Healthcare Professionals' Views on the Effect of Media on Self-Harm in Young People

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by

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Overview

This thesis portfolio comprises three parts:

Part One: Systematic Literature Review

The systematic literature review explored doctors' and nurses' views of self-harm in the UK. A systematic search identified ten suitable papers, which were evaluated using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). Narrative synthesis identified three main themes: *(1)* professional attitudes and understanding of self-harm, *(2)* coping strategies and educational needs, and *(3)* institutional dynamics, social-cultural influences, and stigma. The review assumes a social constructionist lens toward perceptions of self-harm. The review highlighted the importance of recognising the impact of one's attitudes and their impact on patient care. It also highlighted the need for further training for clinicians to help them care for individuals who self-harm to a higher standard. Finally, the research underlined the impact of societal and institutional dynamics on patient care.

Part Two: Empirical Paper

The empirical study explored healthcare professionals' views on the effect of media on self-harm in young people. Ten CAMHS clinicians' views and experiences of the effect of media on self-harm in young people were collected. Critical Discourse Analysis was used to interpret the data. Two main discourses were developed: 'Media as a Disruptor' and 'The Hidden World of Youth' with several sub-discourses also coming up. Clinicians viewed media as an entity with a multifaceted nature, however, the influence of media was found to be mostly negative on young people who self-harm. The negative impact of inaccurate media portrayals, stereotypes, and stigma surrounding self-harm and their influence on young people were highlighted. The research also found the importance of asking about media in assessments with young people and the need for training and education

around the impact of media on self-harm in young people, as well as changes to policies and procedures to improve young people's care overall.

Part Three comprises of the Appendices

Total word count (including abstracts, tables, references, and appendices): 28,822.

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Part One – Systematic Review: Doctors' and Nurses' Views on Self-Harm in the UK

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Please see Appendix C for the "Guideline for Authors".

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Abstract

Self-harm rates in the United Kingdom have been increasing due to various systemic factors (McManus et al., 2019). Doctors and nurses are normally the first port of call for an individual who self-harms when care is sought (Anderson et al., 2003) and their perceptions influence the care that individual receives (Coimbra & Noakes., 2021; Rayner et al., 2019; Mitten et al., 2016; Rosenrot & Lewis., 2020; Hunter et al; 2013; Burke et al., 2019). Despite this, current research has only focused on doctors' and nurses' views separately (bar Anderson et al's., 2003 review) and has not reviewed them together. This systematic literature review used narrative synthesis to bring the research together by exploring doctors' and nurses' views on self-harm. The studies included mostly had good quality, however, some studies did not explicitly state research questions and rationale, which may affect the reliability of the data. The synthesis identified three main themes: *(1)* professional attitudes and understanding of self-harm, *(2)* coping strategies and educational needs, and *(3)* institutional dynamics, social-cultural influences, and stigma. These themes highlighted the importance of recognising the impact of one's attitudes and the impact they can have on patient care. It also emphasised the need for further training for clinicians to help them care for individuals who self-harm to a higher standard and underlined the impact of societal and institutional dynamics on patient care.

Keywords: Doctors' and Nurses'; Self-Harm; Views; Systematic Literature Review; Influence of Attitudes.

Introduction

Self-harm is defined by the National Institute for Health and Care Excellence (NICE) as an intentional act, when an individual harms themselves through self-injury or self-poisoning as an expression of their emotional distress, regardless of their purpose or intent of the behaviour (NICE, 2022).

Self-harming methods can vary; they include self-poisoning, self-injury, and suicide attempts with little or no intent (NICE, 2022). Self-poisoning is defined as using household substances such as bleach, prescribed medication, illegal drugs, or over-the-counter medication, to harm oneself with intent (NICE, 2022). If an individual cuts, stabs, hangs, burns, drowns, jumps from heights or in front of vehicles, and swallows or inserts objects with the intent to harm themselves, this is defined as self-injury (NICE, 2022). The NICE guidelines (2022) also regard suicide attempts with no or little intent as a form of self-harm. This is when an individual harms themselves to communicate feeling distressed, to get relief from their difficulties, or to reduce internal pressures (Miller, 2021).

Research shows that self-harm rates in the United Kingdom are growing. Self-harm increased from 2.4% to 6.4%, from 2000 to 2014 respectively (McManus et al., 2019). Over 200,000 people are estimated to present with self-harm to Accident and Emergency departments every year, the highest figure for Europe, costing the NHS around £162 million a year (Tsiachristas et al., 2017). More recently, data shows that hospital admissions for self-harm in England, include approximately 100,000 individuals each year (NHS Digital, 2023). These statistics suggest that self-harm is a cause for grave concern in the UK.

Moreover, the strongest predictor of suicide is self-harm (University of Manchester, 2017). Therefore, targeting self-harm can be an important part of suicide prevention (Townsend et al., 2016).

Research and its Conflicting Views

It is important to note that, whilst the NICE guidance (NICE, 2022) provides a clear distinction between self-harm and suicide, the current literature has conflicting views on this. Mars et al. (2019) imply that the intent behind self-harming behaviour is complex and versatile, with motivations changing over time and the context surrounding the individual. These fluctuations indicate that the categorisation of behaviours as either self-harm or suicidal is not as clear-cut.

Furthermore, O'Connor and Nock (2014) highlight that self-harm and suicidal behaviours share many risk factors and psychological foundations. This suggests that these behaviours cannot be distinguished as easily as what the intent is behind the behaviour. This is also supported by Klonsky et al. (2013) and Victor and Klonsky (2014) who indicate that intent behind self-harm and suicidal behaviours overlap, blurring the lines between the two.

Therefore, it is important to take an individualised approach to understand self-harm and suicidal behaviours and to acknowledge the variability and multifaceted nature of self-harming and suicidal behaviours (Hooley et al., 2020). While the NICE guidelines (NICE, 2022) provide clear-cut guidelines for understanding self-harm and suicide, the current literature calls for a more flexible and integrative approach.

Healthcare Professionals' Views and the Effect on Care

Studies into healthcare professionals' views on self-harm reveal a diverse range of attitudes, from empathy to discomfort. Coimbra and Noakes (2021) found negative attitudes in healthcare practitioners towards individuals who self-harmed; this had implications for the care as the therapeutic relationship was negatively impacted (Coimbra & Noakes, 2021). Rayner et al. (2019) echoed this, as they charted negativity and inadequate empathy from nurses toward individuals who self-harmed. Furthermore, young people who self-harmed experienced healthcare professionals perpetuating stigma and negative attitudes toward them, leading to a negative care experience (Mitten et al., 2016).

Individuals who self-harm may not want to seek support for their difficulties for a range of reasons; for example, they may fear healthcare professionals showing negative attitudes towards them or worry surrounding their lack of understanding and the shame associated with self-harm (Rosenrot & Lewis, 2020). This may stop individuals who self-harm from seeking professional care for their difficulties or they may disengage from services if they experience negative attitudes (Hunter et al., 2013).

The aforementioned research suggests that the way healthcare professionals view self-harm affects the way they interact and give care to patients. It is therefore important that this is investigated as the treatment of an individual who self-harms can be affected. Moreover, negative attitudes also feed into the negative stigma that surrounds self-harm which further influences an individual who self-harms (Burke et al., 2019). As doctors and nurses tend to be the first port of call for individuals who self-harm (A&E, primary care) the way they care for the patient can impact the patient both negatively and positively (Anderson et al., 2003). It is therefore important to look at their views on

self-harm as we know it can affect patient care and it is important to give clients a more positive experience.

Addressing these attitudes is important for the development and implementation of effective healthcare and better client experiences. The NHS Long-Term Plan highlights the institution's commitment to enhancing mental health services in the institution, with specific service delivery focusing on improving care for individuals who self-harm (NHS., 2019). Comprehensive training, and support for healthcare professionals (reflected in the policy) to manage self-harm are important aspects, which align with the goals of the NHS Long-Term Plan (NHS., 2019). This can aid healthcare professionals in providing more empathetic and effective care. Overall treatment outcomes can in turn be improved through reducing stigma and enhancing client trust.

The present literature review will therefore synthesise current literature to examine doctors' and nurses' views regarding self-harm. The review aims to highlight the perceptions of doctors and nurses on self-harm, specifically these professionals, as they are normally the first point of contact for the care of self-harming behaviours (Anderson et al., 2003). Therefore, they can heavily influence individuals' perceptions of healthcare services and whether they will ask for help for their difficulties in the future. As it can inform knowledge and improve patient care, a key goal of the NHS, this review has important clinical implications (NHS., 2019). To ensure that this review was original the researcher searched the existing literature and found one existing review (Anderson et al., 2003) that addressed doctors' and nurses' views of self-harm in the UK. The NHS has changed a lot in 20 years (Ham., 2023), as has the incidence of self-harm (McManus et al., 2019). Only studies in the UK were included in the review. Moreover, given the focus on doctors' and nurses' views, it was deemed appropriate to only use qualitative research in the review, as it can contribute to a

deeper and richer understanding of the question (Busetto et al., 2020). However, mixed methods studies were also included, with the researcher only using the qualitative data from these studies. This was on the basis that qualitative data from mixed methods studies can still provide rich and meaningful insights into the research (Cresswell & Clark., 2017).

The following research questions were developed:

- What are doctors' and nurses' views on self-harm in the UK?
- Do these views affect the care they give patients?

Method

Search Strategy

A literature search was conducted using the electronic databases Academic Search Ultimate, APA PsycArticles, APA PsycInfo, CINAHL Ultimate, and MEDLINE for relevant articles. Academic Search Ultimate was included as the database includes research in social sciences and medicine. The following search terms were used:

(doctor* OR nurse* OR physician* OR “healthcare professional*” OR “healthcare worker*” OR “healthcare provider*” OR clinic*)

AND

(view* OR opinion* OR belie* OR perception* OR experienc* OR thought* OR attitude* OR qualitative*)

AND

(“self harm*” OR “self-harm*” OR “self injur*” OR “self mutilatio*” OR “self-injur*”)

AND

("United Kingdom*" or "UK*" or "Britain*" or "Scotland*" or "England*" or "Wales*" or "Northern Ireland*")

Article Selection

Articles were chosen based on the following inclusion criteria: (1) they included nurses and doctors as participants, (2) they addressed views on self-harm, (3) they were qualitative studies, and (4) they

were mixed methods studies. Articles were excluded if they met the following criteria: (1) they were not published in English, (2) they were quantitative, (3) they were grey literature, and (4) they were not conducted in the United Kingdom. The articles were then screened by title and duplicates were removed. Afterwards, using the inclusion and exclusion criteria article selection was further refined (see Table 1).

Table 1:

Inclusion and Exclusion Criteria

Inclusion Criteria	**Rationale**
Participants must be doctors or nurses.	This review aims to look at frontline staff's views on self-harm. Frontline staff who treat self-harm are mostly doctors and nurses (Anderson, 2003). Medical students and nursing students were also included due to the fact that they interact and provide care for clients.
The paper addresses views on self-harm.	Research has found that self-harm rates are increasing (Borschmann, 2019). Clinicians' views can impact on client care (Burke et al., 2019)
Qualitative studies	Qualitative studies will be able to capture a deeper and richer understanding of the question (Busetto et al., 2020).

Mixed Method Studies	Qualitative data from mixed methods studies can still provide rich and meaningful insights into the research (Cresswell & Clark, 2017).

Exclusion Criteria	**Rationale**
Studies published in a language other than English	Only studies written in the English language will be included in the review as the researcher can only read English.
Quantitative studies	Quantitative studies are limited in their ability to capture rich and in-depth views due to its reliance on numerical data and statistical analysis (Bryman, 2016).
Grey literature	These types of sources are less likely to be peer-reviewed therefore the validity and reliability of these pieces of research are lower.
Studies not conducted in the United Kingdom	The researcher is based in the UK and UK studies provide insight into NHS practices.

Data Analysis

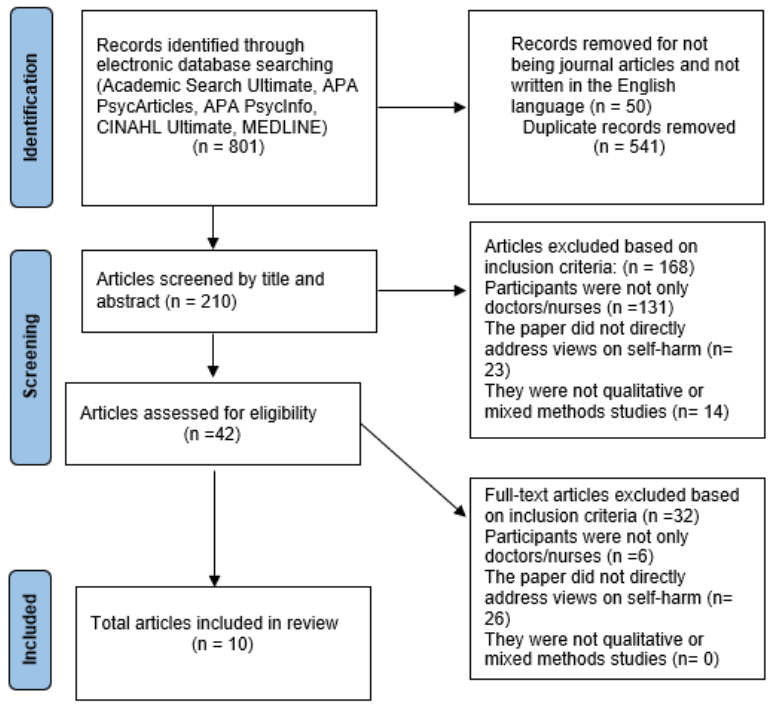
For the data analysis, narrative synthesis based on Popay et al's. (2006) guidelines was used. Popay et al's. (2006) methods allow for methodological variation which is evident in the studies.

Narrative analysis was deemed to be the most appropriate method as it aligns with the approach of understanding views through personal stories. Per Popay et al's. (2011) guidance, studies were read multiple times before generating themes from the relationships observed between them. A quality assessment was undertaken to understand the quality and impact of the findings.

Data Extraction

A table for data extraction was created for the review to extract and summarise crucial information from the studies (see Table 2). The table includes the following information: authors, year of publication, research aims, design and analysis, methods, participants, key findings, and conclusions.

Figure 1: *Article Selection Process (Adapted from "PRISMA Flow Diagram", Page et al., 2020)*



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

Quality Assessment

To assess the quality of the studies, the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) was used. As the included studies used both qualitative and mixed methods, the MMAT was deemed the most appropriate measure as it is suitable for both.

The MMAT can critically and reliably assess the quality of studies compared to other tools (Hong et al., 2018). Out of the ten papers, nine papers met the MMAT's baseline requirements. The remaining study did not state a clear research question. Hong et al. (2018) discouraged scoring when using the MMAT and advised using the detailed criterion to obtain an overall view of the quality ratings. Therefore, a table was created to examine the quality ratings of each study visually.

Moreover, to ensure rater reliability and robustness of the quality assessment, five articles were rated by a peer reviewer who was blind to the original ratings (Hong et al., 2018). The second reviewer rated nine out of ten studies the same as the researcher where one aspect of one study was different, a rating was then agreed upon through discussion. All ten studies provided important perspectives of doctors and nurses; therefore no studies were excluded.

Researcher's Position

The researcher conducting the review is a Brown, British Asian woman who at the time of the review was also a Trainee Clinical Psychologist. The researcher has an interest in the topic due to her own experiences with the negative taboo regarding mental health difficulties and the detrimental effects it can have. The researcher acknowledges that this may have influenced the review; so to minimise research bias the researcher made use of a reflective journal and supervision.

Results

Overview of Included Studies

Ten studies were included in the review and are summarised in Table 2. The studies included were all published between 2002 and 2022. Six studies were published before 2014 and four studies were published between 2014 and 2022. All studies took place in the United Kingdom (UK). Nine studies utilised qualitative methodology and one study used mixed methods methodology with only the qualitative data being included in the review.

The main methodological approach used was Interpretive Phenomenological Analysis (n = 5), with the remaining studies using Grounded Theory (n = 2), Thematic Analysis (n = 1), Ethnography (n = 1), and Narrative Analysis (n = 1). Most studies employed semi-structured interviews (n = 7), the others used semi-structured interviews and focus groups (n = 1), focus groups (n = 1), and questionnaires (n = 1). Participants included nurses (n = 6), doctors (n = 1), GPs (n = 1), medical students (n = 1) and doctors and nurses (n = 1).

Quality of included studies

The quality of the studies was assessed using the MMAT (Hong et al., 2018). No studies were excluded due to the quality assessment as the MMAT discourages excluding studies based on low methodological quality (Hong et al., 2018). Seven of the studies had 'Yes' ratings on all criteria and the remaining three studies received mostly 'Yes' ratings. This implies that overall, the studies have good methodological quality. However, the ratings did indicate some quality issues.

Firstly, Joiner and Kaewchaluay (2022), used focus groups to explore attitudes of medical students towards self-harm. Using focus groups may not have given the medical students the chance to express their views without the fear of feeling judged (Adams & Cox, 2008) by their peers, therefore the data may not be a valid representation of their actual perceptions.

Furthermore, Anderson, Standen and Noon (2003) did not explicitly state why the chosen methodology was used. Therefore, the transparency, validity, and replicability of the study may be affected. Finally, for Dickinson, Wright, and Harrison (2009), the aims of the study were not explicitly stated. They also did not explicitly state why they chose a mixed methods design, and any inconsistencies in the data were not explicitly addressed. This also brings into question the validity, transparency, and replicability of the study.

Table 2

Summary of Included Studies

Author(s) and Year of Publication	Research aims	Design and Analysis	Methods	Participants	Key findings
Anderson, Standen & Noon (2003)	To explore nurses' and doctors' perceptions of young people who engage in suicidal behaviours (including self-harm).	Qualitative study, Grounded theory approach	Semi-structured interviews	45 Nurses and doctors working in A&E, paediatric medicine and CAMHS	Two main themes: - Experiences of frustration in practice. Three subthemes were generated under this: non-therapeutic situations, insubstantiality

			of interventions, and value of life. - Strategies for relating to young people. Two subthemes were generated under this: specialist skills in care and reflection on own experience.

Chandler et al. (2020)	Exploring GP's understanding and views on self-harm.	Qualitative study, Narrative approach	Interview in two parts: - Discussing recent clinical examples - Semi-structured interviews	30 GPs in Scotland	Three themes: - 'The good girl' - 'The problem patient' - 'Out of the blue'
Dickinson, Wright & Harrison (2009)	To explore the attitudes of nurses in secure environments to young people who self-harm	Mixed-methods approach, Grounded theory	Self-Harm Antipathy Scale	60 Registered nurses and nursing assistants working in young people's forensic units and young offenders' institutions	Eight themes: - Sympathy and empathy - Antipathy - Competing for attention - Risk assessment in

	relation to suicide - Insufficient education in self-harm - Difficulty in forming therapeutic relationships and communicating therapeutically - Contentions with a harm minimisation and controlled

					self-harm approach - Labelling
Hadfield, Brown, Pembroke & Hayward (2009)	To explore how doctors working in A&E respond to treating people who self-harm.	Qualitative study, Interpretative Phenomenological Analysis	Interviews with A&E doctors	5 Qualified A&E doctors who had experience of treating people who self-harm.	Three main themes were identified: - Treating the body - Silencing the self - Mirroring cultural and societal responses to self-harm

Hopkins (2002)	To look at nurses on medical units' views of patients that have self-harmed	Qualitative study, Ethnography	Semi-structured interviews	4 Nurses	Three themes: - The busyness of wards - How self-harmers impede the busyness of the wards - Strategies nurses use to cope with the difficulties
Joiner and Kaewchaluay (2022)	- To examine attitudes first and final-year medical students have	Qualitative study, Thematic analysis	Focus groups	21 First and final-year medical students	Findings: - Both negative and positive attitudes

	toward self-harm - To examine how the curriculum may influence the development of views		- Minimal exposure to self-harm through formal curriculum - Exposed to negative attitudes by healthcare professionals through informal curriculum i.e. conversations with other staff - Self-harm is not as

					important as other topics - Discouraged by healthcare staff from seeing people who self-harm
Leddie, Fox & Simmonds (2022)	To explore community nurses' experiences with adolescents who self-harm	Qualitative study, Interpretative Phenomenological Analysis	Semi-structured interviews	10 Registered nurses working in CAMHS	Two main themes: - Personal and professional conflicts. Two subthemes were generated: "keeping everyone happy" and

			"double-edged sword". - Personal and professional development. Two subthemes were generated: "I can switch off.. from being a professional, and be a person" and "it has got easier,

					just with experience".
Sandy (2013)	To explore nurses' explanations of self-harm	Qualitative study, Interpretative Phenomenological Analysis	Semi-structured interviews	25 Nurses working in an adolescent secure unit	- Four superordinate themes were generated: visibility of self-harm, a cry of pain, a cry for help, and detention and institutional factors. - They found that according

						to nurses self-harm has multiple motives such as affect regulation, coping with distress, averting death, regaining control, and attention seeking.
Shaw and Sandy (2016)	-	Examine attitudes of mental health nurses	Qualitative study, Interpretative Phenomenological Analysis	Semi-structured interviews and focus groups	61 Nurses who had at least 2 years experience of working with self-	- Findings: Two second-order themes: positive

	toward service users who self-harm in secure environments - To inform the mental health curriculum development	harm within secure units.	attitudes and negative attitudes. - Six subthemes under positive attitudes: need for training, understanding self-harm, unconditional acceptance, partnership working, optimism, and provision of choice activities.

			- Negative attitudes had five subthemes under them: labelling, rigid authoritative approach, refusal to undertake training, blanket approach, and insensitive responses. - Nurses' attitudes towards self-

					harm were mainly negative - The results led to developing an educational model about factors affecting self-harm
Thompson, Powis & Carradice (2008)	To examine community psychiatric nurses' experiences of working with people who engage in self-harm.	Qualitative study, Interpretative Phenomenological Analysis	Semi-structured interviews	8 Psychiatric nurses	Seven themes: - Trying to understand - Monitoring risk - Struggling with

		boundaries of responsibility - Emotional impact - Relationship factors - There's very little in the way of technique - Learning to cope

Table 3

Quality assessment table: Quality ratings of the included studies

Study	Screening Questions		Qualitative					Mixed Methods				
	S1	S2	1.1	1.2	1.3	1.4	1.5	5.1	5.2	5.3	5.4	5.5
Hadfield, Brown, Pembroke & Hayward (2009)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Hopkins (2002)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Thompson, Powis & Carradice (2008)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Joiner & Kaewchaluay (2022)	Y	Y	Y	N	Y	Y	Y	-	-	-	-	-
Sandy (2013)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Shaw & Sandy (2016)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Anderson, Standen & Noon (2003)	Y	CT	Y	Y	Y	Y	Y	-	-	-	-	-
Leddie, Fox & Simmonds (2022)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-
Dickinson, Wright & Harrison (2009)	CT	Y	-	-	-	-	-	CT	Y	Y	CT	Y
Chandler et al. (2020)	Y	Y	Y	Y	Y	Y	Y	-	-	-	-	-

Note. Y, N and CT indicate yes, no and cannot tell. Refer to Appendix D for full MMAT questions.

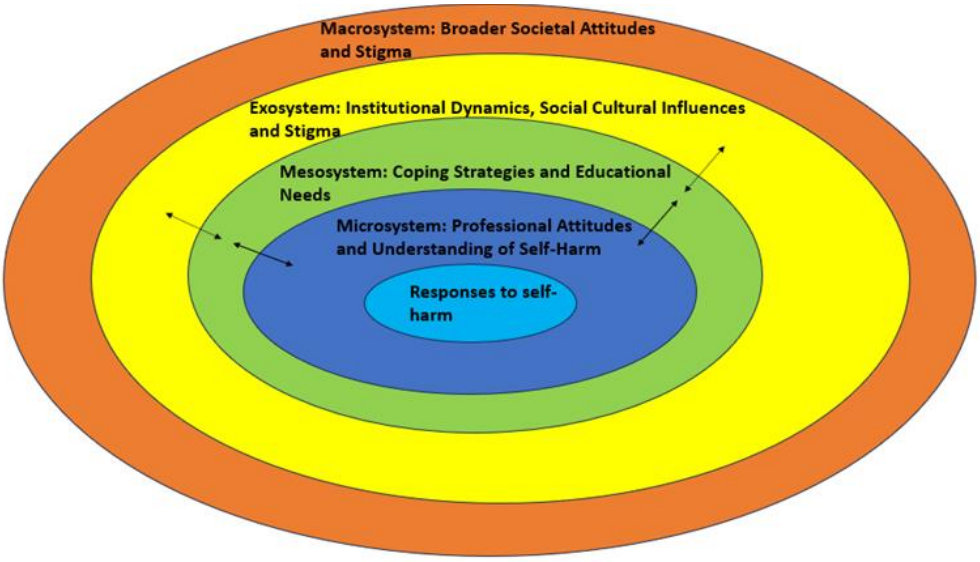
Narrative synthesis

Initially, all extracted data, including qualitative quotes were organised and coded systematically. Through a repetitive process of coding and comparison, patterns that were recurring emerged, which enabled the researcher to identify the overarching themes and their respective subthemes. From the ten studies, three main themes and six subthemes were generated in relation to the views of doctors and nurses regarding self-harm. The three main themes were *(1)* professional attitudes and understanding of self-harm, *(2)* coping strategies and educational needs, and *(3)* institutional dynamics, social-cultural influences, and stigma.

Doctors' and nurses' responses to self-harm were indirectly and directly influenced by the systems around them. Bronfenbrenner's ecological model (Bronfenbrenner, 1979) (Figure 2) was adapted to display the impact of doctors' and nurses' microsystem (immediate system), the mesosystem (the interactions between the microsystems), the exosystem (the indirect influence of the wider social settings, in this case the NHS), and the macrosystem (cultural beliefs and values impacting on the establishment, in this case the government and politics). The model was adapted and used post-analysis as a framework to help integrate the themes that were produced by the narrative synthesis.

Figure 2:

An adaption of Bronfenbrenner's Ecological Systems Theory (1979) demonstrating the systems influencing doctors' and nurses' responses to self-harm.



1. Professional Attitudes and Understanding of Self-Harm

This theme refers to doctors' and nurses' attitudes and understanding of self-harm and how it can affect their responses to self-harm. This theme was present in all ten studies; findings also highlighted the variability of doctors' and nurses' attitudes and the recognition of the complexity of their attitudes and understanding of self-harm. Linking this to the adapted Bronfenbrenner's Ecological system's model (see Figure 2) this theme is the microsystem influencing doctors' and nurses' responses to self-harm. It encompasses the immediate environment where doctors and nurses interact directly, and where their attitudes towards self-harm are shaped by their personal experiences, beliefs, and interactions. These findings indicate the significance of individual-level factors in shaping doctors' and nurses' responses to self-harming individuals.

1.1 Variability in Attitudes

The analysis revealed a diverse range of attitudes among doctors and nurses towards individuals who self-harm which were influenced by personal beliefs, experiences, and contextual factors. The

studies elucidated different reactions among doctors and nurses, which included empathy, compassion, and frustration (Hadfield et al., 2009; Joiner & Kaewchaluay, 2022; Sandy, 2013; Anderson et al., 2003; Shaw & Sandy, 2016; Dickinson et al., 2009; Chandler et al., 2020).

> *"I can't lie; sometimes it just gets frustrating especially if you have already seen them three or four times in the week. It's like, "Why? What do you want from me?" And it's just because you are doing the same thing over and over and stitching them up although you've just stitched them up and whatever. . . . It's more frustrating when they turn up and they don't, they don't really want to engage in the service."(Hadfield et al., 2009, page 759)*

There were also contrasting views among doctors and nurses on medical units where empathy can co-exist with frustration due to self-harming behaviours disrupting clinical routines:

> *"It was characterised by a progressive deterioration in their relationship with others, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable or overdependent" (Hopkins., 2002, page 151)*
>
> *"I have no sympathy for these people as I feel people who are physically ill deserve the beds on there [health care wing] more." (Dickinson et al., 2009, page 949)*

1.2 Recognition of Complexity

Doctors and nurses understood the multifaceted nature of self-harm and recognised the diverse range of underlying motives for self-harm such as coping mechanisms, attention-seeking behaviours, and distress management. Sandy (2013) described multiple motivations for self-harm in the eyes of nurses which include reasons such as attempts to regulate overwhelming emotions and seeking attention:

"Some users hurt themselves openly in the day area. They do it for attention" (Sandy, 2013, page 361)

"When you've got a department or ward take full of severe asthma, meningitis, septicaemia etc and then you've got a couple of young girls who have taken a cocktail of things there will always be the couple of girls at the end of the ward who have taken something. They cannot with our current resources...be looked after in the same way, which I am not saying I am proud of feeling" (Anderson, 2003, page 590)

Joiner and Kaewchaluay (2022) indicated a similar understanding among medical students:

"If you've got such a nice lifestyle, what is it that's making you feel that you need to self-harm?" (Joiner & Kaewchaluay, 2022, page 197)

This indicates a lack of understanding about why an individual may self-harm and how the cause can be more intricate. These negative perceptions may be related to the medical students' education and their experiences of seeing their supervisors interact with individuals who self-harm.

"That's why people in A&E sort of brush these people off, because they think when they know when someone's serious or not" (Joiner & Kaewchaluay, 2022, page 187)

This suggests that medical students may learn from their supervisors that individuals who self-harm are not serious or important enough, which may impact negatively on their perceptions and eventually their care.

2. Coping Strategies and Educational Needs

This theme refers to how doctors and nurses cope with caring for individuals who self-harm as well as what educational training they may need to improve the care they give. This theme was present in all ten studies. Again, this theme can be linked to the mesosystem of the adapted Bronfenbrenner's Ecological systems model (see Figure 2). The mesosystem comprises of the interrelations between the microsystems. It highlights the interactions between doctors and nurses and their institutional (NHS) contexts, as well as the educational resources available to them. Studies such as Dickinson et al. (2009) and Leddie et al. (2022) emphasise the adoption of coping mechanisms by doctors and nurses in response to the emotional strain associated with caring for individuals who self-harm. Furthermore, educational gaps, identified by all the studies indicate that training programs do not prepare doctors' and nurses' ability to effectively intervene and support individuals who self-harm.

2.1 Adoption of Coping Mechanisms

In navigating the emotional complexities inherent in caring for individuals who self-harm, doctors and nurses employed various coping mechanisms while identifying critical gaps in their training. Leddie et al. (2022) highlighted the reliance on coping mechanisms by nurses such as seeking support from colleagues and engaging in reflective practice.

> *"It's a pressure, but a pressure that you can use in a positive way to make you feel more determined and more engaged" (Leddie et al., 2022, page 749)*

> *"You come out the other side, with supervision, with support" (Leddie et al., 2022, page 749)*

"That is the most valuable tool we've got, each other's experiences, and different ways we all manage things" (Leddie et al., 2022, page 750)

Similarly, Shaw and Sandy (2016) and Thompson et al. (2008) emphasised the use of reflection and supervision as coping strategies among mental health nurses in secure units. Nurses also identified training as a coping mechanism to help with responding to self-harm.

"Users sometimes make you feel angry and frustrated particularly when they keep on repeating their behaviours. But training can help us to cope with these emotions" (Shaw & Sandy, 2016, page 411)

"It was the supervision . . . It just helped . . . so it doesn't spill on over. I took this woman to supervision, and we started doing all this work with her about boundaries and containment, and just very simple, sort of , model to use with her, and it was unbelievable what happened." (Thompson et al., 2008, page 158)

2.2 Identification of Educational Gaps

Furthermore, the studies identified significant educational gaps in training programs, which hinder doctors' and nurses' ability to provide effective support to individuals who self-harm. Dickinson et al. (2009) elucidated the lack of adequate training, and the need for more training on self-harm to help with working with individuals who self-harm:

"I would like more training (I have had none) in how to manage and care for self-harming young people. Also, the risk associated with self-harm and how to assess this." (Dickinson et al., 2009, page 949)

Moreover, Chandler et al. (2020) implied a need for more education and training for GPs on self-harm management and assessment:

"I don't know if I've ever done very much, but I don't know if I could have done very much. I've sort of done damage limitation with her. She has been referred, but I suppose she had to lead her own life really, and it is just sad to see people unable to lead it properly" (Chandler et al., 2020, page 248)

"She's got a label of personality disorder and she has had a lot of psychiatric involvement over the years but it doesn't change her behaviour and I just don't know how to deal with her." (Chandler et al., 2020, page 249)

"I haven't really got training to sit and talk to them about, you know, their problems and counsel them, so I tend to leave them alone after they have been medically treated (staff nurse, urban hospital)" (Hopkins, 2002, page 152)

3. Institutional Dynamics, Sociocultural Influences, and Stigma

All ten studies suggested that many external factors impact doctors' and nurses' views on self-harm and in turn their responses to self-harm and the care they give to individuals who self-harm. These external factors include institutional dynamics, sociocultural influences, and stigma. These themes come under the adapted Bronfenbrenner's Ecological systems model (see Figure 2) as the exosystem and macrosystem.

The exosystem extends beyond immediate interactions to encompass broader social and institutional contexts that indirectly influence doctors' and nurses' responses to self-harm. Sandy (2013) highlighted the influence of institutional culture on nurses' attitudes towards self-harm, emphasising the challenges posed by prevailing norms within healthcare settings.

Additionally, Shaw and Sandy (2016) highlighted the impact of societal attitudes and stigma on nurses' ability to provide compassionate care to individuals who self-harm. The findings emphasise that societal norms, values, and cultural beliefs can shape healthcare practices related to self-harm and function within the macrosystem of Bronfenbrenner's (1979) ecological model. The macrosystem includes the broader societal and cultural contexts that influence doctors' and nurses' attitudes and behaviours, as well as the NHS' institutional policies related to caring for individuals who self-harm. Shaw and Sandy (2016) explained the prevalent influence of societal attitudes, and stigma within healthcare environments, preventing the provision of compassionate care to individuals who self-harm. These factors indicate the need for systemic interventions to address societal attitudes and stigma surrounding self-harm and enhance support for doctors, nurses, and other healthcare providers.

3.1 Influence of Institutional Culture

The institutional culture significantly shaped doctors' and nurses' attitudes and approaches towards self-harm. Thompson et al. (2008) highlighted the impact of institutional culture on attitudes, which poses challenges for individuals who self-harm and may contribute to the increase in the frequency of self-harming behaviours. Hadfield et al. (2009) raises the importance of the use of protocol as a positive influence on their care.

However, Hadfield et al. (2009) also mention protocols *'removing emotional thoughts'* (Page 761) which may leave individuals who self-harm feeling like the healthcare professional doesn't care. On the other hand, taking away their feelings and reflections may enable the healthcare professional to care for the individual without negative biases, so it is important to have a balance. Furthermore, Joiner and Kaewchaluay (2022) described how medical students experienced doctors and nurses showing negative behaviours about individuals who self-harm, which may, in turn, impact the medical student's own beliefs, attitudes, and responses towards individuals who self-harm.

"When you've got lots of other people on your caseload. . . the people that aren't getting the attention and start upping the ante, it's, you just feel torn" (Thompson et al., 2008, page 158)

"I think you just have to [manage], or I just have to get on with it unfortunately. . . . So to have that protocol there ensures the patient's safety really, more than ours. . . . It ensures that you are giving best treatment and also it's good because by having a set protocol you're removing any emotional thoughts about the patient yourself . . . no matter what you think, you know what you have to do. It's probably the same way soldiers were." (Hadfield et al., 2009, page 761)

"Students described common experiences of doctors and nurses becoming irritated with people who self-harm and expressing that such people were wasting their time as "they didn't have to harm themselves." Nursing and medical staff gave the impression that people who self-harm were "bedblocking" due to non-medical problems. Students reported witnessing nurses laughing and rolling their eyes at people who self-harm, and saw senior doctors being abrupt or impartial. Students also witnessed senior doctors express self-harm as unimportant by stating people who self-harm are "for the juniors [to see]." (Joiner & Kaewchaluay, 2022, page 198)

3.2 Broader Societal Attitudes and Stigma

Societal attitudes and stigma within healthcare environments play a crucial role in shaping doctors' and nurses' perceptions and responses to self-harm. Hadfield et al. (2009) underscored the impact of broader societal attitudes and stigma on doctors' experiences and responses to self-harm.

"There's a lot of "sad" people out there, you know, who come from poor backgrounds and they've got no expectation in life at all, they've left school early and so they are protected from that point of view. They go and work in a shop, a, you know, factory floor or a line or something, you know, an assembly line and they're always overseen. They're told what to do, they're told how to

do it, they don't have to cope; they just exist. Now that's not right in my opinion, you have to give people, put them into stressful situations for them to learn to cope; otherwise, they will always come back to the copers. . . .We often do, you know, we take everything away from patients, call them what you will, and you don't have that in a lot of countries."(Hadfield et al., 2009, page 761).

"That is why I talk about society's responsibility—it's like with disabled people, lets not label a child something because they are disabled—I think that perhaps it's because society doesn't want to look after them and I think we all have a responsibility" (Anderson et al., 2003, page 593)

Anderson et al. (2003) discussed the impact of unnecessary labels, arising from societal pressure, and their negative effect on the care of individuals who self-harm. They also mentioned changes in societal influence over time and the negative effects:

"When I was a child it's not something that I would have even considered. And you see some children 9 or 10 taking paracetamol. When I was that age, I was just running around, playing football in the park, its not something I would have even contemplated or thought about...even when I was a teenager." (Anderson et al., 2003, page 594)

Discussion

This review aimed to explore the views of doctors and nurses towards self-harm and how these attitudes may influence client care. Through narrative synthesis three key themes were identified from the data, shedding light on the complex dynamics at play within clinical settings.

Overview of Findings

The findings from the review reveal three overarching themes. These themes encompass a spectrum of perspectives, coping mechanisms, and contextual factors that shape caregiving in healthcare settings.

The first theme, ‘Professional Attitudes and Understanding of Self-Harm’, indicated the varied perspectives among doctors and nurses. The review uncovered a range of attitudes towards self-harm, from empathy and understanding to discomfort and negative perceptions. These diverse views imply the complexity of addressing self-harm within healthcare contexts and emphasise the need for tailored support for professionals (Rayner et al., 2019; Coimbra & Noakes, 2021).

The second theme, ‘Coping Strategies and Educational Needs’, identified various coping mechanisms employed by doctors and nurses to manage the challenges associated with caring for individuals who self-harm. From reflection and supervision to seeking additional education and training, doctors and nurses implemented diverse strategies to navigate the complexities of self-harm. Additionally, the review indicated the need for ongoing education and training to address gaps in knowledge and skills related to managing self-harm and assessing self-harm (Mitten et al., 2016).

The third theme ‘Institutional Dynamics, Sociocultural Influences, and Stigma’, encompasses the broader contextual factors that shape doctors' and nurses’ responses to self-harm. The findings

within this theme highlighted the significant influence of institutional culture and societal norms on doctors' and nurses' attitudes and behaviours toward self-harm (Chandler et al., 2020; Burke et al., 2019).

Furthermore, the review reaffirmed the significant impact of broader societal attitudes on doctors' and nurses' perceptions of self-harm. The studies highlighted the challenges posed by societal stigma, which directly affected their interactions with patients (Burke et al., 2019). This indicates the importance of addressing stigma at both individual and societal levels. Training should aim to challenge societal norms while fostering empathy and understanding within healthcare settings. The review revealed how these dynamics contribute to the perpetuation of stigma and negative attitudes, suggesting the need for systemic interventions, ongoing training, and education, to foster a more supportive healthcare environment, and to challenge stigma (Victor & Klonsky, 2014; Hooley et al., 2020).

The review, therefore, contributes to the existing body of literature by shedding light on consistent themes regarding doctors' and nurses' responses to self-harm. Building on previous research by Coimbra and Noakes (2021) and Rayner et al. (2019), the review highlights the prevalent negative attitudes among doctors and nurses toward individuals who self-harm. These attitudes pose significant barriers to establishing therapeutic relationships and delivering effective care, as echoed in the literature (Coimbra & Noakes, 2021; Rayner et al., 2019). This again shows the urgent need for targeted training aimed at addressing negative attitudes and educational gaps while promoting effective coping strategies among doctors and nurses. Such training informed by the literature, has the potential to improve patient care and support in clinical settings.

However, some exceptions to the main findings emerged that shed light on the complex interplay between doctors' and nurses' attitudes, societal norms, and the provision of care for individuals who

self-harm. One such finding was the significant prevalence of stigma perpetuated by doctors and nurses as reported by studies such as Leddie et al. (2022) and Chandler et al. (2020). Despite efforts to provide compassionate care, the review revealed instances where doctors and nurses inadvertently contributed to the stigma surrounding self-harm. This indicates the prevalent nature of stigma within healthcare settings and emphasises the urgent need for training to challenge these attitudes and foster a more supportive environment for individuals who self-harm (Coimbra & Noakes, 2021).

Identifying Limitations

Although the review provides valuable insights into doctors' and nurses' attitudes towards self-harm, the limitations of the review should be acknowledged. Firstly, the focus of the review was limited to studies conducted in the UK due to feasibility constraints. While this allowed for an explanation of attitudes within a specific context, the findings may not be directly transferrable to healthcare settings in other cultural contexts (Knott, 2022).

Additionally, most of the included studies focused on doctors and nurses, with no representation from other frontline healthcare professionals such as paramedics. While this reflects the dominant roles of doctors and nurses in providing care for individuals who self-harm (Anderson, 2003) it also highlights a potential gap in understanding the perspectives of other key stakeholders. Future research should aim to include a broader range of healthcare professionals to provide a more comprehensive understanding of attitudes towards self-harm within the healthcare sector.

Furthermore, the use of self-report measures and focus groups may introduce response biases and limit the depth of understanding (McCrae, 2018). While self-report measures and focus groups are used in qualitative research to capture perspectives, they may be subject to social desirability biases

(Bergen & Labonté, 2019). Alternative methods, such as interviews, could provide richer and more in-depth insights into healthcare professionals' attitudes toward self-harm (Knott, 2022).

Finally, the potential impact of publication bias should be acknowledged and may skew the overall understanding of attitudes towards self-harm (Murad et al., 2018). While every effort was made to include a comprehensive range of studies, using quality analysis, it is important to recognise the limitations of the available studies and consider the broader context in which the findings are situated, including gaps and potential biases, decreasing the validity of the overall research.

Clinical Implications

The findings of this review hold several important implications for clinical practice. Firstly, addressing healthcare professionals' attitudes towards self-harm is essential for promoting patient-centred care and improving treatment outcomes. By fostering empathy and compassion among clinicians, healthcare institutions can create a supportive environment where individuals who self-harm feel understood and valued (Miller, 2021). However, it is important to note that these suggestions need to be reflected in NHS policy before any changes can be implemented in clinical practice.

Furthermore, interventions aimed at challenging stigma and negative attitudes towards self-harm are crucial for reducing barriers to care. Providing education and training programs for healthcare professionals can help raise awareness about the underlying factors contributing to self-harm and equip clinicians with the skills and knowledge needed to provide effective support (Rosenrot & Lewis, 2020).

Utilising Bronfenbrenner's (1992) theory, strategies can be identified to target and limit stigma across the various levels in the system. At the microsystem level, open communication and support within families and peer groups should be promoted, which can be done through family therapy sessions and peer support groups to foster understanding and a supportive environment. At the mesosystem level, it is important to strengthen connections between the already existing microsystems such as schools, workplaces, and healthcare providers. This can be done through school-based mental health programs and regular multidisciplinary meetings to make sure individuals receive consistent support. In addition, at the exosystem level, to reduce stigma in professional settings, workplace policies that support mental health, and more training is required. Furthermore, at the macrosystem level, a more accepting societal attitude is needed towards people and their mental health difficulties (Ahmedani, 2011). Cultural and societal attitudes need to be addressed, which can be achieved by positive and realistic media representation regarding mental health difficulties, public awareness campaigns, and legislation advocating for people who have mental health difficulties. Finally, long-term support programs that offer continuous care and follow-ups are needed at the chronosystem level (Castillo et al., 2019). This helps validate the impact of life transitions on people and to help them navigate these changes. Applying these suggestions can help foster a more supportive and inclusive environment for individuals who self-harm.

Moreover, the identification of coping strategies and educational needs among healthcare professionals' highlights opportunities for targeted training. By addressing specific areas of concern, such as boundary setting and emotional coping mechanisms, healthcare institutions can better support their staff in managing challenges associated with caring for individuals who self-harm (Søvold et al., 2021). However, while it may not be the institution's responsibility to provide direct emotional coping mechanisms, it can play a pivotal role in facilitating access to resources, training, and support to aid clinicians in developing these skills.

In addition, the recognition of institutional dynamics and sociocultural influences shows the importance of systemic changes within healthcare settings. Creating policies and protocols that promote a culture of understanding and acceptance can help address the root causes of stigma and discrimination i.e., a top-down approach, ultimately improving the quality of care provided to individuals who self-harm (Townsend et al., 2016). A top-down approach can be implemented through legislative frameworks to establish care standards that clinicians can follow. Professional organisations such as the Department of Health, the Department of Media, and Parliament should collaborate with the NHS to drive policy reforms, by advocating for evidence-based practice, more in-depth training programs, and ensuring that healthcare policies are always up to date and in line with the latest research. By professional organisations collaborating, an environment that supports people who self-harm, as well as a more inclusive and compassionate healthcare system, can be achieved.

Overall, addressing healthcare professionals' attitudes toward self-harm and implementing targeted interventions can have a positive impact on patient care and treatment outcomes. By fostering a culture of empathy, understanding, and support within clinical settings, healthcare institutions can better meet the needs of individuals who self-harm and promote their overall wellbeing.

Future Directions

Many future directions of research have emerged from the findings of this review.

Exploring Cross-Cultural Variations

Given the focus on studies conducted in the UK, future research should investigate cross-cultural variations in healthcare professionals' attitudes towards self-harm. Comparing attitudes across professionals from different cultural backgrounds and contexts could provide valuable insights into

the impact of cultural factors on the provision of care for individuals who self-harm (Handtke et al., 2019).

Inclusion of Paramedics and Other Healthcare Professionals

There was no representation of paramedics and other frontline healthcare professionals in the included studies, which highlights the need for research that encompasses a broader range of healthcare roles. Future studies should aim to include other key stakeholders such as paramedics to ensure a comprehensive understanding of attitudes towards self-harm across the healthcare sector.

Longitudinal Studies

Longitudinal studies tracking changes in healthcare professionals' attitudes over time, could provide valuable insights into the impact of interventions and educational initiatives, aimed at challenging stigma and promoting understanding. By examining attitudes at multiple time points, researchers could assess the effectiveness of interventions and identify areas for improvement in the provision of care for individuals who self-harm (Caruana et al., 2015).

Exploring the Impact of Training and Education

Further research is needed to evaluate the effectiveness of training and educational initiatives in promoting empathy, reducing stigma, and improving the provision of care for individuals who self-harm. Comparative studies assessing the impact of different training programs and educational interventions could inform the development of evidence-based approaches to addressing self-harm within healthcare settings.

However, it is crucial to recognise the broader political and systemic issues at play. The NHS is a system that is struggling to survive, with the burdens of understaffing across the system, not enough resources, and insufficient support, especially for emergency departments and GPs (British Medical

Association, 2022). Emergency departments are therefore having to handle cases that would be more appropriate for GPs, adding to the current difficulties in the NHS (Care Quality Commission, 2021). Recommendations to improve this include better triages, improved staffing levels, and more support for clinicians. This can alleviate the strain put on services and aid in improving healthcare. These systemic issues are incredibly important to address as healthcare professionals need to have the capacity to deliver supportive and compassionate care. Not acknowledging this and not addressing the wider political and institutional problems, improving empathy, and reducing stigma may not be possible.

Conclusion

This review offers insights into doctors' and nurses' attitudes towards individuals who self-harm. A comprehensive narrative synthesis of qualitative and mixed methods studies in the UK identified three key themes: *(1)* 'Professional Attitudes and Understanding of Self-Harm', *(2)* Coping Strategies and Educational Needs, and *(3)* Institutional Dynamics, Sociocultural Influences, and Stigma.

While the findings imply the importance of addressing stigma and promoting understanding, limitations such as the focus on UK studies exist. Future research should explore cross-cultural variations, include a more diverse range of healthcare professionals, and explore the impact of training and education. Overall, this review contributes to understanding self-harm perceptions and emphasises the need for education and training for healthcare professionals to improve healthcare professionals' responses.

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Part Two – Empirical: Healthcare Professionals' Views on the Effect of Media on Self-Harm in Young People

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Abstract

Healthcare professionals play an integral part in caring for young people who self-harm. Many factors influence young people to self-harm, but a prevalent factor that has kept emerging over the last few years is the media. There is currently no research looking at healthcare professionals' views on the effect of media on self-harm. This study used Critical Discourse Analysis to explore Child and Adolescent Mental Health Services (CAMHS) clinicians' views on the effect of media on self-harm in young people. Two main discourses were developed: 'Media as a Disruptor' and 'The Hidden World of Youth' with several sub-discourses also developing. Clinicians viewed media as an entity with a multifaceted nature, however, the influence of media was found to be mostly negative on young people who self-harm. They also talked about the negative impact of inaccurate media portrayals, stereotypes, and stigma surrounding self-harm and the influence this has on young people. Clinical Implications included the importance of asking about media consumption in assessments with young people and the need for training and education around the impact of media on self-harm in young people, as well as changes to policies and procedures to improve young people's care overall.

Keywords: Healthcare Professionals'; Views; Self-Harm; Media; Young People; Critical Discourse Analysis

Introduction

Self-Harm

The National Institute of Care Excellence (2022) defines self-harm as an act of self-injury or poisoning that is intentional, regardless of the assumed intention or motivation; as an expression of emotional distress (NICE, 2022). Self-harm can occur through self-poisoning, using over the counter or prescribed medication, illegal drugs, or household substances like bleach; it can also occur through self-injury such as cutting, burning, or drowning (NICE, 2022). The NICE guidelines (2022) also consider suicide attempts with little or no suicidal intent as self-harm when used to communicate distress or alleviate internal tension.

Despite the NICE guideline's (2022) definition of self-harm being widely used in clinical practice in the UK, it is important to highlight and consider the complex debate concerning the definitions and distinctions between self-harm and suicidal behaviour within the literature. The literature highlights how there is overlap between the two and distinguishing between them brings challenges (James & Stewart, 2018). Self-harm can be defined as injuring or poisoning oneself, regardless of intent (Rahman et al., 2021) or without suicidal intent (Baetens et al., 2020). Suicidal behaviour can be defined as a behaviour to end one's life with suicidal intent (O'Donnell et al., 2024).

Research shows that self-harm and suicidal behaviours share risk factors and intent, so differentiating between the intent behind the behaviours is not as clear-cut (Klonsky., 2013; O'Connor & Nock., 2014; Victor & Klonsky., 2014). Therefore, it is important to consider this when referring to self-harm and suicidal behaviours. For this study, the terms self-harm and suicidal behaviour will be used interchangeably to refer to injuring or poisoning oneself regardless of intent.

Historical Patterns of Self-Harm

Over the past two decades, self-harm rates among young people in the UK have risen significantly (Diggins et al., 2024). The early 2000s marked an era of more systematic research into self-harm, with the 'Truth Hurts' report (Brophy & Mental Health Foundation, 2006) being at the forefront. The report found that approximately 6.7% of young people had self-harmed, highlighting the prevalence of self-harm and the urgent need for support for young people who self-harm in the UK. By 2014, self-harm had gained more public and professional interest, and a national survey conducted across the UK in 2014 found rising rates of self-harm among young people in the UK between 2002 and 2014 (Brooks et al., 2015).

Recent Patterns of Self-Harm

In 2018-19, 24% of 17-year-olds reported that they had self-harmed during the past year, with 7% reporting they self-harmed with suicidal intent throughout their lives (Patalay & Fitzsimons, 2020). McManus et al. (2019) found that self-harm behaviours in 16-74 years olds increased from 2.4% in 2000 to 6.4% in 2014, an increase of more than double, in under 15 years. More specifically, research has found that self-harm rates in children and young people have doubled over the last 10 years (Diggins et al., 2024).

Gandhi et al. (2018) found that self-harming behaviours are most likely to start at 12 years old, peak between 14–16, and start decreasing at around 18 years old. Furthermore, Diggins et al. (2017) found that individuals aged 12-17 years were more likely to present to the hospital after using self-poisoning to self-harm and that 18–25-year-olds were more likely to present with self-harm due to injuring themselves, mostly due to cutting. Self-harm due to self-poisoning decreased within the age group 18-25 (Diggins et al., 2017).

Understanding Self-Harm: Exploring Risk Factors & Triggers

It is important to explore the intricate web of factors contributing to the occurrence of self-harm. Long et al. (2013), explored the lasting impact of childhood adverse experiences and found that these experiences can be precursors to self-harming behaviours later in life. The effects of these formative experiences resonate through adulthood, shaping individuals' coping mechanisms and vulnerability to psychological distress (Long et al., 2013)

Moreover, more recent research such as Hetrick et al. (2020), found that among young adults who were aged 18-25, distressing emotions, feelings of isolation, exposure to self-harm, interpersonal conflicts, and the pressures of academic or occupational demands were factors that precipitated self-harming. These triggers, intricately intertwined with the complexities of emerging adulthood, indicate the multifaceted nature of self-harm and the myriad of challenges faced by young people.

Delving into the complexities of motivation, studies by Adshead (2011), Barton-Breck and Heyman (2012), and Ogden and Bennett (2015) offered perspectives on the underlying reasons for self-harm. From expressions of distress to attempts at emotional regulation and moments of control, individuals may navigate a troubled internal landscape wrought with difficulties and uncertainty. These motivations, deeply ingrained in the personal experience and psychological resilience of the individual, imply the profound interplay between inner turmoil and external stressors.

Exploring Self-Harm through a Social Constructionist Lens

An alternative position is to consider self-harm through a social constructionist lens. Social constructionism explains that an individual's reality is created through individual experiences with themselves and their relationships and interactions with others (Burr, 2015). There are four aspects: language, cultural and historical specificity, discourse and disciplinary power, and power relations.

The language aspect implies that the way we understand the world is through how the world is represented/produced through language (Burr & Dick, 2017).

Cultural and historical specificity indicates how we understand the world varies culturally (in different places) and historically (over time) (Burr & Dick, 2017). Discourse and disciplinary power imply we understand the world through culturally significant ideas such as personality or disposition (Burr & Dick, 2017). Lastly, the aspect of power relations proposes that the positions people occupy in society affect the way they view the world (Burr & Dick, 2017).

Therefore, the environmental model (Suyemoto, 1998) is a useful model to consider. This model proposes that individual behaviour is due to the way an individual interacts with their environment and the influence of the systems within that environment (Suyemoto, 1998). Moreover, the more the individual interacts with these systems, the more their behaviour continues and is reinforced, suggesting that when this behaviour perpetuates both the individual who is conducting that behaviour and the systems in that environment. The model also suggests that many factors could cause the behaviour and maintain it.

In the case of self-harm, something happening in the individual's environment/system, e.g., familial dysfunction, leads them to have an emotional response which is self-harm (Suyemoto, 1998). This behaviour takes attention away from the real issue, which is the disruption in the family system, producing a state of equilibrium (Markland, 2013). If the individual's environment/system is still disrupted, then the self-harm may continue as it may be reinforced by a possible feeling of relief when the self-harm occurs. This reinforcement may therefore increase the possibility the self-harming behaviour is repeated, especially if the environment/system is still disrupted (Markland, 2013).

Favazza (1996) theorised that the skin can be thought of as a message centre or advertising board and when someone self-harms it may be a way of communicating beliefs. In self-harm, an individual is communicating a message of internal pain. Moreover, Crowe (1996) proposed the body being seen as a 'discursive site' and on this site, an individual's public self and private self both exist, but in dissonance. The objective and subjective coming together at the discursive site causes tension for the individual which cannot be contained; in turn, the person may not be able to express this using their words and therefore acts instead, and self-harms.

The Influence of Media on Mental Health: Perpetuating Stigma & Stereotypes

Currently, media representations have a significant influence over stigmatised societal perceptions of mental health difficulties through sensationalised narratives and distorted portrayals (Srivastava et al., 2018) These portrayals can depict people struggling with mental health difficulties as violent, unpredictable, flawed, and weak, which can impact societal perceptions (Srivastava et al., 2018). Srivastava et al. (2018) also imply the media sensationalises coverage of stories linked to mental health difficulties and can use negative imagery and language to negatively frame individuals who self-harm.

Riddle (2014) researched the impact of media representations on individuals' self-perceptions and further highlighted the deceptive nature of media influence. Documentaries and news reports, while informative can often distort reality, painting an unrealistic picture of mental health difficulties and perpetuating harmful stereotypes. These also influence individuals' perceptions of themselves, contributing to feelings of shame, inadequacy, and self-doubt (Riddle, 2014).

The Role of Media in Self-Harm and Suicide: A Growing Concern

Arendt, Scherr and Romer (2019) and Daine et al. (2013) provided insights into the harmful effects of media depictions of self-harm. The normalisation and sensationalisation of self-harm behaviours

contribute to heightened risk among vulnerable individuals. Bridge et al. (2020) further indicated the profound impact of media sensationalisation on suicide rates, particularly among young people. They found that the television programme '13 Reasons Why' (Yorkey, 2017), aimed at young people, concerning a young person dying by suicide was associated with an increase in suicide rates after the release of the programme.

Furthermore, the 'Werther Effect' (Philipps, 1974) and the 'Papageno Effect' (Niederkrotenthaler et al., 2010) give evidence of the influence of media on suicidal behaviours. The Werther Effect refers to a phenomenon where greater exposure to suicidal behaviours via media leads to an increase in copycat suicides (Stack, 2003). Sisak and Varnik (2012) corroborated this; they found that sensationalist media portrayals of suicidal behaviours can significantly increase suicidal behaviour. The Papageno Effect (Niederkrotenthaler et al., 2010) is a phenomenon where responsible media reporting can have positive impacts by depicting positive coping mechanisms and preventing further suicides.

This shows the potential negative consequences of irresponsible media portrayals and the positive consequences of responsible portrayals. It also highlights the urgent need for responsible media practices and exhaustive preventive interventions. Moreover, it is important to highlight the literature has implied the pressing need for professionals who work with young people to understand the impact of media on them in more depth, achieved by including questions about media consumption as part of their assessments (Bell, 2014).

Polymedia and its Implications

There are guidelines for responsible reporting of suicidal behaviours in the media to reduce the impact of negative effects which advise against glamorising, sensationalising, or romanticising suicidal behaviour and avoiding detailed descriptions of the behaviours (World Health

Organisation, 2023). Research has found that adhering to these guidelines is important as it can reduce imitative suicidal behaviour (Niederkrotenthaler et al., 2010).

Importantly, the nature of media has changed significantly over time and has become more digital and interactive; referred to as 'Polymedia' (Madianou & Miller, 2012), meaning exposure to media has become more integrative, interchangeable, complex, and challenging (Bell & Westoby, 2021). This shift in the platforms of media, increases the accessibility to content that is unhelpful and harmful, making media's role in influencing suicidal behaviour more powerful and prevalent (Competiello et al., 2023). Moreover, Bell and Westoby (2021) elucidate the relationship individuals have with media has evolved over the last few years, making it harder to separate traditional media from digital media. This highlights how the emergence of Polymedia has increased exposure to harmful and unhelpful content, constituting a more complex and multifaceted impact of media.

The Death of Molly Russell; Implications for Media

It is incredibly important to consider the negative effects of media on young people, as it can have fatal consequences. A recent significant case was the death of 14-year-old Molly Russell, bringing significant attention to the impact of social media on self-harm and suicide. Molly's inquest revealed she had been exposed to thousands of images and content relating to self-harm on her devices. The coroner concluded she *'died from an act of self-harm while suffering from depression and the negative effects of online content'* (BBC News, 2022). This was a landmark case as it was the first time where media was directly incriminated in a death (BBC News, 2022). The case highlighted the urgent need for better regulation of media content and led to campaigns by organisations to address the impact of content (HM Government, 2019). Furthermore, Samaritans have developed guidelines for media when reporting on suicide (Samaritans, 2020) in response to cases such as Molly Russell's.

This case, along with recent research discussed, highlights the urgent need for more research to address the influence of media on adolescents in the UK who have lived experience of self-harm and suicidal intent. This is important especially with self-harm rates and suicidal behaviours increasing (Newlove-Delgado et al., 2023), putting pressure on Child and Adolescent Mental Health Services (CAMHS) (Huang & Ougrin, 2021). This would in turn help shape interventions to target these risk factors.

Professional Perspectives on Self-Harm: Addressing Attitudes and Stigma

Among healthcare professionals, attitudes toward self-harm play a pivotal role in shaping patient care and treatment outcomes. Saunders et al. (2012) and Coimbra and Noakes (2021) document prevalent negative attitudes and stigmatisation toward individuals who self-harm, highlighting the need for comprehensive interventions to address attitudes and promote compassionate care. Healthcare professionals must be equipped with the knowledge and skills to provide non-judgemental, evidence-based care to individuals in crisis, fostering an environment of trust, respect, and understanding.

Therefore, the way healthcare professionals view self-harm affects the way they interact with and give care to patients, so must be investigated. Moreover, negative attitudes also feed into the negative stigma surrounding self-harm, influencing the wellbeing of individuals who self-harm.

In summary, there is an association between media and increased risk of self-harm, suicide risk, and mental health difficulties, which are exacerbated by sensationalisation and stigma surrounding self-harm, suicidal ideation, and mental health difficulties. The research also considers the effect of professionals' views of self-harm on an individual's care. However, one gap in the literature is professionals' views on the effect of media on self-harm, which is important as a professional's

view will impact the care given to a client who self-harms. Moreover, understanding if media influences self-harm may help with interventions for individuals who self-harm.

Rationale for the study

This is the first study to explore professionals' views on the effect of media on self-harm. The research is clinically relevant as there are increasing numbers of children and adolescents who use mental health services due to self-harm (Huang & Ougrin, 2021). The findings of the study could help inform the development of interventions tailored to address this. Notably, the perspectives of healthcare professionals can have considerable influence over the quality of care given to a child or young person (Saunders et al., 2012; Coimbra & Noakes, 2021).

Using a social constructionist lens, this study seeks to add to existing literature by providing newer insights into self-harm. Embracing a social constructionist lens, means that the researcher will look at self-harm in a different context, where the societal factors and systematic difficulties are illuminated, shifting undue focus away from the individual. This is important as many discourses surrounding self-harm blame the individual rather than other factors (Dempsey et al., 2023). Additionally, Favazza's (1996) and Crowe's (1996) hypotheses lend credence to the idea that self-harm is a form of communication.

Using critical discourse analysis (Mullet, 2018) as the method, this study aimed to explain the various discourses surrounding the link between media exposure and self-harm (Potter, 1996). Critical discourse analysis will enable the researcher to investigate how notions of self-harm are constructed in the media and their effect on individuals. In turn, the research may help inform interventions and help professionals build better therapeutic relationships with their clients due to a better understanding of the subject.

Research Aims

- To understand professionals' views of the effect of media on young people's self-harm.
- To understand the effect of professionals' views on their care for clients who self-harm.

Research Questions

- What are professional's views on the effect of media on self-harm?
- How do these views impact their care?

Method

Design

This exploratory study of professional's views on the effect of media on self-harm in young people is a qualitative study using semi-structured interviews (See Appendix I for interview schedule). Data was analysed using critical discourse analysis (Mullet, 2018).

Participants

This study aimed to recruit 8-12 participants from CAMHS services across England as literature surrounding qualitative research recommended this, so ten interviews were carried out to produce a quality data set for analysis (Vasileiou et al., 2018).

Inclusion criteria:

- Professionals were CAMHS practitioners from any clinical background, involved in interventions, to ensure that views from different specialities were considered. CAMHS practitioners were the clinicians undertaking the interventions targeting self-harm.
- The clinicians had worked within CAMHS for 1 year or more to make sure they had extensive experience of working with children and adolescents who self-harmed.
- The clinicians had at least one experience of working with children and adolescents who self-harmed within a CAMHS setting.

Exclusion Criteria:

- Unable to speak fluent English, as the interview process required lengthy answers with good, descriptive detail.

Measures

Semi-structured interview: This was used so the researcher could give the participants a space to tell their stories and share views, providing in-depth answers.

Procedure

Participants were healthcare professionals working in CAMHS services in England who volunteered to take part in the study. The researcher approached NHS Trust research departments to gain permission for recruitment of staff within the service. The research departments put the researcher in touch with a clinician in the CAMHS team who sent an email to their staff containing the research poster.

Participants who showed interest contacted the researcher by email. They were provided with an overview of the study, inclusion and exclusion criteria, and an information sheet with further details. The researcher asked if they would be willing to take part in the study. If they agreed they were asked for a convenient date, time, and place for the interview.

If the clinician was still willing to take part in the study (before the interview and at the time of the interview), a written consent form was sent to them to read through and sign. All participants requested online interviews, which were conducted on Microsoft Teams and recorded with their permission. Before each interview started the researcher summarised the details of the study and asked if the participants had questions, which were answered. Verbal permission for the interview to be recorded was obtained and the researcher checked the written permission had been received. The interview was recorded on the researcher's NHS encrypted laptop and lasted on average an hour.

After the interview, the researcher ensured the participants had the researcher's contact details, to enable contact if needed. Finally, a debrief sheet was sent to the participants. It is also important to note and acknowledge that the research was carried out post COVID-19 Lockdown, therefore may have impacted on the study.

Ethics

The University of Hull's Faculty of Health Sciences Research Ethics Committee authorised ethical approval for the study (See Appendix E). Approval was also given by the Health Research Authority due to NHS staff being recruited (See Appendix F). Data collected from the participants were all anonymised. Participants were given an information sheet where they were informed about the study and were made aware that after their interview, they had the right to withdraw at any time until the interviews were anonymised.

Data analysis procedures

The data from the interviews were analysed using discourse analysis, more specifically Critical Discourse Analysis (CDA). Critical discourse analysis is a method of qualitatively analysing data and studying the connection between power, language, and social constructs (Buchholz, 2021). CDA aligns effectively with the social constructionist approach of the study, as it was important to examine the data through the perspective that an individual's reality is shaped through discourse with both internal reflections and external interactions (Burr & Dick, 2017). In addition, social constructionism theorises that people construct meaning in relation to their lives and the environments and systems around them, therefore using CDA allowed the researcher to examine these constructions of meaning surrounding the effect of media on self-harm (White, 2004). The analysis aimed to understand professionals' views on the effect of media on self-harm.

Once the data was collected, the researcher transcribed all interviews. The analytical process adapted Mullet's (2018) seven-step CDA process. The researcher first examined the background of the interviewee and analysed how this may affect their view. The researcher then coded the interview and identified overarching discourses. They then identified any interactions between the interviews and any positionalities the interviewees suggested. Next, the researcher analysed the internal relations in the texts by analysing any patterns, words, or linguistic devices depicting social context, interviewees' positionalities, and power relations (Mullet, 2018). Finally, the researcher interpreted the major discourses and the internal and external relations (Mullet, 2018). During this process, the researcher also noted down their reflections on how their perspectives may have influenced the analysis, questions, gaps they found, and any insights (Mullet, 2018). Reflexivity in qualitative research is essential as it can help enrich the researcher's understanding of the work and can enhance the findings' credibility (Dodgson, 2019).

Results

The data analysis revealed two dominant discourses emerging from the ten interviews with CAMHS clinicians: “Media as a Disruptor” and “The Hidden World of Youth”. The discourses cover the effect of media on self-harm among young people and reflect the clinicians’ perceptions as well as highlighting how language, including metaphors and constructions, positions young people within the context of the influence of media and self-harm.

Media as a Disruptor

The discourse of media as a disruptor appeared across all ten interviews. This discourse looks at how media is seen as a powerful system influencing young people’s behaviours and perceptions, relating to self-harm. The analysis revealed several sub-discourses within the main discourse: ‘Ease and Facilitation of Access’, ‘Multifaceted Nature of Media’, ‘Inaccuracy of Portrayals’, ‘Pathologising Behaviours’, and ‘Stereotypes and Stigmatisation’.

Ease of Facilitation of Access

In this sub-discourse, media is portrayed as a facilitator of dangerous knowledge, with all clinicians expressing concern over the unrestricted access young people have to harmful content relating to self-harm. For example:

“....it allows young people access to information that they shouldn't really have. It's not monitored. You know, some parents don't feel like they have the control to put boundaries in place ...and they have access to information. They have forums where they can find out how to self-harm. They get tips, and chat rooms. So I think it has a real influence on young people.”(Clinician 2)

The clinician uses lexical choices such as *“shouldn’t really have”, “not monitored”, and real influence”* to indicate the danger of easy access to media. The repetition of the verb *“access”*

highlights how easy it is to access harmful information relating to self-harm, whilst the phrases *"find out how to self-harm"* and *"get tips"* indicate a direct link between media and the facilitation of self-harm behaviours. The use of modal verbs like *"should"* and *"can"* implies a prescriptive stance on what is appropriate for young people, which positions the media as overstepping boundaries regarding easy access to inappropriate material relating to self-harm.

Clinician 5 further reinforces this perception:

"So I feel like outside influences do impact their relationship with media and how often they access things that…might lead to them… self-harm in all might sort of start off that spiral that ends in self-harm." (Clinician 5)

The phrase *"outside influences"* is a metonym for media, indicating external factors, such as friends, beyond parental or clinical control. The clinician's use of the verb *"spiral"* metaphorically suggests a downward, uncontrollable trajectory that can be initiated by exposure to media. The hesitations and pauses ("…"") reflect the clinician's struggle to articulate the complex process of media influence and emphasising the deceptive nature of the exposure to media.

Multifaceted Nature of Media

Clinicians also acknowledged the multifaceted role of media, and recognised its potential for both harm and benefit:

"The the young person who was hiding or holding the medication….found out that if I take 1000 milligrams of so so…. I'll kill myself. I can die and that's where…the information came from so I don't know. Yeah, that's quite alarming. At the same time, we've got young people on inpatient that belongs to a suicide pact… meeting total strangers…on social media and getting ideas about self-harming and…hurt themselves …but at the same time, there's one or two young people who meet people online, and they've been advising or please talk to your doctor…ring your phone telling

your mom about what is happening, so it's kind of…it's a two-way things….it's it's sometimes positive. And I've had examples of being positive at the same time. I've had examples of where it is quite negative and alarming."(Clinician 3)

The clinician above juxtaposes harmful and protective aspects of media. The repetition of *"at the same time"* aims to balance the multifaceted nature of media influence. The clinician's narrative shifts from alarming scenarios *("hiding or holding the medication", "suicide pact")* to more positive interactions *("advising", "please talk to your doctor").* The lexical choice *"alarming"* contrasts with *"positive"* implying the ambivalent impact of media.

This is echoed by Clinician 6:

"And I guess, you know, there's lots of…access…to many different and…at many different kind of sites and apps and…I don't even know how…how we keep track of them all, to be honest. So…I think…it I'm defensive about it…I think it can be really good when it's used well and it can be the devil's playground…a lot of the time. I then also think that there is an element of actually. Is there too much?"(Clinician 6)

The use of the metaphor *"devil's playground"* describes the potential dangers of media, suggesting it is chaotic with a dubious reputation. The phrase *"when it's used well"* acknowledges the positive potential of media, while the rhetorical question *"Is there too much?"* implies the overwhelming nature of the everchanging and growing landscape of media.

Inaccuracy of Portrayals

This critical sub-discourse looks at the inaccurate portrayal of self-harm in the media:

"You know, it's not, it's not some some planned out you know like as you say romanticised event it's it's not anything like how it's portrayed in that programme but for the young person you

know they think that that's what it's like because that's their only experience of being shown….whole thing, so definitely damaging." (Clinician 5)

The use of negation by the clinician *("not some planned out", "not anything like")* to show their frustration of the romanticised portrayals of self-harm in media. The use of the verb *"romanticised"* is somewhat loaded, suggesting the deception of self-harm can be unrealistic and idealised and can mislead young people. The repetition of the adverb *"not"* emphasises the clinician's view that media portrayals and the reality of self-harm are two very different and contrasting aspects.

"Negative…Yeah, there's still…Yeah, it's interesting….there's this real idea, or I guess the perception that somebody might have when they when something like that is….put out there in the way that it is with a bias that that young person is damaged. Broken. There's something you know, must be something, really….difficult that they're going, you know. And I'm not saying there isn't, but I guess the the kind of portrayal of that is always really, you know, really negative." (Clinician 7)

The clinician's use of fragmented sentences and hesitations reflects the complexity and sensitivity of discussing media portrayals for clinicians. The use of the verb *"damaged"* and the adjective *"broken"* are metaphorical and imply the media can portray young people who self-harm in a stigmatising light. The repetition of the phrase *"really negative"* underpins the clinician's concern about the detrimental impact of inaccurate portrayals of self-harm in the media.

Pathologising Behaviours

This sub-discourse also criticises media and how it can unnecessarily pathologise common behaviours in young people.

"I feel….that there are more influencers getting involved with regards to mental health, which therefore means that mental health seems to be a very hot topic …and it makes people who

may be struggling…but it's a struggle that is in keeping with the situation, so it's a normal emotional feeling, start questioning whether whether they're suffering from mental health problems." (Clinician 2)

The use of the phrase *"hot topic"* suggests mental health difficulties are being sensationalised and unnecessarily pathologised in the media. The contrast between the phrases *"mental health problems"* and *"normal emotional feeling"* suggests that the media can blur the lines between young people's typical behaviours and mental health difficulties which may lead to needless self-diagnosis.

This is also reinforced by Clinician 9:

"And I suppose, yeah, trying to sort of….get parents to be open to the idea that emotional instability in adolescence is really quite normal….but yeah, but because somebody had said it on the telly, that was, yeah, the kind of the battle that we had that month." (Clinician 9)

The term *"emotional instability"* is used as a nominalisation that abstracts and generalises the concept, while *"quite normal"* sets out to normalise young people's behaviours. The clinician's reference to *"somebody had said it on the telly"* implies the authoritative power of the voices of the media, which can override clinical advice and complicate therapeutic efforts.

Stereotypes and Stigmatisation

Finally, this sub-discourse surveys how the media can reinforce negative stereotypes and stigmatise young people who self-harm:

"And with the news as well, I mean it's always negative, right? I always find the influence that it has is that it makes young people think that….services don't know what they're doing. You know, there's always young people that are ending their lives, and services weren't there, or it was

an inpatient unit that let them go home to too soon. And then things went wrong. So I think the news gives young people a bad a negative impression of services." (Clinician 2)

The clinician uses generalisations *("always negative")* and absolutes *("always", "don't know what they're doing")* to highlight the consistent negative bias in media regarding young people who self-harm. The narrative in the media of *"young people ending their lives"* and *"things went wrong"* constructs a narrative around mental health services failing which can promote distrust and discourage help-seeking in young people who self-harm.

"But then also you do get the…the services are rubbish and stretched and waiting lists and all that good stuff, so it's a tricky one"(Clinician 8)"

The use of informal and colloquial language *("rubbish", "all that good stuff")* minimise serious difficulties in mental health services like long waiting lists, reflecting a casual dismissal that may influence young people's perceptions of services and in turn may negatively impact on seeking help for mental health difficulties that young people may experience.

Hidden World of Youth

This second main discourse focuses on how young people often hide the impact of media on their difficulties from parents, carers, and professionals. It also reveals the clinicians' suggestions for strategies to address media influence and highlights the need for improvements in the approach to caring for young people who self-harm. Three sub-discourses were developed: 'Asking About Media in Assessments', 'Risk Assessments', and 'Importance of Further Education'.

Asking About Media in Assessments

Clinicians acknowledged the need to integrate discussions about media consumption into initial assessments with young people:

"But yeah, I think it's something that often it it will speak about it if they bring it up. I would say it wouldn't be something that I would proactively discuss….No, but I feel like it probably should have to change. I don't feel like… I probably should be better at that…..I think maybe just asking those questions more and just saying to people, because often it's it's offered by them. Really what what they want to share about their…media awareness and how much they pay attention to things…because of the, so we don't do assessments like that in our team typically. So that because of the nature of the way that we work…unless it was an identified problem, I wouldn't naturally bring it up unless they did with me.(Clinician 8)"

The clinician's hesitation and self-reflection *("I would say it wouldn't be something", "I probably should be")* indicate an awareness of the gap in current practice and a recognition of the need for improvements and change to improve the care for young people who self-harm. The phrase *"proactively discuss"* indicates that this approach is different from the previous reactive approach, suggesting a shift towards a more deliberate inclusion of questions related to media consumption in assessments with young people.

Risk Assessments

This discourse on risk assessments reveals concerns about the length and rigidity, which can hinder rapport, therapeutic relationship building, and engagement with young people.

It is easy to have a questionnaire about risk… And you, you you can ask those questions… reading it from a clipboard or you can engage in a conversation… and know the know the bits that

you need to hit to write a really good risk assessment, but without it feeling like the young person's just being interrogated (Clinician 1)

The clinician contrasts the impersonal nature of a *"questionnaire"* with the relational approach of a *"conversation"*. The repetition of *"you"* and the juxtaposition of *"clipboard"* versus *"conversation"* highlight the clinician's preference for a more interactive and less intimidating method of assessment.

"A risk assessment which at the moment in our services are very, very lengthy document. So I think it's almost gone back to that filling a full session on risk and I don't think that's necessarily been useful….I would say….yeah, I almost wish that in this setting it we where we steer away from focusing solely on risk, but ensuring that the young person feels that their individual needs are still being met despite the risk, if that makes sense." (Clinician 4)

The clinician's use of the phrase *"very, very lengthy"* and *"filling a full session"* implies how burdensome the current risk assessments can be for clinicians. The clinician's wish for a shift away from *"focusing solely on risk"* suggests a need for a more balanced risk assessment approach that can address both the risk and the young person's individual needs.

"Yeah, and and it can. It can also, I guess, reinforce dynamics of infantilization and victimisation, and it can prevent clinicians from….seeing and sharing and celebrating the strengths that the child has and the you know the rest of their internal world, which might be rich and fulfilling and….you know, we can miss that and we can reinforce…the problem itself, inadvertently through through that sense of threat that we have and…yeah, I guess the proverbial kind of tail that wags the dog rather than the dog that wags the tail….kind of….that can be what happens, can't it with these processes, that should be just the tip of the iceberg of what we're doing and should be

there to serve what we're doing, but instead can become…the beginning and the end and the the middle of it all. Yeah, it's a risk".(Clinician 10)

The clinician elaborates on the negative dynamics that can arise from a rigid focus on risk. They use complex metaphors *("tail that wags the dog")* and idiomatic *expressions ("tip of the iceberg")* to illustrate the unintended consequences of a risk-focused approach. The phrase *"reinforce dynamics of infantilisation and victimisation"* critiques how risk-focused assessments can make the young person feel like a child and diminish the power and strengths of young people. This in turn can affect the rapport building, therapeutic relationship, and the care of the young person.

Importance of Further Education

Clinicians highlighted the need for ongoing education and training so they can understand and explore the impact of media on self-harm in young people.

"I think it is definitely shown me how little I know about this area. And I think as you quite rightly said…having an understanding of what it is that you know of the world, the online worlds that young people are inhabiting…and the exposure, you know what it what they are exposed to is so crucial for actually being able to engage with them and for them to feel understood and…potentially disclose what's going on so that it's been really helpful on that on that front. And it's made. It made me want to go and do my own research. Really. And, you know, I don't know where that would begin because I'm sure it would lead to all of the things we've talked about that rabbit holes that. Yeah, but I think I think you're right. Some training around this….sounds very appropriate, yeah" (Clinician 10)

The clinician admitted their limited knowledge *"show me how little I know"* conveying a sense of humility and openness to earning. The use of the phrase *"having an understanding"* by the clinician

emphasises the importance of gaining insights into the media consumption of young people and the effect it can have on self-harm. This suggests a desire for understanding and empathy from the clinician. Moreover, the repetition of the word *"exposure"* highlights the clinician's recognition that the media can have a large impact and influence in shaping young people's perspectives and experiences. It also emphasises the prevalence and impact of media exposure and the consumption of media.

Furthermore, the pause *("...potentially disclose what's going on")* draws attention to young people potentially disclosing their experiences when they feel like they are in a safe space and understood, which is important to the care of young people who self-harm. This rhetorical device emphasises the importance of building rapport, fostering trust, and a supportive therapeutic relationship in clinical practice.

Finally, the clinician's mention of *"rabbit holes"* evokes a sense of the overwhelming and extensive nature of the effect of media on self-harm. This implies that more conversations and research into the effect of media on self-harm may lead to more knowledge about the effects on young people. The metaphorical language also indicates the complexity and depth of the effect of media on self-harm in young people.

Discussion

Healthcare professional's views on the impact of media on self-harm among young people are complicated and diverse, as revealed through the Critical Discourse Analysis of ten interviews conducted with CAMHS clinicians. The findings shed light on two prominent discourses: "Media as a Disruptor" and "The Hidden World of Youth" and encapsulate various sub-discourses that indicate the complex relationship between media consumption and self-harming behaviours in young people.

Overview of Findings.

The discourse on "Media as a Disruptor" highlights the prevalent influence of media on young people's perceptions and behaviours related to self-harm. Clinicians expressed concerns about the ease of access to harmful content facilitated by media platforms, including forums and chat rooms where self-harming techniques can be openly discussed. This finding resonates with previous literature such as Patalay and Fitzsimmons (2020) and McManus et al. (2016) who found the widespread prevalence of media platforms, as sources of information and encouragement for self-harm behaviours among young people.

Furthermore, clinicians recognised the complicated nature of media, acknowledging its potential to both exacerbate and mitigate self-harm behaviours in young people. While media often sensationalises or glamorises self-harm, documentaries, and educational content have the potential to raise awareness and connect individuals with support services (Gandhi et al., 2018; Diggins et al., 2017). This polarity implies the importance of critically evaluating representations of self-harm in media and promoting responsible media consumption among young people.

Moreover, the findings of this study align with various theoretical frameworks mentioned previously, offering lenses through which we can interpret and understand the findings of this study.

The concept of social constructionism (Burr, 2015; Burr & Dick, 2017) highlighted the role of discourse and social interactions in shaping perceptions and behaviours. In this study, the discourse of "Media as a Disruptor" among healthcare professionals reflected how media narratives constructed and influenced attitudes toward self-harm in young people. The sub-discourses identified, such as "'Ease and Facilitation of Access', 'Multifaceted Nature of Media', 'Inaccuracy of Portrayals', 'Pathologising Behaviours', and 'Stereotypes and Stigmatisation', aligned with this perspective by demonstrating how media discourse can contribute to the normalisation and glamorisation of self-harm, influencing young people and their caregivers.

In addition, the second discourse, "The Hidden World of Youth" emphasises systemic challenges within clinical practice. Previous research such as Saunders et al. (2012) and Coimbra and Noakes (2021) found negative attitudes and stigma among healthcare professionals towards people who self-harm and highlighted the need to address these attitudes. Through the discourse of "The Hidden World of Youth", sub-discourses were developed: 'Asking About Media in Assessments, 'Risk Assessments' and 'Importance of Further Education'. These sub-discourses underlined the need for change within clinical settings to improve care for young people who self-harm which is in line with previous research.

Additionally, Suyemoto's (1998) ecological model, theorised that sociocultural factors influence self-harm, including the impact of cultural norms and media representation on individual behaviours. This study also corroborates this perspective, particularly in the sub-discourse of "Stereotypes and Stigmatisation". Healthcare professionals' concerns about negative media portrayals perpetuating stigma and hindering help-seeking behaviours among young people resonate with Suyemoto's (1998) model, highlighting the role of media in shaping societal attitudes towards self-harm in young people.

Additionally, Favazza (1996) and Crowe (1996) explored self-harm within the context of skin being a discursive site. It helps us understand how media influences intersect with the complex nature of self-harm behaviours among young people, as revealed in the study. For example, the sub-discourse of "Inaccuracy of Portrayals" resonates with the framework, illustrating to us how media representations often sensationalise or romanticise self-harm for young people, distorting the true emotional experiences underlying these behaviours. The study's findings suggest that such misrepresentation may contribute to the normalisation of self-harm and the perpetuation of harmful stereotypes.

Limitations of the study

Whilst the study provides important insights into healthcare professionals' perspectives on the influence of media on self-harm in young people, limitations should be considered. The study relied on self-report data obtained through semi-structured interviews with CAMHS clinicians. While efforts were made to make sure of the confidentiality and anonymity of clinicians, social desirability bias may have influenced their responses. Clinicians may have provided socially acceptable or expected responses due to feelings of inclination, leading to an underestimation or overestimation of attitudes or experiences related to the effect of media on young people who self-harm.

Another limitation was that the study focused only on the perspectives of clinicians, neglecting the voices and experiences of young people themselves and their parents or carers. Including their perspectives about the effect of media consumption on self-harm would provide a more comprehensive understanding of the phenomenon. Future research should seek to incorporate the perspectives of young people and their parents or carers who have been directly affected by self-harm and the influence of media consumption. This would help inform clinicians of interventions regarding the influence of media on self-harm in young people in the future.

Furthermore, despite the researcher trying to recruit clinicians from multiple parts of the UK, they only recruited one clinician from the South of England, the rest of the nine clinicians were recruited from the North of England. Cultural, social, and institutional factors may influence clinicians' views therefore a more diverse set of clinicians may have been better to help explore this.

Finally, the cross-sectional design of the study limits the ability to draw causal inferences about the relationship between media exposure and self-harm behaviours. Longitudinal studies tracking changes in media consumption patterns and self-harm behaviours over time would provide more robust evidence of any causal relationships.

Clinical Implications

This study's multiple clinical implications imply the need for a few different changes. By recognising and addressing the influence of media, care practices and support for young people who self-harm can be enhanced. Firstly, the findings emphasise the importance of incorporating discussions about media consumption into clinical assessments and interventions. Clinicians should proactively inquire about young people's media consumption, paying particular attention to the types of content they are exposed to and how it may influence their self-harm behaviours. Integration of these questions can help clinicians gain valuable insights into potential triggers and risk factors for self-harm, allowing for more targeted and holistic care plans.

Moreover, the study also highlights that clinicians feel that risk assessments interfere with understanding the young person better, by impacting rapport building and obstructing the therapeutic relationship, influencing care. They feel as if risk assessments should not be lengthy and should not feel like a checklist for both the clinician and the young person. A recommendation is that risk assessments enable clinicians to have more of a conversation with the young person to find

out more information about their risky behaviours which can also help improve the rapport building and therapeutic relationship.

Importantly, even though the NICE guidelines (2022) provide an extensive framework for working with individuals who self-harm, it includes limited guidance regarding the impact and role of media on self-harm. While acknowledging the significance of social media and internet use in children and young people who self-harm, the guidelines do not provide recommendations for interventions, safety planning, harm minimisation, and clinician training regarding media consumption.

Following this study's findings, it is recommended that guidance be updated to incorporate media-specific strategies for interventions and safety planning such as personalised media safety plans, safe spaces, and resources for young people experiencing difficulties with self-harm. In addition, harm minimisation strategies should include psychoeducation on media consumption risks and having healthcare providers collaborate with media platforms to produce safe and regulated platforms for young people. Media platforms should ensure that harmful and unhelpful material regarding self-harm is removed and that more resources supporting young people in distress are more readily accessible.

The guidance should also include recommendations regarding training for clinicians. Training programs should be routinely updated to include the impact of media on self-harm in young people. The training should cover trends in media consumption, social media challenges, the potential risks, and communication strategies for exploring media consumption and its impacts, with young people. It should also cover intervention strategies targeting the impact of media consumption on self-harm such as psychoeducation on critically assessing media content and guiding young people to make safer choices with media consumption.

This research and previous literature underscore the urgent need to update the NICE guidelines (2022) to reflect the impact of media on young people. Inquests into cases such as Molly Russell's have revealed the extent of the effects of media exposure and consumption of self-harm-related content, which no one in her surroundings seemed to be aware of. This was also the first case where media was considered a significant contributing factor (BBC, 2022). Including questions about media consumption in assessments by clinicians is necessary and may help engagement with young people and their 'Hidden Worlds' more, improving care and practice.

Additionally, the findings imply the importance of collaborative working between clinicians, the media, educators, and policymakers to develop and implement strategies for promoting responsible media representations. Advocation is needed for media literacy programs in schools, developing guidelines for media platforms to be more responsible with content, especially in relation to self-harm, and more regulation of online platforms to ensure young people's safety and wellbeing.

Furthermore, clinicians play an important role in challenging stigma and misconceptions surrounding self-harm perpetuated by media platforms. By engaging in curious, open, non-judgemental conversations with young people and parents or carers about media influences, clinicians can help by providing accurate information and empowering young people and their parents or carers to critically evaluate messages about self-harm in the media.

Finally, the present study highlights the need for ongoing education and training initiatives for clinicians to stay informed of the ever-changing media landscape and its impact on young people, their mental health, and more specifically self-harm. Training should aim to equip clinicians with up-to-date knowledge of the current media landscapes, skills to critically evaluate media content, and how to provide evidence-based guidance to young people and their families on safe media consumption practices.

Conclusion

In conclusion, this study explored healthcare professionals' views on the effect of media on self-harm in young people. The study found two main discourses “Media as a Disruptor” and “The Hidden World of Youths”. Clinicians viewed media as an entity with a multifaceted nature, however, the influence of media was found to be mostly negative on young people who self-harm. They also talked about the negative impact of inaccurate media portrayals, stereotypes, and stigma surrounding self-harm and the influence this has on young people. Clinical implications include the importance of asking about media in assessments with young people and the need for training and education around the impact of media on self-harm in young people for clinicians, as well as changes to policies, guidelines, and procedures, to improve young people’s care overall.

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Part Three: Appendices

Appendix A: Reflective statement

Reflection is a process that I have gone through a lot throughout my three years on the Clinical Psychology Doctorate. I have done so much reflection, that at times I have felt 'reflected out'. However, I know how important this technique/strategy is and how helpful it is for my journey into clinical psychology. I also understand how privileged I am to be able to have all these opportunities to reflect and I am grateful for this. I will definitely be using reflections in my practice going forward as well as trying to give time for reflective practice for other healthcare professions. This statement will hopefully offer an insight into my three-year research journey.

Journey Into Research

I am a British South Asian woman who is also a first-generation immigrant from Sri Lanka. I moved to the UK when I was two years old and have lived here ever since. During my time on the doctorate, I often felt like I was an imposter and that my good luck would finally run out with myself being kicked off the course (Wang & Li., 2023). To keep myself going I have constantly had to reflect on a few things. I have had to remind myself of where my roots are and how far I have come. I have also had to remind myself of the sacrifices my parents made to help me get to the place I am currently at, which I am eternally grateful for. This journey has been scary for me as during school I was told that I was not good enough for university by two of my teachers, so my confidence in my academic ability has not been great. However, this journey has helped me get my confidence back and disprove my thoughts. It has given me hope and a feeling of pride about how far I have come.

Empirical Paper

I remember trying to choose my supervisor and topic in my fourth year. It was so nerve-wracking; there were so many choices and so many decisions to make, which I am not the best at. I remember how overwhelming it was writing my first research proposal and the pang of disappointment when I was not able to get my first choice.

I recall thinking to myself whether it was my fault I did not get my first choice and a feeling of not being good enough started to linger. I then got notice of who my supervisor would be, and it was Paul. I was nervous at first meeting him and telling him about my many big ideas. Paul was able to reassure me, and he was very helpful in bringing me back down to earth when I needed it.

I started with wanting to do research into mental health stigma in the South Asian Community. This was a topic that hit close to home due to my cultural background as well as my own experiences of having mental health difficulties. However, upon further thought and many discussions, it was decided that this would not be feasible as a sole researcher due to the vast work that would be needed to do this topic justice.

I then brought up my second topic which was about how young people viewed media and its effects on self-harm. This was an important topic to me as growing up I definitely felt the effects of media on my mental health, and it was something that I had always been interested in due to my own experiences. I recall talking this through with Paul and getting excited that this would be my topic. Unfortunately, looking at young people's experiences would not be feasible. Upon many reflections between me and Paul, we thought that it would not be ethical for me to interview young people about their experiences as it was a sensitive topic and could potentially trigger young people. It was also hard to pinpoint whether I would interview young people who were currently in services or young people who had already been in services. We discussed the ethical implications of this and

the negative impact this could have had on young people and found the negatives outweighed the positives, so we decided not to aim for young people as participants.

So, what could I do? I was very passionate about the effect of media on self-harm in young people and really wanted to do it justice. Who would be the next best participant group that would be able to reflect on this? We decided that it would be CAMHS clinicians. CAMHS clinicians work daily with young people who self-harm, and it is especially salient with self-harm rates rising in the UK (Diggins et al., 2024). They would definitely be able to reflect on experiences to answer the research question, with their valuable knowledge. It was settled, that my empirical paper would be on Healthcare Professionals' Views on the Effect of Media on Self-Harm.

We then moved on to the design of the study, where I had to think about what would do healthcare professionals views justice. I decided on semi-structured interviews to enable the clinicians to have a space to tell me about their experiences and perceptions on the topic (DeJonckheere & Vaughn, 2019). Paul then set me the task of figuring out which method I was going to use for analysis. This was such a long process. I had no clue about what I was doing and the vast number of methods available made it feel so overwhelming. I remember looking through all the different methods and Critical Discourse Analysis was one that stuck in my mind. The importance it puts on power and societal influences made me think about the power of media and its influences (Fairclough., 2013). I thought this would be amazing for my research. I then made my choice; I would be using Critical Discourse Analysis.

Then before my fourth research proposal was due, my whole world fell apart. In October 2022, my family friend Dinal, who was like a brother to me and who was someone I had grown up with, died by suicide at age 16. I remember getting a call from my younger brother, Dinel, who I could not understand as he was unintelligible. Through his tears, he told me that Dinal had died. I was in so

much shock and pain. Dinal, his family, my family, and a few other family friends had just come back from a lovely holiday away on the Tuesday night. Dinal died by suicide in the early hours of Thursday morning of the very same week. I was frozen. Dinal was someone I had known since the day he was born, and I couldn't believe or understand that he was gone. I had just seen him in August, and I remember having a laugh and a good time with him. Guilt racked over me, and I started thinking 'Should I have seen this coming? /I should've known, 'Should I have done something/ I should have done something?'. Here I was working in the NHS as a Trainee Psychologist, helping other people with their mental health difficulties but I couldn't help my own. I felt like a fraud. I was heartbroken and kept searching for answers which in hindsight I shouldn't have as I know don't always come.

Everyone also kept looking at me for answers and I couldn't give them any. Why would Dinal do this? He was so talented and had his whole future ahead of him. He was such a lovely, kind, and sweet soul, why would he do this? This shook our whole community, especially the Sri Lankan community. There was still a stigma around mental health in our community, no one liked to talk about it. The silence was deafening. People could not understand why he would do this, in their eyes he had the perfect life, and he couldn't possibly have any problems. What mental health difficulties they said, he's 16. No one understood and this frustrated me. I knew I needed to start opening people's eyes. Through many, many conversations, even with my parents, I have noticed a shift in my family's thoughts surrounding mental health difficulties. We later found out that Dinal took his life as he was being blackmailed over Snapchat for money. The anger I felt was enormous. What kind of evil person would do this to a child? The anger I felt then and the anger I feel now have helped keep my passion for my research and it has shown even further how important this topic is and how something really needs to be done to safeguard our children and young people.

Using my feedback from my research proposals I finalised the study with Paul. During the summer of 2023, I then got the news that Paul was leaving his post at the university, and I would have a new research supervisor. It was all feeling so uncertain. But I kept in mind what Paul had continuously told me ‘Back yourself, Tharushi’. Using this I continued my work and used what was left of Paul’s time to get his feedback on my research.

I was then told that Annette would be my supervisor going forward. From the get-go, she made sure I was on track and the transition went well. Annette knew what I needed, which included a firm approach, otherwise I would procrastinate and not make progress. Annette’s words of wisdom and valuable knowledge have got me through. Through many emails and meetings, we started the next steps in my research journey.

Next came Ethics. I had heard horror stories about the ethics process, especially NHS ethics, and the amount of time and effort it took to get approval. It was true, it did take a lot of time and effort, but it was not as bad as I thought it was. Yes, there was a lot of going back and forth with corrections, however, once they were done approval was quick.

I then moved on to my recruitment. I had definitely underestimated the time and work it would take for this. I would definitely recommend getting in touch with NHS research departments before you send off your IRAS application, as the process of finding a collaborator in the trust and looking at feasibility takes time. I sent many emails to many trusts in the hope of someone saying yes. Some trusts I still have not got a reply from! I managed to recruit from trusts mainly in the North of England and one in the South of England.

Once the email about my study went out, I got so many emails from eager clinicians wanting to take it back. I was so grateful for the response I received as I was not expecting that many clinicians to

get back to me so quickly. This was reassuring for me and showed me that clinicians were eager to share their views and experiences on the topic. I recruited 10 clinicians from CAMHS services in England.

Before I started the interviews, I felt nervous as I was going to be asking experienced clinicians questions. Who was I to ask questions? I was just a trainee! However, all the clinicians were lovely and very much wanted to talk about their experiences and views, which gave me so many valuable insights. I knew then that I was doing something important, especially with all the clinicians saying how media is very much a prevalent factor they see that affects young people who self-harm.

Afterwards, it was time to transcribe and analyse all the data. Ten, one hour- one hour and a half interviews. I was dreading it. It took me such a long time to transcribe and I thought at some points I would never finish. But I did finish. I definitely overlooked the importance of transcribing as it gave me a very good insight into my data. I then moved on to my analysis process using CDA. This was one of the hardest parts of my journey. I definitely did not take into account how much extra work CDA would take, especially the analysis of the language. Taking themes into supervision was helpful, as the feedback I received enabled me to see things in a different type. During this process, Jo Bell also joined my research supervision. Her insights have been so valuable, especially as she is a researcher in this field. Her thoughts and advice have helped shape my research.

Systematic Literature Review

I started thinking about my SLR with Paul just before he left. I knew the topic had to be connected to my empirical paper, so I looked into the rising rates of self-harm and how important it was to look at this (McManus et al., 2019). I started with self-harm in South Asian communities, and during my research into this topic, I found that there was not enough data to do this topic justice.

Therefore, I decided to expand my remit a bit further. I remember forgetting about this part of my research for a while. I was then prompted by Annette to start refining my SLR topic and start the process. I reflected on my experiences of difficulties with my mental health and used this to think about what an important piece of research would be.

I started to think about the interactions I had had with mental health professionals and how this had shaped my views and perceptions (Coimbra & Noakes., 2021). I then looked into healthcare professionals' views of self-harm, which is a subject I had already started researching for my empirical paper. Through my further research, I found that a lot of the literature involved doctors, nurses, and their perceptions of self-harm. No current reviews were looking at doctors' and nurses' perceptions of self-harm in the UK. As the research also showed us that clinicians' views impact on care, I thought it would be best to bring together research regarding doctors' and nurses' views on self-harm in the UK (Mitten et al., 2016). Further rationale for this was also doctors' and nurses' tending to be the first port of call for individuals who self-harm, and that their views would impact the individual's care and in turn their help-seeking behaviours (Anderson et al., 2003)

The End is in Sight

As I write this I am nearly at the end of my journey on the doctorate. And wow, what a journey it has been. I have learnt so much and experienced so much that I am grateful for. My research has given me so many valuable insights from clinicians that I will definitely be taking forward and integrating into my practice. Here's to breaking barriers and making sure people from minority groups get their chances, whether it be becoming a Clinical Psychologist or being able to access mental health services for help. And to younger Tharushi, you have made it!

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Appendix B: Epistemological statement

Willig (2019) looks at epistemology as the "nature of knowledge" and defines it as the beliefs and processes surrounding knowledge and how knowledge is gained. On the other hand, Ontology is defined as the "theory of being" and is an interpretation of the connotations around existence (Willig., 2019). The researcher needs to know and be aware of their epistemological and ontological positions. It can help aid the researcher to reflect upon their work and understand the impacts of their own lenses they bring to their research (Bracken, 2010). This epistemological statement will present the researcher's epistemological position regarding their portfolio thesis.

The researcher's ontological position is relativism, and their epistemological stance is social constructionist which informed and guided their research. Relativism takes the position that there are no right standards of reality and that it differs between different cultures and different time periods Baghramian (2001). Moreover, the social constructionist epistemology takes the stance that an individual's reality is created through that individual's experiences with themselves and their relationships and interactions with others (Burr, 2015). This stance aligns with the researcher's own views and also brings a valuable lens to look at professional's views on the effect of media on self-harm. The researcher also acknowledges that they will bring their own perspectives into this research which may affect the analysis of data.

As this study was the first to look at healthcare professional's views on the effect of media on self-harm in young people, with an emphasis on their perceptions and experiences, it was deemed necessary by the researcher to use a qualitative approach for the study. It would also enable the researcher to hear about the clinician's individual experiences in depth. In this case, the qualitative method chosen by the researcher for the analysis of the data was Critical Discourse Analysis (CDA). The study aimed to explain the various discourses surrounding the link between media

exposure and self-harm (Potter, 1996). CDA therefore enabled the researcher to investigate how notions of self-harm are constructed in the media and their effect on individuals.

Moreover, another reason why CDA was chosen to analyse the semi-structured clinician interviews was due to the approach focusing on power. The CDA approach likes to analyse the way power emerges in the use of language (Jiang, 2023). As the researcher was looking at the influence of media on self-harm in young people, where media is positioned as the entity with the power, it was important to explore this power in the research. Hence, CDA was chosen. In addition, CDA aligns effectively with the social constructionist approach of the study, as it was important to examine the data through the perspective that an individual's reality is shaped through discourse with both internal reflections and external interactions. (Burr & Dick., 2017). Also, social constructionism theorises that people construct meaning in relation to their lives and the environments and systems around them, therefore using CDA allowed the researcher to examine these constructions of meaning surrounding the effect of media on self-harm (White., 2004).

It is also important to know that at the time of the research, the researcher was a Trainee Clinical Psychologist working within the National Health Service (NHS), who also had experience working with young people who self-harmed and with CAMHS clinicians who worked with young people who self-harmed. Due to these experiences, the researcher felt like interviews would help give the clinicians a space to reflect and think about their perceptions of the effect of media on self-harm. The researcher was very aware of the busy schedules of the clinicians, so they were flexible on the dates and times of interviews. Furthermore, due to these busy schedules, the researcher offered all clinicians the opportunity for an online interview, knowing from their own experiences that it may make things easier for the clinicians. This was further echoed by all ten clinicians interviewed choosing online interviews.

Finally, the researcher also completed a systematic review of doctors' and nurses' views on the effect of media on self-harm in the UK, through a narrative synthesis. Nine of the studies that were included in the review used qualitative methodology, whilst one used mixed methods but only the qualitative data was included from this study. The social constructionist epistemology, therefore, aligns with the choice of narrative synthesis and the research question, as the epistemological position looks at an individual's reality being created through that individual's experiences with themselves and their relationships and interactions with others (Burr, 2015). Doctor's and nurses' views would be influenced by their personal experiences with people who self-harm, echoing a social constructionist stance.

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Appendix C: Notes or Guideline for authors for the systematic literature review and empirical paper

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that order) and *, **, *** should be reserved for P-values. Statistical measures such as SD or SEM should be identified in the headings.

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Although authors are encouraged to send the highest-quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted.

Click here for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Legends should be concise but comprehensive – the figure and its legend must be understandable without reference to the text. Include definitions of any symbols used and define/explain all abbreviations and units of measurement.

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- **Effect size:** In normal circumstances, effect size should be incorporated.
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All papers need to be supported by a data archiving statement and the data set must be cited in the Methods section. The paper must include a link to the repository in order that the statement can be published.

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9. EDITORIAL OFFICE CONTACT DETAILS

For help with submissions, please contact: Hannah Wakley, Associate Managing Editor (bjop@wiley.com) or phone +44 (0) 116 252 9504.

Appendix D: Mixed Methods Appraisal Tool (Hong et al., 2018)

Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Appendix E: University Ethical Approval

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

PRIVATE AND CONFIDENTIAL
Tharushi Denipitiya
Faculty of Health Sciences
University of Hull
Via email

Friday 16th June 2023

Dear Tharushi,

FHS 22-23.68 – Healthcare professionals views on the effect of media on self-harm.

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

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

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

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Maureen Twiddy

Dr Maureen Twiddy
Chair, FHS Research Ethics Committee

UNIVERSITY OF HULL

Maureen Twiddy | Senior Lecturer in Applied Health Research Methods | Faculty of Health Sciences
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Appendix F: Health Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Tharushi Denipitiya
Trainee Clinical Psychologist
Humber NHS Teaching Trust
University of Hull
Aire Building, Room 129
Hull
HU6 7RXN/A

Email: approvals@hra.nhs.uk

18 August 2023

Dear Miss Denipitiya,

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

Study title:	**Healthcare professionals views on the effect of media on self-harm.**
IRAS project ID:	**327196**
Protocol number:	**N/A**
REC reference:	**23/HRA/3304**
Sponsor	**University of Hull**

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix G: Information sheet

Version Number 3 16/08/23

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INFORMATION SHEET FOR PARTICIPANTS

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Healthcare professionals' views on the effect of media on self-harm.

I would like to invite you to participate in a research project which forms part of my Clinical Psychology Doctorate research. The sponsor for this research is The University of Hull. 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. Please ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

There currently is a lot of research around the effect of media on self-harm which has emerged in recent years. The majority of this research focuses on an individual's experience of this. However, as we now know through research a healthcare professional's views on a certain difficulty can impact the interactions between the professional and the patient as well as the care given. As a result, a gap in the literature is the professional's views on the effect of media on self-harm. Therefore, in order to inform interventions and professional practice, research into this area is needed.

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 community clinical team who has experience of working with children and young people who use self-harm. The information sheet is being shared with the 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 choose to take part in the study, you will be asked to 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. If it is more convenient to meet online, then I am happy to set up Microsoft Teams video meeting at an agreed time and date. I will ask you to answer some short questions about you, for example your gender, age and your professional training. Then I will ask you to take part in a semi- structured interview where I will ask you questions about your views on the effect of media on self-harm, in the context of children and young people you have worked with. **Within the interview, please remember to not disclose any identifiable information of the children and young people you work with or people in their lives.** I will audio record the discussion. There are no right or wrong answers as I am only interested in your views and experiences. After the completion of the interview, I will personally transcribe the interview. After I have finished transcription, I will delete the audio recording completely. I am aiming to do this by May 2024.

Appendix G: Information Sheet Continued

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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, we 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?

Participation in the study will require approximately 60 minutes of your time and although the researcher will try 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 self-harm and the effect of media on them because it may bring to mind any difficult memories and situations that they have experienced. Recalling the effects of media on self-harm may also bring up distressing images or memories. If this happens to you the researcher will offer support and help you gain access to further help from your supervisor, occupational health team or your GP, if required.

What are the possible benefits of taking part?

The researcher cannot promise that you will have any direct benefits from taking part in the study. However, the researcher hopes that the study will offer the staff the space and opportunity to talk about their experiences of working with children and young people who self-harm and the effect of media on them. The findings from the study may also help with looking at interventions to target any effects of media on self-harm.

How will we use information about you?

We will need to use information from you and your working experiences 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.

Your data will be processed in accordance with the UK-GDPR and the Data Protection Act 2018. 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 online storage repository at the University of Hull for a period of 10 years. The only time that information cannot be kept confidential is if you disclose something that suggests you or someone else

Appendix G: Information Sheet Continued

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.

What are your choices about how your information is used?

You are free withdraw at any point of the study, without having to give a reason but we will keep information about you that we already have.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- By asking one of the research team
- By contacting the University of Hull Data Protection Officer by emailing dataprotection@hull.ac.uk or by calling 01482 466594 or by writing to the Data Protection Officer at University of Hull, Cottingham Road, Hull, HU6 7RX
- By reviewing the University of Hull Research Participant privacy notice: https://www.hull.ac.uk/choose-hull/university-and-region/key-documents/docs/quality/research-participant-privacy-notice.pdf

Data Protection Statement

The data controller for this project will be the University of Hull. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under GDPR is a 'task in the public interest'

If you are not happy with the sponsor's response or believe the sponsor processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

Appendix H: Consent forms

Version number and date: V1.4 18/08/23

[IRAS ID: 327196]

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CONSENT FORM

Title of study: Healthcare professionals views on the effect of media on self-harm

Name of Researcher: Tharushi Deniplitiya

Please initial box

1. I confirm that I have read the information sheet dated 16/08/23 version 3 for the above study. I have had the opportunity to consider the information, ask questions and have had any questions 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 quotes may be used in research reports and conference presentations. ☐

4. I understand that the research data, which will be anonymised (not linked to me), will be retained by the researchers and may be shared with others and publicly disseminated to support other research in the future. ☐

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

6. I understand that my personal data will be kept securely in accordance with data protection guidelines and will only be available to the immediate research team. ☐

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

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

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

When completed: 1 for participant; 1 for researcher site file.

Appendix I: Semi-Structured Interview Schedule

Date: 16/08/23
Version number: 1.2

Draft Interview Schedule

The researcher will provide an explanation of the research aims and the purpose of the interview prior to the interview. This information will reiterate the information in the information sheets provided.

Participants will be offered another copy of this information sheet before the interview and will have the opportunity to ask further questions.

Interview questions

The following questions will be used to guide the interview. The interviewer will then adapt the questions to suit the participants' responses. Prompts and follow up questions may be used if participants do not understand the question or to gather further information. The researcher will ask general prompts such as "can you tell me a bit more about that" as well as some of the more specific prompts detailed below.

If participants struggle to answer a question, or are unsure what to refer to, a practical example may be given to give the question some context (e.g. could you tell me about a time when a child or young person has really struggled with self harm while in your care?)

1) Could you describe your current role in the service?

Prompts:

What years of children or young people do you work with?

How long have you been a CAMHS practitioner for?

Are you a support worker, occupational therapist, mental health and wellbeing practitioner etc?

2) Had you heard of the term "self harm" before agreeing to take part in

this study?

Prompts:

If so, what is your understanding of it?

If not, would it be helpful to have a brief description?

Appendix I: Semi-Structured Interview Schedule Continued

Date: 16/08/23
Version number: 1.2

3) How does this relate to your line of work?

Prompts

Could you tell me a bit more about that?

4) Could you tell me about your experience of working with children who self-harm?

Prompts

Do you think you work with these children differently?

Do you think your colleagues would work differently to you?

Do you think your colleagues would agree/disagree with you?

5) What are your thoughts on media (news, TV, film, internet) and how they affect children and adolescents?

6) How do you hear media spoken about in your workplace setting?

7) What do you think the beliefs/attitudes that surround children who have self-harmed in media are?

Prompts

How do you think CAMHS practitioners think about the effect of media on self-harm?

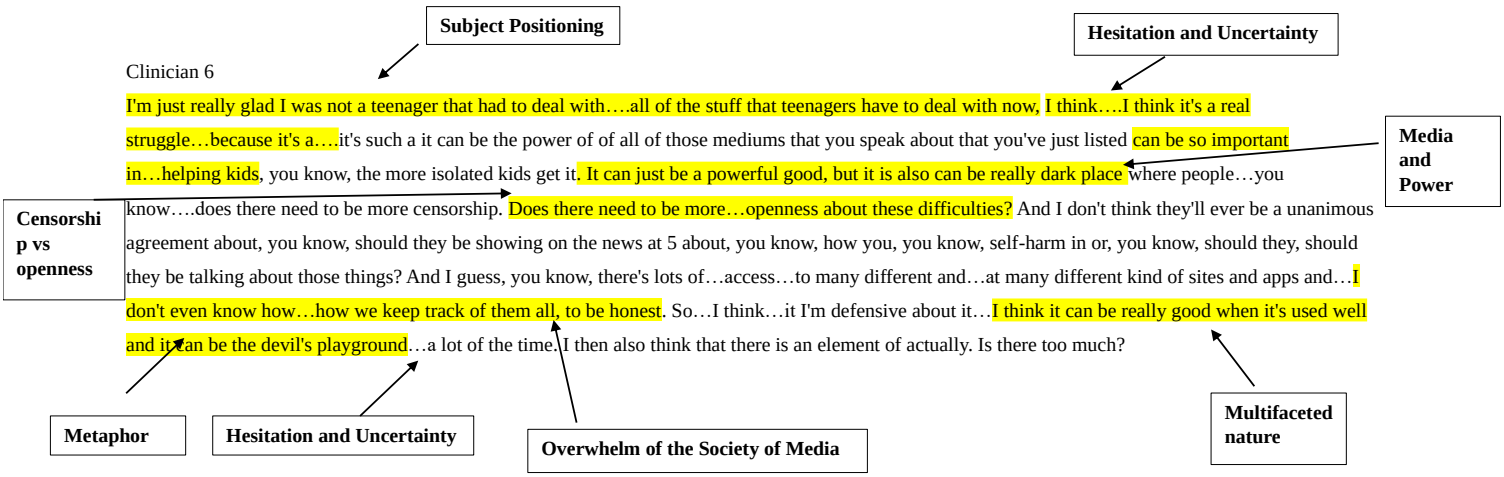
Do you think practitioners know about the effect of media on self-harm?

8) How much do you think media can affect an individual who self-harms? Do you have any experience in this?

9) How much do you think your own perspectives in media influence the way you care for clients who have been affected by it?

10) Is there anything you've thought of whilst we've been talking related to the children you work with and the effect of media on self-harm, that you haven't had the opportunity to say?

Appendix J: Qualitative analysis extract



Subject Positioning – clinician positions themselves outside the current teenage experience, emphasising relief that they didn't face the same issues.

Hesitation and Uncertainty – frequent pauses and self-corrections imply the clinician's uncertainty of the topic due to its complexity. The use of filler words and repeated phrases suggests ambivalence towards the effect of media.

Censorship vs Openness: Questions indicate a tension between protecting young people and being transparent. Reflects societal debates – how much information about self-harm should be publicly available?

Overwhelm of the Society of Media– Clinician expresses a sense of being overwhelmed by the everchanging nature of media platforms and the difficulty keeping on top of them. Broader concerns are highlighted about the rapid evolution of media and how it outruns the ability of caregivers and professionals to manage the impact.

Defensiveness– Clinician is defensive and indicates a personal investment in the topic. Implies how invested CAMHS clinicians are in the care they give young people.

Multifaceted Nature- Media being referenced as the "devil's playground" is a **metaphor** to indicate the dangerous nature of media and how media can play games with young people and their

mental health difficulties. This metaphor is juxtaposed with the potential benefits of media and implies the clinician's internal conflict around the effect of media.