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Doctoral Thesis:

Looked After Children's experiences of self-harm: A qualitative analysis

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	Main Text	Appendices (including tables, figures and references)	Total
Thesis abstract	252	-	252
Literature Review	7,968	5,266	13,232
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Critical Appraisal	3,934	811	4,725
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Thesis Abstract

Adolescent self-harm is a growing international concern. As the parent-child relationship and parental support can influence adolescent self-harm this review aimed to synthesise existing qualitative research on parents' experiences of young people who self-harm. A systematic search of electronic databases was conducted, identifying 15 qualitative papers for the metasynthesis. Five concepts emerged: the turmoil of discovery and beyond; searching for certainty; the ultimate blame; vigilant parenting: treading carefully; and the ripple effect. Findings demonstrated the impact of adolescent self-harm on parental wellbeing, the challenges of understanding self-harm and how this behaviour influenced their ability to support their child. This understanding provides a framework for clinical services to offer support to parents of young people who self-harm.

The second section of the thesis is the empirical paper. The aim of this research was to understand the experiences of young people who engage in self-harm whilst living in residential care. Five young people participated in semi structured interviews. Using Interpretive Phenomenological Analysis, four themes were identified: 'The black hole of self-harm', 'Seeking genuine care through a protective mask', 'The cry to be understood' and 'Loss of control to the system'. Young people who self-harm in residential care are exposed to new experiences, boundaries and support networks, all of which can influence their self-harming behaviours. Clinical implications and future research recommendations are also discussed.

Finally, the critical appraisal captures the journey throughout this research, including why the topics were chosen, the challenges with recruitment and reflections on the research process as a whole.

Declaration

This thesis records work undertaken for the Doctorate in Clinical Psychology at Lancaster University from August 2016 to June 2017.

The work presented here is the author's own, except where otherwise stated. The work has not been submitted for the award of a higher degree elsewhere.

Name: Charlene Rouski

Signed:

Date:

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Firstly, I would like to thank all my participants for agreeing to take part in this research and sharing their stories.

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Section One: Thesis Literature Review

Understanding the experiences of parents of young people who self-harm: A meta-synthesis

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Abstract

Background: Adolescent self-harm is a growing international concern. The parent-child relationship and parental support can influence adolescent self-harm. In addition, adolescent self-harm can have a significant impact on parental wellbeing and influence their ability to support their child. Therefore, this review aimed to synthesise existing qualitative research on parents' experiences of young people who self-harm.

Method: A systematic search of electronic databases including PsycINFO, CINAHL, MEDLINE, PsycARTICLES and Academic Search Complete was conducted. Fifteen qualitative papers were identified for the metasynthesis. Data were synthesised and concepts were developed using the meta-ethnographic 7 step method outlined by Noblit and Hare (1988).

Results: From the 15 papers included in the review, five concepts emerged: the turmoil of discovery and beyond; searching for certainty; the ultimate blame; vigilant parenting: treading carefully; and the ripple effect.

Conclusions: Findings encompass the challenges for parents and conceptualise their experiences when supporting young people who self-harm. This understanding provides a framework for clinical services to support parents of young people who self-harm. Clinical implications are discussed.

Keywords: Systematic review; self-harm; young people; parents; experience

Self-harm has been recognised as an international healthcare concern (Hawton, Rodham, Evans, & Harris, 2009; Hawton, Saunders, & O'Connor, 2012). The National Institute for Health and Care Excellence [NICE] (2013) defines self-harm as, “self-poisoning or self-injury carried out by a person, irrespective of their motivation” (p. 6). However, within the literature there are debates and variation around terminology used to describe self-harm. Within the United Kingdom (UK), the term ‘self-harm’ is favoured (Caine, 2012), however other countries, such as North America (Kapur, Cooper, O'Connor, & Hawton, 2013), use the term Non-Suicidal Self-Injury (NSSI) to distinguish between self-harm and behaviour with suicidal intent (Andover & Gibb, 2010).

Research has suggested that there may be a distinction between self-harm and suicidal behaviour (Andover & Gibb, 2010), although this topic is complex. Some research has suggested that a distinguishing feature of suicidal behaviour is whether there is suicidal ideation and intent to end one's life (Andover & Gibb, 2010; Brausch & Gutierrez, 2010; Nock & Kessler, 2006). However, when adolescents who self-harm are compared with adolescents who engage in suicide attempts, those who self-harm had a stronger implicit identification with death and suicide compared to the adolescents with a history of suicide attempts (Dickstein et al., 2015). Some maintain that self-harm and suicidal behaviour should not be categorised separately based on intent to die (Orlando et al., 2015) as many individuals report engaging in both self-harm and suicidal behaviour (Andover & Gibb, 2010; Kapur, Cooper, O'Connor, & Hawton, 2013; Nock et al., 2006).

Given these challenges, self-harm is defined broadly within this review as referring to any form of self-harm regardless of the motivation behind it. Throughout

this review all forms of self-harm, including behaviour labelled in the original articles as NSSI, will be referred to as self-harm.

There are worldwide concerns regarding young people (YP) who self-harm (Doyle, Treacy, & Sheridan, 2015; Hawton et al., 2012; Kidger et al., 2012; Muehlenkamp et al., 2012; O'Connor, Rasmussen, & Hawton, 2014). Although self-harm is common in adolescents (Hawton et al., 2012; Muehlenkamp et al., 2012; Rowe et al., 2014), there are challenges collating accurate prevalence rates, as many adolescents do not seek medical care so self-harm may remain unknown (Doyle et al., 2015; Hall & Place, 2010; Hawton et al., 2012; Kidger et al., 2012; Madge et al., 2008; McMahon et al., 2014). It is estimated that within the UK, one in ten adolescents will self-harm (Hawton & James, 2005; Mental Health Foundation, 2006) and over half of adolescents who self-harm go on to repeat the behaviour (Madge et al., 2008).

The most common self-harming behaviours in YP include cutting of the skin, self-inflicted burns (Klonsky & Muehlenkamp, 2007), self-strangulation or self-poisoning (Skegg, 2005). It has been suggested that self-harm is adopted in an attempt to relieve psychological distress (Klonsky, 2007; Madge et al., 2008), regulate intense emotions (Klonsky, 2007, 2009), to reduce distress associated with difficult relationship dynamics (Fox, 2004) or to distract from difficult thoughts (Teague-Palmieri & Gutierrez, 2016). Self-harm can also be utilised as a form of self-punishment (Klonsky, 2009), a method of communication (Laye-Gindhu & Schonert-Reichl, 2005; Scoliers et al., 2009; Young et al., 2014) or to determine if one is loved by others (Baetens et al., 2011; Scoliers et al., 2009). However, the motivation behind self-harm can fluctuate and differ from one episode to the next (Kapur et al., 2013).

Approximately half of adolescents who self-harm do not seek help from others as they fear being judged or have concerns relating to confidentiality (Rowe et al., 2014). When YP do seek support, this is usually from informal networks including family members or friends. Thus, it is often parents who are faced with providing support to YP when they become aware that their child is self-harming.

Supporting YP who self-harm can have a significant impact on parents and the family system (Baetens et al., 2014; Kissil, 2011; Morgan et al., 2013; Power et al., 2009; Trepal, Wester, & MacDonald, 2006). The family system can be seen as an emotional unit where individuals within that family cannot be understood in isolation (Kerr & Bowen, 1988). Therefore, if a young person within a family is displaying behaviours that may be concerning, such a self-harm, this is likely to influence other members of the family system (O’Gorman, 2012). This is evident for parents of young people who self-harm, as parents have highlighted the detrimental impact that self-harm can have on their relationship with their child (Byrne et al., 2008) and questioned their competence as a parental figure (Raphael, Clarke, & Kumar, 2006). Parents also have raised concerns of how self-harm within a family system may influence siblings (Ferrey et al., 2016a) and family dynamics (Kelada et al., 2016).

The initial exposure to self-harm can also be emotionally overwhelming for parents (Byrne et al., 2008; Hughes et al., 2017a; Rose, Cohen, & Kinney, 2011) and parents can experience distress (Arbuthnott & Lewis, 2015; Morgan et al., 2013). Parents may experience anger, fear and confusion which may impact how they respond to their child (Trepal et al., 2006). Parents have been found to feel frustrated as their child has not “lived up to” their expectations or unhappy as they do not know

how to support their child (Yip, Ngan, & Lam, 2002). Emotions can also be heightened if parents cannot conceptualise why this behaviour has occurred (Trepal et al., 2006).

Unsurprisingly, the emotional impact for parents when YP self-harm can influence their ability to provide the necessary support (Byrne et al., 2008; McDonald, O'Brien, & Jackson, 2007; Oldershaw et al., 2008). This is problematic because a lack of emotional support from parents is itself associated with self-harm in YP and may increase the risk of maintaining self-harm (Baetens et al., 2015). One of the support mechanisms needed for YP who self-harm is emotional support, which is an important predictor for stopping self-harm (Tatnell et al., 2014).

Research specifically exploring adolescent perspectives on how to support YP who self-harm revealed that there is a need for parents to adopt a non-judgmental approach when communicating with their child (Berger, Hasking, & Martin, 2013). Therefore, parent and child communication is a significant factor to consider. Research has highlighted that YP, particularly females, are less likely to engage in self-harm if they find it easier to communicate with their parents about their difficulties (Latina, Giannotta, & Rabaglietti, 2015). However, if YP perceive that they cannot confide in their parents and perceive communication between parent and child to be poor, then they are more likely to engage in self-harm (Portzky, De Wilde, & van Heeringen, 2008; Tulloch, Blizzard, & Pinkus, 1997). In addition, there are associations between young people who live in invalidating environments, where they feel criticised, not listened to or not understood by parents and the occurrence of self-harm (Tan, Rehfuss, Suarez, & Parks-Savage, 2014; You & Leung, 2012).

There are also links between parenting styles and self-harm. Recently, Buresova, Bartosova, and Cernak (2015) conducted a large-scale quantitative survey, in Czech Republic, comparing YP who engage and do not engage in self-harm. It was found that YP who self-harmed perceived their parents to be inconsistent and provided limited guidance. Both of these factors were associated with more frequent self-harm.

Given the key role played by parents in supporting YP who self-harm there is a vital need to understand their experiences of this. This understanding could enhance clinical services' ability to provide essential support to young people and families, which can support a reduction in self-harm.

Arbuthnott and Lewis' (2015) descriptive review of research into the role of parents with YP who self-harm integrated both quantitative and qualitative research. They adopted the construct of deliberate self-harm but excluded papers concerning self-poisoning or suicidality. They considered parents of YP who self-harm within four specific categories, which included considering the risk factors, help seeking behaviours, interventions involving parents and the parental experience of self-harm. They found that family factors and specific parent factors (socio-economic status and parental mental health) were important. The impact of self-harm on the family was also considered and the value of parental involvement in YP's professional support was highlighted.

It is important to consider and capture the parental experience of supporting YP who self-harm to understand how clinical services can empower parents to support YP and reduce the risks associated with this behaviour. To the author's knowledge, no systematic literature review that synthesises qualitative research into

the experience of parents of YP who self-harm has been published. Therefore, the current meta-synthesis aims to build upon the review by Arbuthnott and Lewis (2015) and provide an in-depth interpretive synthesis of the experiences of parents of YP who self-harm. This review specifically focuses on the parental experiences from qualitative research alone and provides a synthesis of these findings rather than reporting them discursively. It also adopts an inclusive definition of self-harm and utilises a quality appraisal check of the literature within the review, unlike the review of Arbuthnott and Lewis. Finally, Arbuthnott and Lewis excluded papers that referred to the experiences of parents of young people older than 19 years old, whereas this review does not have an upper age limit, as the aim was to capture the experiences of parents of supporting young people, regardless of the young person's age.

Method

Search strategy

A systematic search of PsycINFO, CINAHL, MEDLINE, PsycARTICLES and Academic Search Complete was conducted in December 2016. An exhaustive search strategy of titles and abstracts, combining free text search and thesaurus terms, was conducted. Within this review, self-harm has been defined in accordance with NICE Guidelines (NICE, 2013), which includes any form of injury to self, regardless of the intent perceived to be underlying this behaviour. The aim was to focus on parental experiences of their child's self-harm, rather than considering the perceived lethality of the behaviour. Consequently, studies that included terms such as "suicide" were included in the review where this referred to attempted rather than completed suicide. Therefore, a variety of inclusive terms were used to define self-harm which

included: ("Self N3 Injur*") OR "self-mutilat*" OR "Suicid*" OR "Self-harm*" OR "Non suicidal self-injur*" OR "Deliberate self-harm*" OR "self-cut*" OR "self-poison*". Comprehensive details of the search strategy are described in Appendix 1-A.

Selection criteria

The following inclusion criteria were applied: articles published in English peer reviewed journals only to maintain scientific rigour, as it is considered that these are of a higher quality compared to other publications; and studies must have employed qualitative methods of analysis to explore parental experiences of a young person's self-harming behaviour and have included participant quotes. This could include the experiences of carers in a parental role. The term young person was defined inclusively, based on how it was used within the studies. The reason for this was not to exclude any relevant articles based on an arbitrary age cut-off, as ultimately the purpose was to explore the parental experience. For the same reason, articles were included if they explored parental experiences of their child using any method of self-harm, regardless of the intent behind it.

Articles were excluded if they explored parental experiences of the role of self-harm in relation to other psychological difficulties, such as eating difficulties. This was because the purpose of the review was to explore the parental experiences of their child's self-harm, rather than the parental experiences of their child's mental health difficulties as a whole. Articles that included the parental experience of a child completing suicide were also excluded.

3631 articles identified through the initial search were screened for relevance on the basis of title, and if there was uncertainty about the relevance, the abstract was read to clarify suitability. 30 remaining articles were retrieved as full text articles and read to establish if they met the inclusion/exclusion criteria. In an attempt to identify any further suitable papers, a hand search of the references lists from included papers was also performed. One further article was identified, giving a sample of 15 papers. Throughout the screening process, 3616 papers were excluded. A summary demonstrating the flow of paper selection is detailed in figure 1.

Insert Figure 1

Study Characteristics

From the initial search, fifteen papers were identified for the metasynthesis, which were published between 2003 and 2017. Eight of the studies were conducted in the UK, four studies were European samples, one was conducted in Hong Kong, one in Australia and one in the USA. It was unclear where Daly's (2005) research was conducted.

Four papers appeared to use the same sample and data collection for analysis, although this is only clearly stated within one paper (Stewart et al., 2016). As all of these papers met the inclusion criteria and looked at different aspects of the parental experiences, they were included for review. Some of the papers did not describe parent gender, however, those that did are detailed in Table 1. Three of the studies included experiences from carers in addition to parents (Byrne et al., 2008; Oldershaw et al., 2008). All of the young people within the papers were aged 28 years and below. Further details are included in Table 1.

Insert Table 1

Quality appraisal

To identify the strengths and limitations of each study, an appropriate critical appraisal tool was completed, specifically The Critical Appraisal Skills Programme (CASP) checklist (Public Health Resource Unit, 2006). This ten-item tool was used to evaluate the credibility of each of the qualitative studies. The first two items review the aims and chosen methodology of the research and require a “yes or no” rating. A further eight questions consider the overall value of the qualitative research. These were applied using the rating scale developed by Duggleby et al. (2010) where a score of 1 indicates weak quality, 2 indicates moderate and a score of 3 indicates strong quality. The maximum total score was 24. CASP score ranged between 13-19.

Insert Table 2

Data Synthesis

Data were synthesised using the meta-ethnographic 7 step method outlined by Noblit and Hare (1988), which includes ‘getting started, deciding what is relevant, reading the studies, determining how the studies are related, translating the studies into one another, synthesising translations and expressing the synthesis.’ The aim was to produce an interpretative analysis of the experiences of parents of young people who self-harm. After identifying a suitable research question and relevant papers, all papers were read several times to enable the researcher to become familiar with the data and to identify recurring themes and key findings within each study. Key themes and concepts that were relevant to the research question were extracted from each paper.

Each of these themes and concepts were grouped together, through a method of constant comparison between studies. This was achieved by creating a list and then placing the original themes and concepts alongside each other to establish connections. These were noted and can be found in Table 3 (column 1). The groups were then renamed to generate overarching new key themes (final iterations).

Upon referring back to the newly created list of themes, it was established that the relationship between the studies was reciprocal in nature. This allowed for reciprocal translation, which has been defined as “ the comparison of themes across papers...to "match" themes from one paper with themes from another, ensuring that a key theme captures similar themes from different papers” (Atkins et al., 2008, p. 6). Therefore, the next stage involved interpreting and translating the studies into one another. This was achieved by looking at themes from study one and comparing them with study two, interpreting this to produce a synthesised finding, then comparing this with study 3 and so on. Each key theme was considered and interpreted, using them as building blocks, to construct the development of the second order constructs (Refer to Table 3, column 3).

The final process of synthesis allowed for second order constructs to be refined and further developed, allowing third order interpretations to be established to create an overarching model of findings. Third order constructs have been described as “the researchers’ interpretations of the original authors’ interpretations” (Toye et al., 2014, p. 7). This led to the development of five overarching core concepts (third order constructs), which are presented below.

Insert Table 3

Results

Five concepts emerged following the metasynthesis process: the turmoil of discovery and beyond; searching for certainty; the ultimate blame; vigilant parenting: treading carefully; and the ripple effect.

The turmoil of discovery and beyond

The first encounter with their child's self-harm was a challenging experience for many parents. The process of discovery often occurred through parents' own suspicions or through third-party notifications such as from school, healthcare staff or the police (Ferrey et al., 2016a, 2016b; Oldershaw et al., 2008; Rose et al., 2011). There was also a sense of secrecy and some YP would not let parents see their self-harm (Yip, Ngan, & Lam, 2003): "To the best of my knowledge [she was] asleep in bed, [but she] had been in touch with one of the agencies...and...was talking about self-harming" (Ferrey et al., 2016b, p. 3). This secrecy may have influenced parents' ability to trust their child.

The discovery of self-harm elicited an intense emotional journey for most parents (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Hughes et al., 2017a; Lindgren, Åström, & Graneheim, 2010; McDonald et al., 2007; Raphael et al., 2006; Rose et al., 2011): "The whole thing is really, really scary" (Byrne et al., 2008, p. 498). Parents experienced an array of emotional responses such as shock, fear, shame, anger, denial and devastation. This led to some parents feeling unsure how to respond to their child: "At first, when you see these marks on your child's beautiful

skin, you're just filled with every emotion that you can possibly think of- fear, anxiety, disbelief, anger and just not knowing what to do" (Ferrey et al., 2016b, p. 3).

Some parents attempted to minimise their child's difficulties and were reluctant to seek support (McDonald et al., 2007; Oldershaw et al., 2008; Rissanen, Kylmä, & Laukkanen, 2009) whilst other parents believed that they should have been able to notice the severity of their child's distress (McDonald et al., 2007; Raphael et al., 2006). Some parents reflected on how their child's difficulties appeared externally camouflaged: "I knew she had problems of some kind, but her problems were bigger...they could not be seen from the outside" (Rissanen et al., 2009, p. 1713).

The emotional responses continued for parents. Some felt betrayed and rejected by their children, perhaps linking to the sense of secrecy surrounding their child's behaviour (Daly, 2005; Rissanen et al., 2009). Other parents felt a sense of loss, perceiving that their child was no longer the same person (Oldershaw et al., 2008; Rose et al., 2011): "I miss my little girl and that's...quite hard" (Oldershaw et al., 2008, p. 143). Anxiety was experienced by some parents as they did not know how to respond (Byrne et al., 2008; Ferrey et al., 2016b) or they feared the potentially fatal consequences associated with self-harm: "if she cuts deeper, and cuts the arteries, then it would be fatal. I was so worried" (Yip et al., 2003, p. 411). Parents also reported anger and frustration, at times, directed towards the YP (Byrne et al., 2008; Yip et al., 2003): "How dare [she]...it's upsetting the whole household" (Byrne et al., 2008, p. 498). These emotional responses continued as young people had stable periods where they did not self-harm followed by periods of increased self-harm. Consequently, there was an ongoing impact on parents' emotional wellbeing (Ferrey et al., 2016b; Oldershaw et al., 2008).

Some parents wanted to escape from the emotional turmoil and had to consider how to keep an emotional distance (Daly, 2005; Yip et al., 2003). This method of self-defence was achieved if the parent could manage their child's self-harm by blocking the emotional impact and focusing on practical strategies of support (Ferrey et al., 2016a): "practical mode was easier to deal with than emotional mode...so you look after the cuts because that's the easy bit" (Ferrey et al., 2016a, p. 3). Understandably, some parents experienced emotional exhaustion as a result of their child's behaviour (Ferrey et al., 2016b). This exhaustion could also be linked to the unsustainability of avoidant coping strategies utilised by some parents. The experience was stressful (Ferrey et al., 2016b) which led parents to experience a state of panic, fearing another episode of self-harm (Byrne et al., 2008; Oldershaw et al., 2008).

Searching for certainty

Following the discovery, most parents attempted to make sense of their child's self-harm. Some found it challenging to comprehend (Hughes et al., 2017a; Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008) and felt fuelled by confusion (Daly, 2005; Hughes et al., 2017a; Kelada et al., 2016; Raphael et al., 2006; Rissanen et al., 2009; Rissanen, Kylmä, & Laukkanen, 2008; Yip et al., 2003): "I am really, really confused as to what on earth is going on in her head" (Hughes et al., 2017a, p. 218). Some parents wanted to conceptualise the self-harm (Ferrey et al., 2016a; Hughes et al., 2017a; Rose et al., 2011) and understood that gaining information may provide a platform to aid understanding (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a; Hughes et al., 2017a; Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008; Rose et al., 2011): "if you have

the knowledge... you feel more confident in dealing with it” (Byrne et al., 2008, p. 499).

Parents sought information from external sources, perhaps instead of talking to their child about their self-harm, as communication between parent and child became challenging (Oldershaw et al., 2008; Rissanen et al., 2008). Some parents were unsure if self-harm was a typical “teenage behaviour” (Ferrey et al., 2016a; Hughes et al., 2017a; Rissanen et al., 2008), whether it was an attempt by the YP to exert control (Ferrey et al., 2016a) or whether it was a way to manage emotion or “attention-seeking behaviour” (Byrne et al., 2008, p. 500).

Although parents wanted to gain an intellectual understanding of their child’s difficulties, this did not mean that parents could accept the behaviour (Oldershaw et al., 2008). How parents conceptualised their child’s behaviour and the internal conflict of understanding also had an influence on how they responded: “Sometimes I can be very sympathetic and sometimes I can’t because sometimes I think it is naughty behaviour and sometimes I think it’s mental health behaviour” (Ferrey et al., 2016a, p. 4).

The challenges of understanding left most parents feeling unsure of how to respond to their child in what was perceived as the “right way” (Byrne et al., 2008; Hughes et al., 2017a; Kelada et al., 2016; Lindgren et al., 2010; McDonald et al., 2007; Stewart et al., 2016). Parents wanted practical solutions rather than managing and tolerating emotional distress. This desire for simple solutions to a complex issue left parents feeling unsure about what to do next (Hughes et al., 2017a; Kelada et al., 2016; Rissanen et al., 2009; Stewart et al., 2016): “What am I going to do with my kid? I can’t watch her fall apart in pieces, I can’t handle that” (Lindgren et al., 2010,

p. 4). Therefore, many parents wanted to be guided in how to respond and prevent future episodes of self-harm (Byrne et al., 2008; Kelada et al., 2016; Lindgren et al., 2010; Oldershaw et al., 2008; Stewart et al., 2016): “Is there a parent’s guide to what to do when your daughter cuts? I don’t know...if there is, I wish I had seen it” (Kelada et al., 2016, p. 3411).

Some parents felt anxious about the future and wanted to be hopeful, but this was challenging when faced with uncertainties (Ferrey et al., 2016a, 2016b; Hughes et al., 2017a; Lindgren et al., 2010): “I want hope [starts to cry]. I want to feel that there’s a solution. I need to know what we can request and...how to treat her” (Lindgren et al., 2010, p. 4).

Whilst on this quest to gain certainty and make sense of self-harm, parents required support from others, including professional services. However, many parents perceived professional support as inadequate (Byrne et al., 2008; Kelada et al., 2016; Lindgren et al., 2010; Raphael et al., 2006; Rissanen et al., 2009; Stewart et al., 2016): “Trying to find the right person...someone who specialises in this area....there is not much out there” (Kelada et al., 2016, p. 3411). Some parents appreciated that professional support was necessary but found that there was a lack of reassurance and on-going support from services (Raphael et al., 2006; Stewart et al., 2016): “ I think I would have liked more parental support...it would be really nice to pick up the phone and talk to someone who knows what you are talking about” (Stewart et al., 2016, p. 5). Peer support and sharing of similar experiences was valued by some parents (Ferrey et al., 2016b; Hughes et al., 2017; McDonald et al., 2007): “Just hearing other people’s stories makes you feel like you’re less alone...you can gain a lot of strength from that” (Ferrey et al., 2016b, p. 4).

The ultimate blame

Many parents blamed themselves for their child's self-harm (Ferrey et al., 2016b; Hughes et al., 2017a; McDonald et al., 2007; Raphael et al., 2006; Rose et al., 2011): "...if I'd have known...I'd have stopped it" (Rose et al., 2011, p. 199). The feelings of responsibility manifested in self-blame for parents (McDonald et al., 2007; Raphael et al., 2006; Rose et al., 2011): "It was like, what have I done?...You tend to blame yourself...I wasn't watching, I wasn't caring enough, I wasn't showing enough love, I wasn't giving enough praise" (McDonald et al., 2007, p. 303). This was also emphasised if parents had engaged in self-harm themselves and wondered whether this precipitated their child's difficulties (Ferrey et al., 2016b). Parents questioned their competence and speculated that they had ultimately failed as parents (Byrne et al., 2008; Daly, 2005; Lindgren et al., 2010; McDonald et al., 2007): "Feeling you are no good as a parent...a failing" (Byrne et al., 2008, p. 498). Some parents questioned whether the self-harm would even have occurred if they had been a better parent (Daly, 2005).

Most parents experienced a sense of guilt or shame associated with their child's self-harm (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016b; Hughes et al., 2017a; Lindgren et al., 2010; McDonald et al., 2007; Yip et al., 2003): "The guilt...that's the hard thing to deal with" (Byrne et al., 2008, p. 498). Some parents felt embarrassed (Ferrey et al., 2016b; McDonald et al., 2007), which may suggest external shame from worries about the perceptions of others, or ashamed (McDonald et al., 2007) of their child's behaviour as they perceived that they were not able to bring their child up to manage their distress: "I'm embarrassed by it, you know, because you think you've failed because if they were normal, well-balanced children

they wouldn't be doing these things.” (Ferrey et al., 2016b, p. 3). Some of the guilt was linked to parents wondering about how they may have caused their child's distress (Ferrey et al., 2016b; Hughes et al., 2017a; Lindgren et al., 2010; McDonald et al., 2007; Rose et al., 2011) and some parents questioned where they had gone wrong (Daly, 2005; Rose et al., 2011): “I wasn't caring enough, I wasn't showing enough love, I wasn't giving enough praise”(McDonald et al., 2007, p. 303).

As parents were critical of their child-rearing, some feared being judged by others (Daly, 2005; Ferrey et al., 2016b; Lindgren et al., 2010; McDonald et al., 2007; Rose et al., 2011; Stewart et al., 2016). This understandably led to parents feeling isolated and that they had to manage the difficulties alone (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016b; Lindgren et al., 2010; McDonald et al., 2007). Some felt others would not understand or they would be met with ridicule (Daly, 2005; McDonald et al., 2007): “It can be very lonely...you can tell everybody but people will then cross the road to avoid talking to you” (Ferrey et al., 2016b, p. 4). To prevent this from occurring, many parents managed independently and there was a level of secrecy within the family (Daly, 2005; Ferrey et al., 2016b; Lindgren et al., 2010): “The family doesn't want to talk about it. They think it is shameful” (Daly, 2005, p. 26).

Vigilant parenting: Treading carefully

Following the discovery of self-harm, most parents changed the way that they parented their child. There was an increased parental burden where parents doubted their abilities (Byrne et al., 2008; Daly, 2005; Kelada et al., 2016; Lindgren et al., 2010; Oldershaw et al., 2008). A power shift between parent and child was also experienced by most parents (Byrne et al., 2008; Ferrey et al., 2016a; Kelada et al.,

2016; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006). It was perceived that the child held a position of power and was now the focal point within the family system.

Parents had new found challenges with maintaining boundaries and using appropriate discipline when necessary (Byrne et al., 2008; Oldershaw et al., 2008; Raphael et al., 2006): “I tend to give in to her now” (Byrne et al., 2008, p. 499). Many parents felt that they were “walking on egg shells” when trying to balance appropriate parenting skills (Daly, 2005; Lindgren et al., 2010; Oldershaw et al., 2008). This led to cautious parenting where most parents felt hyper-vigilant, attentive and perhaps intrusive into their child’s lives (Daly, 2005; Ferrey et al., 2016a, 2016b; Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008): “It means that you are constantly aware, watching them for any signs... You feel like you are sneaking around all the time.” (McDonald et al., 2007, p. 305). There was an intense fear that parents would trigger another incident (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Kelada et al., 2016; Oldershaw et al., 2008; Raphael et al., 2006): “[I] couldn’t even have a normal row with my daughter because I was so scared...she’d get upset and go upstairs and self-harm” (Ferrey et al., 2016a, p. 3).

The balance between being vigilant parents and not becoming overpowering was difficult to manage. Some parents were concerned that changes within the parent-child relationship would equally increase the self-harm (Ferrey et al., 2016a): “[It would] force her into being more wound up” (Ferrey et al., 2016a, p. 3). Most parents naturally became consumed with monitoring their child’s safety (Ferrey et al., 2016b, 2016a; Kelada et al., 2016; McDonald et al., 2007; Oldershaw et al., 2008). This manifested in some parents becoming more inquisitive, engaging in increased

monitoring, such as sleeping near their child at night, and invading their child's privacy: "If she went out I used to go into her drawers, which is something I swore I would never do, but she was just so secretive and always told lies" (McDonald et al., 2007, p. 305).

Some parents perceived that they had not provided enough care prior to self-harm, therefore needed to now (McDonald et al., 2007). Consequently, parents altered their supporting strategies and provided more physical affection or supported their child to engage in distraction techniques (Ferrey et al., 2016a; Yip et al., 2003). Some parents found themselves taking on the role of therapist: "I was her therapist instead of just being her mother" (Lindgren et al., 2010, p. 4).

The change in parenting styles had an influence on the parent-child relationship. Some parents felt no longer able to communicate effectively with their child (Daly, 2005; Kelada et al., 2016; Oldershaw et al., 2008) and that the trust within the relationship had diminished (Byrne et al., 2008; Daly, 2005). However, some parents also perceived that the change in parenting strategies had led them to become closer to their child (Kelada et al., 2016; Oldershaw et al., 2008).

The ripple effect

Self-harm was perceived as an obstruction to family life which led to damaged family dynamics (Byrne et al., 2008; Ferrey et al., 2016a, 2016b; Kelada et al., 2016; Lindgren et al., 2010; McDonald et al., 2007): "It becomes the centre of the family and the whole dynamic breaks down and it's all about one person" (Byrne et al., 2008, p. 499). It was highlighted that some parents believed that their roles in life, such as mother or wife, had been diminished as they were no longer able to meet

expectations of others, due to providing care to the child who was self-harming (McDonald et al., 2007).

Parents' relationships with partners were also compromised (Ferrey et al., 2016b, 2016a; Hughes et al., 2017a): "You are just putting life on hold until this is sorted out. Because if you try to make demands on each other during the middle of this, you're not going to survive it" (Ferrey et al., 2016b, p. 3). For some parents, there were differing views and conflicts in how to best support their child (Ferrey et al., 2016a; Raphael et al., 2006): "...my attitude to bringing up children is vastly different to her father's..." (Ferrey et al., 2016a, p. 4). Therefore, the self-harm was perceived to be a family burden for some parents.

Many parents were concerned about how their child's self-harm may influence siblings (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008). These concerns included the fear of exposing the siblings to the self-harm (Ferrey et al., 2016a, 2016b) or fear that siblings were being neglected, as the main focus was supporting the child who was self-harming (Ferrey et al., 2016a; McDonald et al., 2007; Rissanen et al., 2008): "There was nothing in place for my other children. They were stuck in the middle; so was the whole family. You can't give them [siblings] what they deserve because you are too wrapped up" (Daly, 2005, p. 26).

There was also a financial burden associated with self-harm. Parents had to take unpaid time off work, leave their job or be available for their child regardless of employment commitments (Ferrey et al., 2016b; McDonald et al., 2007; Raphael et al., 2006): "...I have decided I'd um I'd resign...[the YP] obviously comes first..." (Raphael et al., 2006, p. 16).

The ripple effect of self-harm understandably led to a deterioration in many parents' wellbeing: "I had three months off work and was put on antidepressants, which I take to this day and will never stop taking because they keep me sane" (Hughes et al., 2017a, p. 218). Some parents found it challenging to maintain their own identity whilst supporting their child (Ferrey et al., 2016a, 2016b) and disregarded their own needs (McDonald et al., 2007; Oldershaw et al., 2008). Parents became emotionally burnt out and exhausted (Ferrey et al., 2016a, 2016b; Hughes et al., 2017a; Kelada et al., 2016; McDonald et al., 2007): "I'm tired. Emotionally, I'm so tired and I want it to stop" (Ferrey et al., 2016b, p. 3). This manifested not only as psychological distress but also impacted on some parents' physical health (Ferrey et al., 2016b; Kelada et al., 2016).

Discussion

This meta-synthesis aimed to explore the experiences of parents of young people who self-harm. The synthesis resulted in five concepts, which capture the core elements of those experiences.

The discovery of self-harm triggered multiple emotions for parents, experienced simultaneously, which is congruent with findings from other research (e.g. Morgan et al., 2013; Trepal et al., 2006; Yip, Ngan, & Lam, 2002). Most parents discovered their child was self-harming through other people, which is reflected in findings from Arbuthnott and Lewis (2015). This secretive aspect of self-harm is common among adolescents as they try to conceal their self-harm from family

members (Baetens et al., 2011) and are reluctant to seek help (Berger, Hasking, & Martin, 2017; Rowe et al., 2014).

The majority of parents were overwhelmed by emotion as their child continued self-harming and they felt unsure of how to support them. This level of emotional arousal may have made it increasingly difficult to provide the necessary containment for their child. The concept of containment (Bion, 1962) describes how a child will project feelings that are unmanageable onto their parents, who will make sense of these and return them to the child in a more tolerable form. As one of the factors that supports young people to reduce or stop self-harm is emotional support from parents (Tatnell et al., 2014), parents need to be able to provide emotional containment to their child.

Most parents experienced guilt and shame, and blamed themselves for their child's behaviour. Parents questioned whether they had provided their child with enough love and care throughout their lives and considered how their parenting may have influenced their child's self-harm. Similarly, Crowe et al., (2011) found that parents of young people who are experiencing psychological distress also report self-blame and question whether they may have influenced the development of their child's difficulties. Parental self-blame for their child's distress has also been linked to a decline in parents' own emotional wellbeing (Moses, 2010) and many of the parents in this review reported that their own wellbeing had suffered. Furthermore, parental wellbeing is inversely correlated with their child's difficulties (Morgan et al., 2013).

Some parents feared being judged and perceived that others would avoid them if they became aware that their child was engaging in self-harm. This could be linked

to public stigma around self-harm and fears that they would be perceived as a “bad” parent. Public stigma is associated with experiencing devaluation and discrimination from the general public (Pattyn et al., 2014). This fear led many parents to become isolated and at times managing distress alone. Again, this could also be linked to a decline in parental wellbeing.

In order to understand self-harm, parents attempted to gather information, as many parents felt ‘clueless’ about what to do. This search for advice emphasises that parents wanted to help their child but they were unsure how to do so. To gain reassurance and advice, parents understood the value of seeking support from professionals, but at times found this support inadequate. However, peer support and the sharing of similar experiences were perceived to be validating for parents.

The fear of the unknown was difficult for parents to tolerate which may have further exacerbated parents’ desire for certainties regarding how to support their child. To try to cope, it appeared that parents predominantly wanted to focus on practical strategies, rather than focusing on the emotion attached to the self-harm, as this was difficult to tolerate. Coping responses can be defined as either emotion focused, problem focused (Lazarus, 1984) or engaging in avoidance strategies (Amirkhan, 1990). If parents solely are focusing on practical strategies rather than attending to emotional needs, the emotions may have been dismissed and expression of emotion may have been suppressed within the household. Young people learn coping strategies through a modelling process between parent and child (Skinner & Zimmer-Gembeck, 2007), therefore, if young people observe emotional expression to be generally suppressed by parents, they may find other ways to express emotion, such as engaging in self-harm.

In addition, some parents emphasised how verbal communication between parent and child was challenging. As there are associations between challenges in communication and the maintenance of self-harm (e.g. Portzky et al., 2008; Tulloch et al., 1997), parents feeling unable to effectively communicate with their child may have influenced the young person's self-harm, or even led them to communicate through the use of this behaviour (Scoliers et al., 2009).

Many parents felt unable to parent and became cautious when maintaining appropriate discipline and boundaries for their child. Parents struggled with discipline, as they became hyper-vigilant but continuously feared triggering self-harm. Of concern, inconsistencies and limited guidance from parents have been associated with more frequent self-harm (Buresova et al., 2015).

The synthesis of parental experiences has demonstrated that some of the parental responses may unintentionally contribute to the maintenance of self-harm. Ultimately, parents are trying their best to support their child, but are experiencing their own emotional responses and are unsure of the "right way" to support their child. Therefore, it is imperative that parents receive the guidance they need to be able to respond in a helpful way.

The self-harm also influenced the whole family system, which is consistent with other research (Baetens et al., 2014; Power et al., 2009; Trepal et al., 2006). In terms of family systems theory (Kerr & Bowen, 1988), it is necessary to consider that distress from an individual within a family should be conceptualised as being influenced and experienced by the whole family. Within this review, family relationships deteriorated for some parents and conflicts within parental relationships appeared. Some parents also perceived that their life roles had diminished, as their

sole purpose was to care for their child who was self-harming. Naturally this led to parents feeling that siblings were being neglected and overall family life was disrupted.

Finally, findings from this metasynthesis revealed some similarity to the descriptive review by Arbuthnott and Lewis' (2015) into the role of parents with YP who self-harm. This included how self-harm may negatively impact parental psychological wellbeing, the challenges with parenting a young person who self-harms and the impact of this behaviour on the family system. However, this review enhanced existing findings as it provided an in-depth interpretive synthesis of the experiences of parents of YP who self-harm.

Strengths and limitations

This is the first literature review that synthesises qualitative research into parents' experiences of supporting a young person who self-harms. Studies reviewed were conducted across a variety of countries and findings revealed similar narratives from parents across different national settings.

A limitation is that, where it was documented, parents in the studies were predominantly female, meaning a dominant maternal experience was captured. In addition, participants who took part in the research may have been more invested in sharing their experiences, compared with parents who may have different experiences that they did not wish to share, so the experiences captured in the review cannot be assumed to be representative.

A further limitation is related to the lower quality appraisal scores of some of the papers included in the metasynthesis. For example, most of the papers had lower

scores in the reflexivity and ethical consideration domains. However, due to the limited number of identified papers, scores were used to critically appraise the quality of each study rather than to exclude articles.

There were also challenges with having a clear distinction between what constitutes suicidal behaviour and self-harm when completing the literature search as definitions of self-harm were inconsistent and at times vague. For example, some articles included self-harm and suicidal behaviour (Byrne et al., 2008) and some stated NSSI (Kelada et al., 2016). Details of all studies can be found in Table 1.

It is possible that the parental experience differs depending on whether they perceive the YP to be self-harming or engaging in suicidal behaviour. However, this was not observed within the review itself. In addition, research from Buus et al., (2014) explored parents' experiences of their child attempting suicide and themes highlighted in that research mirror the findings from this review. For example, findings included parents experiencing overwhelming emotional response, changes to parenting, parental self-blame and the impact on the wider family systems.

Implications for clinical practice

As parents usually provide ongoing support for their children, it is essential to consider how they could influence and minimise self-harm. Therefore, clinical services should aim to provide parents with accessible information about self-harm and how to support their child. This information should be provided at the earliest opportunity, preferably at first point of contact, even if parents are discussing suspicions that their child may be self-harming. Given the waiting time to access Child and Adolescent Mental Health Services in the UK, parents could seek advice

from other sources, such as through schools, as findings suggest that parents sometimes first become aware of their child's self-harm via school. It would be useful for services to help parents to support their child to emotionally regulate in safe ways and promote communication of distress within the home.

Clinical services should also acknowledge the complexities associated with self-harm and the self-blame and shame that parents may experience. Therefore, parents need sources of non-judgmental advice and support to reduce the possibility of parents feeling blamed for their child's behaviour.

The emotional impact on parental wellbeing should also be acknowledged by clinical services. With this in mind, parents and carers of individuals who self-harm should be provided with access to verbal and written information about self-harm and how to gain an assessment and support for their own wellbeing (NICE, 2011). It would be useful if services can provide a validating, supportive environment for parents. This could include 1:1 support and peer group support, as sharing of experiences can be valuable.

In addition, there is a need for services to consider that parents may feel disempowered when parenting YP who self-harm. Services should support parents to maintain appropriate boundaries. This should include helping parents to communicate effectively with their child and considering how parents can provide emotional containment. In order for parents to provide emotional containment, they need to feel contained themselves. Professional therapeutic relationships can provide the essential emotional containment for parents' unmanageable feelings. As research has highlighted the effectiveness of family intervention with young people with emotional and behavioural difficulties (Porter & Nuntavisit, 2016), this support could be

delivered through family interventions, where families are encouraged to consider their own potential roles in the family distress.

Future research

This review highlighted the impact of self-harm on parents and the family system. Future research could aim to qualitatively explore how siblings conceptualise their experiences and what support may be beneficial. From here, family support packages could be tailored to not only support the YP who is self-harming, but also support the family.

In addition, this review captured mainly experiences of mothers. It is important for future research to capture the experiences of fathers who support young people who self-harm to determine if paternal experiences differ. This would be clinically relevant so that parental support packages could be tailored accordingly.

Conclusions

This review aimed to explore experiences of parents of young people who self-harm. The synthesis of 15 articles revealed five concepts. These concepts encompass the challenges for parents when supporting YP who self-harm. Understanding these experiences provides a framework for clinical services to adapt support and meet the needs of families of children who engage in self-harming behaviour. Clinical services need to be able to not only acknowledge but also understand the systemic needs of a family to be able to provide the support needed to reduce risks associated with self-harm.

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Tables/figures

Table 1: Study characteristics

Author/Country	Participant characteristics	Self-harm	Aims/Research question(s)	Data collection and methodology	Main findings
Byrne et al., (2008) Ireland	25 participants: 15 parents 10 carers Young people: 16 years and below	Deliberate self-harm or suicidal behaviour	To explore parents and carers experiences of self-harm in their child to identify their support needs	Focus Group Conceptual analysis used to identify basic themes. Inductive approach	Seven themes: Support; Emotions; Parenting; Family; Psycho-education; Managing self-harm; Other: beliefs, school, internet
Daly (2005) (Country unknown)	6 mothers Young people: 25 years and below	Suicidal gestures or attempts No definition	To describe the experiences mothers living with suicidal adolescents	Unstructured interviews Thematic analysis	Six themes: Failure as a good mother; The ultimate rejection; Feeling alone in the struggle; Helplessness and powerlessness in the struggle; Cautious parenting; Keeping an emotional distance
Ferrey at al.,	37 parents: 32 mothers	Self-harm included	To explore how the discovery of self-harm can effect parenting	Interviews	Five themes:

<p>(2016a) UK</p>	<p>5 fathers Young people under 25 years old 29 daughters and 6 Sons</p>	<p>regardless of intent. Cutting, overdose, burning and strangulation</p>	<p>styles</p>	<p>Thematic analysis</p>	<p>Changes in parenting; Conceptualising self-harm; Parenting siblings; Differing views between parents; Suggestions for other parents</p>
<p>Ferrey et al., (2016b) UK</p>	<p>37 parents: 32 mothers 5 fathers 29 daughters and 6 sons Aged 14-28 years old</p>	<p>Cutting, overdose, burning and strangulation</p>	<p>To explore the emotional, physical and practical effects of young person's self-harm on parents and family</p>	<p>Narrative interviews Thematic analysis</p>	<p>Nine themes: Immediate impact; Ongoing impact on parents' emotional state and mental health; Impact on partners; Impact on siblings; Impact on wider family; Social isolation and social support; impact on work and finances; Parents' conceptions of the future</p>
<p>Hughes et al., (2017) UK</p>	<p>41 parents: 34 mothers 5 fathers 2 female carers Young people up to 25 years old</p>	<p>Overdose, burning, strangulation and "other methods"</p>	<p>To explore parents experiences of young peoples' self-harm from a sense making perspective</p>	<p>Narrative interviews Cross-sectional thematic analysis</p>	<p>Three themes: Bewilderment and confusion; Search for information; Building a new way of seeing.</p>

<p>Kelada et al., (2016) Australia & USA</p>	<p>Study one- 16 parents: Mothers 15 Father 1 Young people aged between 14-17 years old Study two- 22 parents: 18 Mothers 4 Fathers No age of young people</p>	<p>Non suicidal self-injury (NSSI)</p>	<p>To explore the impact of adolescent NSSI on parents</p>	<p>Study one- questionnaire with open ended questions Thematic analysis Study 2 semi structured interviews Thematic analysis</p>	<p>Study one- one relevant theme: Changes in parent-adolescent relationship Study two- Three themes: Lack of knowledge; uncertain about how to interact with child; negative experiences with professionals</p>
<p>Lindgren, Astrom & Graneheim (2010) Sweden</p>	<p>6 parents Daughters aged between 21-25 years</p>	<p>Cutting, burning, and scratching</p>	<p>To discover and describe lived experiences of professional care and caregivers among parents of adults who self-harm.</p>	<p>Narrative interviews Phenomenological hermeneutic approach</p>	<p>Four main themes: Being trapped in a situation with no escape; Groping in the dark; Being in the prisoner’s dock; Finding glimmers of hope</p>
<p>McDonald, O’Brien & Jackson (2007)</p>	<p>6 mothers Adolescents aged between 12- 21</p>	<p>Cutting, burning or risk-taking</p>	<p>To explore the personal experiences of mothers of children who self-harm</p>	<p>Interviews Hermeneutic phenomenological</p>	<p>Six themes: Dilemmas of guilt and shame; searching for a reason; echoes</p>

Australia	years old 6 daughters and 2 sons	behaviours		methodology	from other relationships; embarrassment; becoming hyper vigilant; diminished roles.
Oldershaw et al., (2008) UK	12 participants: 9 Mothers 2 Fathers 1 Carer Young people aged between 13-18 years old	Self-harm is non fatal injurious act regardless of intent	To gain an understanding of parents of adolescents who self-harm perspective on the history of self-harm, their ability to make sense of self-harm, the emotional impact and parental skills and hope for the future.	Semi structure interviews Interpretive phenomenological analysis	Four themes: Process of discovery; making sense of self-harm; psychological impact of self-harm on parents; effect of self-harm on parenting and family
Raphael, Clarke & Kumar (2006) UK	9 parents 5 Mothers and 4 fathers Young people aged between 16-24 years old 4 daughters and 3 sons	Overdose, cutting and burning	To understand parents' concerns, expectations and experiences following an episode of self-harm in a young person	Primarily face-to-face interviews with parents Phenomenological approach	Three themes: Emotional responses; what to do next; health professionals
Rissanen, Kylma & Laukkanen (2008)	4 parents: 3 Mothers 1 Father	Self-mutilation	To describe self-mutilation from perspective of parents of self-mutilating adolescents.	Interview Content analysis	Four categories: Phenomenon of self-mutilation; factors contributing to self-

Finland	Female adolescents				mutilation; the purpose of self-mutilation; sequels of self-mutilation
Rissanen, Kylma & Laukkanen (2009)	4 parents: 3 Mothers 1 Father	Self-mutilation	To explore parents views on how to help adolescents who self-mutilate	Interview Content analysis	Description of a self-mutilating adolescent; Helping a self-mutilating adolescent; Helping the parents and the family
Finland	Adolescent gender unknown				
Rose, Cohen, & Kinney (2011)	5 mothers Adolescents: All female Aged 15-16 years old	Overdosing, cutting, scalding and scratching.	To explore mothers' experiences of the mental health services with which they came into contact following their child's self-harm	Interview Interpretative Phenomenological Analysis	Three themes: The unknown Shame and blame Knowledge
UK					
Stewart et al., (2016)	37 parents 32 Mothers and 5 fathers 35 young people 29 females and 6 males Aged 14- 28 years	Cutting, overdose, burning and strangulation	To explore parents experiences of support for young people and themselves following self-harm	Interview Grounded theory approach to thematic analysis	Three themes: Attitudes towards the young person; practical aspects of help and involvement of parents
UK					

	old				
Yip, Ngan & Lam (2003) Hong Kong	3 parents 3 adolescents: 2 females and 1 male Aged 14-16 years old	Self-cutting	The parental influence on and response to self-cutting	Interviews Inductive analysis	Relevant findings: Parental response to adolescent self-cutting; communication with their children; dealing with parent and child conflicts

Table 2: CASP quality appraisal scores

Study	Research design	Sampling	Data Collection	Reflexivity	Ethical Issue	Data Analysis	Findings	Value of Research	Total Score
Byrne et al., (2008)	2	2	3	1	1	2	3	2	16
Daly (2005)	2	2	3	1	3	1	2	1	15
Ferrey et al., (2016a)	2	1	2	1	2	2	3	2	15
Ferrey et al., (2016b)	2	2	2	1	2	2	2	3	16
Hughes et al., (2017)	1	2	2	1	1	2	3	3	15
Kelada et al., (2016)	1	2	1	1	2	1	2	2	12
Lindgren, Astrom & Graneheim (2010)	2	1	3	1	3	3	3	3	19
McDonald, O'Brien & Jackson (2007)	2	2	2	1	3	2	3	3	18

Oldershaw et al., (2008)	1	3	3	1	1	3	3	3	17
Raphael, Clarke & Kumar (2006)	2	3	3	1	1	3	3	2	18
Rissanen, Kylma & Laukkanen (2008)	2	2	2	1	1	2	3	1	14
Rissanen, Kylma & Laukkanen (2009)	3	2	2	1	1	2	3	2	16
Rose, Cohen, & Kinney (2011)	2	2	3	1	1	3	3	2	17
Stewart et al., (2016)	2	2	3	1	1	2	3	3	16
Yip, Ngan & Lam (2003)	2	2	2	1	2	2	1	1	13

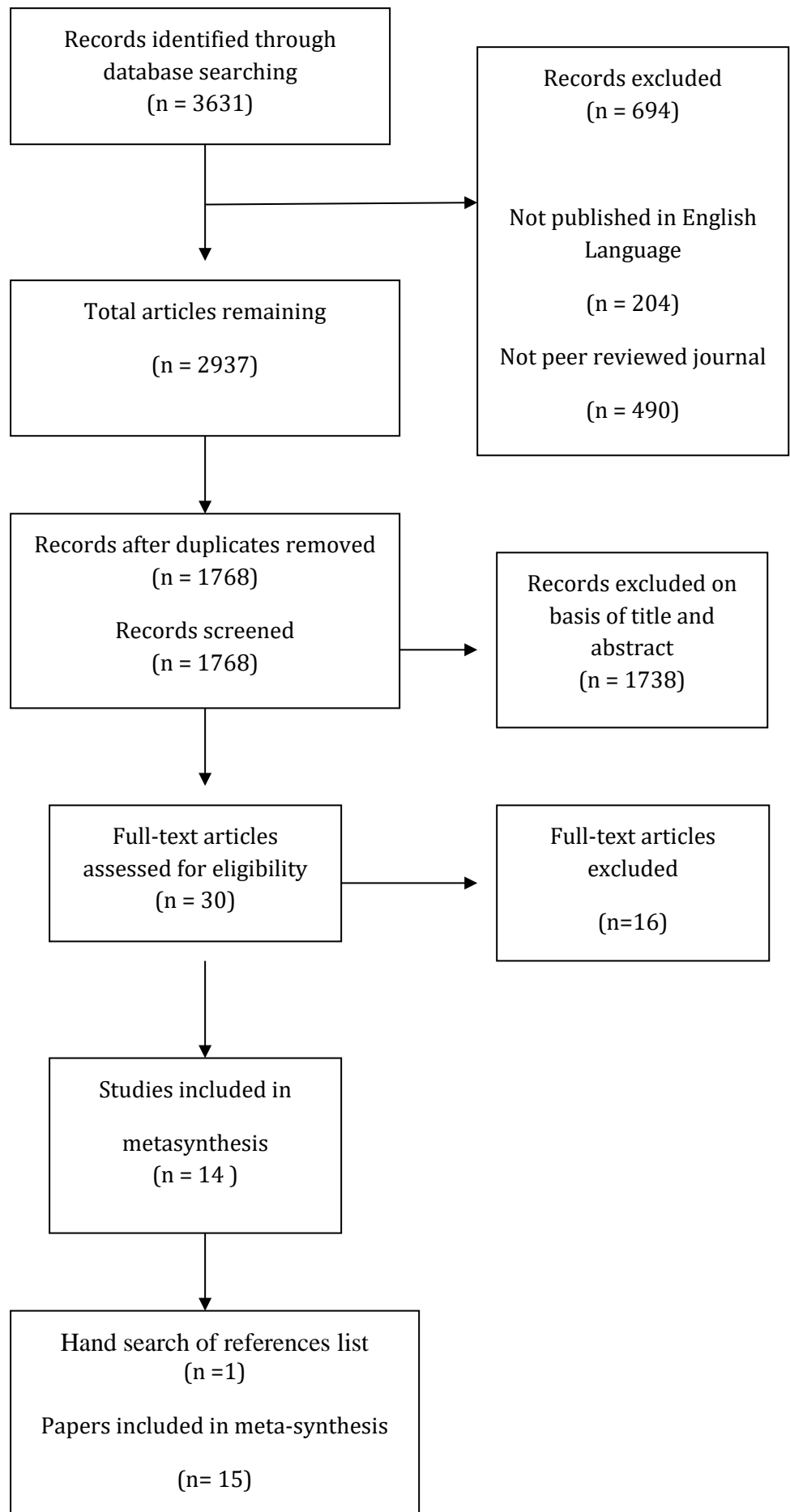
Figure 1: Flow chart of paper selection

Table 3: Data analysis

Key themes, phrases and quotes first iterations	Key themes, final iterations	Core concept, first iteration (second-order constructs)	Core concept, final iteration (third-order constructs)	Relevant papers that contributed to theme
First exposure to self-harm Confusion and lack of understanding	Process of discovery Overwhelming multiple emotions	Overwhelming process from discovery onwards	The turmoil of discovery and beyond	(Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Hughes et al., 2017b; Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Rissanen et al., 2009; Rose et al., 2011; Yip et al., 2003)
Denial or minimise difficulties	Confusion and bewilderment			
Multiple emotions experienced	Ongoing emotional journey			
Negative feelings towards young person				
Exhaustion due to all consuming impact of self-harm				
Feeling powerless				

Attempting to conceptualise self-harm	Desire to make sense	Facing the unknown but wanting answers	Searching for certainty	(Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Hughes et al., 2017b; Kelada et al., 2016; Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Rissanen et al., 2009, 2008; Rose et al., 2011; Stewart et al., 2016; Yip et al., 2003)
Uncertainty about the future	Search for answers			
Searching for information	Not knowing what to do			
Need for guidance	Seeking professional support			
Experiences of professional support	Barriers and benefits of support			
Shame and guilt	Blaming self	The impact of feeling responsible	The ultimate blame	(Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016b; Hughes et al., 2017b; Lindgren et al., 2010; McDonald et al., 2007; Raphael et al., 2006; Rose et al., 2011; Stewart et al., 2016; Yip et al., 2003)
Perception that should have recognised and prevented self-harm	Failure as a parent			
Blame self and think about past traumatic/ difficult experiences within family	Isolation and stigma			
	Invisibility			
















Isolation as others will not understand
 Fear of judgment from others

Loss of trust within parent child relationship	Adapting parenting style “Walking on eggshells”	Adaptation and vigilance	Vigilant parenting: Treading carefully	(Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Kelada et al., 2016; Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006)
Increased monitoring	Loss of power			
Hyper vigilance				
Unable to maintain boundaries and limits				
Fear of triggering self-harm				
Shift in power dynamic				

Family disruption	Influence on family system and work life	The influence on multiple layers of life	The ripple effect	(Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a, 2016b; Hughes et al., 2017b; Kelada et
Perceived neglect towards				

other siblings	Impact on wellbeing and health	al., 2016; Lindgren et al., 2010; McDonald et al., 2007; Oldershaw et al., 2008; Raphael et al., 2006; Rissanen et al., 2008)
Differing views and conflict between parent	Diminished roles	
Relationship breakdown		
Negative impact on employment		
Financial burden		
Denial of own needs		
Need to seek own support		
Parental mental and physical health deterioration		

Appendix 1-A: Search strategy

<input type="checkbox"/> Select / deselect all <input type="button" value="Search with AND"/> <input type="button" value="Search with OR"/> <input type="button" value="Delete Searches"/>		
	Search ID#	Search Terms
<input type="checkbox"/>	S15	 S4 AND S7 AND S11 AND S14
<input type="checkbox"/>	S14	 S12 OR S13
<input type="checkbox"/>	S13	 AB qualitative OR interview* OR "focus group*" OR "case stud*" OR "grounded theory" OR narrative OR thematic OR experienc*
<input type="checkbox"/>	S12	 TI qualitative OR interview* OR "focus group*" OR "case stud*" OR "grounded theory" OR narrative OR thematic OR experienc*
<input type="checkbox"/>	S11	 S8 OR S9 OR S10
<input type="checkbox"/>	S10	 AB "Self N3 Injur*" OR "Self-Mutilat*" OR "Suicid*" OR "Self-harm*" OR "Non suicidal self- injur*" OR "Deliberate self-harm*" OR "self-cutt*" OR "self-poison"
<input type="checkbox"/>	S9	 TI "Self N3 Injur*" OR "Self-Mutilat*" OR "Suicid*" OR "Self-harm*" OR "Non suicidal self- injur*" OR "Deliberate self-harm*" OR "self-cutt*" OR "self-poison"
<input type="checkbox"/>	S8	 DE "Self-Injurious Behavior" OR DE "Self-Mutilation" OR DE "Suicide" OR DE "Attempted Suicide"
<input type="checkbox"/>	S7	 S5 OR S6
<input type="checkbox"/>	S6	 AB adolescen* OR child* OR son* OR daughter* OR "young person*" OR "young people" OR teenager*
<input type="checkbox"/>	S5	 TI adolescen* OR child* OR son* OR daughter* OR "young person*" OR "young people" OR teenager*
<input type="checkbox"/>	S4	 S1 OR S2 OR S3
<input type="checkbox"/>	S3	 AB (("Parent*") OR ("Mother*") OR ("Father*"))
<input type="checkbox"/>	S2	 TI (("Parent*") OR ("Mother*") OR ("Father*"))
<input type="checkbox"/>	S1	 ((DE "Parents") OR (DE "Mothers") OR (DE "Fathers"))

Appendix 1-B: Author Guidelines for Journal***Child and Adolescent Mental Health***

Edited by: Jane Barlow, Kapil Sayal, Paul Harnett, Bernadka Dubicka and Nick Midgley

Impact Factor: 1.405

ISI Journal Citation Reports © Ranking: 2015: 67/120 (Pediatrics); 71/122 (Psychology Clinical); 84/139 (Psychiatry (Social Science)); 102/142 (Psychiatry)

Online ISSN: 1475-3588

Associated Title(s): Journal of Child Psychology and Psychiatry

Original Articles: These papers should consist of original research findings.

Review Articles: These papers are usually commissioned; they should survey an important area of interest within the general field..

Authors' professional and ethical responsibilities

Disclosure of interest form

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

submission.

Manuscripts reporting systematic reviews or meta-analyses should conform to the PRISMA Statement.

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work <http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields> and on quasi-experimental <http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research> and mixed method designs <http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>

Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6

Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributions differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.

Footnotes should be avoided, but end notes may be used on a limited basis.

Running head: LOOKED AFTER CHILDREN'S EXPERIENCES OF SELF-HARM

Section Two: Empirical Paper

Looked After Children's experiences of self-harm: A qualitative analysis

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Abstract

Background: Looked After Children and Young People (LACYP) are perceived to be one of the most vulnerable populations in society. Of concern, self-harm is prevalent in LACYP, with rates of self-harm being higher in residential care settings. The aim of this research was to understand the experiences of young people who engage in self-harm whilst living in residential care and to understand what influence the environmental context may have on self-harming behaviours.

Method: Five young people residing in residential care homes participated in semi structured interviews. Data was analysed using Interpretive Phenomenological Analysis.

Results: Four themes emerged from the analysis: 'The black hole of self-harm', 'Seeking genuine care through a protective mask', 'The cry to be understood' and 'Loss of control to the system.'

Conclusions: LACYP who self-harm are exposed to new experiences, boundaries and support networks when living in residential care and this inevitably has an influence on their self-harming behaviours. Clinical implications and future research recommendations are also discussed.

Keywords: Looked After Children, self-harm, residential care

Looked-After Children and Young People (LACYP) in the United Kingdom (UK) are defined as, “young people in the care of the Local Authority, either voluntarily or subject to a care order made by court to grant shared parental responsibility with a local authority” (Jones et al., 2011, p. 6). In the year ending March 2016, there were 70,440 LACYP within the UK (Department for Education, 2017) and 7,600 young people living in residential care settings (Department for Education, 2016).

LACYP are usually placed in residential homes after multiple unsuccessful foster placements (Department for Education, 2015b). They are often the most vulnerable of LACYP (National Institute for Health and Care Excellence, [NICE], 2015) and display high levels of emotional and behavioural difficulties, which can include mental health difficulties, aggressive behaviours and risky behaviours that put young people in a vulnerable position (Berridge, Biehal, & Henry, 2012). Such difficulties can at times be exacerbated by living in residential care systems and there is a need to further understand how contextual factors can influence LACYP behaviour and needs (Department for Education, 2015b).

Residential children's homes aim to support the development of nurturing bonds, meet the child's needs and provide a safe environment (Department for Education, 2015a). On average, each residential children's home offers four placements for LACYP in individual houses (Department for Education, 2016), with 24 hour staff support. Residential homes generally have an average of 11-15 staff members (Department for Education, 2016) and there should be appropriate staffing levels to meet the needs of all LACYP residing in that home (Department for Education, 2015a).

Clear role specific frameworks have been established to help staff to understand their role when working with LACYP (Royal College of General Practitioners, Royal College of Nursing, & Royal College of Paediatrics and Child Health, 2015). Frontline staff need to receive high quality training (NICE, 2015), however, there have been concerns relating to the qualifications and skills of staff working in residential care (Department for Education, 2015c). Therefore, it is now a requirement for residential staff in England to complete a Level 3 Diploma in Children and Young People's Workforce and recent figures show that 92% of staff were working towards or had completed this (Department for Education, 2015c).

Providing professional support to LACYP in residential care can be emotionally challenging (Barford & Whelton, 2010). It can be difficult for staff to adopt a dual role of managing behaviours whilst simultaneously providing support as a parent would (McLean, 2015). Research with residential care staff in Australia revealed the multiple tensions when managing behaviour that challenges (McLean, 2015). Tensions included being in a professional parental position and wanting to support LACYP, yet needing to maintain a professional distance, and providing a dual role of managing behaviour and maintaining a therapeutic relationship with LACYP.

LACYP are considered to be one of the most vulnerable populations (Pinto & Woolgar, 2015) with figures suggesting that over half of LACYP have experienced abuse or neglect (Department for Education, 2017). Early exposure to trauma has been linked to psychological distress (Mooney et al., 2009; Rahim, 2014), such as difficulties in affect regulation (Kisiel et al., 2014), social interactions (Rademaker et al., 2008), self-harm (Lawson & Quinn, 2013) and attachment (Bollinger, Scott-Smith, & Mendes, 2017; Cook et al., 2005).

Neglect and adverse childhood experiences also affect the developing brain (Bollinger, Scott-Smith, & Mendes, 2017; De Bellis, 2005; Delima & Vimpani, 2011; Fisher, 2015; Watts-English et al., 2006). This includes changes in areas of the brain that are involved in cognitive development, emotional and behavioural regulation (De Bellis, 2005). Experiences of trauma can also affect the biological stress response system (Watts-English et al., 2006), resulting in young people experiencing an elevated stress response (Delima & Vimpani, 2011). Therefore, young people experience high levels of emotional arousal where this may feel overwhelming (Rahim, 2014), become hyper-alert and interpret the world as dangerous (Bollinger et al., 2017; Lawson & Quinn, 2013).

LACYP can therefore experience higher levels of emotional distress when compared to young people in the general population (Cousins, Taggart, & Milner, 2010; Harpin et al., 2013; Meltzer et al., 2003; Tarren-Sweeney, 2008; York & Jones, 2017). A recent study of the emotional wellbeing of LACYP who had been in care for at least 12 months, utilising the Strengths and Difficulties Questionnaire (Goodman, 1997), showed that over half of the LACYP had difficulties with their emotional wellbeing (Department for Education, 2017).

There is also a wealth of evidence showing that LACYP experience high levels of mental health and behavioural difficulties (Andrew, Williams, & Waters, 2014; Durka & Hacker, 2015; Gearing et al., 2015; Harpin et al., 2013; McNicholas et al., 2011; Tatlow-Golden & McElvaney, 2015), with LACYP residing in residential care having more mental health difficulties compared to foster placements (Meltzer et al., 2003). UK research exploring the experiences of LACYP in residential care and foster placements revealed the emotional impact of being moved away from family,

the potential of multiple placements and being surrounded by other LACYP with their own difficulties (Stanley, 2007). This is in addition to the experiences encountered prior to being placed into care of the Local Authority.

Given their high levels of emotional distress, it is unsurprising that self-harm is also a behaviour displayed in LACYP (Andrew et al., 2014; Grenville, Goodman, & Macpherson, 2012; Stewart et al., 2014) as self-harm is often used to regulate intense emotions (Klonsky, 2007; Nock & Kessler, 2006), or to relieve unwanted feelings (Laye-Gindhu & Schonert-Reichl, 2005) or thoughts (Teague-Palmieri & Gutierrez, 2016). Self-harm can also be used as a form of self-punishment (Klonsky, 2009) or a method of communicating to others (Scoliers et al., 2009; Young et al., 2014).

Self-harm is defined here as an act of self-injury or self-poisoning regardless of the motivation or intent that may drive this behaviour (NICE, 2013). Common methods include cutting, scratching and burning the skin or banging body parts and taking medication overdoses (Klonsky, 2007; Klonsky & Muehlenkamp, 2007; Skegg, 2005). Within Europe, it is documented that up to 10% of adolescents have engaged in self-harm at some stage of their life (Madge et al., 2008). However, LACYP are up to five times more likely to engage in self-harm (Department of Health, 2012), whilst in residential settings prevalence rates have been reported to be up to 60% (Messer & Fremouw, 2008).

There are also other risk factors associated with LACYP self-harm in residential care settings. Research in the UK shown that LACYP living in residential care display more self-harming behaviour when compared to those in foster placements (Hamilton et al., 2015). In addition, research conducted in USA

residential care, revealed risk factors and predictors of self-harm, including younger age, higher levels of aggression and previous episodes of self-harm (Gallant, Snyder, & Von Der Embse, 2014).

Currently, there is a dearth of research into self-harm within the LACYP population (Grenville et al., 2012; Harkess-Murphy, MacDonald, & Ramsay, 2013). It is a necessity for LACYP voices to be heard (Department for Education & Department of Health, 2015) and making subsequent changes can support the empowerment of LACYP (Stanley, 2007). However, the views of LACYP are seldom reported (Stanley, 2007; Tatlow-Golden & McElvaney, 2015), especially in relation to self-harm.

Research, as discussed above, has indicated the higher prevalence rates of self-harm in LACYP living in residential care, the potential influence of the environmental context and difficulties in supporting young people in residential care. All professional services need to support the emotional wellbeing of LACYP (Bazalgette, Rahilly, & Trevelyan, 2015) and it is important to understand the experiences of LACYP who self-harm whilst in residential care.

Qualitative findings will help further develop our understanding of the psychological needs of LACYP who self-harm and how clinical psychologists and other professionals can support change within care systems. Thus the aim of this research was to explore the experiences of LACYP in residential care settings to understand their experiences of self-harm. It was of particular interest to understand if the environmental context of living in residential care impacted on self-harm and whether staff responses to self-harm influenced the young person's experience. Interpretative phenomenological analysis (IPA) was used to allow the development of an in-depth understanding of how LACYP make sense of their self-harm.

Method

Design

This research employed a qualitative design based on IPA, a method that aims to explore what meaning individuals give to their experiences (Smith, Flowers, & Larkin, 2009). IPA is interpretative and the researcher engages in a double hermeneutic to make sense of how the participants make sense of their experiences (Smith et al., 2009).

Semi-structured interviews were used to explore how LACYP experience self-harm. These provided structure to the interview but allowed elements of flexibility for the participants to raise topics relevant to them, but not planned for.

Participants

The target sample was LACYP, who were either currently or had previously engaged in self-harm, whilst living in residential care.

Inclusion criteria:

- LACYP residing in residential care.
- Aged between 13- 18 years old.
- Currently engaging in self-harm or had previously engaged in self-harm whilst in residential care.

Exclusion criteria:

- If the registered manager of the care home deemed that the young person would not be suitable based on the likelihood of it evoking undue distress.
- If the registered manager of the residential care home deemed that the young person did not have the cognitive ability to participate.
- If the registered manager felt the young person presented with high levels of risk to self or others and would not be suitable for interview.

A total of five participants, two males and three females, were recruited from two residential care providers. Full participant characteristics can be found in Table 1.

[Insert Table 1]

Recruitment

The researcher and supervisor contacted several residential care providers to gain approval to use them as recruitment sites for the study. A total of four residential sites participated at this stage. The researcher attended relevant staff meetings to discuss the project. The inclusion and exclusion criteria were made explicit at these meetings. Designated staff members were responsible for identifying and initially approaching eligible participants.

Recruitment packs were made available to staff members to hand out to eligible young people. Designated staff members within each care organisation contacted the researcher when eligible participants wanted to participate. The researcher again discussed the eligibility criteria and the

consent process with the staff member. A suitable time for interviewing was then arranged.

Consent

The process of consent was discussed with a nominated member of staff prior to the interviews. Consent/assent was obtained from all young people, as appropriate, through completion of the relevant consent form (Appendix 4).

Where the young person was 16 years or older, written consent was obtained directly before the interview. Where the young person was under the age of 16 years, the assent form was completed prior to interview and consent was obtained from the individual with Parental Responsibility, for example social worker. This consent was needed before the interview could take place.

Ethical considerations

Ethical approval was obtained from the university research ethics committee. Please refer to the ethics documentation for comprehensive ethical considerations (Appendix 4).

Data Collection

All interviews took place in an appropriate location, on a 1:1 basis and on average lasted 45 minutes. The interviews were digitally recorded using a Dictaphone.

Before digital recording commenced the young people were given the opportunity to ask questions and confidentiality was discussed. A consent form and demographic form (Appendix 4) was completed and signed.

A topic guide was used to structure the interview (Appendix 4). This was designed to give space for young people to express their experiences and feelings in a number of different ways, with the hope to support young people to feel at ease. The researcher asked follow-up questions to aid the participant's thinking and to try to explore their experiences in depth. At the end of the interviews, participants were given the opportunity to ask questions and were debriefed. All participants were reminded of the helplines and support available if they wished to seek this.

Data analysis

The researcher transcribed all the interviews verbatim. Data was analysed using IPA (Smith et al., 2009). For a detailed explanation of the IPA process, please refer to Smith et al., (2009). This analysis allowed for an idiographic focus and individual meaning behind self-harm experiences to be explored. IPA allowed the researcher to deconstruct individual narratives of self-harm experiences using a two-stage process of interpretation in the analysis. It was felt that IPA would be the most appropriate method for analysis in comparison to other qualitative approaches, as the study aimed to explore individual meaning of self-harm experiences.

The initial stages of analysis involved reading and re-reading the individual transcripts one at a time and the researcher made relevant annotations down the right-hand side. These annotations included descriptive statements, linguistic features and tentative interpretations of the data (Appendix 2-B). From here, emergent themes were generated and added to the transcript. This included working with the annotations developed and

interpreting each chunk of text. The emergent themes were then collated and grouped together, based on similarity, to generate participant superordinate themes. This process was repeated for each individual transcript. Once all participant superordinate themes were created, the author pooled them together, again based on similar ideas, to develop master themes for the whole data set (Appendix 2-C).

In an attempt to increase the validity of the analysis, the researcher sought regular consultation from the academic supervisor. The researcher also kept a reflective diary to allow her to document and reflect on her own responses to the data and how this may have impacted on the interpretations. Once the main themes for the whole data set were developed, the researcher checked these with both the academic and field supervisor.

Results

The final analysis revealed four main themes: 'The black hole of self-harm', 'Seeking genuine care through a protective mask', 'The cry to be understood' and 'Loss of control to the system.'

The black hole of self-harm

This theme captures the consuming and challenging relationship that participants had with their self-harm. The black hole encompasses the idea of 'falling into' the black hole and feeling stuck within repeating patterns of behaviour. Although all participants wanted to stop their self-harm, they were uncertain whether they could due to their dependence on it as a coping strategy and the functions it served.

All young people discussed their intense relationship with self-harm and how they engaged in certain behaviours that served different functions for them: "If I was angry...I'd tend to burn myself...if I was just sad...I'd tend to cut myself" (Chantelle); "I used to self-harm because...there was no way out but then...I liked pain. So at one point, I used to self-harm because I loved the pain..." (Bob).

Participants discussed feeling consumed by self-harm. Iris used the metaphor of self-harm being like a black hole which described a loss of control and the hole perhaps representing a cycle of behaviour: "...this black thing in my head. It's like a round thing and it's like a hole...that hole in my head tells me go and do that" (Iris). Lilli reflected on the unachievable internal expectations of what was deemed to be "good enough" self-harm, which maintained her behaviour: "You never overdose enough, you never cut enough...you just never have done enough" (Lilli). Iris considered the toxic nature of self-harm and how she did not want it to dictate her future: "But I don't want to get locked up or sectioned because that would ruin the rest of my life" (Iris).

This feeling of being in a dark place was echoed when participants described how self-harm was like an addiction: "Once you start self-harming depending on not whether you like it or not you carry on" (Bob). Chantelle did not anticipate her consuming self-harm journey ahead: "I wish I'd not started it in the first place. Because obviously that time I started it was nowhere near the end" (Chantelle). This journey would continue for Chantelle as she was now exposed to lifelong reminders, in the form of scars: "I didn't know it was going to be something that happened all the time and would stay with me in some way forever".

There was a sense that participants were stuck in a repeating pattern of self-harm: "And it happened again and again and they wouldn't get you any help to stop it

from happening” (Finn). However, most participants reported ambivalence about stopping: “Erm because I want to stop but I don’t...” (Iris). This was entangled with feeling unable to stop: “I’d love to stop. But I can’t” (Lilli). Chantelle’s desire to stop was hindered by the presence of her scars so instead, she was focusing on harm reduction: “the damage is already done so if I want to do it, I’ll just do it. I try to...do it so I don’t have to...go to hospital” (Chantelle).

Finn reflected how the strategy that he once perceived as useful to seek support was having a detrimental influence on his family: “I was like this needs to stop as it’s not good any more” (Finn). Although Iris questioned her self-harm, the defence of not holding regrets was intense and perhaps protective: “It’s like, what have I done that for? And I won’t go I wish I never did that...I don’t regret doing anything” (Iris).

Some participants were fearful when they considered the potential lethality associated with self-harm, emphasising its dark nature: “I’ll accidentally cut too deep or take too many pills, or tie a ligature that’s a bit too tight” (Lilli); “I feel scared...like what if I do die” (Iris). Some participants were able to distinguish between self-harm and suicidal behaviours, where others felt that this was challenging to decipher: “You sort of look back and go so what preparation did I make in case I die” (Lilli); “When people say that, I don’t really know to be honest” (Chantelle).

Despite feeling stuck and fearful, young people acknowledged the useful aspects of self-harm. Finn described engaging in self-harm in an attempt to communicate the need to see his mother: “I knew that if I put myself in hospital then mum would come...I’d be constantly cutting myself” (Finn). Self-harm was also a method to regulate emotion and a preferred option to quickly reduce intense emotion: “I just find it easier... It’s like opening the bottle and all the pain just releases” (Bob).

This theme highlights the individual experience of self-harm for participants, which is consuming and challenging to navigate through. Although the behaviour served a useful function, perhaps even pleasurable, some participants felt stuck and unsure if they could stop self-harming.

Seeking genuine care through a protective mask

This theme captures how participants did not want to display emotional vulnerability, so they would reject and push away support. Although this served a protective function, it was also a barrier to seeking care. Young people valued feeling genuinely cared for, where their emotional needs were attended to.

There was a protective narrative portrayed by some of the participants, which held a position of pushing others away. This could serve as a protective strategy for young people, as displaying vulnerability may be too unsafe: "No one really seems to really respond to it. Which is all right with me because that means, I know no-one is going to be too worried about me" (Bob). Some participants reported that they preferred to cope alone, which may be a familiar pattern, so accepting support from staff creates defensiveness: "people mollycoddle me and I'm like leave me alone...F**k off yeah and when I say I'm OK, I'm OK" (Iris).

Even though young people stated a preference to cope alone, there was an overarching narrative portrayed by participants of feeling uncared for. In an attempt to seek support, Bob reported that he would communicate his needs through self-harm: "...look at my arms, I am bleeding and I want attention" (Bob).

Some participants also discussed not feeling listened to which may impede the acceptance of support: "It makes me want to self-harm more because they won't listen to me..." (Iris). However, even though participants felt ambivalent about seeking

support, this was overruled when young people were fearful about the risks associated with their self-harm: "Only if I really scared myself and I thought I was going to die, I'd tell someone" (Chantelle).

There appeared to be a critical timeframe in which support needed to be offered following self-harm. The wait for support perhaps felt like support was not available when needed, so when it was offered, it was refused: "It's already been and gone now. What good is talking about it with you?" (Chantelle).

It was also essential that support felt like genuine care. Sometimes, participants were aware that the support provided to them was for risk management purposes, as opposed to what felt like sincere care: "Yeah I'm getting attention and everything but it's like for a bad thing. I'm literally getting this because they think I'm going to kill myself" (Finn). Bob made particular reference to support being offered as part of a job role: "...They've got to make sure I'm ok." Chantelle also reported that staff responses were implemented so staff could demonstrate that they were doing what they "should be", echoing that this did not feel like genuine care: "I think it's more like, to make it look like they're doing what they should be doing, if you know what I mean." However, Chantelle reflected that she valued when support felt genuine: "You can usually tell when staff are not happy... she [staff] wasn't like that, she genuinely cared. And that's what made the difference" (Chantelle).

The need for emotional containment, during and after self-harm, was crucial for the participants. Participants needed support in regulating their emotions so that they felt safe enough to stop self-harming: "...unless you're going to bring me down I've got no reason to take it [ligature] off" (Lilli). Bob perceived that although his physical health needs were addressed when he self-harmed there was a lack of emotional containment: "It's not helping me emotionally, but it's helping me

physically". Lilli, Bob and Finn described that, at times, they believed that the staff supporting them were unable to manage their distress, which may have led to feeling beyond help: "They didn't quite have the training and they didn't quite know how to deal with me" (Finn).

Self-harm could also evoke observable emotional distress in staff, which may have led to feelings of emotional un-containment for the young person: "They get scared and they panic...they need to relax..." (Iris). Chantelle reflected that she felt that professionals were unable to provide the support she needed: "...they're all supposed to be like the ones looking after me". Finn also reported that it was unhelpful when staff, who he had established a relationship with, would become upset when he self-harmed: "I think what were bad was that staff wise, obviously if it's one that I have known for two years, get quite upset". However, Bob reported that expression of staff emotion was helpful as it demonstrated a genuine care for wellbeing: "At least they're showing emotion and they are actually worried about people in their job and they are not just here because they have to".

There was also a desire for help and direction from staff. Iris reflected that she needed support and guidance in order to make meaningful change to her self-harm: "That's what I want help with, people finding me solutions what to do" (Iris). It seemed that she was locating all power for change to her self-harm in staff and desperately needed that support.

The value of a trusting relationship was described as crucial and Chantelle reported that she valued having a safe relationship, where she would not be exposed to judgments: "It's more about having someone there that when it has happened who won't judge you or make you feel like an idiot". Developing trusting relationships

allowed participants to feel safe enough to open up more to staff, although their underlying vulnerability meant that they continued to withhold some information:

Well once I got to know the staff a bit and built relationships with them, I felt like I could tell them...I still wouldn't tell them before I do it, but if I done it and it was quite bad then I could tell them... (Chantelle).

It seemed that there was also a need for a parental figure in the young person's life that could emotionally contain distress and be psychologically attuned to subtle early warning signs of distress: "She knows when we're upset... She knows when something is bothering us without a doubt" (Bob). Lilli discussed how she valued the choice of support from staff, which led to shared control, and the how consistent responses to her self-harm supported her to feel contained: "Like you've not got the whole...what will they do if I do this or what will they do if I do that?" Participants also appreciated a genuine interest in their wellbeing, which supported the belief of receiving genuine care: "They check on you all the time... so if you say I'm not feeling so good they can stop and have that chat. And it don't feel forced because it's just relaxed: (Finn).

This theme emphasises that even though participants may reject and obstruct care, there is a strong desire to feel supported and emotionally contained. The development of trusting, secure relationships with staff is crucial in this process.

The cry to be understood

This theme considers the challenging experience of conceptualising self-harm on a personal level and wanting others to understand their behaviour. Young people

feared judgments from others in the process of understanding their own self-harm, yet they desperately wanted others to understand their distress.

Most participants reflected on the challenges of understanding their self-harm and that making sense of their difficulties was a confusing process. Chantelle suggested that she was dealing with her behaviour rather than fully conceptualising it: “[I understand] to an extent, but I wouldn’t say fully, no...I just, just deal with it really”. For Iris, making sense of her self-harm involved making links to how her early life experiences may have influenced her current behaviours: “Because the way I act is because of how I have been brought up. I haven’t had the best life...”

Young people also felt that there was a lack of understanding from staff. Iris described needing staff to listen to her to try and support the making sense process: “...listen to my point and like, understand why I am the way I am” (Iris). There was a narrative that staff perceived self-harm to be “attention seeking” behaviour designed to elicit care. However, Iris emphasised that she had not explicitly asked for care: “They just think, oh she just wants the attention, but I genuinely don’t...I didn’t ask them to check on me” (Iris). Lilli described how she felt judged by staff who lacked an understanding of the context of their self-harm: “I was like you know what, go and f**k yourself. Cos at that point they knew nothing about my history.... And yet, they decided that they can make that quick judgement”.

The young people wanted staff to have an awareness of their life story and to have conversations with staff about the reasons behind their self-harm. However, it was felt that there was limited exploration of self-harm initiated by staff: “I just don’t see why people don’t, aren’t just direct” (Chantelle). Chantelle believed that discussing self-harm was an uncomfortable topic for staff: “I found that people

avoided it, like they didn't want to talk about it because it made them uncomfortable kind of thing" (Chantelle).

Most participants reflected that they needed and wanted others to understand their behaviour so that adequate support could be provided. Young people were aware that many staff supporting them had an intellectual understanding of self-harm, but felt that they did not understand their individual self-harm: "They think...all different ways but it's not really to the point of why" (Bob); "You can't just give a couple of reasons and expect it to fit every single box" (Lilli). There was a sense that ultimately staff could never connect with self-harm as they lacked lived experiences of this behaviour: "I think unless you have gone through it yourself you don't understand it" (Lilli). Finn suggested that professional understanding may increase if training sessions include narratives from young people: "...let young people who have self-harmed in the past...do a couple of training sessions...then they get the emotional bit".

This theme encompasses the challenge for young people to understand their own difficulties and the belief that staff were also unable to conceptualise their self-harm. As staff were unlikely to be able to draw upon their own experiences of self-harm, young people needed staff to connect and understand their life story to try to recognise what may have precipitated and be maintaining their self-harm.

Loss of control to the system

This theme highlights the loss of control that young people experienced whilst being in residential care as they were exposed to new experiences and boundaries that were enmeshed in policy to manage risk. This experience was challenging for young people, as it differed from experiences of "home life".

Interestingly, all participants had an awareness of how staff “should” respond to self-harm in accordance with policy: “They can only take it if it’s around your neck and sometimes they can take something off you” (Iris). Chantelle perceived policy to be “punishing” and risk assessments to be depersonalised in nature: “sticking to the script”. Young people were frustrated, perhaps due to a lack of understanding as to why staff needed to take control: “They will be like this is my job...right I have to do this. No you don’t have to do it” (Bob).

The young people discussed the risk management plans implemented, which included room searches, limited access to specific items and restricting independent access in the community. Such boundaries were a new and unfamiliar experience to Bob: “I’ve not really had many boundaries in my life until I come into care. So it’s a new thing”. Iris and Chantelle also made links to differences in the restrictive nature compared to their home life: “...it makes you more mad because...in real life, when you were at home you could do that” (Iris); “It just made me a bit sad that I wasn’t at home really. Just reminded me that it weren’t my home” (Chantelle).

Some participants reflected that boundaries did not prevent self-harm as ultimately the young person still held control over their behaviour: “They’re not stopping me, they are just saying don’t do it. And then what are they going to do like. They can’t do anything about it” (Iris). If the desire to self-harm was intense, the young people would find a way to self-harm, regardless of risk management plans: “...you’re gonna find something to do it with. I could hurt myself with a padded cell” (Lilli). Chantelle and Iris reflected that boundaries could in fact increase the urge to self-harm, as distraction techniques may be restricted: “you’re making me more dangerous to myself because you won’t let me do what I want to do” (Iris).

Young people were exposed to room searches, which included removal of personal belongings if they were associated with potential risks. Lilli suggested that objects that could be used to self-harm had significant value to her: "...they don't find everything but they find the most important things to you". Iris felt there was an element of secrecy in room searches which she perceived as theft: "If they did it in front of me then fair enough but they do it behind my back and to me that's theft". Removal of objects also led to Finn feeling that he was deprived of his own personal belongings and luxuries: "it were kind of upsetting because I could go home to family and it would be their rooms would be absolutely kitted out" (Finn).

It was perceived that increased observations were implemented to manage risk: "They start doing like every 15 minute checks to make sure you're still alive" (Bob). Being observed through the night was particularly challenging and Lilli described how she found it difficult to sleep with staff present in her room: "How would you like somebody to watch you sleep. It's not good, very unnerving".

It was felt that personal space was at times invaded in order to manage risk: "I have a right to privacy and they just stick to the policies and procedures" (Chantelle). Iris reported that her distress would escalate if she felt that staff were invading her personal space: "Because when I'm angry, people have to leave me to calm down myself because if they get in my face...I will smack them" (Iris).

There were also confrontations between staff and young people regarding the extent to which self-harm injuries required medical attention: "They just take me to hospital and I'm like I don't need to go to hospital over a scratch" (Iris). Chantelle hypothesised that staff sought medical guidance to ensure that they did not end up getting into trouble, rather than providing genuine support: "...just probably don't want it to be worse than it is and they get in trouble for it I suppose".

Young people also felt a lack of control in their living environment, including who they resided with. It was acknowledged that living with other young people could provide a peer support network: "If he sees that my normal attitude has dropped...he will talk to me and do stuff with me to kind of help me" (Finn). However, living with other young people who engage in self-harm was perceived as generally problematic: "That just weren't like, an appropriate placement for us both...when I'd be ok, she'd sometimes self-harm and like there would be blood in the floor...I just found it a bit triggering really" (Chantelle). Chantelle was clear that this was difficult for her and she resented being placed in what she perceived as an unsuitable placement: "I don't feel like I should have had to deal with that. We shouldn't be placed together". Other detriments included peer rivalry associated with self-harm: "I was like I've got to beat you to it [knife]" (Lilli). This could perhaps be understood in terms of self-harm contagion.

This theme describes the tensions surrounding the boundaries and procedures that participants are exposed to when self-harming behaviour occurs. Such boundaries may be a new experience to young people, leading them to feel a loss of control. The challenges of being in an environment with peers, who young people did not choose to live with, were also highlighted.

Discussion

Four themes emerged from the data analysis: 'The black hole of self-harm', 'Seeking genuine care through a protective mask', 'The cry to be understood' and 'Loss of control to the system.' Their relationship with self-harm led the participants in the study to feel stuck and alone within a 'black hole'. Young people felt dependent on self-harm, as a way of coping with emotional distress, which made it difficult for

them to stop this behaviour without an alternative outlet. They wanted to be genuinely cared for by staff, but being vulnerable and accepting support was a difficult dynamic to manage. Overall, it was challenging for both young people and staff to understand self-harm. Young people wanted to make sense of their own behaviour and for staff to engage in this understanding. Finally, living in the care system brought new experiences and boundaries into the young people's lives and this, at times, influenced their self-harm.

Similar to findings from previous research, the young people in this study reported engaging in self-harm as a method of coping (Laye-Gindhu & Schonert-Reichl, 2005) to regulate intense emotions (Klonsky, 2007; Nock & Kessler, 2006; Penn et al., 2003). Self-harm has been found to serve different functions, that can differ each time an individual self-harms (Kapur et al., 2013) and findings from this research revealed that the function of self-harm differed depending on the nature of emotional distress experienced by the young person. Young people felt consumed and dependent on self-harm which is consistent with findings from Nixon, Cloutier and Aggarwal (2002), who posited that self-harm is reinforced due to subsequent sense of relief experienced following the behaviour. This sense of relief is gained as the body releases endorphins which can lead to individuals becoming stuck in an addictive cycle of coping (Hicks & Hinck, 2008).

Some participants also described enjoying the experience of pain and blood when they self-harmed. The desire to feel pain may have been an attempt to replace the emotional pain experienced with physical pain (Hicks & Hinck, 2008). Wanting to see blood is common in adolescents and there are

perceived reinforcing roles associated with seeing blood, such as reducing distress and releasing tension (Glenn & Klonsky, 2010).

In line with previous research, the young people needed and valued feeling listened to (Ward, Skuse, & Munro, 2005). Young people wanted to establish genuine, trusting, emotional connections with staff but they were fearful of this and obstructed support. Exposure to early trauma can make it difficult to establish trust (Cook et al., 2005), which can influence the ability to accept support. It may also be that accepting and seeking support is threatening, based on previous experiences. This could be understood in terms of attachment theory which emphasises the importance of early relationships and the influence this can have on social and emotional development (Bowlby, 1969). Disrupted early attachments are common in LACYP (Bovenschen et al., 2016; Woolgar & Baldock, 2015) and may predispose young people to either reject care or become preoccupied with wanting to be close to others (Mikulincer, Shaver, & Pereg, 2003) or alternate between these two patterns (Golding, 2007; Scott, 2011). Young people can also be fearful of establishing intersubjective relationships, which have been described as reciprocal, responsive relationships (Golding, 2017). Subsequently, young people may avoid relationships as they fear being rejected (Golding, 2017).

Participants wanted to understand their self-harm and to be understood by others. Young people needed staff to curiously initiate conversations and for staff to have a much greater awareness of how young people's life stories may influence their self-harm. In addition, staff need to have an understanding of the influence of adverse childhood experiences and developmental trauma and the links to self-harm and regulating emotions (Kisiel et al., 2014; Lawson & Quinn, 2013). It was also apparent that if staff did not understand factors that precipitated self-harm, then young people

were left feeling invalidated and dismissed. Invalidation occurs when an individual shares an experience with another and they respond in an inappropriate, dismissive manner (Linehan, 1993). Individuals who are exposed to invalidating responses experience higher levels of emotions and physiological arousal when compared to those who experience validating responses from others (Shenk & Fruzzetti, 2011). Therefore, when staff members respond in a manner that may be perceived as invalidating, young people's distress may increase, which may lead to engaging in self-harm as a method of emotional regulation (Klonsky, 2007; Nock & Kessler, 2006).

All young people made reference to policy that surrounded them in residential care and the detriments of control being within the care system. This included being exposed to new boundaries, living with peers in care and the implementation of risk management plans. Similar to findings reported by Munro (2001), where LACYP reported having little influence within reviews about their care, young people in this research may have experienced feeling that they did not contribute to the decision making process about their self-harm, especially in relation to room searches and community access. This could be in addition to feeling a lack of control in the decision to be taken into care of the Local Authority.

Being surrounded by boundaries and risk management strategies may have also hindered the ability of young people to fully connect with staff members. It is challenging for staff members in a dual role (McLean, 2015), which includes keeping a young person safe and maintaining a therapeutic relationship, as risk management may hinder this process. However, maintaining an effective, trusting therapeutic alliance with individuals who self-harm is crucial in supporting alternative methods of coping (Nafisi & Stanley, 2007). In addition to establishing a bond within the

relationship, the therapeutic alliance requires mutual and shared goals (Bordin, 1979). If staff goals are primarily focused on risk management, then this is likely to negatively impact the therapeutic alliance with young people. Research has demonstrated that the therapeutic alliance was perceived to be lower in residential settings, compared to outpatient settings, which was attributed to the potential influence of not only being involuntarily taken into residential care but also of enforced boundaries from staff (Duppong Hurley et al., 2013).

Throughout the interviews, it was noticed that young people predominantly gave descriptive responses rather than emotional experiences. This could be linked to the context of the interview and challenges of sharing emotional experiences with a researcher. However, it may also be that young people were 'cut off' from their emotional language. This perhaps links to earlier adverse experience, disrupted attachments and developmental trauma and the development of emotional regulation (De Bellis, 2005; Kisiel et al., 2014) is likely to have made it increasingly difficult for young people to understand and articulate their feelings. Some participants also made reference to staff feeling uncomfortable and not encouraging discussions about self-harm. However, talking about emotions supports the development of emotional literacy skills and the ability to understand emotions (Suveg et al., 2008), therefore if young people are not exposed to this, they may not be able to develop their emotional language.

Clinical implications

Findings from this research demonstrate the need for secure relationships between LACY and staff. However, this desire for connection was also entangled in the fear of forming relationships. It is essential that professionals establish a way of letting young people know that it is safe to form relationships with them. To help

young people feel safe, it would be important for staff to take a curious, empathic, accepting stance when communicating with young people and to demonstrate that they are not uncomfortable talking about self-harm.

Secondly, young people reported that the initiation of discussion about self-harm was limited. To create a new culture, services should aim to support young people to have discussions with key staff members about their self-harm. This should include promoting and encouraging young people to engage in discussions about distress.

Residential care home may also benefit from collaboratively developing safety plans with young people that are regularly reviewed. These plans could support staff to recognise the early warning signs that young people may be distressed and how they can best support them.

There is also a need for young people to be involved in risk management plans that are young person friendly. This is to ensure that they are person centred and specifically tailored to young person's needs, as opposed to the perceived depersonalised nature of standardised risk assessment.

Staff training packages are needed to enhance understanding of self-harm, particularly supporting staff to understand the context of self-harm and how this behaviour may serve different functions. This could be understood through the use of psychological formulation, as it is necessary to focus on the distress and underlying mechanisms that maintain the behaviour. Training should also include ways that young people can be supported to reduce their self-harm, such as alternative coping strategies. This is necessary so that staff can offer practical ways to support when this is wanted. It would be useful if such training includes young people's perspectives,

particularly those of young people who are still within care. It may be useful if a young person could co-facilitate part of this training package.

Finally, working with young people who self-harm can be emotionally challenging for staff teams, especially working in a dual role of providing therapeutic care and managing risk. The use of clinical supervision for staff would be helpful in enabling staff to consider the complexity of their roles, their own emotional responses to self-harm and how this may influence their ability to care for young people.

Strengths and limitations

The findings from this research are novel and highlight the personal perspectives of LACYP in residential care, which is a rarity in current research to date. The findings are clinically relevant as they provide crucial insights into the experiences of self-harm from LACYP perspectives, which is vital given the higher prevalence rates of self-harm within this group of young people. The findings are unique as they also detail how the environmental context of living in residential care may influence self-harm. This specifically includes the perceived challenges of staff in understanding the behaviour, being exposed to new boundaries and risk management plans, receiving emotional support from 'paid' professionals and how such experiences in residential care ultimately differ to 'home life'.

There were challenges in the recruitment process throughout this research as there were particular barriers to accessing LACYP. Managers within services were the 'gatekeepers' to recruitment and the challenges were mainly centred around concerns regarding the vulnerability of LACYP and whether discussing current difficulties may exacerbate distress. Several discussions occurred with service providers to overcome these obstacles, but recruitment remained low. It may have been useful to have amended the recruitment strategy and recruit care leavers as well

as young people residing in care. However, the purpose of the research was to capture the voices of young people currently in the care system and the final sample of 5 young people provided sufficient depth of data to address the research question.

Future research

Given the small sample size within this research, future qualitative research could look to build on findings from this study, using a wider national location to increase participation. It would be beneficial for research to explore the experiences of young people who have left care, where they can reflect back to their in care experiences of self-harm to determine if similar experiences were revealed.

It would also be useful if future research could explore staff's experiences of their 'dual role' of providing therapeutic care, whilst also needing to manage the young people in care. Specifically, qualitative research could explore LACYP staff's views of whether their therapeutic relationship with young people in care is affected by their need to use more formal risk management processes. In addition, future research could consider the impact of different risk management strategies or therapeutic provision provided on self-harming behaviours within residential care.

Conclusion

This research aimed to capture young people's experiences of self-harm whilst living in a residential setting. Findings demonstrated how young people in residential care were exposed to new experiences, boundaries and desperately needed staff support and guidance. Understanding these context specific experiences increases understanding of the experiences of LACYP who self-harm in residential care with the aim to adapt and support LACYP to minimise this behaviour.

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Tables

Table 1: Participant characteristics

Participants	Gender	Age	Self-harm behaviour	Approximated length of time in residential care
Iris	Female	14 years	Cutting, scratching, ligatures	1 year 6 months
Lilli	Female	16 years	Head banging, cutting, self-induced vomiting	4 years 6 months
Finn	Male	16 years	Cutting	3 years
Bob	Male	16 years	Cutting	4 months
Chantelle	Female	18 years	Cutting and burning	3 years

Appendix 2-A: Extract of coded transcript

P: yeah, the cutting. It's really relaxing. But like, and like, when I tie ligatures I want the help. So I do that because I think somebody is going to help me and listen to me. And get my... and listen to my point and like, understand why I am the way I am.

I: And does that happen when you ligature, do people help you and understand your point?

P: yeah they actually listen to me and I want that. I want them to help me. And my only way I think, I think to help me and listen to me, like properly listen is to do that.

I: and do the staff listen?

P: Yeah and sometimes they don't and I go listen and they listen.

I: and what kind of self-harm have you tried?

P: ligatures, hanging, erm, rope around a tree

I: and what did you do with the rope?

P: tied it around a tree but that was before I moved into care. Erm, cut erm, I got a Stanley knife when I was younger. Erm, that's it really.

I: ok, so self-harm is something that is in your life, how do you feel you cope with this?

P: I just like, I don't know what you mean?

I: do you feel you cope with your self harm?

P: no, I feel scared when I do it. I feel like what if I do die. What are they going to say to my family? What, how like, what are they going to say like, what are they going to tell my brothers and my grandmother? They are going to blame themselves aren't they? And my mum for not being there. Like... I'm not crying, I have a sore throat. And its hard for them to understand why I act the way I act. They couldn't cope that's why they put me in care

I: was it because of the self-harm?

P: yeah and my anger. My anger and my aggression, my self-harm. everything.

I: so self harm scares you a little bit sometimes?

P: yeah like whoa what am I doing and then I'm like, yeah?

I: and does that, does being scared stop your self-harm?

Different methods serve different function

Cutting: Relaxing element... to cope? Calm down?

Desire to be heard

FUCNTION: to communicate need care "I want help"/need listened too

Understanding my journey

Need to be understood links to difficult childhood?

Ligature: the only way to elicit care

Ligature to seek care and gets needs met- Others listen- only way to do this

Longing for care

Need for help and support
The only way to get help/ elicit care
Frustration when others don't listen

DSH Methods: lig, hanging, cutting

Multifaceted Fear of death (ligatures)

Fear
Risk of death
Fear of how family would respond
Fear family will blame self

Hard to understand journey

Association with self-harm and mum not being there
Sense of responsibility for others
Need to make it clear not getting emotional- why?
Reluctant to show vulnerability

Can't be vulnerable**"What am I doing": confusing nature of dsh- out of control**

"put me in care" cold and impersonal tone

The mask: Putting up a front

Hard for family to understand- links family not coping with becoming LAC
Can't understand - questions self
Whoa? Strong term of not being able to understand

Appendix 2-B: Table of super ordinate themes and emergent themes for one participant

Participant	Super ordinate themes and emergent theme examples	Page/line	Example quotes
Iris	<p>The mask of defence?</p> <p>The mask: putting up a front Defence The mask Putting on a front Contradiction Cant be vulnerable Desire to be heard Not feeling heard Not feeling cared for Push others away Reject others Care is intolerable? Feeling unsupported Desire for help Longing for care Need for containment Need direction to stop Fear of accepting care – intolerable Lack of love/nurture Feeling unloved/ uncared for</p> <p>The battle of control</p> <p>Battle for control Passive to control Lack of control</p>	<p>3:101 3:142 2:92 6:283 14:682 1:16/2:79 2:54 4:161/7:304/14:669 10:484 3:104/7:295/12:559 3:100 5:214 8:343 4:164 2:59 3:125 11:506 12:568 1:10 9:404</p> <p>3:107/ 5:227 3:119 1:46</p>	<p>“yeah, I don’t listen to them, I do what I want”</p> <p>“I just tell them to f**k off and kick them out me room and lock the door”</p> <p>“...if that’s going to help me I want the help”</p> <p>“if you said well do this were like say if you and we did this and you did that and this and that. Then I would”</p> <p>“I think what’s the point in living you don’t love me anyway”</p> <p>“they get scared and they panic so they cant open the door. So they need to relax”</p> <p>“...because they are not taking it off me are they? they cant physically take it out of your hands. They not stopping me they are just saying don’t do it”</p>

Desire for control	6:284	<p>"...in real life when you were at home you could do that"</p> <p>"I'm going backwards. Im not going forwards. I'm going backwards and that's not fair"</p> <p>"I just have this like, just this black thing in my head. It's like a round thing and its like a hole. And when I get, when I get really, when I get really pissed off then that hole in my head tells me go and do that"</p> <p>"...pain is like, oh its amazing"</p> <p>"sometimes but I just lock it away but when I'm pi**ed off that comes back"</p> <p>"Because the way I act is because of how I have been brought up"</p>
Loosing control	8:355	
Taking control	11:501	
Detriments of care	6:272	
Secrecy of Room search	8:350	
Restrictive nature compared to home life	13:610	
Detriment of boundaries: feeling stuck	13:625	
Invasion of personal space	6:264	
Black hole of self-harm		
Black hole of self-harm	1:43	
Pleasure of self-harm	1:47	
The only way to elicit care	2:52	
Self-harm and lethality	4:187	
Multifaceted Fear of death	2:76	
Expected responses	6:250	
Ambivalence	10:488	
Desensitisation: my reality	12:580	
Repeating patterns	5:243	
Brain trauma	3:134	
Coping mechanism	3:147	
Avoidance strategies as alternatives	11:531	
Avoidance of distress, challenges	1:14	
Dominance of anger	8:349	
Intolerable feelings emerge	9:415	
Avoidance of emotional distress	9:411	
Sense making and fear		
Trying to make sense	1:13	
Understanding my journey	2:55	

	<p>Regrets vs no regrets "What am I doing" Hard to understand my journey Others don't understand Confusion Confusion: wanting solutions Wanting to be understood Limited exploration of self-harm Fear of future judgements Stigma and fear of sectioning Hope for independence Fear for the future: toxic nature of self-harm</p>	<p>3:141 2:88 2:82 6:282 12:583 9:418 14:665 12:555 10:447 5:238 13:632 11:493</p>	<p>"...listen to my point and like, understand why I am the way I am" "...like whoa what am I doing..." "they just think oh she just wants the attention but I genuinely don't. Because I didn't ask them to check on me..." "sometimes I say no but they know I have. They don't like to say yeah you have, no you haven't they just leave it and write it down"</p>
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Appendix 2-C: Master table of themes for the whole data set

Final themes	Participant themes and <i>emergent themes</i> *
The black hole of self-harm	<p>Black hole of self-harm Conflicting love The consequence of craving Narrative of self-harm The evolving nature</p>
Seeking genuine care through a protective mask	<p>The mask of defence? Ambivalence and vulnerability Desperate seek for genuine care Attachment and emotional containment Needing emotional containment to explore The relational connection</p>
The cry to be understood	<p>Sense making and fear Sense making Avoidance and the judgemental other Holistic conceptualisation</p> <p><i>Inability for staff to fully connect</i> <i>Understanding life journey</i> <i>Need for training</i> <i>Service user involvement</i></p>
Loss of control to the system	<p>The systemic influence Detriments of living with similarity Regimented to policy Like a prison The battle of control</p> <p><i>Awareness of procedures</i> <i>Staffs responsibility Vigilant to risk –</i> <i>Boundaries: do not influence</i> <i>Punishments for distress</i> <i>Peer emotional connection</i></p>

* Italic text represents emergent themes

Key for participant:

Red: Iris

Blue: Bob

Green: Finn

Purple: Chantelle

Orange: Lilli

Appendix 2- D: Author Guidelines for Journal***Child and Adolescent Mental Health***

Edited by: Jane Barlow, Kapil Sayal, Paul Harnett, Bernadka Dubicka and Nick Midgley

Impact Factor: 1.405

ISI Journal Citation Reports © Ranking: 2015: 67/120 (Pediatrics); 71/122 (Psychology Clinical); 84/139 (Psychiatry (Social Science)); 102/142 (Psychiatry)

Online ISSN: 1475-3588

Associated Title(s): Journal of Child Psychology and Psychiatry

Original Articles: These papers should consist of original research findings.

Review Articles: These papers are usually commissioned; they should survey an important area of interest within the general field..

Authors' professional and ethical responsibilities

Disclosure of interest form

All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

Ethics

Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval

Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study country. Within the Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given. submission.

Manuscripts reporting systematic reviews or meta-analyses should conform to the **PRISMA Statement**.

The Equator Network is recommended as a resource on the above and other reporting guidelines for which the editors will expect studies of all methodologies to follow. Of particular note are the guidelines on qualitative work <http://www.equator-network.org/reporting-guidelines/evolving-guidelines-for-publication-of-qualitative-research-studies-in-psychology-and-related-fields> and on quasi-experimental <http://www.equator-network.org/reporting-guidelines/the-quality-of-mixed-methods-studies-in-health-services-research> and mixed method designs <http://www.equator-network-or/reporting-guidelines/guidelines-for-conducting-and-reporting-mixed-research-in-the-field-of-counseling-and-beyond>

Manuscripts should be double spaced and conform to the house style of *CAMH*. The first page of the manuscript should give the title, name(s) and address(es) of author(s), and an abbreviated title (running head) of up to 80 characters. Specify the author to whom correspondence should be addressed and provide their full mailing and email address.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Keywords: Please provide 4-6

Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Original Articles should not exceed 5,500 words, including References and Tables. Occasionally, longer articles may be accepted after negotiation with the Editors. Authors should include a word count of their paper.

Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

All manuscripts should have an Acknowledgement section at the end of the main text, before the References. This should include statements on the following:

Study funding: Please provide information on any external or grant funding of the work (or for any of the authors); where there is no external funding, please state this explicitly.

Conflicts of interest: Please disclose any conflicts of interest of potential relevance to the work reported for each of the authors. If no conflicts of interest exist, please include an explicit declaration of the form: "The author(s) have declared that they have no competing or potential conflicts of interest".

Contributorships: Please state any elements of authorship for which particular authors are responsible, where contributions differ between the author group. (All authors must share responsibility for the final version of the work submitted and published; if the study includes original data, at least one author must confirm that he or she had full access to all the data in the study, and takes responsibility for the integrity of the data and the accuracy of the data analysis). Contributions from others outside the author group should also be acknowledged (e.g. study assistance or statistical advice) and collaborators and study participants may also be thanked.

For referencing, *CAMH* follows a slightly adapted version of APA Style <http://www.apastyle.org/>. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.

Footnotes should be avoided, but end notes may be used on a limited basis.

Running head: MY RESEARCH JOURNEY

Section Three: Critical Appraisal

My research journey

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This section of the thesis provides the opportunity to engage in personal reflections on the experiences of this research. To start, both the literature review and empirical paper will be summarised and findings combined will be detailed. From here, I will discuss my research journey, detailing why the topics were chosen and the challenges encountered. I will also consider and reflect on my own emotional responses throughout this research journey.

Summary of the research

As self-harm amongst adolescents is a growing international concern, the literature review aimed to synthesise research on parents' experiences of their children's self-harm. Using the meta-ethnographic seven-step method outlined by Noblit and Hare (1988), five concepts emerged: the turmoil of discovery and beyond; searching for certainty; the ultimate blame; vigilant parenting: treading carefully and the ripple effect. Findings demonstrated the significant impact of adolescent self-harm on parental wellbeing and how this behaviour influenced their ability to support and provide boundaries. Parents also found it difficult to conceptualise self-harm and blamed themselves for their child's behaviour. This led to parents searching for certainties, as they were unsure of what was the "right" thing to do to help their child. Therefore, clinical services need to focus on supporting parents, as they care for young people who self-harm.

Looked After Children and Young People (LACY) are one of the most vulnerable populations in society, with higher rates of self-harm than the general population, and higher rates still for those in residential care. The aim of the empirical paper was to understand the experiences of LACY who engage in self-harm whilst

living in residential care. Particular attention was focused on whether the environmental context and being supported by professionals influenced self-harming behaviours.

Five young people were interviewed, and four themes emerged from the analysis of this data: 'The black hole of self-harm', 'Seeking genuine care through a protective mask', 'The cry to be understood' and 'Loss of control to the system.' Findings demonstrated the intense relationship that young people had with their self-harm and how this was difficult to make sense of. Although they were desperate to be understood by others, there was the belief that staff members did not truly understand their self-harm. There was a strong sense that the young people needed to feel genuinely cared for by staff members, who were now in a parent-like position. Finally, the young people were also exposed to new experiences, boundaries and support networks in residential care that differed to 'home life'. Such factors can influence young people's self-harming behaviours and should be considered by residential care providers, and services adapted accordingly.

The findings combined

Combined, both the literature review and empirical paper also provide crucial insight into the relational influence of self-harming behaviour in young people, including those in residential care, and the challenges of understanding self-harm.

From both papers, it was apparent that communication was challenging; both between parents and children in the literature review, and between young people and staff members in the empirical study. Interestingly, among other functions, self-harm can be utilised as a method of communication (Laye-Gindhu & Schonert-Reichl, 2005; Scoliers et al., 2009; Young, Sproeber, Groschwitz, Preiss, & Plener, 2014). In

the literature review, some parents felt unable to effectively communicate with their child (Oldershaw, Richards, Simic, & Schmidt, 2008; Rissanen, Kylmä, & Laukkanen, 2008). Similarly, in the research paper, young people needed staff to initiate conversations and to not be uncomfortable when discussing self-harm. If verbal communication within young person and adult relationships is impaired, then it is possible that young people may utilise self-harm as an alternative means of communicating distress. Both parents and residential care staff are in a position to support young people who self-harm, therefore it is necessary to consider how communication can be enhanced.

Both papers also detailed the complexity and challenges of understanding self-harm for all involved; parents, young people themselves and professionals supporting them. In the research paper, young people wanted their behaviour to be understood by the staff team around them, including why they may engage in self-harm and what functions this may serve. Therefore, these findings illustrate the importance of developing an understanding of self-harm, within the multiple layers of the system around the young person.

Why This Research?

There are many experiences throughout my academic and clinical journey that have led to me becoming interested in this topic of research. My clinical interest in young people, including those in residential care, began prior to starting clinical psychology training and became more prominent during my first clinical placement within a Child and Adolescent Mental Health Service. During clinical supervision and reflective case discussions on placement, I began to realise the adverse impact that traumatic early experiences and disrupted attachments can have on psychological

wellbeing. I learnt how such vulnerabilities might predispose young people to experience psychological distress and utilise behaviours to manage this distress, such as self-harm.

From here, I became curious about the functions of self-harm and how the systems around young people, such as parents, family and professional services, may influence and maintain this behaviour. This continued to evoke curiosity in me and I decided this was an area that I wanted to further explore within my thesis.

Whilst working with young people and families it became apparent that self-harm influenced not only the young person, but also their parents, and in turn parental experiences influenced the young person's self-harming behaviour. Therefore, I wanted to focus my literature review on research that details the parental experiences of supporting a young person who self-harms. I was also aware that young people who self-harm may not live with parents, but may instead be supported by professional staff who fulfil that parental role. I wondered how their experiences may differ from young people in the general population and whether the environmental context of living in residential care may influence their self-harm. I was increasingly aware that gaining a better understanding of these experiences would provide a framework for clinical services to support young people, parents and residential care staff.

The complex recruitment process

Throughout this research, there were challenges with recruitment, particularly in relation to accessing participants. Gaining access to young people for research participation can be difficult (Fargas-Malet, McSherry, Larkin, & Robinson, 2010) and research involving LACYP can be a particularly complex process as it requires

consent from a range of different gatekeepers (Heptinstall, 2000). Therefore, I was aware of the potential challenges of recruitment from the outset, so I started discussions about the research early on with directors and senior managers within the organisations through which I intended to recruit.

Fear of evoking distress

I was conscious that gatekeepers might resist involvement in the research in an attempt to protect young people (Huang, O'Connor, Ke, & Lee, 2016), from possible unfavourable effects of participation (Smyth, 2001; Thomas & O' Kane, 1998; Tinson, 2009). Much of the discussion with potential recruitment sites was in relation to fear of evoking undue distress or "triggering self-harm" as a result of participation. In addition, other concerns articulated by managers included my ability, as a researcher, to manage and contain distress (Thomas & O' Kane, 1998); reassurances were needed that I would communicate concerns to the staff members, where appropriate, following the interviews.

Although there are concerns raised about the potential adverse effect of discussing self-harm with young people, there is little empirical evidence to support this (Lloyd-Richardson, Lewis, Whitlock, Rodham, & Schatten, 2015). Participation in research can lead to benefits, such as an increase in wellbeing, derived from the value of talking about difficult experiences and being heard by the researcher (Biddle et al., 2012; Huang et al., 2016; Whitlock, Pietrusza, & Purington, 2013). Research has also demonstrated that many people who self-harm want to contribute to research and any potential distress that may be experienced is outweighed by the desire to participate and support the process of change in services (Biddle et al., 2012). Thus, not

allowing individuals to take part in research because of their perceived vulnerability prevents them from gaining the potential benefits of research participation (Biddle et al., 2012; Schelbe et al., 2015).

I also considered the potential of harm in not engaging with the views of young people (Alderson, 2011) and whether this was ethical in itself. This was discussed in meetings with all gatekeepers so that they could be aware of the not only the risks, but also potential benefits of the research.

Supporting potential distress

I gave careful consideration to the potential for the interviews to evoke distress in young people and developed a clear plan for reducing the likelihood of distress and for responding to it should it occur.

This included having clear inclusion and exclusion criteria that all service providers were made aware of. Designated staff members, usually Residential Care Home Managers, agreed to be responsible for screening and selecting young people who met these criteria. If young people were deemed eligible then staff members initially approached the young people to discuss the research. This was done through the use of the Participant Information Sheet and discussions with the allocated member of residential care staff. This process was implemented to support participants to make an informed decision as to whether they would like to participate and discuss the topic. If young people expressed an interest in the research, then staff members contacted me and I phoned them to discuss consent and arrange an interview.

In addition, at the start of the interview I made it clear to the young people that they could withdraw from the study and did not have to answer any

questions they did not want to. To facilitate this process, I negotiated with the young person how they could communicate this in the interview. For example, it was established whether they could verbally or non-verbally communicate this and together with one young person it was decided that they could point to a “stop” piece of paper to end the interview. During the interview, participants were also reminded that they could take a break at any point.

Finally, following every interview the participants were carefully debriefed (Clark, 2005) and provided with details of helplines and sources of support. If there were any concerns raised within the interview (e.g., safeguarding concerns) then I agreed to provide feedback to the staff team at the end of the interview. It was agreed that I would only share information about concerns relating to risk and distress of the young person and I made this explicit to young people.

It was hoped that these strategies would reduce the potential for participants to become distressed and would reassure gatekeepers that the research might be beneficial for young people. However, some recruitment sites still appeared to be concerned about the topic of the research and chose not to participate.

Challenges with the consent process

The consent process approved by the NHS research ethics committee was for young people aged 16 years old and older to provide their own consent and young people under 16 years old to complete an assent form giving permission for the individual who held Parental Responsibility to be contacted to provide consent. From

here, the individual who held Parental Responsibility would give consent to participate. However, concerns were raised by some service providers, who wanted their own consent processes implemented. This was particularly regarding young people aged 16 and over providing individual consent. Some recruitment sites anticipated that parents and social workers would still need to provide consent for all young people who chose to participate. In addition, one recruitment site suggested that a five-stage recruitment process would be necessary involving consent from managers within the organisation. At this point, I advised that individual recruitment site consent processes could be developed, however, consideration needed to be given to maintaining participant anonymity. My concern was that if an array of staff members inside and outside the organisation were aware of participation, then young people may feel less protected in their accounts and unable to share their true experiences of self-harm.

Concerns were also raised at the earlier recruitment stages regarding communication, so systems were put in place to ensure all relevant parties were informed about participation. This included senior management, residential care staff, social workers and when appropriate parents of the young person. Again the implications arising from limits to the anonymity of the participants were acknowledged. However, these measures were felt to be necessary as professionals were responsible for caring for the young people so it was essential that they were aware of their participation in the study. This was particularly important so that I could liaise with staff members following interviews to discuss any risk concerns if they were to arise. For example, during one interview a young person asked for a break. Before the interview recommenced the participant was able to negotiate how the rest of the interview proceeded and he asked to answer one other question only.

This was facilitated. The researcher provided feedback to the staff team, sharing only relevant information, which the young person agreed to. Based on clinical experiences and the basis that residential care providers were concerned about distress evoked through participation, I felt it was important to briefly provide staff with information so that the staff could support the young person if it was felt needed.

Reflections on recruitment

Following each meeting with recruitment sites, I made reflections in my research journal in an attempt to fully understand the barriers to recruitment. From meeting with senior members of staff, it appeared that residential services were adopting a culture of being risk averse, which seemed understandable considering the reasons for young people entering care are usually neglect and abuse (Department of Education, 2017).

As reflected in the empirical paper findings, challenges with recruitment could also be linked to the culture of not talking about psychological distress and self-harm. Service providers made it clear that they felt talking about self-harming experiences may “trigger” distress and this needed to be avoided. However, it has been demonstrated that talking about emotions supports young people to develop emotional literacy skills and the ability to understand emotions (Suveg et al., 2008), therefore if young people are not exposed to this, they may not be able to develop their emotional language. I also wondered if LACYP were exposed to this protection in day to day support and whether discussing self-harm was also discouraged. Several discussions occurred with service providers to overcome these obstacles, including the potential benefits of exploring emotional distress.

In addition, one of the senior managers in a national residential care organisation who agreed to the research taking place informed me that that they rarely look at any

research protocols as they are seen as potentially hard work for the organisation with limited benefit for the organisation itself. I wondered whether difficulties in recruitment might be linked to staff having a high workload and subsequently feeling unable to find time to prioritise recruitment.

Some participants were also identified as potentially suitable for the research but were unable to take part as one moved to a different service provider and two more were deemed inappropriate due to an escalation in risk to self. Some services also reported that LACYP chose not to participate in the study, which could reflect the challenges of facilitating young people's engagement in research per se. However, this might also indicate the existence of barriers specific to the LACYP services. For example, I wondered how the research was discussed with potential participants and whether this was done in a non-threatening way. As recruitment proved difficult, I decided to discuss this with senior managers within the recruitment sites to try to ensure that the research was discussed with participants in a way that was comprehensive and allowed them to make an informed decision regarding participation.

Having experienced these challenges with recruitment I understand why researchers might avoid researching this population or may decide to "give up" with recruiting. However, I felt that that it was important not to dismiss the possibility of doing research with LACYP because of the challenges around recruitment. Young people have stories that are worth telling and need to be listened to in order to make meaningful change within services. Consequently, I decided to continue with the recruitment strategy in an attempt to access enough participants to complete the research.

Despite some of the recruitment challenges, a total of five participants were recruited, which was deemed an acceptable number as participants provided a rich account of their experiences and there was sufficient depth of data to address the research question.

Interviewing process

As I have clinical experience of working therapeutically with young people, I was mindful that engaging in discussions with a stranger may be anxiety provoking for participants. I also wanted to try to help young people feel at ease whilst sharing their stories and for the process to be an empowering experience.

When conducting research interviews with young people, it is crucial for the interviewer to build a rapport with the participant, which can naturally take time (Irwin & Johnson, 2005). As I was aware of the potential challenges for the young people in discussing self-harm with a stranger, I wanted to ensure that they felt as comfortable as possible. Before each interview, I took the time to get to know the young person, discuss the research and allow them to ask questions.

To maintain this rapport and to ensure that the young person did not feel threatened, I started the interview with an initial question that was general and easy to answer (Cameron, 2005). As recommended by Cameron (2005), I also used non-verbal communication and regularly gave verbal prompts to signify to the young people that I was actively listening and I was interested in hearing their stories.

I was also mindful of the inherent power imbalance, as an adult researcher interviewing a young person (Kirk, 2007), and I wanted to try to reduce this. For example, I engaged in reciprocal conversation, demonstrated that I was enthusiastic

to hear their story and emphasised that there was no “right or wrong” answer, I was just curious to listen and try to understand.

Throughout the interviews, I paid particular attention to each participant’s level of comfort (Clark, 2005) and kept checking their emotional wellbeing. This included noticing any subtle changes in presentation or evidence of distress. I noticed that adopting this approach appeared to support the young people to feel more able to open up and give more detailed answers. At the end of the interview, one young person reported that she had felt more at ease as the interview progressed and that I had made her feel more comfortable as I treated her in a “normal” rather than a formal manner.

My journey with the research topic

Throughout the process of writing the thesis, I considered how my own values, psychological training and clinical experiences might have influenced the research process. To support this, I regularly wrote in my reflective research journal (Alley, Jackson, & Shakya, 2015) as I wanted to learn about the experience of self-harm, through interacting with participants about their own personal experiences (Enosh & Ben-Ari, 2016), rather than being influenced by my own ideas on the topic.

I also gained awareness throughout the interviews of my desire to validate and contain emotional distress, as this is a natural response within clinical practice. For example, I wanted young people to be aware that I acknowledged how difficult their experiences were and in the early interviews I found myself wanting to explore and formulate their distress and consider ways in which they could access support or reduce psychological distress. However, I was not in a clinical role; I was there to listen to their stories, not to offer guidance or psychological support. I further

discussed this with my academic supervisor and considered ways to manage this. During subsequent interviews, the tensions between being a trainee clinical psychologist and researcher were still present, but I was able to be mindful of my role and questioning technique, ensuring my questions were relevant to the research. I also started to inform young people at the start of the interview that I would be listening to their experiences rather than offering my perspective. In addition, I regularly summarised information to the participant to ensure that I had fully understood their intended meaning. This is something that I regularly do in clinical practice, but was in keeping with the study's phenomenological approach as it ensured that I had a good understanding of young people's own meanings, rather than relying on my own interpretations.

Certain topics of a sensitive nature have the potential to influence not only the participant's wellbeing, but also the researcher's (Elmir, Schmied, Jackson, & Wilkes, 2011). Following the interviews and particularly during the stages of transcribing, I reflected on the individual narratives and how brave the young people were to share their stories and experiences with me. Engaging in the transcribing process can also have an emotional influence on the researcher (Etherington, 2007; Kiyimba & O'Reilly, 2016). Therefore, I considered how each interview might have influenced me, not only as a researcher but also on a personal emotional level. Again, I found myself engrossed in my reflective journal, writing about how harrowing the young people's accounts were. In particular, I was saddened by their traumatic lives and how difficult it must be for young people to experience not feeling "genuinely" cared for by the system that supports them.

As the research became more intense, I perhaps had not anticipated the potential personal impact and the consuming nature of the research topic, particularly

as deadlines became imminent. Clinically, I had also started my final placement working with young people with complex mental health needs, including engaging in self-harming behaviours. Upon considering my own dual role, as a researcher and clinician, it seemed at times that my own personal world was consumed with thinking about the topic of self-harm.

I became aware of this and ensured that I accessed frequent supervision (Lloyd-Richardson et al., 2015) to ensure that I had space to reflect on my own emotional response. It also made me wonder how accessible support is when in the midst of intense academic research and if this can be obtained in a timely manner. Fortunately, I was able to seek the relevant supervision when necessary.

During the final stages of the thesis project, the emotional influence of the research topic dampened. I was, and still remain, hopeful and passionate that service providers will consider the findings outlined carefully and that meaningful change can occur with residential care settings.

Conclusion

This thesis explored two aspects of the experience of self-harm: a metasynthesis of parents' experiences of young people who self-harm and LACYP experiences of self-harm. Both papers demonstrate the powerful influence of self-harm and the challenges in understanding this behaviour. The empirical paper also provides insights into how the context of living in residential care settings can influence young people who self-harm. Both papers offer insight into a complex behaviour that is still not fully understood either by researchers or clinicians.

Looking back over my research journey, it has at times been challenging, however I have thoroughly enjoyed the process and remain passionate about supporting change for young people. Listening to the voices of such a vulnerable population, who were open to sharing their stories and experiences, placed me in a privileged position that I am grateful for. I hope that their stories will continue to be shared, as findings from this research are disseminated and as I start my career working with LACYP.

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Section Four: Ethics Application

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**Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University**

**Application for Ethical Approval for Research involving
direct contact with human participants**

Instructions *[for additional advice on completing this form, hover PC mouse over 'guidance']*

1. Apply to the committee by submitting:
 - a. A **hard copy** of the University's **Stage 1 Self Assessment (part A only)** and **Project Questionnaire**. These are available on the Research Support Office website: [LU Ethics](#)
 - b. The completed application **FHMREC form**
 - c. Your full research proposal (background, literature review, methodology/methods, ethical considerations)
 - d. All accompanying research materials such as, but not limited to,
 - 1) Advertising materials (posters, e-mails)
 - 2) Letters/emails of invitation to participate
 - 3) Participant information sheets
 - 4) Consent forms
 - 5) Questionnaires, surveys, demographic sheets
 - 6) Interview schedules, interview question guides, focus group scripts
 - 7) Debriefing sheets, resource lists

Please note that you DO NOT need to submit pre-existing handbooks or measures which support your work, but which cannot be amended following ethical review. These should simply be referred to in your application form.

2. Submit the FHMREC form and all materials listed under (d) by email as a **SINGLE attachment in PDF format** by the **deadline date**. **Before converting to PDF ensure all comments are hidden by going into 'Review' in the menu above then choosing *show markup>balloons>show all revisions in line*.**
3. Submit one collated and signed paper copy of the full application materials **in time for the FHMREC meeting**. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the [FHMREC website](#). Applications must be submitted by the deadline date, to:

Dr Diane Hopkins
B14, Furness College
Lancaster University,
LA1 4YG
d.hopkins@lancaster.ac.uk
5. Prior to the FHMREC meeting you may be contacted by the lead reviewer for further clarification of your application.
6. Attend the committee meeting on the day that the application is considered, if required to do so.

1. Title of Project: Looked after children's experiences of self-harm: A qualitative analysis

2. Name of applicant/researcher: Charlene Rouski

3. Type of study

√ Includes *direct* involvement by human subjects.

Involves existing documents/data only, or the evaluation of an existing project with no direct contact with human participants. Please complete the University Stage 1 Self Assessment part B. This is available on the Research Support Office website: [LU Ethics](#). Submit this, along with all project documentation, to Diane Hopkins.

4. If this is a student project, please indicate what type of project by marking the relevant box/deleting as appropriate: (please note that UG and taught PG projects should complete **FHMREC form UG-tPG**, following the procedures set out on the [FHMREC website](#))

PG Diploma Masters dissertation PhD Thesis PhD Pall. Care
 PhD Pub. Health PhD Org. Health & Well Being PhD Mental Health MD
 DClinPsy SRP [if SRP Service Evaluation, please also indicate here:] DClinPsy Thesis ✓

Applicant Information

5. Appointment/position held by applicant and Division within FHM

Trainee Clinical psychologist

6. Contact information for applicant:

E-mail: c.rouski@lancaster.ac.uk

Telephone: [REDACTED]

Address: [REDACTED]
 [REDACTED]
 [REDACTED]

7. Project supervisor(s), if different from applicant:

Dr Bill Sellwood & Dr Suzanne Hodge (Academic supervisors)

Dr Sue Knowles (Field Supervisor)

8. Appointment held by supervisor(s) and institution(s) where based (if applicable):

Dr Suzanne Hodge- Lecturer in Health Research at Lancaster University.

Dr Bill Sellwood- Course and Research Director at Lancaster University.

Dr Sue Knowles- Clinical Psychologist [REDACTED]

9. Names and appointments of all members of the research team (including degree where applicable)

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (indicative maximum length 150 words):

Looked after children and young people (LACYP) are known to be a vulnerable population who engage in self-harm. This behaviour is individualised and varies dependent on context. However, there is limited exploration into the experiences of self-harm in this population.

This research aims to explore looked after children's experiences of self-harm. It is hoped that that findings will highlight specific experiences of young people, develop our understanding of LACYP psychological needs and contribute to how LACYP are supported by professionals. The findings will provide valuable insight to shape future development of services.

Participants will be recruited from residential care settings across England. They will be invited to attend a semi-structured interview where their experiences of self-harm will be explored. The interviews will be digitally recorded and data then will be analysed using Interpretive Phenomenological Analysis (IPA).

11. Anticipated project dates (month and year only)

Start date: September 2016

End date: May 2017

12. Please describe the sample of participants to be studied (including maximum & minimum number, age, gender):

The target sample will be looked after children who are living in residential homes, who are either currently engaging in self-harm, or who have previously engaged in self-harm whilst living in care. It is hoped that between 4 and 10 participants will be recruited. Both males and females will be recruited who meet the below eligibility criteria.

Inclusion criteria:

- Looked after children residing in residential care
- Aged between 13- up to 18 years old
- Currently engaging in self-harming behaviours or have previously engaged in self-harming behaviours whilst in residential care

Exclusion criteria:

- If the registered manager of the residential care home deems that the young person would not be suitable for the research based on the likelihood of evoking undue distress
- If the registered manager of the residential care home deems that the young person does not have the cognitive capacity to participate
- If the registered manager of the residential care home perceives that the young person presents with high levels of risk to self or others and would not be suitable for interview
- If consent from young people under the age of 16 years old is not obtained by the legal guardian or adult who is responsible for their care (e.g., social worker)

13. How will participants be recruited and from where? Be as specific as possible.

The researcher and supervisors have contacted several residential care providers to gain approval to use them as a recruitment site for the study. At present the following residential care providers have provisionally approved or expressed an interest in the study (subject to ethical approval): [REDACTED]

[REDACTED] As it can be difficult to recruit from a LAC population, if the desired number of participants has not been recruited within 2 months of advertising the study, then the researcher and supervisors may make the decision to expand the potential participant pool to include further residential care providers.

At this stage, the researcher may also decide to attend Young Person's groups within residential care provider services to advertise the research. This will be arranged through residential managers of the care homes. The researcher will attend the Young Person's groups and distribute recruitment flyers to the young people. If young people wanted to participate they would discuss this with the residential manager who would contact the researcher via email. Eligibility to participate would be discussed at this stage.

The researcher will attend relevant staff and registered manager meetings (which may differ depending upon the provider) to discuss the project with the residential care staff. The researcher will make recruitment packs with all information within a sealed envelope. The recruitment packs will include a covering letter highlighting why the young people have been approached and a Participant Information Sheet. Packs will be made available to staff.

Staff members will be requested to hand out recruitment packs to eligible young people. The inclusion and exclusion criteria will be made explicit within these meetings. It is hoped that an allocated staff member, preferably the registered manager of the residential care home, will be the researcher's point of contact. This will be confirmed within these meetings. If a young person would like to find out more information, the designated member of staff can contact the researcher to arrange this discussion with the young person via telephone. The young person is not obliged to commit to taking part throughout this process. They will have the opportunity to think about participation and inform the designated staff member to contact me if they wish to take part.

Eligible participants who are interested in taking part will be asked to speak to the designated staff member, for example the registered manager, who will then contact the researcher via email/phone call. The researcher will confirm whether the young person meets the eligibility criteria. A suitable time for interviewing will be arranged with the young person and residential home.

If there are too many potential participants, then participants will be selected purposively to reflect a range of young people who are cared for (e.g. ages, gender) by a range of residential providers.

14. What procedure is proposed for obtaining consent?

The process of consent will be discussed with staff team and young person prior to the interviews and will be made clear in the participant information sheet. The researcher will pay particular attention to ensuring that all young people understand the information sheet and what participation will entail. Consent/assent will be obtained from all young people through completion of the relevant consent form (Appendix 4/5).

If the young person is 16 years or older, consent will be obtained before the interview. The participant will consent to their participation and will be asked to complete and sign the relevant consent form. If the young person is under the age of 16 years, they will complete and sign an assent form prior to arranging an interview. This will give permission for the researcher to obtain consent (on their behalf) from their legal guardian, for example social worker. The legal guardian will be contacted by either email or telephone initially. The researcher will discuss the research and participant information sheet with the legal guardian. They will also have an opportunity to ask any questions about the research. A copy of the consent form (Appendix 6) will be given to the legal guardian electronically via email or in the post. An electronic or written signature will be obtained and sent/emailed back to the researcher.

15. What discomfort (including psychological eg distressing or sensitive topics), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks. State the timescales within which participants may withdraw from the study, noting your reasons.

It is recognised that the client group for this research can be a vulnerable population. However, research has highlighted that vulnerable young people's voices are not heard and that their accounts are a valuable contribution to research (Biddle et al, 2013). To decrease the potential of distress for young people, there will be a rigorous screening process that is utilised to identify eligible participants. The registered manager of the care home will be liaised with prior to the researcher discussing the research with any young person. The researcher will discuss the eligibility criteria at this stage. Consent will also be obtained from young people under the age of 16 years from the young person's legal guardian/social worker. Risk of distress will be discussed at several stages throughout the recruitment process and if it is deemed that the young person may not be appropriate at any stage they will not be eligible to participate.

All participants will have also received an information sheet prior to interviews and informed about the content of the interview. This will allow participants to make an informed decision as to whether they would like to participate and discuss the topic. The researcher will also clearly inform the participants at the start of the interview that if they choose not to answer certain questions that this is acceptable. The researcher will negotiate with the young person how they will communicate this in the interview. During the interview stage, participants will be given the opportunity to take a break at any point if they feel that the content is overwhelming. If a participant becomes increasingly distressed during an interview then the researcher will discuss the potential of stopping the interview or asking if the participant would like a break. Following the interview, all participants will be provided with details of helplines and support that is available if they choose to seek further support. If there are any concerns raised within an interview, the researcher will provide feedback to the staff team at the end of the interview. Staff members will be available to discuss this. The researcher will not disclose specific information about the interview. The researcher will only share information about concerns relating to risk and distress of the young person. The researcher also has clinical experience of working with young people with mental health difficulties. This will be helpful in terms of noticing potential risk concerns during the interview process.

Participants will be reminded of their right to withdraw during the interview. They can withdraw their participation and data at any time, without given a reason for doing so. If requested, all client specific information and interview data can be withdrawn, up to two weeks following interviewing. After this time, the data may be incorporated into the data analysis. If this is the case it may not be possible to withdraw data, although every attempt will be made to extract the data.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risks (for example, noting the support available to you; counselling considerations arising from the sensitive or distressing nature of the research/topic; details of the lone worker plan you will follow, and the steps you will take).

During the recruitment process, designated staff members within the residential care homes will be provided with the researcher's university email address and a university work phone number for correspondence. This is the same for correspondence with legal guardians when obtaining consent. No personal email addresses will be provided.

All interviews will take place within a suitable, safe location that has been prearranged. The lone worker policy for Lancashire Care will be adhered too. More specifically, the field supervisor will be informed of scheduled interview dates and times. The names of the participants will not be shared. If it is prearranged that the interviews are to take place outside of the residential care home, a buddy will have a copy of the interview location details. This will include date and time of the scheduled interview. This will be provided in a sealed envelope to ensure confidentiality. Staff members within the care home will also be notified. The buddy will be notified of a time that the researcher will contact to ensure the researcher safety. If the buddy has not been contacted in the agreed timeframe, then appropriate actions will be implemented in accordance with Lancashire care policies. To maintain confidentiality, this information will be in a sealed envelope and is only to be opened if the buddy is not contacted within the agreed timeframe. The researcher will also discuss potential risk concerns prior to the interviews with the staff team based at the residential care home. If any risk concerns are raised concerning the safety of the participants, the interviews will not take place.

There is a potential that the nature of the research may be distressing for the researcher. If this occurs, the researcher will seek regular supervision from supervisors to discuss any issues that may arise.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

There may be no direct benefits of participation in this study. However, research has indicated that young people who may be perceived as a vulnerable population, such as the young people within this project, gain benefits by providing valuable insight into their experiences (Biddle et al, 2013). It is also anticipated that the accounts shared in the interview will help to inform future assessment, formulation and intervention for young people who engage in self-harm in residential care. It also hoped that the research findings would help to shape future service.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no incentives for participation in this study.

19. Briefly describe your data collection and analysis methods, and the rationale for their use. Please include details of how the confidentiality and anonymity of participants will be ensured, and the limits to confidentiality.

Eligible participant's who meet the inclusion/exclusion criteria will be invited to attend a semi-structured interview that will last about 1 hour. All interviews will take place in an appropriate, safe location that has been pre-arranged with the young person. It will also be made explicit that participants do not have to answer any of the questions if they feel this may cause them distress. The researcher will negotiate a way for the participant to

communicate this to me during the interview. Participants will be reminded that they have a right to withdraw, without giving a reason, at the beginning and the end of the interview.

Data will be analysed using IPA, following the detailed guidance developed by Smith et al., (2009). This will allow for an idiographic focus and individual meaning behind self-harm experiences to be explored. The initial stages of analysis will generate emergent themes from the data set, followed by superordinate themes. It is felt that IPA would be an appropriate method for analysis, in comparison to other qualitative approaches, as this study aims to explore individual meaning of self-harm experiences. For example, thematic analysis would not be appropriate as this method would allow for exploration of themes across the whole data set and may not allow for individual experiences to emerge.

All interviews will be digitally recorded using a Dictaphone. The researcher will complete all transcribing and pseudonyms will be assigned. This is an attempt to increase anonymity, at the analysis stages. Participants will also be made aware that although participant quotes will be used, all identities will be made anonymous in the final report and other dissemination materials.

It is acknowledged that this research is taken place with a population where there is a need to liaise with the staff team. There are constraints in anonymity as residential staff members will be aware of which young person participates in the research. However, it is staff member's responsibility to care for the young people and they need to be aware of the day-to-day whereabouts of each young person. It is essential that staff members are aware of participation in the study so that the researcher can liaise with them about risk concerns and can feedback presentations after participation in the study. Participants will be made aware of this prior to interviewing to increase transparency.

All participants will be informed at the beginning of the interview regarding the limits of confidentiality. It will be discussed that all information discussed during the interview stage will be kept confidential unless there is a disclosure to suggest the participant or another person may be at risk. Confidentiality will be broken if the participant has indicated that they may cause harm to themselves or others. This will then be discussed with the participant and relevant safeguarding procedure will be followed. Staff members within the residential care home will be immediately informed after the interview. If a participant discloses worrying information regarding staff practice this will be further discussed with the participant and the field supervisor will be immediately informed via telephone.

All participant information will be kept confidential. The process of data storage will also be made explicit to participants. This is also detailed on the participant information sheet, consent sheet and will be discussed and prior to interviews taking place.

20. If relevant, describe the involvement of your target participant group in the *design and conduct* of your research.

N/A

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

All hard copies of data, which contains personal details, for example demographic information sheets and consent sheets, will be stored in a secure lockable cabinet and destroyed as soon as possible. All data will be transferred to a password protected file space on the University server within 48 hours after interview. These files will be password protected and encrypted. No data will be stored on any personal computer. All data will then only be accessible from the University server.

In accordance with the University and DClinPsy programme policy, all data will be electronically stored for ten years in encrypted file space on the University server. This will be permanently deleted after 10 years. A member of the programme team will be responsible for deleting this.

22. Will audio or video recording take place? no ✓ audio video

If yes, what arrangements have been made for audio/video data storage? At what point in the research will tapes/digital recordings/files be destroyed?

All audio data will be transferred from the digital recorder to password protected file space on the University server within 48 hours after interview. This is because it is not possible to encrypt the portable device. These files will be password protected and encrypted. Audio data will then be deleted from the recording device. No data will be stored on any personal computer. Only the researcher and her academic supervisors will have access to these files. The researcher's academic supervisors will have access to audio files of the interviews, in order to provide the researcher with guidance on the interview process, and similarly she will have access to complete transcripts in order to provide guidance on the analysis process. The field supervisor will not have access to any participant data. In accordance with the University and DClinPsy programme policy, all data will be electronically stored for ten years in encrypted file space on the University server. This will be permanently deleted after 10 years. A member of the programme team will be responsible for deleting this.

23. What are the plans for dissemination of findings from the research? If you are a student, include here your thesis.

The findings of this research will be included in the main report for academic submission of the researcher's thesis on the DClinPsy. It is hoped that findings will also be submitted for publication in an appropriate academic/professional journal. Findings will also be disseminated to the residential care homes where participants have participated. The dissemination strategy for this will be negotiated with each residential care provider. Participants will also have the opportunity to receive a written summary of findings.

24. What particular ethical considerations, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek guidance from the FHMREC?

Signatures: Applicant: Charlene Rouski

Date: 26.06.2016

*Project Supervisor (if applicable): Suzanne Hodge & Bill Sellwood

Date:

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

**The Division for Health Research**

Doctorate in Clinical Psychology

Research Protocol**Title:** Looked after children's experiences of self-harm: A qualitative analysis

Applicant: Charlene Rouski

Research Supervisors: Bill Sellwood, Programme Director and Suzanne Hodge,
Lecturer in Health Research, Doctorate in Clinical
Psychology Programme, Lancaster University
Sue Knowles, Clinical Psychologist

Introduction

Looked-after children and young people (LACYF) in the United Kingdom are defined as, "children and young people in the care of the local authority, either voluntarily or subject to a care order made by court to grant shared parental responsibility with a local authority" (Jones et al., 2011, p.613).

The Department of Education (2015) released statistics of prevalence rates for the number of looked after children in the United Kingdom. Prevalence rates continue to increase. In the year ending of March 2015, there were 69,540 looked after children. This was a 1% increase from the previous year and a 6% increase from 2011. Throughout the year ending March 2015 there were 99,230 children looked after at some point, up 91,180 in 2011. Within the most recent figures, there were 2,600 children placed in a variety of settings, such as secure units and children's homes.

On a societal level, LACYP are considered to be one of the most vulnerable populations (Simkiss, Stallard, & Thorogood, 2013; Tarren-Sweeney, 2008). LACYP experience high levels of mental health and behavioural difficulties (Andrew, Williams, & Waters, 2014; Beck A, 2006; Cousins, Taggart, & Milner, 2010; Ford, Vostanis, Meltzer, & Goodman, 2007; Harpin, Kenyon, Kools, Bearinger, & Ireland, 2013; McNicholas et al., 2011; Tatlow-Golden & McElvaney, 2015). When considering the emotional wellbeing of looked after children, by utilising the Strengths and difficulties Questionnaire (SDQ), 13% have emotional and behavioural health that is considered “borderline” and 37% considered to be a “cause for concern” (Department of Education, 2015). However, LACYP views of these experiences is seldom reported (Tatlow-Golden & McElvaney, 2015).

The National Institute for Health and Care Excellence (NICE, 2013) define self-harm as “self-poisoning or self-injury carried out by a person, irrespective of their motivation” (p. 6). LAYP frequently engage in self-harm (Andrew et al., 2014; Grenville, Goodman, & Macpherson, 2012; Stewart, Baiden, Theall-Honey, & Dunnen, 2014) but self-harm in this group varies according to context (Gallant, Snyder, & Von Der Embse, 2014), highlighting the individualised nature of such behaviour.

Factors that can contribute to self-harming behaviours include the age that the young person went into care, levels of displayed aggression and previous episodes of self-harm (Gallant et al., 2014). Additional research has suggested that factors that may influence self-harm include the time of day, with self-harm being more often in the evening, or more often for LACYP who are placed within temporary care arrangements (Grenville et al., 2012).

Quantitative research compared LACYP who self-harm with LACYP who do not self-harm. Findings detailed that LACYP who engaged in self-harming behaviours reported fewer reasons to live and more self-critical thoughts in comparison to their peers (Harkess-Murphy, MacDonald, & Ramsay, 2013). In addition, LACYP experienced higher levels of psychological distress in comparison to other young people (Cousins et al., 2010; Harpin et al., 2013). Moreover, LACYP showed higher rates of self-harm (Gabrielli et al., 2015).

However, there is a dearth of research into LACYP mental health (Cousins, Taggart, & Milner, 2010) and self-harming behaviours of populations within LACYP (Grenville et al., 2012; Harkess-Murphy, MacDonald, & Ramsay, 2013). It is important to understand if there are differences in the experiences of young people who are in residential care, compared to those of young people who are not living in care. Therefore, there is a need for further understanding to allow care systems to psychologically support those within their care (Grenville et al., 2012).

As there is a paucity of research exploring LACYP experiences of self-harm, qualitative research is needed to fill this gap. It is hoped that qualitative findings will help further develop our understanding of the psychological needs of LACYP who self-harm and of how clinical psychologists can support change within care systems.

This project will be largely exploratory. The aim is that looked after children's individual experiences of self-harm can be broadly understood from their perspective. Interpretive phenomenological analysis (IPA) will allow for gaining an in depth individualised understanding of how young people make sense of their self-harm.

Research question:

- What are Looked After Children's experiences of self-harm?

Additional research questions:

- Does the environmental context of living in residential care impact on self-harming behaviours?
- Do staff responses to self-harm influence the young person's experience of self-harm?

Method

Design

This research will employ a qualitative design. Semi structured interviews will explore how looked after children experience self-harm. Semi structured interviews are useful to provide an element of structure the interview but to allow elements of flexibility.

Interviews will be transcribed verbatim by the researcher and analysed using IPA. IPA is a method that looks to explore what meaning individuals give to their experiences (Smith & Osborn, 2007).

Participants

The target sample will be looked after children who are living in residential care. Participants will be recruited from a number of care providers across the UK. This will include recruitment amongst one of the [REDACTED] homes run by [REDACTED].

Inclusion criteria:

- Looked after children residing in residential care
- Aged between 13- 18 years old
- Currently engaging in self-harming behaviours or have previously engaged in self-harming behaviours whilst in residential care

Exclusion criteria:

- If the registered manager of the care home deems that the young person would not be suitable for the research based on the likelihood of evoking undue distress
- If the registered manager of the residential care home deems that the young person does not have the cognitive ability to participate
- If the registered manager perceives that the young person presents with high levels of risk to self or others and would not be suitable for interview
- If consent for young people under 16 years old is not obtained by the legal guardian or adult who is responsible for their care (e.g., social worker)

It is hoped that a minimum of 4 and maximum of 10 participants will be recruited.

Materials

Throughout the recruitment process, eligible participants will be provided with a participant information sheet. All participants will be asked to complete a demographics form. Participants over the age of 16 years will complete a consent form, participants under the age of 16 years will be asked to complete an initial assent form, confirming that the researcher can contact their parent/legal guardian. All parents/legal guardians will complete a consent form. A topic guide will be used to structure the interview schedule in accordance with the research question.

Recruitment

The researcher and supervisors have contacted several residential care providers to gain approval to use them as a recruitment site for the study. At present the following residential care providers have provisionally approved (subject to ethical approval): [REDACTED]. [REDACTED]. As it can be difficult to recruit from a LAC population, if the desired number of participants has not been recruited within 2 months, then the researcher and supervisors may make the decision to expand the potential participant pool to include further residential care providers. At this stage, the researcher may also decide to attend Young Person's groups within residential care provider services, to advertise the research and distribute recruitment flyers. If young people wanted to participate they would discuss this with the residential manager who would contact the researcher via email.

The researcher will attend relevant registered manager meetings to discuss the project with the residential care staff. The researcher will make recruitment packs, including a covering letter highlighting why the young people have been approached and a Participant Information Sheet available to staff.

Staff members will be requested to hand out recruitment packs to eligible young people. The inclusion and exclusion criteria will be made explicit within these meetings. It is hoped that

an allocated staff member, preferably the registered manager of the residential care home, will be the researcher's point of contact. This will be confirmed within these meetings.

If a young person would like to find out more information, the designated member of staff can contact the researcher to arrange this discussion with the young person via telephone. The young person is not obliged to commit to taking part throughout this process.

Eligible participants who are interested in taking part will be asked to speak to the designated staff member who will then contact the researcher via email/phone call. The researcher will confirm whether the young person meets the eligibility criteria. A suitable time for interviewing will be arranged.

If there are too many potential participants, then participants will be selected purposively to reflect a range of young people who are cared for by a range of residential providers.

Consent

The process of consent will be discussed with staff teams and young person prior to the interviews and will be made clear in the participant information sheet. The researcher will pay particular attention to ensuring that all young people understand what participation will entail. Consent/assent will be obtained from all young people through completion of the relevant consent form.

If the young person is 16 years or older, consent will be obtained before the interview and will be asked to complete the relevant consent form. If the young person is under the age of 16 years, they will complete and sign an assent form prior to arranging an interview. This will give permission for the researcher to obtain consent (on their behalf) from their legal guardian, for example social worker. The legal guardian will be contacted by either email or telephone initially. The researcher will discuss the research and participant information sheet with the legal guardian. They will also have an opportunity to ask any questions about the research. A copy of the consent form will be given to the legal guardian electronically via email or in the post. An electronic or written signature will be obtained and sent/mailed back to the researcher.

Data Collection

Eligible participants will be invited to attend a 1:1 semi-structured interview that will last about 1 hour. All interviews will take place in an appropriate, safe location that has been pre-arranged. This could include a room within the care home where disruptions are less likely, or at a time when the care home is likely to be quieter. However, if the young person would prefer a staff member/legal guardian to be present, this can be accommodated. The interviews will be digitally recorded using a Dictaphone.

The first ten minutes of the interview will allow for introductions, to discuss confidentiality and its limits and participants will be reminded of their right to withdraw. It will also be made explicit that participants do not have to answer any of the questions if they feel this may cause them distress. We will negotiate a way for the participant to communicate this to me during the interview. Participants can ask further questions regarding the research before taking part and the information sheet will be reviewed. A consent form/demographic form will be completed and signed at this stage.

A sample interview topic guide will be used to structure the interview. The researcher will use open questions and follow up questions to aid the participant's thinking and to try to explore young people's experiences in depth. At the end of the interviews, participants will be given the opportunity to ask questions and will be debriefed. All participants will be reminded of the helplines and available opportunities for support if they wish to seek this.

Proposed analysis

The researcher will transcribe all the interviews verbatim. Data will be analysed using IPA, following the detailed guidance developed by Smith, Flowers, & Larkin (2009). This will allow for an idiographic focus and individual meaning behind self-harm experiences to be explored. IPA will allow the research to deconstruct individual narratives of self-harm experiences. This involves a two-stage process of interpretation in the analysis.

The initial stages of analysis will generate emergent themes from the data set, followed by superordinate themes. It is felt that IPA would be an appropriate method for analysis in comparison to other qualitative approaches as this study aims to explore individual meaning about self-harm experiences.

In an attempt to increase the validity of the analysis the researcher will seek regular consultation from the academic supervisor during the analysis stages. The researcher will also keep a reflective diary during the analysis phase to allow her to document and reflect on her own feelings and responses to the data and how this may impact on the interpretations. This can be further discussed if felt necessary with the academic and field supervisor.

Data Management and Storage

All hard copies of data, which contains personal details will be stored in a secure lockable cabinet and destroyed as soon as possible. All data will be transferred to a password protected file space on the University server as soon as possible after interview. These files will be password protected and encrypted. No data will be stored on any personal computer.

All audio data will be transferred from the digital recorder to password protected file space on the University server as soon as possible after interview. These files will be password protected and encrypted. Audio data will then be deleted from the recording device. Only the researcher and her academic supervisors will have access to these files. The researcher's academic supervisors will have access to audio files of the interviews, in order to provide the researcher with guidance on the interview process, and similarly they will have access to complete transcripts in order to provide guidance on the analysis process. The field supervisor will not have access to any participant data, unless there are concerns following interviews, for example safeguarding concerns.

In accordance with the University and DClinPsy programme policy, all data will be electronically stored for ten years in encrypted file space on the University server. This will be permanently deleted after 10 years. The research co-ordinator will be responsible for deleting this.

Ethical concerns

- *Anonymity and confidentiality* – It is acknowledged that this research is taking place with a population for whom there is a need to liaise with the staff team supporting them. There are constraints in anonymity as residential staff members will be aware of which young person participates in the research. However, it is staff members' responsibility to care for the young people and they need to be aware of the day-to-day whereabouts of each young person. It is essential that staff members are aware of participation in the study so that the researcher can liaise with them about risk concerns and can feedback any concerns after participation in the study. In an attempt to increase anonymity, pseudonyms will be assigned to participants at the analysis stages.
- *Vulnerable population*- It is recognised that the client group for this research can be a vulnerable population. However, research has highlighted that vulnerable voices who self-harm are often not heard and that their accounts are valuable contributions to research (Biddle et al., 2012). To decrease the potential of distress for young people there will be a rigorous screening process and the researcher will liaise with the registered manager of the care home prior to the researcher discussing the research with any young person. Risk of distress will be discussed at several stages throughout the recruitment process and if it is deemed that the young person may not be appropriate for research they will not be eligible to participate.
- *Potential emotive topic of discussion* – All participants will have been informed about the content of the interview. This will help participants to make an informed decision as to whether they would like to participate and discuss the topic. The researcher will also clearly inform the participants at the start of the interview that if they choose not to answer certain questions that this is acceptable. The researcher will negotiate with the young person how they will communicate this in the interview. During the interview stage, participants will be given the opportunity to take a break at any point if they feel that the content is overwhelming. If a participant becomes increasingly distressed during an interview then the researcher will discuss

the potential of stopping the interview or asking if the participant would like a break. Following the interview, all participants will be provided with details of helplines and support that is available if they choose to seek further support.

- *Potential disclosures* – All participants will be informed at the beginning of the interview regarding the limits of confidentiality. It will be discussed that all information discussed during the interview stage will be kept confidential unless there is a disclosure to suggest the participant or another person may be at risk. This will then be discussed with the participant and relevant safeguarding procedure will be followed. Staff members within the residential care home will be immediately informed after the interview. If a participant discloses worrying information regarding staff practice this will be further discussed with the participant and the field supervisor will be immediately informed via telephone. The researcher and field supervisor will discuss an appropriate plan of action.
- *Researcher Safety*- During the recruitment process designated staff members within the residential care homes will be provided with the researcher's university email address and a university work phone number for correspondence. All interviews will take place within a suitable, safe location that has been prearranged. The lone worker policy for Lancashire Care will be adhered to. The researcher will also discuss potential risk concerns prior to the interviews with the staff team based at the residential care home. If any risk concerns are raised concerning the safety of the participants, the interviews will not take place.
- *Risks and benefits*- There are no direct benefits of participation in this study. However, research has indicated that vulnerable populations, such as the young people who self-harm, may gain benefit by providing valuable insight into their experiences (Biddle et al, 2012). It is also anticipated that the accounts shared in the interview will help to inform future assessment, formulation and intervention for young people who self-harm in residential care. It is also hoped that findings will help to shape future service development.

Timescales

Submit application to University ethics:	June 2016
Recruitment Process:	August 2016
Start data collection:	September 2016
Begin Analysis:	November 2016
Submission of draft report:	April 2016
Deadline for submission of final report:	May 2017
Dissemination to the service:	June 2017
Submit for Publication:	Summer 2017

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Appendix 4-A: Advertising poster

We want to hear from you.

We are looking to interview young people with experience of self-harm within residential care.



My name is Charlene Rouski. I am a Trainee Clinical Psychologist with Lancaster University and I am undertaking a research project.

If you are interested in taking part or finding out more then please inform your residential manager who will pass on your details to me. This does not mean that you have to take part; you can think about this and then make a decision.

Appendix 4-B: Covering Letter & Participant Information Sheet

Hello, My name is Charlene Rouski. I am trying to find out how young people who have self-harmed think and feel about their experiences. This is so we can work out ways to support young people to manage their difficulties.

Staff members have been asked to approach young people who may want to take part. You have been given this letter because you are living in a residential setting and you are either currently self-harming or have done in the past. I would be really interested in talking to you about your experiences of self-harm whilst living in residential care.

If this is something that you might be interested in talking about then please read the Participant Information sheet for more information. This will tell you a bit more about the research.

Thank you for taking the time to read this covering letter.

Charlene Rouski

[INSERT]

Researcher's photograph

The Division for Health Research
Doctorate in Clinical Psychology

Participant Information Sheet

Looked after children's experiences of self-harm: A qualitative study

My name is Charlene Rouski and I am conducting this research as part of my training in clinical psychology. We are trying to find out how young people who have self-harmed think and feel about their experiences. This is so we can work out ways to support young people to manage their difficulties.

If you would like to take part then it is important that you understand what taking part would involve and why the research is being done. Please read the following information carefully. Thank you for your interest so far and please contact me if you have any questions.

Why have I been approached?

You have been approached because you are currently a young person who is living in a residential setting. Staff members have been asked to approach young people who are currently self-harming or have done in the past, to see if they might be interested in taking part in this research. I would be really interested in talking about your experiences of self-harm whilst living in residential care.

Do I have to take part?

No. It is completely your choice whether or not you want to take part. If you decide that you do not wish to take part, this will not have any negative impact on your current treatment and support within your residential home. If you do decide to take part, but then change your mind this is ok and we can stop the interview at any point. You can also ask for your information to be removed from the research any time up to two weeks after you have taken part. After this point it might not be possible to withdraw your information from the study because it will have been put together with other young people's information. However, I will try my best to remove this if I can.

What will I be asked to do if I take part?

If you decide you would like to take part, you would be asked to take part in an interview that will last about 1 hour. This will be a 1:1 interview with me. During the interview you will be asked questions about your experiences of self-harm. If at any point you do not want to answer a certain question, this is completely fine. We will think about how you can let me know this before we start the interview.

We can think together about the best place to do the interview. We might be able to find a room in your home, or we might need to find somewhere else nearby. The interview will be arranged for a time that is best for you.

All interviews will be audio recorded and I will type this up afterwards.

Will my data be kept confidential and will I be identifiable?

The information you provide is kept private (confidential). This means that I will not share this information with anyone else in a way that identifies you. There are some occasions where I may need to share your information. For example, if what is said in the interview makes me think that you, or someone else, is at risk of harm, I will not be able keep this private and speak to a member of staff about this. This includes if you say you may harm yourself or someone else. If you do tell me such information, I will have to share this information with my supervisor and the care staff within your residential home. If possible, I will tell you if I have to do this.

All the information that I collect about you for this study will be kept safe and stored securely. Only myself and my academic supervisors at Lancaster University will be able to see this data:

- o Audio recordings from the interviews will be deleted once I have typed up the interview transcripts.
- o Any information that is likely to identify you will be removed when the interview is typed up. This includes your name and the names of other people and places. I may use direct quotations from your interview when I write up the research, but I will use a false name next to this. This means that your name will not be in the research.
- o I will keep your information on the computer. This will be encrypted (that is no-one other than the researcher will be able to access it) and the computer itself password protected.
- o All your personal information will be kept private (confidential) and will be kept separately from your interview.

What will happen to the results from this study?

The results will be written up as part of my clinical psychology qualification and may be submitted for publication in an academic or professional journal. This is so other professionals can see what we have found.

A summary of what we have found will also be fed back to you, the other young people taking part in the project, and the staff. It is hoped that the findings will provide useful information about the experiences of self-harm of young people in residential care and identify what support may be helpful to you and other young people.

Are there any risks?

There are no significant risks from taking part in this study. However, the research is about a topic that you might find difficult and upsetting. If you are finding it difficult before, during or after the interview, please let me know and we can stop the interview or take a break. There are also some details of organisations/helplines that might be useful at the end of this sheet. It may also be helpful for you to talk to the staff who support you.

Are there any benefits to taking part?

You may find it interesting and helpful to share your experiences about self-harm. However, there are no direct benefits in taking part.

Who has reviewed the project?

This study has been reviewed by my university (the Faculty of Health and Medicine Research Ethics Committee) and they have agreed that I can do this research.

How can I take part in the study?

If you would like to take part in this research then please speak to the registered manager of your home. They will contact me and we can arrange a time for me to come and interview you.

If you have any further questions about the study, please ask your registered manager to contact me. I am more than happy to answer any questions you may have.

The project is supervised by Dr Sue Knowles, who is a Clinical Psychologist who works with children in residential care, and Dr Suzanne Hodge and Professor Bill Sellwood, who are both part of the clinical psychology course at Lancaster University.

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Professor Bill Sellwood Tel: (01524) 593998

Research Director,

Email: b.sellwood@lancaster.ac.uk

Faculty of Health and Medicine
Division of Health Research
Furness College
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Psychology Doctorate Programme, you may also contact:

Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk

Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

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

Resources in the event of distress

If you feel upset or distressed either after taking part, or in the future, the following support and numbers/websites may be useful for you contact:

- Care home support staff (This information will be tailored to include specific residential details)

- Child line
You can call ChildLine at any time on **0800 1111**
www.childline.org.uk

- Young minds
For general enquiries about YoungMinds call: **020 7089 5050**
www.youngminds.org.uk

- Self-harm UK
www.selfharm.co.uk

Appendix 4-C: Demographic Information Sheet



The Division for Health Research
Doctorate in Clinical Psychology

DEMOGRAPHIC INFORMATION FORM

Please think of a pseudonym (false name) that will be used in this research:

.....

Please circle the appropriate response

1. Gender

Male Female Other (please specify).....

Please provide an answer for each question below:

2. Age in years and months

.....

3. Ethnicity

.....

4. Length of time in residential care

.....

5. Total number of placements (including foster placements, residential care home etc.)

.....

6. When did you last self-harm (years and months)?

.....

7. What age did you start to self-harm?

.....

8. What are your main types of self-harm? (e.g. scratching your arms, banging your head)

.....

Thank you for completing this questionnaire

Appendix 4-D: Consent and Assent forms

CONSENT FORM

Research title: **Looked after children's experiences of self-harm: A qualitative analysis**

Researcher: Charlene Rouski, Trainee Clinical Psychologist

We are asking if you would like to take part in a research project that will consider your experiences of self-harm whilst in residential care.

Before you consent to participating in the study could you please complete the consent form below? Please read through each statement and mark each box below with your initials if you agree.

If you have any questions before signing the consent form please speak to the researcher, Charlene. Once you have done this, please write and sign your name in the box at the end to confirm that you would like to take part.

- I have read through the Participant Information Sheet fully and I understand what is expected of me throughout this study.
- I have had the opportunity to ask any questions about the research.
- I am aware that I can change my mind about taking part at any point during the interview, and can ask for the information I give to be destroyed up to two weeks after the interview.
- I understand that once my data have been anonymised (made unidentifiable) and incorporated into themes, it might not be possible for it to be taken out of the data, though every attempt will be made to extract my data.
- I understand that my interview will be audio recorded and then made into an anonymised written transcript. My information will not be identifiable.

- I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published in a journal.
- I consent to information and quotations from my interview being used in reports, conferences, training events and publications. All quotations used will be anonymised.
- I understand that if I disclose any information that makes the researcher concerned about my safety or the safety of anyone else that this may not remain confidential and may need to be investigated appropriately.
- I also understand that the discussions within study may be potentially upsetting and I agree to inform the researcher if I become distressed during the interview.
- I consent to Lancaster University keeping electronic written transcriptions of the interview for 10 years after the study has finished.
- I understand that my data will be shared and discussed with the researcher's supervisor who is based at Lancaster university and the researcher's field supervisor.
- I agree to take part in the research.

Participant Name:

Signature:

Date:

Researcher Name:

Signature:

Date:



The Division for Health Research
 Doctorate in Clinical Psychology

ASSENT FORM

Research title: **Looked after children's experiences of self-harm: A qualitative analysis**

We are asking if you would like to take part in a research project that will consider your experiences of self-harm whilst in residential care.

Please read the following statements carefully and put a tick in the boxes if you agree:

- I have read through the Participant Information Sheet fully and I understand what I have been told
- I have had the opportunity to ask any questions
- I can stop the interview at any point and I will tell Charlene if I start to feel upset or distressed
- I know that a tape recorder will record me
- I would like to participate
- I give permission to the researcher to contact my legal guardian

My name:

My Signature:

Date:

Researcher Name:

Signature:

Date:



The Division for Health Research
 Doctorate in Clinical Psychology

PARENT/GUARDIAN CONSENT FORM (on behalf of young people under 16 years of age)

Research title: **Looked after children's experiences of self-harm: A qualitative analysis**

Researcher: Charlene Rouski, Trainee Clinical Psychologist

I have been in discussions with [name of young person] who has shown an interest in participating in a research project that will consider looked after children's experiences of self-harm whilst in residential care. Please refer to the information sheet for more information on this research.

As [name of young person] is under the age of 16 years old, there is a need to obtain consent from their parent/legal guardian before [name of young person] can participate. Please could you complete the consent form below? Please read through each statement and mark each box below with your initials if you agree.

If you have any questions before signing the consent form please speak to the researcher, Charlene. Once you have done this, please write and sign your name in the box at the end to confirm that you agree that [young person's name] can decide to take part.

- I have read through the Participant Information Sheet fully and I understand what is expected of the young person throughout this study.
- I have had the opportunity to ask any questions about the research.
- I am aware that the young person's participation is voluntary and that they can withdraw from the study at any point. The young person can ask for the

information they provide to be destroyed up to two weeks after the interview.

- I am aware that after this stage, data may be anonymised and incorporated into themes, therefore it might not be possible for it to be taken out of the data. However, every attempt will be made to extract data.
- I understand that the interview will be audio recorded and then made into an anonymised written transcript. The information will not be identifiable.
- I understand that the information from the interview will be pooled with other participants' responses, anonymised and may be published in a journal.
- I consent to information and quotations from the young person's interview being used in reports, conferences, training events and publications. All quotations used will be anonymised.
- I understand that if the young person discloses any information that makes the researcher concerned about their safety or the safety of anyone else that this may not remain confidential and may need to be investigated appropriately.
- I also understand that the discussions within study may be potentially upsetting for the young person and that the young person has agreed to inform the researcher if they become distressed during the interview.
- I consent to Lancaster University keeping electronic written transcriptions of the interview for 10 years after the study has finished.
- I understand that the young person's data will be shared and discussed with the researcher's supervisors who are based at Lancaster University.
- I agree that the participant can take part in the research, if they chose to do so.

Young person's Name:	
Parent/guardian Name:	
Signature:	
Date:	
Researcher Name:	
Signature:	
Date:	

Appendix 4-E: Interview Topic guide



The Division for Health Research
 Doctorate in Clinical Psychology

INTERVIEW TOPIC GUIDE

Opening question:

Can you tell me a little bit about yourself?

How long have you been living in this home? How long have you been in care?

Is it ok if I ask you questions about your self-harm?

Exploratory questions:

‘Can you tell me a little bit more about your self-harm?’

What kind of self-harm have you tried? (methods)

‘How do you feel you cope with these experiences?’

What do people tend to do when you self-harm? (staff/other young people)

How have other people responded to your self-harm?

What has been a helpful/less helpful response?

How do you think other people understand your self-harm?

How have other people tried to support you around your self-harm?

Within your home environment there may be certain rules or restrictions, does this impact your self-harm in any way? For example make your self-harm better or worse?

What is it like self-harming in an environment where other young people may self-harm?

Has your self-harm changed in anyway since you have moved into residential care?

Young people tend to self-harm for lots of different reason; I just wondered if you could share with me why you might self-harm?

How do you feel about your self-harm now? Is it something you would like to continue to do or stop?

Is there anything that you have tried to reduce self-harm?

When you have self-harmed, what do you do afterwards?- (let people know, cope alone ect)

How do you feel after you self-harm?

Last question

This research is about self-harm in young people who are in the residential care system. Is there something that you think should change to help support other young people?

Additional prompt questions:

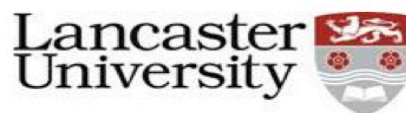
'Could you tell me more about that?'

'What was that like for you?'

'What did you think about that?'

'How did that make you feel?'

Appendix 4-F: FHMREC Approval



Applicant: Charlene Rouski
Supervisor: Bill Sellwood and Suzanne Hodge
Department: Health Research
FHMREC Reference: FHMREC15116

23 August 2016

Dear Charlene

Re: Looked-after children's experiences of self-harm: A qualitative analysis

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

A handwritten signature in black ink that reads "Diane Hopkins". The signature is written in a cursive, flowing style.

Dr Diane Hopkins
Research Integrity and Governance Officer, Secretary to FHMREC.