenOffice, please save your manuscript as a .doc or .docx file in Microsoft Word format). Maximum file size: 5MB. To avoid formatting errors we recommend using our JSPP Accepted-Manuscript Template: Download JSPP Accepted-Manuscript Template. *Note:* Do not send manuscripts by email. Instead, please log into your JSPP author account to upload the final author version of your manuscript.
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Electronic Supplementary Materials (EMS)

Authors may submit study data, analysis scripts, and other study materials for manuscripts that involve new data as Electronic Supplementary Materials (ESM). The Electronic Supplementary Material (ESM) is not included in the word count. In general, ESM contains additional items that are not essential for inclusion in the full text but would nevertheless benefit the reader (e.g., raw data sets).

ESM will be published at the PsychArchives repository. PsychArchives is a disciplinary repository for psychology, provided by Leibniz Institute for Psychology (ZPID). All ESM will be published under a CC-BY license, meaning that authors grant others permission to use the ESM in whole or in part provided that the original work is properly cited. (Please check that no copyrighted material is included unless that material has also been made available under a CC-BY license. For more details see Supplementary Material Guidelines.)

ESM will be published online as received from the author(s) without any conversion, testing, or reformatting. They will not be checked for typographical errors or functionality. The responsibility for the content and functionality remains entirely with the author(s).

Appendix B – Initial Data Extraction

Author(s) & Year of Publication & Geography	Research Aims	Participant Sample	Design	Inclusion/Exclusion Criteria	Measurement tools	Method of Analysis	Key Findings
Barnes, M. C., Gunnell, D., Davies, R., Hawton, K., Kapur, N., Potokar, J., & Donovan, J. L. (2016). UK	To understand events and experiences leading to the episode of self-harm and to identify opportunities for prevention or mitigation of distress.	• N=19 • 9 male; 10 female • Aged 19-56 • Had attended hospital following self-harm in 2 UK cities and specifically cited job loss, economic hardship or the impact of austerity measures as a causal or contributory factor • Purposive sampling	Semi-structured, in-depth, face to face interviews.	*Inclusion:* • Referred to a mental health specialist for a psychosocial assessment following presentation to A&E. • Indicated that a precipitating factor in their self-harm included financial, employment, or other difficulties related to economic hardship or austerity. *Exclusion:* • overt psychotic symptoms at the time of hospital admission • Unable to give informed consent, including those	Beck Suicide Intent Scale - (low 0-6, moderate 7-12, high 13-20, very high >20) Self-completed VAS to monitor for distress pre-interview & post-interview	Grounded Theory.	Key themes *Circumstances that led to the SH episode* – employment difficulties, debt & benefits, housing difficulties *Co-existing or long-standing problems raised when discussing distress related to economic hardship* – salient source of despair, justification for feelings of despair and worthlessness, abusive or neglectful childhoods, bullying, sexual identity issues, abusive adult relationships, significant bereavements and long-standing MH problems. *Perceptions of available help and support* - Need for clear practical help for economic difficulties and

				not fluent in English			counselling or therapeutic support for co-existing or historical problems.
Hawton, K., Bergen, H., Geulayov, G., Waters, K., Ness, J., Cooper, J., & Kapur, N, (2016). UK	To investigate the impact of the 2008 recession on rates of self-harm in England, which gender and age groups were most affected, how any effects were related to local changes in rates of unemployment and the nature of participants' characteristics & problems which might explain any associations found.	• People who self-harmed during 2005-2007 were compared to those who self-harmed during 2008-2010*. • Data from Multicentre study of self-harm (hospital presentations for self-harm in Oxford, Manchester & Derby from 2000-2010). * end of 2007/beginning of 2008 defined as the onset of recession.	• Data analysed included: • Gender • Employment (for those aged 15-64 years) (employed, unemployed, sick/disabled) • Problems precipitating self-harm (any current difficulty reported by patient or identified by clinician as being related to self-harm).	• *Inclusion:* • Received a psychosocial assessment while in general hospital (as information about employment and problems not available for non-assessed patients) • First assessed episode for each person in each year.	N/A	Interrupted Time Series analysis - Segmented regression analysis (estimate the mean quarterly rate of self-harm after the start of the recession compared with the projected (expected) mean quarterly rate of self-harm based on the trend during the pre-recession period) Chi-square – proportions of patients who	Significant increases in rates of self-harm in 2008-2010 compared to those expected based on pre-recession trends, in both genders in Derby, and males in Manchester. Little change was seen for either gender in Oxford, or for females in Manchester. No significant overall decreases in the proportion employed following onset of recession but increases in both genders in those who were unemployed and marked decreases who were registered sick or disabled. Changes occurred in Derby &

						self-harmed pre-& post-onset of recession were compared on employment status & type of problems. All analyses conducted for two genders separately.	Manchester but not Oxford. Marked increases in proportions of assessed patients who were identified as having problems at the time of self-harm related to employment, finances and, in females only, housing. For those who were employed, there was an increase in proportion of males with problems related to employment, and of females with employment, financial and housing problems in 2008-2010 compared with 2005-2007.
Barnes, M.C., Donovan, J.L., Wilson, C., Chatwin, J., Davies, R., Potokar, J., Kapur, N., Hawton, K., O'Connor, R. and	To understand and describe the experiences of people with financial, employment and benefit difficulties as they sought help for their problems and the consequences of their difficulties on mental health.	• 3 groups of people in 2 UK cities • 'self-harm' n=19 (people who had self-harmed due to employment, financial or benefit concern) • 'community' n=22 (people	Individual face to face interviews (all groups) Focus groups • Service providers – staff from debt advice centre n=5 & Samaritans outreach team n=7 • Community – Young parents	*Inclusion:* • Aged 18-65	Beck Suicide Intent Scale - (low 0-6, moderate 7-12, high 13-20, very high >20)	Grounded Theory	Key Themes & subthemes *Service Provision* • Employment & benefit agencies • Independent /charity services • Health services

Gunnell, D., (2017). UK		who were struggling financially) • ‘service providers’ n=25 (frontline staff from voluntary and statutory sector organisations providing support services to the groups) • Targeted sampling	support centre n=5)			Accessing services difficult. Free debt advice considered most useful. Community sample reported more knowledge of how to access debt advice than self-harm group. *Informal support* Self-harm group reported fewer sources of support and less supportive networks than community sample. Self-harm group reported more difficult circumstances *Unmet Need* • Practical guidance through system • Benefit & debt information • Co-ordinated services All groups indicated that practical help for financial & benefit issues would help and they wanted clear information about services

							available and how to access them. Coordination between services would help. Help for current and past mental, emotional and physical difficulties was necessary. *Mental Health* Participants in the self-harm group reported a stronger belief that they should be self-reliant in the face of economic and mental health difficulties than the community group
Clements, C., Hawton, K., Geulayov, G., Waters, K., Ness, J., Rehman, M., Townsend, E., Appleby, L. and Kapur, N, (2016). UK	• Describe incidence rates and trends in self-harm over time in men & women aged 40-59, using data from the Multicentre study of self-harm. • Compare key characteristics & explore outcomes (repetition, mortality by	Data from people aged 40-59 years* from the Multicentre study of self-harm. N= 12601 (n=5886 men; n=6715 women) Subgroup comparisons for those who first presented 2002-2007 compared with those who first presented 2008-2013. Cohorts were	Observational data from the Multicentre study of self-harm (hospital presentations for self-harm in Oxford, Manchester & Derby from 01/01/2000 – 31/12/2013). Data included details on: • Mental state • Psychiatric history • Risk • Needs • Age	*Inclusion:* • Aged 40-59 • Presented to hospital following self-harm	N/A	Negative binomial regression models were used to assess trends. Comparative analysis used logistic regression models for binary outcomes. Repetition and suicide mortality were	There were 24599 presentations to hospital following self-harm by people in midlife during the study period. 46% of presentations were made by men; 54% were made by women. 61% received a specialist psychiatric assessment in the emergency department. Rates of self-harm:

	suicide), identify possible differences in subgroups of those who self-harm in midlife.	chosen to reflect equal time periods before and after the economic recession in 2008. *Age group defined to match age groups with highest suicide rates in men & woman.	• Gender • Date & method of self-harm		assessed by Cox proportional hazard models.	Men: 363 per 100 000 Women: 449 per 100 000 Small increase in rates over time in men which increased more rapidly after 2008. Risk of suicide was particularly high within 12-months, especially in men. Men: self-harm more often characterised by alcohol use, unemployment and precipitating problems relating to finances and housing. Women: more often associated with indicators of mental ill health. Socioeconomic & mental health related factors became more common antecedents over time. In 2008-2013 cohort, self-harm was more often associated with economic distress (high unemployment, problems with finances & housing).

							Self-harm for the first time in midlife seems to be influenced by situational factors such as socioeconomic factors & relationship difficulties.
Perry, I. J., Corcoran, P., Fitzgerald, A. P., Keeley, H. S., Reulbach, U., & Arensman, E. (2012). Ireland	The development of a national deliberate self-harm (DSH) registry in the Republic of Ireland to determine and monitor the incidence and repetition of DSH, to identify high-incidence groups and areas and to inform services and practitioners concerned with the prevention of suicidal behaviour.	People who presented to hospitals with DSH in the Republic of Ireland 2003-2009.	Dataset included: • Encrypted patient initials • Gender • Date of birth • Area of residence • Date & hour of attendance at hospital • Method(s) of self-harm • Drugs taken (if applicable) • Recommended next care.	*Inclusion:* Presented to hospital following DSH.	N/A	Repeat event analysis: conditional risk set analysis using multivariate cox regression (age, gender, method of DSH and number of previous self-harm episodes examined as factors for risk of repetition)	75,119 DSH presentations involving 48,206 individuals Average annual rate of persons presenting with DSH: Total: 198 per 100 000 Male: 173 per 100 000 Female: 224 per 100 000 Most notable annual changes were two successive 10% increases in male rate of DSH in 2007 from 162 to 179 per 100,000 in 2008, and to 197 per 100,000 in 2009. Authors noted that these changes coincided with the advent of the economic recession in Ireland.

Sex difference has reduced in recent years; female rate was higher by 13% in 2009 (down from 38% in 2005). Highest rates of DSH by females was those aged 15-19 years (17-years particularly). Highest rates for males were among 20-24 years.

Drug overdose was most common method, followed by self-cutting.

Repetition of DSH

- 22% of people presented on at least 2 occasions
- 10% presented on at least 3 occasions
- 1% presented at least 10 times

Risk of repetition was highest in the time immediately

							after a DSH presentation.
Corcoran, P., Griffin, E., Arensman, E., Fitzgerald, A. P., & Perry, I. J. (2015). Ireland	To assess the impact of economic recession and austerity in Ireland over the 5 years 2008-2012 on national rates of both suicide and self-harm.	• Data relating to suicide deaths and deaths of undetermined intent occurring in Ireland in 1980-2012 from the Irish Central Statistics Office. • Data on self-harm presentations to all hospital emergency departments in Ireland in 2004-2012 from the Irish National Registry of Deliberate Self-harm. • The first time period of 2008 defined as advent of recession. • Unit of time used in analyses for self-harm was month (period 2004-	Dataset included: • Gender • Age	*Inclusion:* • Self-harm presentation to hospital emergency departments in 2004-2012. • Suicide death or death of undetermined intent in 1980-2012	N/A	Interrupted Time Series Analysis.	• 2000-2007 male suicide rate was decreasing by -0.2 per 100 000 per quarter; this trend was reversed by the recession. • Women – recession associated with 1.7 per 100 000 step increase in suicide but a decreasing trend during 2008-2012 of -0.1 per 100 000 per quarter. • Advent of recession associated with an increase in self-harm (men-40.5 per 100 000; women – 21.2 per 100 000) • By end of 2012, self-harm rates were estimated as 31% higher

		2012 provided 108 months); quarterly for suicides.					for males, and 22% higher for females than if pre-recession trends continued. • Male & female suicide rates were 57% and 7% higher respectively. • Men aged 25-64 years were most affected in terms of suicide and self-harm. • Increase in self-harm by women was among 15-24 year olds.
Barnes, M.C., Haase, A.M., Scott, L.J., Linton, M.J., Bard, A.M., Donovan, J.L., Davies, R., Dursley, S., Williams, S., Elliott, D. and Potokar, J., (2018). UK	To determine the feasibility and acceptability of a brief psychosocial intervention (the 'HOPE' service) for people presenting to hospital emergency departments (ED) following self-harm or in acute distress because of financial, employment or welfare (benefit) difficulties	N=19 Intervention n=13 (up to 6 sessions of 1:1 support provided by community support staff trained in Motivational Interviewing) Control n=6 (one-off session signposting to relevant support organisations) Characteristics • Mean age= 44years (SD=9) • 58% male • 95% white	Mixed methods. Questionnaires (standardised outcome measures & questions about debt, employment, benefits & self-harm) Qualitative interviews (participants and HOPE workers).	*Inclusion:* • Age 18+ • Had self-harmed and/or in psychological distress but not meeting the criteria for referral for secondary mental health care • Financial, employment, welfare benefit or housing problems contributing to distress.	• PHQ-9 (depression severity) • GAD-7 (anxiety severity) • EQ5D-5 L (health related quality of life) • FSES (financial self-efficacy)	Descriptive statistical analysis (PHQ-9, GAD-7, EQ5D-5L, FSES). Narrative case study approach (interviews). Data saturation not reached.	Interviews indicated benefits of intervention including resolution of specific financial problems, provision of support at a time when it was needed most, insight into coping behaviours. Reduction in mean PHQ-9 scores from baseline (n=19) to 3-month follow up (n=13). Randomisation and outcome measures

		• 84% lived in rental accommodation .		*Exclusion:* • In receipt of help from agencies providing similar support to HOPE • Experiencing a psychotic episode, had thought disorder or were unable to give consent • Addiction was their primary problem • Not fluent in English • Lived outside of the catchment area for the HOPE service			used were acceptable to most but HOPE workers will need to be prepared and sensitive to clarify, explain and reassure about the process. There are potential adaptations to be made for the full trial including flexibility in approach (a stepped approach a possibility of postposing sessions until participant feels mentally well enough to benefit; option of a more directive approach).
Geulayov, G., Kapur, N., Turnbull, P., Clements, C., Waters, K., Ness, J., Townsend, E. and Hawton, K. (2016) UK	To examine trends in non-fatal self-harm in England in 2000-2012 using data from the Multicentre Study of Self-harm	N=47 048 (84 378 episodes of self-harm)	Face to face assessments or scrutiny of ED electronic databases. Dataset included: • Rates of self-harm • Methods of self-harm • Psychiatric history • Repetition of self-harm • Provision of psychosocial assessment of self-harm	*Inclusion:* • Aged 15 years and over • Presented to 5 general hospital EDs following self-harm in Oxford, Manchester & Derby. • Presented between January 2000-2012	N/A	Negative Binomial Regression Models - assess for trends in rates of self-harm accounting for overdispersio n in the data* Logistic regression models – assess binary outcomes	During 2000-2012 84378 episodes of self-harm (41.4% by males, 58.6% by females, 25 sex unknown). Episodes involved 47048 people (43.1% males, 56.8% females). 38.4% of individuals were aged under 25 years; 62.1% were under 35 years.

	• Gender • Age	(assessed vs non-assessed) Likelihood ratio tests – test for deviation from linearity in trends over time. Spearman’s rank – examine correlation between rates of self-harm and suicide rates. * Used data from each individuals’ first episode of self-harm and only included date from people within local catchment area.	Rates of self-harm declined over the study period (2000-2012) among females and males but male rates were not linear. When trends were examined by period (2000-2007 vs 2008-2012) rates declined until 2008 followed by an increase thereafter. Rates of self-harm were strongly correlated with suicide rates in England for both males & females. Average rates were considerably higher in Manchester and Derby than in Oxford. Self-poisoning most common method of self-harm (74.6% self-poisoning only). The number of self-injury episodes increased over the study period (2003-2012).

2003-2012 53.2% of episodes of self-harm had a psychosocial assessment. People who self-harmed using self-injury alone were less likely to receive a psychosocial assessment than someone who used self-poisoning alone.

31.3% of individuals were in contact with mental health services at the time of presentation (data only available from 39,279 episodes of self-harm).

Appendix C – Quality Assessment Checklist

Screening Questions

S1. Are there clear research questions?

S2. Do the collected data allow to address the research questions?

Study Design & Quality Assessment Questions

Interrupted Time Series

1.1. Is there a clearly defined point in time when the intervention occurred?	1.12. Are there at least 3 data points before and after the intervention?	1.2. Is the intervention independent of other changes?	1.3. Are there sufficient data points to enable reliable statistical inference?	1.4. Was the intervention unlikely to affect data collection?	1.5 Was the data set complete?	1.6 Were there reliable primary outcome measures?

Qualitative Studies

2.1. Is the qualitative approach appropriate to answer the research question?	2.2. Are the qualitative data collection methods adequate to address the research question?	2.3. Are the findings adequately derived from the data?	2.4. Is the interpretation of results sufficiently substantiated by data?	2.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?

Quantitative Descriptive Studies

3.1. Is the sampling strategy relevant to address the research question?	3.2. Is the sample representative of the target population?	3.3. Are the measurements appropriate?	3.4. Is the risk of nonresponse bias low?	3.5. Is the statistical analysis appropriate to answer the research question?

Mixed Methods

4.1. Is there an adequate rationale for using a mixed methods design to address the research question?	4.2. Are the different components of the study effectively integrated to answer the research question?	4.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	4.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	4.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

Appendix D – Social Science and Medicine Author Guidelines

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health and healthcare from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and the organization of healthcare. We encourage material which is of general interest to an international readership.

Journal Policies

The journal publishes the following types of contribution:

1) Peer-reviewed original research articles and critical analytical reviews in any area of social science research relevant to health and healthcare. These papers may be up to 9000 words including abstract, tables, figures, references and (printed) appendices as well as the main text. Papers below this limit are preferred.

2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.

3) Peer-reviewed short communications of findings on topical issues or published articles of between 2000 and 4000 words.

4) Submitted or invited commentaries and responses debating, and published alongside, selected articles.

5) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.

Due to the high number of submissions received by Social Science & Medicine, Editorial Offices are not able to respond to questions regarding the appropriateness of new papers for the journal. If you are unsure whether or not your paper is within scope, please take some time to review previous issues of the journal and the Aims and Scope at https://www.journals.elsevier.com/social-science-and-medicine/.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details:

- E-mail address
- Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided • Indicate clearly if color should be used for any figures in print *Graphical Abstracts / Highlights files* (where applicable)

Supplemental files (where applicable)

Further considerations
• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Manuscript does not exceed the word limit
• All identifying information has been removed from the manuscript, including the file name itself
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• Relevant declarations of interest have been made
• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

NEW SUBMISSIONS

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.
As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay- out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/ book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting Requirements

The journal operates a double blind peer review policy. For guidelines on how to prepare your paper to meet these criteria please see the attached guidelines. The journal requires that your manuscript is submitted with double spacing applied. There are no other strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.
Divide the article into clearly defined sections.

Peer review

This journal operates a double anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Double anonymized review

This journal uses double anonymized review, which means the identities of the authors are concealed from the reviewers, and vice versa. More information is available on our website. To facilitate this, please include the following separately:
Title page (with author details): This should include the title, authors' names, affiliations, acknowledgements and any Declaration of Interest statement, and a complete address for the corresponding author including an e-mail address.

Anonymized manuscript (no author details): The main body of the paper (including the references, figures, tables and any acknowledgements) should not include any identifying information, such as the authors' names or affiliations.

REVISED SUBMISSIONS

Use of word processing software

Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Essential cover page information

The Cover Page should **only** include the following information:

• ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article's aim and health relevance.
• ***Author names and affiliations in the correct order.*** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and

in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

• ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.**

• ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Text

In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

Title

Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

Appendix E – Ethical Approval Letter

Appendix F - Poster

ARE YOU A CAMHS EMPLOYEE WHO HAS CLINICAL EXPERIENCE WORKING WITH CHILDREN AND YOUNG PEOPLE WHO USE SELF-HARM?

Would you like to share your story of these experiences?

For more information or to express interest please speak to [recruitment contact name and NHS email]

As part of research towards a doctorate in clinical psychology, this study is looking to understand more about how CAMHS staff experience working with children and young people who self-harm through exploring the stories or narratives staff construct.

Amber George a.j.george-2018@hull.ac.uk

Appendix G- Participant Information Sheet

INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of study **The experiences of Children & Adolescent Mental Health Services (CAMHS) staff working with children and young people who use self-harm**

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 very little about what it is like for CAMHS clinical staff to work with children & young people who self-harm and how they have made sense of these experiences in the context of their professional identities. This study is looking to understand more about how CAMHS staff experience working with children and young people who self-harm through exploring the stories or narratives staff construct. We hope that this study will help us understand more about the relationships between staff and young people they work with which may influence how we improve work in this area.

Why have I been invited to take part?

You are being invited to participate in this study because you are a member of a CAMHS clinical team who has experience working with children and young people who use self-harm. This information sheet is being shared with people who may fulfil the criteria to take part in the study as they may be interested in participating.

What will happen if I take part?

If you agree to take part, please send me your contact details to the email address below. Then I will contact you to arrange a meeting at a convenient place and time. A video conference call may be used if it is not possible or convenient to meet in person. I will ask you to answer some short questions about you, for example your gender, age and details of your professional training. Then you will have a conversation with me which will last around 60 minutes. I will ask you to tell a story of your experiences of working with children and young people who use self-harm in the context of your professional identity. **Within the interview please remember to not disclose any names or identifiable information of the children and young people you work with or people in their families or systems.** I will audio record the discussion. There are no right or wrong answers and I am only interested in your experiences and stories.

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 consent form and you will be given a copy of this consent form to keep.

What are the possible risks of taking part?

Participating in the study will require 60 minutes of your time and although the researcher will endeavour to meet at a mutually convenient time and place, this may be inconvenient for you. Some people may experience emotional distress when they talk about their experiences of working with children and young people who use self-harm because it may bring to mind difficult memories and experiences. If this happens to you the researcher will offer support and help you to gain access to further help from your occupational health team or your GP, if needed.

What are the possible benefits of taking part?

We cannot promise that you will have any direct benefits from taking part in the study. However, it is hoped that the study will offer staff the opportunity to have their voices heard and tell their stories of working with children and young people who self-harm. The findings may also help to inform services how they support practitioners working with these potentially difficult experiences.

Data handling, protection and confidentiality

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

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'.

We will need to use information from you for this research project. This information will include your name and contact details. People will use this information to do the research or to check your records to make sure that the research is being done properly.
People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these. Please be aware that there is a possibility that you will disclose

your profession during the interview which may limit confidentiality if there is only one or two individuals from your profession that participate.

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.

You can stop being part of the study at any time, without giving a reason. You are able to withdraw your data from the study up until data analysis has commenced, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed. Information collected from this study will be used for this study only and will not be used for any other purpose.

You can find out more about how we use your information at https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/data-protection.aspx or by emailing 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 withdraw at any point of the study, 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 data analysis has commenced, after which withdrawal of your data will no longer be possible as the data will have been anonymised and/or committed to the final report. If you choose to withdraw from the study before this point the data collected will be destroyed.

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 or presented at conferences.

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:

Amber George
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel:
E-mail: a.j.george-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 & Dr Paul Walton
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Email address: A.Schlosser@hull.ac.uk
P.P.Walton@hull.ac.uk

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

Appendix H – Consent Form

CONSENT FORM

Title of study: **The experiences of Children & Adolescent Mental Health Services (CAMHS) staff working with children and young people who use self-harm.**
Name of Researcher: Amber George

Please initial box

1. I confirm that I have read the information sheet dated 18.12.2020 (version 1.6) 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 without giving any reason, without my legal rights being affected. I understand that the data I have provided up to the point of withdrawal will be retained. ☐

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 understand that the information collected about me will be used to support other research in the future and may be shared anonymously with other researchers. ☐

5. I give permission for the collection and use of my data to answer the research question in this study. ☐

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

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

Appendix I – Example of holistic-form analysis

Plot axis – learning curve

Plot axis trajectory	Transcript	Phase/Appraisal of Events
Shallow decline	I suppose when I first became aware or understood more of self-harm, what self-harm was with young people and children it was in a previous role. And it took me quite a while, I suppose, actually to be able to understand, perhaps, how young people use that as a way of coping or. Yeah, I guess kind of, I suppose personally for someone who has never self-harmed, it was quite hard to put myself in the shoes of someone who does. So, as I started to learn more about self-harm and understand that, that was quite a process itself for me, in a previous role.	Being new to working with self-harm, struggling to make sense of it.
	And there was a lot of anxiety around that and managing my own anxiety as a professional is something that I think is just a whole other set of skills you learn to develop throughout your career.	Feeling anxious about how to work safely
Positive turning point	I've come into CAMHS, I've done a year in the practitioner role but I did a year as a CAMHS assistant before that. That was a huge piece of learning really that year as a CAMHS assistant in in the training that I undertook and what I observed and shadowed really. And that's where I really learnt the value of formulation and and how that works and.	Phase 2- learning Gaining more experience and understanding how to make sense of self-harm

So although I knew of self-harm I think I'm quite naive to much more than just knowing what of it, kind of thing and I think as I've progressed through the career, the shift has come through learning about, obviously, specifically about mental health, but things like how to formulate the impact of trauma. You know, influence of peers, parental mental health. All those sorts of things and how they impact on a young person and what can lead a young person to self harm. And that actually self-harm doesn't always mean that a young person wants to hurt themselves or end their life and that actually it can be managed safely.

Gaining confidence in working safely

Continued incline

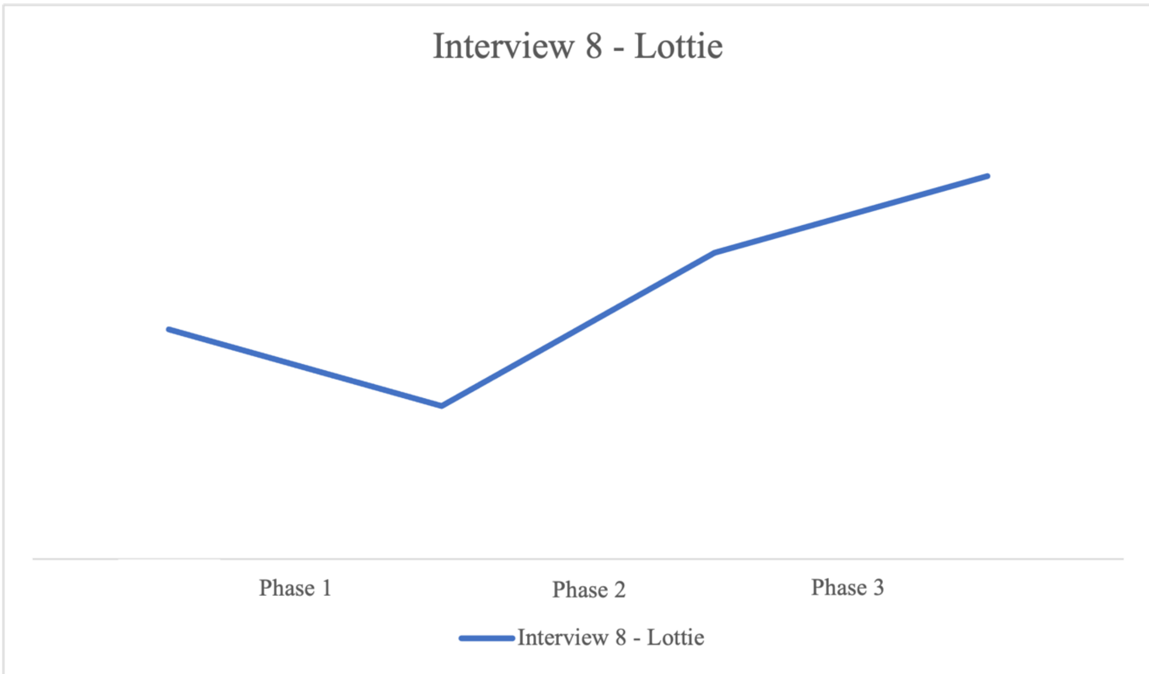
So yeah, I guess you know, five years ago my understanding of self-harm was very limited. I feel now it's developed a lot in terms of how I can understand that and how, how to manage that I suppose helpfully for young people. How to risk managed that as well, quite, you know, in an effective way.
And work with other professionals in supporting these young people by formulating and understanding self-harm in a different way I suppose to, to what I would have done before. So yeah, it's been a big learning curve for me really.

Looking back on how far their understanding has come and comparing past and present ways of working

I suppose it made me reflect on perhaps how much I've learnt, you know, in a relatively short space of time really, and sort of even how this time last year, relatively new into the practitioner role, any young person that mentioned self harm was kind of like 'Oh my God, Red flags ohh my gosh'. Whereas now, it's kind of like OK, so let's have a think about this a bit more and I just feel in a really different position to be able to manage that and support young people with that differently because

	my understanding of it has, has become so much more developed and the skills that I've learned throughout, throughout my career in CAMHS has really kind of equipped me to support young people hopefully as best as I can, but yeah, see self-harming as part of the picture rather than the whole. And yeah, sort of unpicking that in terms of formulation and a communication method really helps in being able to support young people most effectively I guess.	Phase 3 – sense of mastery

Phase	**Event and brief summary**	**Direction**
1	Previous role, struggling to understand why a person would self-harm, unsure how to work with young people who use self-harm. Coping with own and team anxiety.	Shallow decline.
2	New job roles that provided experiences to learn how to formulate self-harm.	Steep incline
3	Reflecting on professional learning journey. Feeling confident in own understanding and approach.	Positive trajectory


Interview 8 - Lottie
Phase 1
Phase 2
Phase 3
Interview 8 - Lottie

Appendix J – Example of categorical-content analysis

Principal sentences contributing to minor category *'Anxiety'*

Interview 1 - Olive

it made me feel really anxious

you get caught up in your anxiety rather than just listening

it was only, as I've begun to manage my own anxiety and started listening more as opposed to trying to do, that I was able to get a clearer sense and understanding of why people would turn to that

you get clinicians that are just really anxious and totally just like freak out

it's a full 360. It was, it's a different form of anxiety now. At first it was anxiety about how do, how do I work with self harm and now it's anxiety about not being able to work with self-harm, which is just so so bizarre

just families ringing, 'we don't know what to do'. Clinicians feeling like they don't know what to do cause we don't have capacity to respond so we put it back to the parents and then give them that advice, so we've done what we need to do and then parents feel uncontained so they feel like they need to do what they need to do, which is ring us and be like I need help and it's just this constant passing of.

Yeah, just, just anxiety isn't it, I've talked a lot about anxiety.

But yeah, passing of responsibility.

Interview 3 - Martha

Kids will come in a contact point and if they have self-harmed then the advice is remove everything you know, make your house safe, and if they don't then it almost becomes a safeguarding issue. So the expectation is that the self-harm stops. So then parents become, you know, quite anxious without kind of realising that, actually, there's a process. There's a journey to go on, often before self-harm can be let go of.

I think there's a lot of tolerating and sitting with risk and um. And tolerating that the kind of uncertainty that comes with that. But without really feeling very reassured that that would be supported.

Interview 4 - Seren

I think there was a lot in the staff team of kind of panic and like, no they're children, they're getting hurt, and they getting hurt on our watch as well, like this can't happen.

Interview 5 – Zebra

You know you almost kind of going into that sort of fight response yourself, you get that burst of adrenaline you work with that young person

Interview 8 – Lottie

the anxiety around us as a professional team around these young people is really high because they are risky

managing my own anxiety as a professional is something that I think is just a whole other set of skills you learn to develop throughout your career.

even how this time last year, relatively new into the practitioner role, any young person that mentioned self harm was kind of like ‘Oh my God, Red flags ohh my gosh’.
Whereas now, it's kind of like OK, so let's have a think about this a bit more

Interview 9 - Jenny

I suppose I do find self-harm quite anxiety provoking because of the experience that I've had [involved in three completed suicides].

when they contact crisis services feeling suicidal, but they don't meet this threshold for treatment, until I've done something like either overdose or ligature and then that that takes services so much longer to assess and to, and its, and the risk has been raised massively, which at which raises anxiety in the system, and we just seem to be going round in a, a sort of a vicious circle. I think if we could only have more time at that earlier intervention right at the outset, then we might prevent tragedies happening.

Appendix K - Epistemological Statement

The aims of the empirical research were to understand clinical staff members experiences of working with children and young people who self-harm and how they have made sense of these experiences. Epistemology is concerned with what can we know, and how can we know it; ontology is interested in the existence of reality (Willig, 2013). Guided by epistemological position, methodology relates to how we approach studying a research topic (Willig, 2013). This statement aims to illustrate the epistemological viewpoints that guided and shaped this research.

The researcher conducted this research from a social constructionist epistemology, that knowledge and meaning are created or perceived, that there are therefore multiple truths, which are constructed within cultural, historical, and linguistic contexts (Burr, 1995; Willig, 2013). This position aligns with the researcher's views on the nature of knowledge and reality and was consistent with the research aims to offer clinicians an opportunity to reflect on their experiences and explore the meanings and ideas other than the 'taken-for-granted' truths available about self-harm and working with young people who use it (Burr, 1995).

Being the first to explore multi-disciplinary CAMHS staff experiences of working with self-harm and being interested in how staff create meaning from their experiences leant the research to the use of a qualitative methodology, specifically a narrative approach. Narrative analysis is interested in how people make meaning of their experiences by creating stories (Riessman, 1993) and was therefore chosen because the research aimed to learn about staff's experiences of self-harm and how they have constructed these experiences into stories that are meaningful to them (Silver, 2013).

Another important reason that a narrative approach was chosen is the used of non-directive interviews which will allow for all and any narratives to enfold and avoid the telling of narratives being overly influenced by the pre-planned questions (Josselson, 2011).

Considering the role of the interview context and researcher in how the narratives are constructed, the researcher attended to their position as a trainee clinical psychologist, with limited experience of working with children and young people who self-harm, but with clinical experience of working with people who present with 'mental health' difficulties which, in the researcher's experience, largely make sense given their experiences and context. Interview context was thought about during study design with consideration given to offering participants the choice of completing interviews during or out of work hours and settings.

The systemic focus of narrative analysis also attends to the wider social and cultural contexts in which these stories are formed and how these shape how people create and understand themselves using language and the story making process (Silver, 2013). As this research is interested in the stories CAMHS staff have constructed within the context of their professional identities, narrative analysis offered a framework for this context to be considered and acknowledged. For example, the context of the covid-19 pandemic and how this had shaped clinicians most recent experiences was demonstrated in the stories that they constructed.

The aim of the systematic literature review was to explore what understanding current research offers about the relationship between austerity and self-harm in the UK and Ireland. Due to the studies included in the review being a combination of qualitative, quantitative, and mixed methods, an epistemological position for this research aligned with a pragmatism paradigm;

the use philosophy and methodology which is best suited to answer the research question, with a focus on the consequences of the research rather than the methods used.

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Appendix L - Reflective Statement

The only thing I can compare this journey to is a marathon and having run marathons, even they seem like a small task compared to this. Throughout this, advice from supervisors to keep taking forward steps and reassurance that I was making progress when I felt I was plodding on with little movement has been invaluable. For others who are at the starting line, small steps are all you need to keep going and trust that you will have the energy to take more and bigger steps when you need to. Although it seems surreal that I am nearing mile 26, I have learnt a lot about my values and hope that this research reflects and aligns with those.

Empirical paper

Choosing a topic

There were several topics which caught my attention at the research fair, and I spent a lot of time thinking about why I was interested in these topics; other topics struck chords with personal experience whereas self-harm was a professional interest and something I wanted to understand better as I began my doctorate, which helped me reach my decision.

The initial idea for the topic involved interviewing families about their experiences of engaging with systemic interventions for self-harm. I was interested in this because a systemic perspective on emotional distress makes sense to me; I remember from a young age my mum talking to me about looking at the 'bigger picture', for example when I came home from school with questions about why some children behaved differently to others, she would explain to me about their family or wider circumstances that may have been impacting on them. To me, this made sense because a child does not exist in isolation, and I wanted to learn more about this. The study then evolved to understanding clinical staff experiences,

attending to other parts of some of the immediate systems around young people. I remember feeling shocked at the lack of research attending to clinical staff experiences, and through supervision and reflection on my position as a trainee beginning to work with self-harm, these were stories which I thought were important to hear and could offer so much value in how self-harm is understood and why it seemed to be growing.

Designing the study

Following feedback from research presentations suggesting a narrative approach would better align with a social constructionist epistemology, further reading led to reflections about how powerful stories are for making sense of and sharing human experience; we tell stories in so many ways, through art, music, books.

Reflecting on my position within the research, I also felt that the use of non-directive interviews was more appropriate than semi-structured interviews. The lack of research into staff experiences added further weight to the use of a narrative approach as I was interested in what experiences were important for staff to share, rather than being constrained by structured questions.

Ethical Approval

I had been told by friends who have trained on other courses that the process of gaining ethical approval would be a challenge. I think throughout this research process I have taken the approach of continuing to take forward steps, no matter how small they are, and this is the approach that got me through ethics when there seemed to be an overwhelming amount to prepare. I think one thing I have learnt is the extensive time the various stages of approval

take, which were amplified by the context of the coronavirus pandemic; I underestimated this.

Recruitment and data collection

The context of the pandemic meant I had a change of plan compared to how I had imagined recruitment and collection; I had been looking forward to attending team meetings of the services I was recruiting from and getting to know the people and the teams as part of the process. At the beginning of recruitment I had interest from a field supervisor and a colleague from within a clinical team I currently work with; despite worry that recruitment would be difficult due to not having the networking opportunities from pre-covid, I thought that the dual roles that these people would play if they participated could create a bias in the sample and blur the lines of the researcher-participant relationship, I therefore declined this interest.

My recruitment concerns were short lived as I was overwhelmed and pleasantly surprised at how many people expressed interest so quickly – I took this as a reassuring indication that people had stories that they wanted to share.

Analysis and writing up

As I transcribed interviews, I felt a sense of grief hearing the stories about the challenges clinicians faced due to restraints within systems and during one transcription I cried when re-hearing one participant talk about being unable to uphold their values in their clinical work and feeling scared that this is the reality of the systems I am entering as a clinician.

Throughout analysis I was also interested in how people's professional backgrounds and training had shaped what they included in their stories; this is something I think would be interesting for future research.

I also reflected on how I had constructed my interview prompt, and wondered whether the inclusion of examples of what people might talk about too heavily shaped what people included in their stories; if I was to conduct narrative research in future, I would be wary of this.

I found it interesting during analysis and writing up that I had a sense of when categories or forms weren't quite right; I hoped that this was a sign of me having a good sense of the stories and knowing when my analyses reflected these. This process was helped greatly by supervision and bringing the 'not quite there yet' analyses to supervisors who were able to reflect back to me what they saw and heard to help me bring findings together.

Systematic Literature Review

The topic for my literature review was constructed within conversations with supervisors prompted by curiosity about why self-harm seems to be growing. Although ideas initially focussed on children and young people, they quickly broadened to attending to wider levels of context, and the idea of austerity was raised. I think what drew me to being interested in the relationship between austerity and self-harm was that austerity was something I knew very little about, and I felt that this was a story untold (as compared to the story about the impact of social media and self-harm, for example) (Pearce, 2005).

Initial database searched confirmed the limited research investigating this relationship which brought the challenge of defining inclusion criteria. In particular I struggled to decide whether to include literature conducted in Ireland; after a period of flitting back and forth and re-reading the relevant papers, my decision to include them came to that they offered something valuable in understanding the relationship between austerity and self-harm.

I found the process of analysing the data exciting; I was finally bringing together the data I had spent so much time getting to know during quality assessment and data extraction. I remember feeling surprised at how the themes came together, and that the process of analysis felt familiar as it in part reflected formulation within clinical work. The time needed for data extraction is something I will know for future research and although that process felt arduous at times, the process of data extraction was 'doing the work' as when it came to analysis and writing up it saved time as I knew my data and key findings so well.

I experienced mixed feelings towards my review and there were moments of feeling overwhelmed at choosing a topic perhaps further out of my comfort zone than other options. However, this learning journey has been invaluable and I feel proud that I have been able to do something that aligns with my values about making sense within context.

Reaching the finish line

As I head towards the finish line, I am taking the stories I have heard and the lessons I have learnt with me with the hope that I can use them to better my practice, and alter the systems around me as I begin my journey beyond training.