What outcome goals do young people aged 16 to 20 years who self-harm have for therapy and what in therapy helped or hindered them in achieving these goals?

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I declare that this thesis is my own work and has not been submitted for the award of a higher degree elsewhere.

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> I can do everything through Him who gives me strength.
>
> Philippians 4:13 (NIV)

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Abstract

Investigations reveal that instances of self-harm by young people are rising and are an increasing challenge for healthcare and mental health services (Morgan et al., 2017; McManus et al., 2019; Barker, 2020). Young people's negative experiences of accessing help and support when they self-harm have been a contributing factor to them not seeking help in future episodes (Wadman et al., 2018; Jones et al., 2019)

This thesis illustrates a systematic review which is concerned with young people's barriers to help seeking, what outcomes they wanted for therapy, and whether they experienced therapy as helpful or unhelpful. It also presents an empirical study which explored the experience of therapy for 10 young people who had a history of self-harm with an IAPT service in the East of England.

For the systematic review, a systematic search for relevant literature produced since 1978 was conducted across six databases. A total of 8768 records were sourced from six databases. After scrutiny for duplicate records, assessment for suitability, and full-text eligibility screening, 142 papers were included for synthesis. Following synthesis and quality appraisal, it was observed that literature fell into two overarching themes: young people, self-harm and help seeking, and young people's experiences of therapy. It was also noted that studies have been published into the epidemiology and prevalence of self-harm and also for the efficacy of therapy from the perspective of the client. However, no studies have combined the two in one exploration of therapy with young people who self-harm.

The empirical study focuses on analysis of 10 qualitative semi-structured interviews. Interviews were audio recorded, transcribed, coded, and analysed using reflective thematic analysis from a social constructive viewpoint, underpinned by a person-centred and social constructionist theoretical perspective. The reflective thematic analysis identified four themes: Hope of feeling more in control, Therapy changed the way I see things, Therapist enabled a positive therapeutic space, and There are consequences to admitting to self-harming. The findings suggest that having or regaining a sense of control, beyond the common desire, is a goal for therapy of young people who self-harm. The findings suggest the reasons for participants feeling they did not achieve their goals for therapy included poor therapeutic alliance, resistance to change and idiosyncrasies of service provision in rural locations.

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Chapter 1 – Introduction

I hurt myself today, to see if I still feel.

I focus on the pain, the only thing that's real.

Hurt - Nine Inch Nails, 1995; Johnny Cash, 2002

1.1 Overview

The research questions of this study are:

> What outcome goals do young people aged 16 to 20 who self-harm have for therapy and what in therapy helped or hindered them in achieving these goals?

This study is motivated by the experiences of the assessment and therapy process described to the researcher by young people in his role as a counsellor over a period of 15 years, but particularly whilst working with an Improving Access to Psychological Therapies (IAPT) service in the east of England between 2014 to 2019. The research goal was to remain open-minded to the outcomes yet curious to gauge if these experiences are more common and if so, what can be done to improve the young people's experiences. Additional motivation for this study comes from NICE Clinical Guidance 16 section 2 which recommends studies using an appropriate and rigorously applied qualitative methodology should be undertaken to explore user experiences of services in order to improve them (NICE, 2004). In undertaking this study, the goal was to afford an opportunity for the voice of young people to be heard beyond the therapy room about their experiences.

Evidence demonstrates that self-harm behaviour is increasing and is a growing public health concern (Rowe et al., 2014; Morgan et al., 2017; Griffin et al., 2018; McManus et al., 2019; Barker, 2020). It is clearly important to make support for young people who self-harm, particularly therapy accessible and effective. Understanding the motivations for seeking help and how young people experience therapy to overcome the compulsion or tendency to engage in self-harming behaviour is important for a number of other reasons. Exploring personal accounts of the goals for therapy and their perspective of the therapy journey of young people who self-harm can inform therapeutic protocols and service provision as to best practice and lead to potential improvements in delivery. Analysis of individual accounts of therapy for young people who self-harm can educate health professionals and service providers about the complexities, sensitivities and impacts that young people encounter when services gather information during assessments and during therapy, and take this into account when developing or updating services and therapy interventions (Klineberg et al., 2013). Furthermore, chronicling negative as well as positive experiences can inform understanding of young people's experiences of therapy which can then inform changes in the way therapy is provided to avoid undesirable consequences such as resistance to therapeutic change and drop out due to the belief that therapy is not working or services are not supportive. It is also important for young people who self-harm to be heard and to place them at the centre of any investigations in order to elicit from them what, for them, actually constitutes help and what they wanted as an outcome of therapy as opposed to opinions and theories of others which can be imposed on them.

There are a growing number of studies that report on the efficacy of therapy or the growing aetiology and incidence of self-harm in young people. While important, do not relate to the core interests of this study. They have nonetheless been instrumental in setting these research questions. There is an absence of literature that centres on the therapy process for young people who self-harm and understanding of their goals or expectations when engaging in therapy. Furthermore, current literature focuses primarily on the effectiveness of Dialectical Behaviour Therapy (DBT), and Family Therapy where the presentation of psychological distress includes self-harm, for example see Priebe et al. (2012); Cottrell et al. (2018). There is a lack of qualitative studies reporting on a young person's perception of the effectiveness of counselling or CBT in a primary care setting where young people who self-harm engage in therapy.

1.2 Definition of key terms

Our understanding of definitions or terminologies are conditional on the situation and circumstances of their use (indexicality) (Suchman, 1987). A formal definition of what a term means requires a description of the context or situation it is being used and every situation has an indefinite range of possibly relevant features. The practical solution to this theoretical problem is not to itemise the relevant circumstances but to offer a generalised definition for the circumstances of this research. Therefore, based on the current literature, and the situatedness of this research, the following definitions have been adopted for this study.

1.2.1 Young people

The term young people appears in literature as early as the 17th Century, for example Crook (1686). In a search of literature in the 21st Century, the term young people is more commonly adopted but is often interchangeable with the term adolescent, youth, emerging adult or young adult. Literature relating to these terms offers either conflicting or no definition of the specific age range they refer to. According to the United Nations, youth is an identical term to young people and refers to an age range of 15 to 24 (United Nations, 2017). The General Medical Council consider young people to be aged 16 to 18 (GMC, 2017). Alternatively, the World Health Organisation refers to young people being adolescents aged between 10 and 19 years old (World Health Organisation, 2017). Patel et al. (2007) identifies young people as being aged 12 to 24. However, Cleaver et al. (2014) classifies young people as aged 12 to 18 years. In literature, this lack of agreement confounds the issue of a definition (Hawton and James, 2005; Lynass et al., 2012; Cottrell, 2013). In the United Kingdom, there is no legal definition of young people only for child and adult, with a child being defined in the Children's Act 1989/2004 as being under 18 years old (Graham, 2004). Current legislation in the UK further confounds a definition of adulthood and hence young people. A young person can be considered as having the capacity of an adult at 16, 17 or 18 depending on the situation, for example riding a moped, sexual activity, getting married, driving a car or buying alcohol (Colman, 1995)

Adopting the term adolescence for this study is difficult because as with the term young people, it is not attributable to a quantifiable age range. Adolescence is

accepted to begin after puberty but there is no specific ontogenetic event that signifies the end of adolescence (Arnett and Taber, 1994). The biological transition from adolescence to adult has no specific marker that identifies the end of adolescence. Accelerated brain development triggered in puberty associated with the adolescence is understood to continue on into the mid-twenties (Graham, 2004). It is acknowledged in developmental biology and psychology that identifying the end of adolescence and hence a definition of age span is ungeneralisable because of the influence of diversity, biological, psychological, and social factors (Colman, 1995; Graham, 2004; Roenneberg et al., 2004).

Prior to data gathering, an informal poll of 20 young people aged between 16 and 20 known to the researcher was carried out to ascertain which descriptor they preferred. From a list that included adolescent, youth, young adult, emerging adult, young people, and an option for a name of their own choosing that was not listed, the respondents overwhelmingly chose young people as their preferred terminology. The term adolescent was considered derogatory and relating to early teenagers and youth was not considered suitable as it was associated to misbehaviour and crime in the eyes of the respondents.

In this thesis, the term young people is used based on the naming preference of peers of participants of this study. The term young people has also been selected to identify those aged 16 to 20 based also on an amalgam of current definitions and to indicate the period of overlap between adolescence and adulthood, a period of life which has a value and importance in its own right and

is not a just a transition phase, being considered somehow less than being an adult.

1.2.2 Self-harm.

There is currently no standard definition of self-harm (Hetrick et al., 2020). There are many varied types of self-harm undertaken in different contexts with different individual motives and meaning attached to the self-harm act, therefore a definition of self-harm is not straightforward (Hicks and Hinck, 2008; Royal College of Psychiatrists, 2010). The amount of knowledge concerning self-harm is increasing but at the same time, since the 1960s, there has been an increasing number of descriptive terms used for causing injury to oneself that is not intended to result in death, for example self-injury, self-injurious behaviours, non-suicidal self-injury, non-suicidal self-harm, deliberate self-harm, parasuicide or self-mutilation (Casey, 2005; Skegg, 2005; Waldorf, 2005; Sutton, 2007; Hicks and Hinck, 2008; Kelly et al., 2008; Wichstrøm, 2009; Millard, 2015). The characteristics of each term used are indistinct and a common term and definition of injury to self that is not intended to end one's life can hamper generalisation of research (Wichstrøm, 2009). The terms for self-harm used in the UK pre 1970s were commonly non-fatal suicidal behaviour, parasuicide and attempted suicide but these were superseded by the term deliberate self-harm in recognition that not all episodes involved a suicidal intent (Kapur et al., 2013).

Definitions of self-harm in literature do not include harm caused by overeating, body piercing or tattooing, acute consumption of alcohol or recreational drugs,

nor from starvation (Waldorf, 2005; Hicks and Hinck, 2008; International Society for the Study of Self-Injury, 2016). An exhaustive list of self-harm actions would be impracticable as trends change and literature has yet to agree a definitive statement (Fox and Hawton, 2004; Plener et al., 2015). However, some narratives do name specific actions in their definitions. The Royal College of Psychiatrists in developing National Institute for Health and Care Excellence (NICE) Clinical Guideline 16 and Quality Standard 34 defines self-harm as either self-poisoning or self-inflicted injury regardless of the intent of the act (NICE, 2004, 2013). Turp (2003) describes self-harm as the act of causing injury to oneself by cutting, burning, intense scratching, hitting, or poisoning as well as deliberately not attending to injuries or taking appropriate care of oneself. The World Health Organisation's International Statistical Classification of Diseases and Health Related Problems (ICD-10) definition of self-harm includes self-inflicted poisoning or injury by exposure to substances and chemicals, strangulation or suffocation, firearms, explosives, smoke, fire and hot objects, sharp and blunt objects, jumping or lying in front of moving objects, intentionally crashing vehicles or aircraft, and other specified or unspecified means (World Health Organisation, 2016). While individuals harm themselves using one method, for example cutting, some individuals switch methods of self-harm between episodes (Doyle et al., 2017; Kelada et al., 2018; Burton, 2019; McManus et al., 2019). Definitions of self-harm in literature do not encompass those who use different methods of self-harm at different times. Owens et al. (2015) reported that some individuals who attended hospital, switched between methods of harming themselves (22.5% of 21255 participants). Switching was

observed to be slightly more common in males (37%) when compared to females (33%).

There is on-going discussion in literature regarding the connection between self-harm and suicidal intent. Some reports suggest that definitions of self-harm and suicidal intent should clearly separate the concepts (Nock, 2010; Selby et al., 2012), whilst others propose that intent is difficult aspect to separate from self-harm (Kapur et al., 2013; Brunner et al., 2014). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), self-harm diagnostic criteria include the requirement that over the past year, the person has engaged in self-injury for at least 5 days, with no suicidal intent but with the anticipation that the injury will result in some bodily harm. Additional criteria for a diagnosis of self-harm is that the act is not considered socially acceptable and is not occurring during psychotic episodes, delirium, substance intoxication, or substance withdrawal and cannot be explained by another medical condition (American Psychiatric Association, 2013). The DSM-5 describes the purpose of self-harm to gain relief from negative emotions and personal issues (American Psychiatric Association, 2013). Reviews by Zetterqvist (2015) and Cipriano et al. (2017), reinforces the DSM-5 understanding of self-harm as being different from suicidal intent. In their report, the Royal College of Psychiatrists (2010) describe self-harm as any intentional act of self-injury or poisoning regardless of the level of suicidal intent. Huang et al. (2017) places self-harm and attempted suicide on a continuum of varying severity.

Some literature includes behaviours or ways of thinking in their definitions of self-harm. Turp (2003) offers that self-harm is a term that encompasses behaviours that result in physical damage occurring whether by actions or deliberate in-action that goes beyond limits of customary behaviour. Klonsky and Olino (2015), in the same way as the DSM-5, include a socially unacceptable aspect in their definition of self-harm. Cutting, scarifying, piercing of the skin may be culturally accepted when connected with religious or spiritual associations, healing or rites of passage and thus have different meanings to self-harm (Sutton, 2007).

This study adopts the definition of self-harm outlined in NICE Clinical Guidance 133 - Self-harm in over 8s: long-term management, for the longer-term psychological treatment and management of self-harm in people aged 8 and over (NICE, 2011). CG 133 (NICE, 2011) defines self-harm as 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' but does not include 'harm to the self, arising from excessive consumption of alcohol or recreational drugs, or from starvation arising from anorexia nervosa, or accidental harm to oneself.' This definition is adopted for this study as it does not distinguish self-harm based on intent and because it is under CG133 directive the participants of this study will have received support and therapy within the IAPT service.

1.2.3 Hope

Hope is a complex concept making it difficult to define (Eliott and Olver, 2002; Eliott and Olver, 2007; Johnson, 2007). A meta-analysis of 46 articles published

between 1975 and 1993 concluded that there was a lack of precision and agreement in the description of hope across all the studies and that here is a need for further work to clarify the concept of hope (Kylma and Vehvilainen-Julkunen, 1997).

The expression of hope is different to an expectation. Hope is expressed as a desire or wanting of the situation a young person is experiencing to change. An expectation would have been articulated in a more demanding way, expressing what the individual wants to happen regardless of what is actually happening or was possible (May, 1993). While expectation is the assumption that something is actually going to happen, hope is the wish for something to happen and is not constrained by previous experience nor does it extinguish if it goes unmet (May, 1993).

The definition of hope adopted by this study is that hope is the anticipation or expectation through thinking and feeling that looks to a future realisation of goals or outcomes that are personally meaningful and are realistically possible, even if there is some uncertainty about them being achieved (Default and Martocchio, 1985; Stephenson, 1991; Tutton et al., 2009). It is the conclusion of this researcher that this particular definition fits well with the expression of hope articulated by the participants of this study.

1.3 Background

1.3.1 Self-harm

Self-harm is not a new phenomenon. Chronicles of acts of self-harm can be found in early literature (Gilman, 2013). For example, Book Six of The History, Herodotus (5th century B.C.) describes the actions of a Spartan leader:

> Cleomenes took the weapon and set about slashing himself from his shins upwards; from the shin to the thigh, he cut his flesh lengthways, then from the thigh to the hip and the sides, until he reached the belly…
>
> (Hornblower and Pelling, 2017)

Self-harm is also mentioned in the Holy Bible in Mark chapter 5 verses 2 to 5 written c. 66–74 AD about events c. 30-33 AD:

> When Jesus got out of the boat, a man with an impure spirit came from the tombs to meet him … no one was strong enough to subdue him. Night and day among the tombs and in the hills he would cry out and cut himself with stones. (NIV)

One of the earliest attempts to explain self-harm behaviours regarded self-harm as an action to promote healing and to avert suicide (Menninger, 1938). Influential studies into self-harm emerged in the 1950s and 1960s, predominately relating to taking excess medication as a means of communicating psychological distress (Millard, 2015). In the 1960s, Graff and Mallin (1967) recognised self-harm as a psychiatric problem noting that at the time self-harmers had become the new chronic patients. In the late 1970s and

early 1980s, literature shows a recognition that the number of recorded overdoses were decreasing but instances of cutting of wrists and forearms were increasing as a means of relieving internal tension (Hawton, 1978; Millard, 2015). From 1980 onwards, research increased into the epidemiology, functions and rates of self-harm (Favazza, 1996; Hawton et al., 2000; Gilman, 2013; Millard, 2015).

Self-harm is known to be associated with a variety of risk-taking behaviours and co-morbid mental health difficulties, such as low mood, anxiety, and adverse childhood experiences (Kaess et al., 2013; Brunner et al., 2014). Self-harm can be used for diverting attention from overwhelming emotional pain to a more tolerable, easier to manage physical pain as well as a way of communicating how much the individual is hurting (Sutton, 2007; Hicks and Hinck, 2008; Gilbert et al., 2010). Literature spanning forty years records descriptions of the time leading up to self-harm being essentially identical in that individuals experience increasing tension which leads to compelling urges to self-harm and many may disassociate just before harming themselves (Waldorf, 2005).

Several physiological and psychological functions of self-harm have been advocated including gaining control, correlation with adverse childhood experiences and psychiatric disorders being most consistently reported in the literature (Nock, 2009). However, there is no consensus about the number of different functions of self-harm, for example Nock (2009) documents that there are four functions whilst Sutton (2007) promotes eight. Studies have shown that the most common theme emerging from research into functions of self-

harm is one of communicating emotional distress where words are not available (Craigen and Foster, 2009; Scoliers et al., 2009; Hill and Dallos, 2011; Edmondson et al., 2016). Self-harm has other functions for the young person including affect regulation, self-punishment, soothing, feeling alive or a release of tension (Turp, 2003; Sutton, 2007; Klonsky, 2009). Hicks and Hinck (2008) describe a function of self-harm as altering an intense emotional pain to a more manageable physical pain, as a means of relief; to feel pain on the outside instead of inside. Young people describe the physical pain experienced during or after self-harm as being preferable or thought of as being easier to manage than working through emotional pain (Brown and Kimball, 2013). Self-harm can regulate affect, be an emotional release or relief of emotional distress bringing temporary calming through the release of endorphins particularly dopamine which creates feelings similar to getting a high from a drug or from drinking alcohol (Gratz, 2003; Sutton, 2007; Hicks and Hinck, 2008; Gilbert et al., 2010; Burton, 2019). These could reasonably be considered as a description of the individuals not feeling that they have control and are striving to move from a state of feeling emotionally out of control to one of feeling more in control; to have some sense of control over one aspect of their lives through self-harm (Turp, 2003; Sutton, 2007; Klonsky, 2009).

There is a significant psychological and physical impact of self-harming behaviour on the young person, and it is often very distressing for family, friends and others who have contact with the young person (Ferrey et al., 2016b). Parents and family of young people who self-harm can find it difficult to understand and can associate their child self-harming with failed or bad

parenting and shame (Oldershaw et al., 2008; Cello and YoungMinds, 2012; Ferrey et al., 2016a). Often young people do not experience empathy and understanding from some family members or professionals when they self-harm, for example see Rayner et al. (2019). Giving time and space to listen carefully is sometimes not possible for family members, peers or friends and sometimes it is not considered important to others, especially within a family who may be the cause of, or contributing to the distress being experienced by the young person (Sinclair and Green, 2005). It has also been the case that young people who self-harm have been criticised by professionals, family and peers as attention seekers or of manipulation to acquire a caring response from others (Favazza, 1992; Conterio and Lader, 1998; Sandy, 2013; Doyle et al., 2017; Burton, 2019). Research in 2012 found that almost half GPs, teachers and parents surveyed felt that young people who self-harm do so in a way to manipulate others (Cello and YoungMinds, 2012). Labelling someone who self-harms as an attention seeker is to criticise and vilify someone who is already experiencing emotional distress. It is therefore not unsurprising that young people find the fact that they self-harm stigmatising and shaming, hence difficult to talk about with professionals or other individuals in a position to support them (Amoss et al., 2016). Whilst undoubtedly, some individuals have attempted to communicate by showing others how much distress they are in by self-harming, the premise that self-harm is a form of attention seeking and manipulative is inconsistent with other clinical and empirical research which demonstrates that this negative belief is more likely to be a mistaken one (Gratz, 2003; Doyle et al., 2017). It has been shown that self-harm is more often an act carried out in private and hidden from others, often with self-harmers harming in areas not

normally visible i.e. the top of their legs or covering their wounds with clothing for example, wearing long sleeved tops in warm weather (Turp, 2003; Brown and Kimball, 2013; Klineberg et al., 2013; Doyle et al., 2015). Therefore, self-harm cannot have the intent of manipulation of the attention of others when these circumstances prevail (Favazza, 1992; Conterio and Lader, 1998; Gratz, 2003; Waldorf, 2005; Borrill et al., 2009; Doyle et al., 2015; Burton, 2019). The way therapist interacts with a young person who self-harms is crucial in determining whether the young person will experience increase their sense of shame and stigma and not add to the unaccepting critical voices the young person has experienced before.

1.3.2 Effectiveness of therapy

A psychotherapy intervention can be defined as a therapeutic procedure implemented to accomplish a particular task or goal (Cooper, 2008). Research into the effectiveness of therapy has moved on significantly since a 1952 article in the Journal of Consulting Psychotherapy which claimed that psychotherapy was ineffective and potentially harmful (Eysenck, 1952). Not only is the efficacy of psychotherapy now well recognised, but meta-analyses, trials, and reviews demonstrate its effectiveness in different settings, modalities and for different presentations, for example see Chorpita et al. (2011); Munder et al. (2019); Barkham et al. (2021). Research into helpful or meaningful events investigates important aspects of the therapy process, whether they be helpful or hindering, primarily from the perspective of the client (Timulak, 2010). This research can be helpful to therapists by increasing understanding of therapy processes and activities that may contribute to therapeutic change when their client has used

self-harm as a coping behaviour for example see, Watson et al. (2012); Cooper and McLeod (2015); Swift et al. (2017).

Quantitative data, putting emphasis on statistical measures, can greatly inform us about the efficacy and success of therapy for a given condition. However, these studies can overlook an important evaluation of effectiveness of therapy i.e. the client lived experience and meaning attributed to events. Additionally, because of the differences in cognitive, emotional, and social interactions, the use of data from adult research into therapy where self-harm is a factor being transposed to younger age groups is not adequate or appropriate (Colman, 1995; Nelson et al., 2007; Kwon et al., 2013; Griffin et al., 2018). Research concentrating on the perspective of the client in therapy can increase the understanding of how client's make sense of their experience and may ultimately help to gain insight in to how they interact in the therapy process (Gordon, 2000). This study, being an exploratory analysis of lived experience, will embody a framework of qualitative discovery rather than of hypothesis verification or a statistical relationship (Giorgi, 1985).

1.4 Participants journey through the IAPT service in the east of England

It is relevant to understand the referral, assessment, and therapy process of the IAPT service the participants are drawn from in order to give this study some context. Young people can be referred to the IAPT service by their GP or by the Psychiatric Liaison Team at the local hospital Accident and Emergency department after being admitted for physical injuries deemed to be caused by

poor mental health issues. They can also self-refer confidentially though the IAPT service website, or through a Freephone telephone number. On receipt of a referral, a 45 minute telephone assessment is conducted with the client which includes collecting demographic information, information to identify what and where the client wishes to make changes in their lives or improvements to their mental health state. This assessment also includes an appraisal of any risk to the individual by identifying any suicidal tendencies, any self-harming behaviours or any behaviours which may indicate harm may be caused to them by others and is in essence an attempt to predict future risk behaviour of the person (NCISH, 2018). Risk information is gathered through an IAPT Minimum Dataset (MDS) questionnaire (Appendix E). A section of the MDS is the nine question Patient Health Questionnaire - PHQ-9 which includes the question whether in the past two weeks the respondent has been bothered by 'thoughts that you would be better off dead or thoughts of hurting yourself in some way' (Kroenke et al., 2001). A further question asks whether the respondent has any plans or intent to harm themselves or to end their life. The MDS is completed at every appointment and risk reappraised based on the responses and client presentation. The MDS also provides a vehicle by which recovery or deterioration can be monitored, recorded, and evaluated.

IAPT services adopt a stepped-care model of delivering therapeutic interventions. The stepped care model provides different levels, or steps of treatment by allocating clients to the intensity of treatment appropriate to their presentation and difficulties (Hagga, 2000; Bower and Gilbody, 2005; NCCMH, 2020). Each step provides increasingly more intense interventions which are

delivered by more highly trained specialists. The main feature of the stepped care model is that clients are initially allocated to the least intense intervention, one which is still likely to provide the maximum benefit with the minimum of intrusion (Davison, 2000; Bower and Gilbody, 2005). As a result of the assessment, the client will be offered either self-help materials (Step 1), group interventions or low level interventions (Step 2) or one to one talking therapy (Step 3) (NCCMH, 2020). Where self-harm or thoughts to end life are disclosed, a risk management plan is formulated and agreed with the client. The MDS, completed at each session assists therapists in making decisions regarding whether to continue, stop, step up or step down the treatment (NHS Digital, 2020). Under the IAPT provision, clients will be discharged when they complete the allocated number of sessions and have shown reliable improvement, or if they meet a determined recovery score. These scores are predominantly measured by the responses to mood (PHQ-9) score and anxiety (GAD-7) scores on the MDS recorded at each contact (Kroenke et al., 2001; Spitzer et al., 2006; Health and Social Care Information Centre, 2020; NHS Digital, 2020).

To place the situation of the demand for therapy services at the time of this study it is worth noting that IAPT, like many other therapy services, are constrained by funding and staffing levels, and this can have a detrimental effect on service provision and meeting the needs of young people who self-harm. A recent survey of 1000 GPs in December 2019 revealed that 73% of GPs feel Child and Adolescent Mental Health Services (CAMHS) have deteriorated over the preceding year and that 54% of young people aged 11-18 years referred to CAMHS services by GPs are rejected. Of those accepted, 28% wait up to 12

months for treatment, while a further 27% wait three to six months (Stem4, 2020). Pressure on services is increasing: figures released in January 2020 from the Mental Health Statistics for England briefing report the number of referrals through the Improving Access to Psychological Therapies (IAPT) programme stood at 1.4 million in 2016/2017 (Barker, 2020). Nuffield Trust (2020) reports that in 2011/12 there were 887,452 referrals to IAPT, and this increased to 1,676,985 referrals in 2019/20, an 89% increase. The impact of this is clear and the service from which the participants of this current study received therapy attempted to mitigate barriers to access and waiting times by adopting a model of placing their staff in local GP Services rather than a central hub. Cases reported on in this study and in the literature supports evidence suggesting that miscommunication, impracticalities, and inconvenient appointments can be a significant cause for therapy sessions not being attended. However, it is important to recognise that dropping out of therapy due to appointment availability, distance etc. is not the always the entire reason for drop out. It may be the case that young people will be unwilling to make the effort of spending time and money travelling to sessions if they do not think they are achieving what they want from therapy.

1.5 Summary

In this chapter the rationale for this thesis, exploring the experiences of young people who received therapy with an IAPT service in the east of England, was illustrated. Definitions of the key terms of ‘young people’, ‘self-harm’, and ‘hope’ were described as they connect with the context and content of this study. The background to this study was clarified. A description of the route to referral and

the process the participants of this study would have undergone to access therapy was given. In the next chapter the theory underlying this study is highlighted to give clarity to the underlying assumptions and motivations for the research question and methodologies employed in this study.

Chapter 2 – Theoretical Framework

2.1 Introduction

This research and thesis are underpinned and viewed through the theoretical lens of the person-centred theories originally proposed by Carl Rogers (1902-1987). Person-centred theory is humanistic in orientation, relating to the whole person and acknowledges that each individual is unique. However, humanistic theory encompasses a broader field and does not share all the same metatheoretical suppositions that depict person-centred theory (Mearns and Thorne, 2000; Patterson and Joseph, 2007). Person-centred theories are phenomenological in nature and recognise the individual's subjective, conscious experience as being both valuable and important (Rogers, 1959, 1962, 1980)

The ontological position of the person-centred model constructs individuals as striving to fulfil two main primary needs or drives. Firstly, there is the formative tendency to maintain and enhance themselves and secondly the need to be valued and loved. Person-centred theory proposes that the epistemological basis of gaining knowledge and understanding of the self can be obtained by creating conditions including acceptance, congruence and empathy which make possible the expression of the experienced self. (Rogers, 1957, 1959, 1962, 1980; Mearns and Thorne, 2000; Mearns, 2011).

The tenets of person-centred theories have helped frame the methodological choices, the development of the research questions, data gathering, and the

approach to analysis of this study. Adopting a person-centred methodology to research is a germane way to approach gaining of knowledge on the nature of young people's experiences of therapy when self-harm is a factor in their presentation. This is because the person-centred approach is suited to investigations where the expression of the emotional and psychological difficulties experienced by young people who self-harm, some of which are introjected from others, is the aim of the study (Mental Health Foundation, 2006; Cello and YoungMinds, 2012; McCormack et al., 2017).

Person-centered theories and approaches are also apposite for this research study because they focus on the innate resourcefulness individuals have to change the way they view themselves (self-concept), their attitudes, and behaviours in response to any given situation or experience. If negative or non-growth promoting experiences are encountered (conditions of worth and failure of positive regard), individuals may not be able to access this innate ability, tension and internal confusion will be experienced, producing dissonant or perplexing behaviours (Rogers, 1959; Stumm, 2005). This could conceivably describe the experience, thought processes, and actions of a young person who self-harms. The person-centred approach is built around the Rogerian 'core conditions' of acceptance, empathy and congruence, found in all modalities of therapy, are particularly relevant to young people who are continuing to grow and develop greater reasoning capabilities, logical and critical thinking, learning to accept others perspectives, and striving for greater independence and peer acceptance (Gentry and Campbell, 2002). Given that the Rogerian core conditions are established in most therapeutic encounters of all modalities, a

perspective of the person-centred approach will provide a basis of understanding of the therapeutic alliance in other types of therapy (Hazler and Barwick, 2001; Horvath et al., 2011).

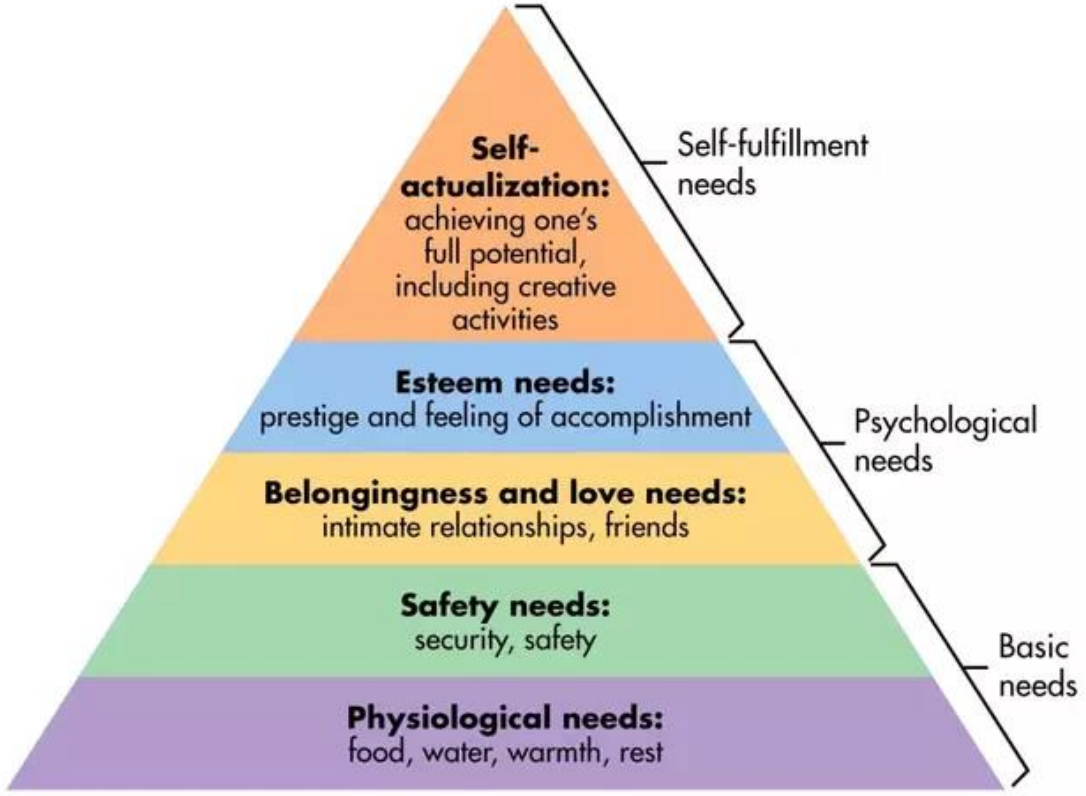
2.2 The actualising tendency, and organismic valuing process

The person-centred model holds the view that human beings have a substantial capacity to be self-determining and are able to access an innate motivation to satisfy their needs, helping them to move closer to fulfilling their unique identities (Rogers, 1962, 1980, 2004). Maslow (1943) proposed that in order for a person to be all they can be, certain needs must be met, for example the need for food, sleep, security, intimacy, and self-esteem (Fig 1).

This hierarchy of needs when satisfied ultimately leads the individual towards becoming fully functioning, a concept referred to as self-actualisation (Maslow, 1943, 1954). Individuals are motivated to satisfy needs lower in the hierarchy to a greater extent before they can move on to satisfying needs at a higher level. Lower needs tend to occupy the mind if they remain unsatisfied for any length of time. Unless the physiological need for food and shelter is met for example, one cannot feel safe, and the pursuit of these physiological needs become all encompassing. As lower needs begin to be satisfied, though not yet fully met, higher needs may begin to present themselves as more pressing (Maslow, 1943, 1954; Rogers, 1962, 1980; Maslow, 1998). Rogers unlike Maslow, believed a fully self-actualised person was not theoretically possible, but he theorised that individuals are constantly moving though phases attempting self-

change without a fixed or permanent inner self (Rogers, 2004; Douglas et al., 2016).

Figure 1: Abraham Maslow's Hierarchy of Needs (1943)[1]



Rogers named the formative tendency towards becoming a fully functioning person the actualising tendency (Rogers, 1962). The actualising tendency is regarded as the most predominant and motivating drive of existence and encompasses actions that influence the whole person, it is also considered the motivating influence for all behaviour (Rogers, 1959, 1962). The actualising tendency can be defined as the tendency of all people towards growth, autonomy, and freedom from control by external forces (Schunk, 2020). Rogers

[1] Sourced from: https://www.simplypsychology.org/maslow.html accessed 2nd October 2021

(2004) describes the actualising tendency as being demonstrated by the motivation to seek and engage in activities to satisfy the need to grow as a person. In person-centred theory the term self-actualisation refers to a process not a condition of a fully functioning person (Rogers, 1962; Wilkins, 2003).

The actualising tendency is linked closely to the organismic valuing process based on our inner nature, internal rationality, and individual decision making; it is our innate tendency to decide and move towards what is good for us (Rogers, 1962, 1980, 2004). The organismic valuing process is a natural motivation towards growth both physically and psychologically (Rogers, 1964, 2004). In the organismic valuing process psychological growth not only encompasses learning of cognitive skills but also growth toward greater wellbeing in the way in which an individual develops different ways of relating both to the self and the social world, and how the social context can foster or stifle this process (Rogers, 1964, 2004; Proctor et al., 2016).

Psychologically, the actualising tendency reveals itself through the organismic valuing process as a greater personal growth through a greater understanding and connection with the self (Rogers, 1959, 1964, 2004). Encounters that are experienced as enhancing are positively valued, whereas those that are experienced as not organismically enhancing are negatively valued (Proctor et al., 2016). Over time, the individual learns to be accepting of their reactions to a given situation and be capable of noticing and understanding how they react and feel as they do. The actualising process requires individuals to be able to communicate with themselves and gain insight into their ‘phenomenological

field' which becomes the primary force to learning positive self-regard through openness and self-awareness (Rogers, 2004). Rogers (1963) acknowledged that any action which actualises the individual's potential to bear pain or act in a self-destructive way is experiencing perverse or unusual conditions i.e. self-harm. It is the underlying causes of emotional and psychological distress that limits an individual's access to, and ability to utilise their actualising tendency and this in turn can result in them engaging in self-harm.

The actualising tendency is relevant to this study because young people who engage in self-destructive behaviours will have, through adverse life experiences or social rejection, experienced perverse or unusual conditions and as a result, their actualising tendency suppressed or reversed (Rogers, 1963; Merry, 2008; McGarry, 2020).

The individual's actualising tendency and organismic valuing process can be observed by their actions and in narratives of therapeutic encounters, and in studies recording individual accounts of psychological distress and therapeutic encounters.

2.3 Self-image, ideal self, and self-worth

Inherent in person-centred theory is a view of human nature that individuals are essential good, are typically positive, forward-moving, constructive, realistic and trustworthy (Rogers, 1962, 1980). Person-centred principles consider that everyone lives in a constantly changing private world, which Rogers called their experiential field (Rogers, 1962, 2004). Everyone exists at the centre of their

own experiential field, and this field can only be fully understood from the perspective of the individual. An individual's behaviour is understood as a reaction to their experience and perceptions of this field. Person-centred theory proposes that each person is capable of finding a personal meaning and purpose in life, and dysfunctionality is in essence a failure to learn and change (Rogers, 1962). Rogers (1962) suggested a fully functioning person is able to live in the moment and to experience inner freedom, creativeness, compassion and embrace challenges, even when an individual is experiencing emotional or physiological difficulties.

In person-centred theory, the self is not considered an agent or an item within an individual person, but it is considered a phenomenologically derived concept: how the person regards themselves. Consequently the self constantly changes, and it reforms more as an individual integrates new self-experiences (Stumm, 2005).

Person-centred concept of the self maintains that it is the fragmented parts of the self which result in a dysfunctional state are self-worth, self-image, and the ideal self. Simply stated, the greater the gap between the individual's concept of an ideal self and their current self-image and sense of self-worth, the greater the distress and dysfunctionality is experienced (Schmid, 1998; Mearns et al., 2013). When dysfunctionality between self-image, self-worth, and ideal self is experienced, an individual may develop self-protective systems which enable them to survive psychological stress and distress; self-harm can be considered one example. In normal social systems the actualising tendency will allow

individuals to grow, to reconfigure as the dangers diminish or increase and as their social circumstances change. However, individuals can become fixed and will find it difficult to move forward (Rogers, 1962; Mearns et al., 2013). The process of adjusting an individual perception of self-image and self-worth as well as making an ideal self a more realistic concept is the process of therapeutic change (Rogers, 1951, 1957, 1959).

2.4 Conditions of worth

In order to stimulate the actualising tendency, the characteristics of the psychosocial environment of the individual have a crucial role. The growth process and the organismic valuing process require positive conditions particularly the esteem of another person without conditions of worth. Conditions of worth are viewed as the source of psychopathology (Rogers, 1959, 2004). The organismic valuing process can be disturbed in a social environment where the individual experiences conditional positive regard (Rogers, 1959). When a significant person in the lives of an individual cherishes them or offers affection in some respects and not others, this establishes a condition of worth. The need of individuals for affirmation or approval is substantial in the maintenance of positive self-worth and self-image.

Conditions of worth can be established in childhood and are carried though to adolescence and adulthood. Children are influenced by parents as the child strives for their approval by doing things to please them which leads to feeling loved. Through childhood and into adolescence, the individual experiences responses to their behaviour which will point towards whether love, acceptance,

and valuing is given to them in either an unconditional or conditional way. As they develop, the child introjects from others the understanding that they feel happier under conditions where they experience positive regard and so behave in ways to ensure they will receive positive regard and value their own self-worth from an external locus of evaluation (Rogers, 1962). If the child's behaviour does not meet with parental approval, this can lead to the child feeling less loved or even rejected. The child may then experience incongruence between self-image and experience, and this may lead to psychological maladjustment hindering personal growth towards self-actualisation even as a child (Rogers, 1959, 1962). In childhood, as well as later in life, when an individual receives conditional regard from parents and others, feelings of worth develop if the individual behaves in ways that engender love or acceptance because conditional acceptance teaches the person to feel valued only when conforming to others wishes. The act of self-harm can be in response to feelings of not being worthy of love and affection, or not being valued by others (Turp, 2003; Mental Health Foundation, 2006; Royal College of Psychiatrists, 2010; Cello and YoungMinds, 2012; Brown and Kimball, 2013; MIND, 2020).

Rogers (1959) gave no indication that the developing child would be differentially affected by interactions with distinctive parental behaviours or different significant others. Barrett-Lennard (2005) advocates this is likely to happen and is a logical extension of Rogers' original hypothesis. When a child receives different degrees of conditionality in response to their behaviours from different parents or significant others, the child will need to learn to navigate multiple pathways to feeling acceptable and worthy. Once firmly established,

conditions of worth become assimilated into an individual's own valuing and experience as positive or negative solely based on those conditions of worth taken from others, not because the experience enhances or diminishes their being (Rogers, 1959). Thus, a person may reject or alter a perception when someone on whom the individual depends for approval sees a situation differently (Rogers, 1962, 1980). These conditions of worth become the dominant guiding principle for determining behaviour which sets the foundations for potential psychological difficulties later in life (Rogers, 1959). Therefore, in a social environment when conditional positive regard is displayed, individuals do not self-actualise in a direction consistent with their actualising tendency but in a direction consistent with their conditions of worth (Joseph and Linley, 2004).

2.5 Configurations of self

Configurations of self is a relatively new concept in person centred theory. Cooper (1999) explored the notion of multiple self-concepts and how they determine the way we act in differing environments. Cooper proposed that in different environments we could have different experiences and develop different self-concepts (Cooper, 1999). Mearns and Thorne (2000) developed the theory of multiple self-concepts adopting the term 'configurations of self'. They hypothesised that individuals experience different patterns of feelings, thoughts, and behaviour in difference circumstances that often act as a means of protecting the self-concept. Mearns et al. (2013) advocate that individuals are capable of different 'configurations of self' based on diverse conditions of worth from others and these configurations are developed as a means of self-defence, as well as self-expression. Each configuration functions as the

presenting self when engaged in interactions with others, responding to the situation or social context of a set of conditions of worth. Some configurations are specific to a particular environment and some shared with other configurations (Tudor, 2010). It is essential not to suggest that these parts of the self are totally separate but is a holistic view of the individual trying to conform to different environments and interactions (Tudor, 2010). Configurations of self explain how young people who self-harm are able to interact with others and exist in school, college or social situations whilst hiding their emotional distress and their acts of self-harm. Because self-harm is often secretive young people can wear a mask of a different self to survive these situations and dissuade others that they are experiencing difficulties.

2.6 Person-centred approach to therapy

The person-centred approach to psychotherapy is a relational approach with mutuality at the centre (Rogers, 1951, 1957, 1959). Rogers' theoretical proposition states that when six necessary and sufficient conditions are present, they create a relational environment in which therapeutic change can occur and the individual's organismic growth process can be energised (Rogers, 1957, 1959, 2004). Rogers (1957) records these conditions as:

1. That two persons are in contact.
2. That the client is in a state of incongruence, being vulnerable, or anxious.
3. That the therapist is congruent in the relationship.
4. That the therapist is experiencing unconditional positive regard toward the client.

5. That the therapist is experiencing an empathic understanding of the client's internal frame of reference.

6. That the client perceives, at least to a minimal degree, the unconditional positive regard, and the empathic understanding of the therapist. (p.95-96)

The relational and mutuality aspect of the person-centred approach is best described by empathy which must not only be communicated to the client by the therapist but also received by the client. The extent to which this happens is not entirely determined by the empathising therapist but is also dependent upon characteristics associated with the receiving client (Barrett-Lennard, 1981). Wilkins (2000) advocates that in reaching mutuality, both client and therapist are able to offer each other unconditional positive regard and empathy.

Person-centred philosophy holds that only the individual can really understand and be the expert on their processes and potential reality, and not the therapist in the desirable therapeutic conditions (Rogers, 1951, 1959; Anderson and Goolishian, 1992; Rogers, 2004; Mearns et al., 2013). This theory is in contrast to psychoanalysis theories of Sigmund Freud (1856 – 1939) and the cognitive behavioural theories of Aaron Beck (1921 - 2021). Freudian theories conceptualise the therapeutic relationship as consisting of two main layers and constructs the therapeutic relationship as a dialectical tension between the transference-countertransference layer and the real or personal relationship layer (Freud, 1919, 1937). At the transference-countertransference layer, the client projects unwanted parts of the self onto the therapist by transferring

feelings from other relationships onto the therapeutic relationship. In so doing, a transference relationship is formed, and the therapist then offers the client their constructed interpretations based on this layer of the relationship and the therapist's expertise. Countertransference is the therapist's emotional reactions to the transference. In perceiving the therapeutic relationship in this way it is only the therapist, not the client, who adopts the role of expert, offering insight to the unconscious processes of the client through the management of the countertransference (Freud, 1919, 1937). Cognitive behavioural theories hypothesise that an individual's emotions and behaviours are shaped by their perceptions and interpretations of events and situations (Beck, 1964, 1976; Fenn and Byrne, 2013). Taking the client's experiences, the therapist creates a hypothesis about the reason, influences and negative thoughts that lead to an individual's problems, this is known as a formulation (Fenn and Byrne, 2013). This formulation is intended to make sense of the individual's experience and engender a mutual understanding of the difficulties (Beck et al., 1979; Fenn and Byrne, 2013). CBT practitioners aim to teach clients to understand their current ways of thinking, identify the maladaptive ways of thinking and learn skills to make changes (Fenn and Byrne, 2013). The CBT therapist adopts an active-directive approach, informed by Socratic questioning, which is structured to the aim of changing how the individual thinks (cognitive) and what they do (behaviour), with the specific interventions depending on the individual's formulation (Fenn and Byrne, 2013). This is a collaborative process in a limited way and more recent advances in CBT are based on establishing a facilitative therapeutic relationship by fostering the Rogerian style core conditions (Wright,

2006; Leahy, 2008). However, in CBT the relationship is considered necessary but is also deemed to be secondary to technique (Kazantzis et al., 2017).

Although Rogers' theoretical viewpoint is more associated with adults, his contributions to the wellbeing of young people are also significant, particularly in developing the way for young person to direct the session for self-exploration and personal development (Behr and Cornelius-White, 2008). Some therapists have identified the need to refine and combine Rogers' core concepts with creative methods when offering therapy to children and young people (Prever, 2010). Offering a variety of creative approaches based on the person-centred core conditions, where the relationship is paramount, is significant to this study and therapy with young people who self-harm and their drive to be heard and experience greater control.

2.7 Person-centred approach to research

A person-centred approach can be applied to the research as a framework for understanding individuals within existing research practices (Mearns and McLeod, 1984; McCormack et al., 2017; Sandvik and McCormack, 2018). The fundamental principle of person-centred approach to research is the relational and contextual view of person (participant) and the topic i.e. connectivity (Jacobs et al., 2017). Jacobs et al. (2017) assert that person centred way of doing research draws on three principles: attentiveness and dialogue, empowerment and participation, and critical reflexivity. Titchen et al. (2017) argue that the epistemology of person-centred research comes from a related

togetherness with participants. A person-centred approach to research includes:

> An environment of shared power, psychological safety so that participants (and the researcher) can participate authentically. Invitations to share lived experiences, and respecting the level of participant engagement, self-determination, mutuality and reciprocity. Shared decisions on the degree of open-endedness and structuredness of data gathering. Non-judgmental interactions and sympathetic presence. Attentiveness given to invitations to (creatively) share lived experiences and respecting the level of participant. Methods for (collective) critical (and creative) analysis of (own/others) lived experiences. Researcher's influence on/voice in the data gathering and analysis process. (Titchen et al., 2017 p.43)

For a study where the lived experience of the participants involves an element of guilt and shame, and achieving the aim of giving the participant a voice, a person-centred approach to qualitative research is entirely suitable (Mearns and McLeod, 1984). A person-centred approach can be effective in enabling research participants to be able explore and verbalise areas of feeling and vulnerability in a way that could have been impossible with more structured methods (Mearns and McLeod, 1984). A person-centred approach supports removal of the power imbalance that can occur between researcher and participant (Jacobs et al., 2017). If there is less of an inequality, the participant may feel more inclined to offer their thoughts and ideas (Jacobs et al., 2017;

Sandvik and McCormack, 2018). The use of empathic questioning and responding demonstrates to the participant that the researcher is truly listening and wants to hear and understand what they have to say. The expression of acceptance by the researcher towards the participant allows them to feel able to offer their own thoughts and beliefs without fear of condemnation. This illustrates that a person-centred approach to research is appropriate for the topic and participants of this current study.

2.8 Criticisms of person-centred theory

2.8.1 Not scientific

Person-centred theories and practice have been criticised as lacking scientific study or measurability. To counter this argument, it should be born in mind that Rogers pioneered conducting empirical research on therapeutic processes and practice by documenting cases in counselling and psychotherapy. He disseminated these findings widely (Rogers, 1942; van Kalmthout, 2007; Barrett-Lennard, 2013). Roth and Fonagy (2005) argue that the person-centred approach is not subjected to rigorous trials to determine efficacy. The difficulty for the person-centred approach has been until recently that there has been very little research into its efficacy compared to other modalities, for example CBT (Cooper et al., 2013). There is growing emphasis on evaluating the impact of services and clinical interventions, typified by the more recent evidence-based practice (EBP) agenda (Warner and Spandler, 2012). Previously, proof for the effectiveness of the person-centred approach has not been recorded in ways that satisfy EBP methodologies that meet the demands of organisations such as National Institute for Health and Clinical Excellence (NICE) endorse

(Warner and Spandler, 2012; Cooper et al., 2013). This has begun to change with efficacy of the Person-Centred approach being demonstrated in ways that would be considered 'scientific' for example, see Barkham et al. (2021); Cooper et al. (2021).

2.8.2 Culture, gender, and social context

We are all products of a complex mix of influences including culture, ethnicity, gender, sexual orientation, and religious beliefs. Person-centred theories have been criticised for lacking social context and lacking acknowledgement of gender difference, for example see Geller (1982); Spinelli (1989); Proctor (2004); Schmid (2004); Proctor (2008). Person-centred theories have also been criticised as being confined to the culture of well-educated, white, middle class American men of the 1950s and 1960s being bound to the North American culture and have no relevance to twenty first century society. (Geller, 1982; Wilkins, 2003). As Wilkins (2003) points out, fundamental to person-centred therapy is its flexibility to adapt to the individual and to the zeitgeist, dispels the accusations of relevance in this modern age. To counter the criticisms of cultural relevance, Bohart (2013) highlights that the person-centred view of self is compatible with cultures that have an individualistic or relational view of self, as well as cultures that have no concept of self. Examples of the multicultural relevance of person-centred theories are found in literature for example, Morotomi (1998) and Kuno (2001) both discusses how the person-centred theory is compatible with the Japanese view of life and Buddhism. It has also been shown that the person-centred model is compatible with African Zulu and aspects of Islamic culture (Wilkins, 2003; Dwairy, 2006; Rassool, 2016)

Person-centred, humanistic psychology and Maslow's hierarchy of needs have been criticised as gender biased as they are believed to be linked to high dominant masculine values at the time of the development of the theories (Cullen and Gotell, 2002; Dye et al., 2005). Person-centred theories have also been critiqued for the constant focus on the man or woman and there being no analysis of gender dynamic forces when attempting to understand the person (Proctor, 2004). Schmid (2004) highlights that person-centered theory does not take into account gender in the context of the importance of conceptualising human beings as persons as man or woman 'not sexually neutral' (p. 181)

Person-centred theories do not distinguish differences in the development of males or females, nor did Rogers suggest that, for example the actualising tendency, were any different depending on biological gender (Wolter-Gustafson, 1999). However, differing rates of maturation between young males and females will have an impact on the drive to meet psychological needs and hence the imperative to seek help in emotionally distressful situations (Brody, 1985). Theories of conditions of worth are not specifically pointing to patriarchal systems negatively impacting possibilities for women, it is in fact indicating that any given woman or man perceives a condition of worth being imposed on her or him from any biological gender, social or cultural source (Natiello, 1999; Bozarth and Moon, 2008).

It has been argued that Rogerian theory fails to realise the power of cultural and social factors on an individual's behaviour (Ryan, 1995; Kensit, 2000).

However, Mearns and Thorne (2000) emphasise that the actualising tendency is moderated by social mediation. Conditions of worth can be exercised by others outside the parental relationship for example, in the workplace, school or college, or in social contexts. They are experienced in the same way that individuals experience conditions of worth from parents or significant caregivers. In a social environment where conditional positive regard is present, individuals do not move in a direction consistent with their actualising tendency but in a direction consistent with those conditions of worth. As discussed earlier, this results in a different presentation of self in different situations in order to be valued or gain approval of other people. The formative growth process is only able to progress when the impacts of social contexts are recognised (Mearns et al., 2013). This aspect of person-centred theory is particularly apposite to the participants of this study where they have experienced conditions of worth as young people, for example in school or college, about body shape or size, or style of clothing they wear and have developed different self-concepts as a result.

The person-centred approach has been accused of being the friendly face of neoliberalist psychology and has become something that rigidly upholds the pureness for fear of contamination (Bazzano, 2018). Neoliberalism often refers to an economic and political movement that advocated minimal democracy and a limited government intervention. Accompanying this neoliberal political agenda is an understanding of civil society as a collection of individual entities (Adams et al., 2019). Adams et al. (2019) affirm that a primary feature of neoliberal is a sense of freedom from constraint that reflects and affords an

experience of radical extraction from context. Neoliberalism emphasises freedom, especially freedom from restriction on growth and self-expression above other values e.g. equality and social commitment (Adams et al., 2019). Rogers (1990) reinforced the radicalism of the person-centred approach from the medical model and freedom from restriction and growth:

> The politics of the client-centered approach is a conscious resignation and avoidance, by the therapist, of all control over, or decision making, for the client (p. 381)

Based on the descriptions of neoliberalism in this text, it would seem that it is not a criticism but an apt description of the person-centered approach.

With regards to the criticism of rigidly upholding the pureness of the person-centred approach, whilst there are therapists who consider themselves 'classical' person-centred therapist who hold true to the original philosophies of the person-centred approach, the accusation that the person-centred therapy is rigid, tradition and doctrine based is untrue. This is aptly demonstrated by the creative 'contaminations' of the approach into different manifestations e.g. Focusing, Emotion Focused Therapy, Person-Centred Experiential Counselling for Depression, Pluralistic Approach (Gendlin, 2003; Cooper and McLeod, 2011; Saunders, 2012; Bazzano, 2018).

2.8.3 Therapeutic conditions

Not everyone agrees with the person-centred theory of the relational conditions as necessary and sufficient, and some suggest that holding to a one size fits all

theory is inflexible and does not encompass the idiosyncrasies of the individual in therapy at a given time and place in their lives (Norcross and Lambert, 2018). Research illustrates that the therapeutic alliance and the core conditions of acceptance, empathy, and congruence, are linked to positive therapeutic outcomes (Horvath et al., 2011; Elliott et al., 2018; Norcross and Wampold, 2019). Other reviews and examinations of person-centred theory have concluded that the therapeutic relationship conditions may be strong element of a successful outcome to therapy, but they are not entirely sufficient, for example see Goldfried and Davila (2005); Hill (2007). In the context of this study, what these therapeutic conditions do offer is a way for children and young people to be able them to communicate with the therapists in ways that can help them to be easily understood (Hopper, 2007). Facilitating a therapeutic relationship through the core conditions has been shown to be effective in therapy with clients who self-harm. However, other factors in the creation and maintenance of the therapeutic alliance with self-harming clients also requires other qualities including the therapist skills including time keeping, understanding, and creative techniques for client engagement and positive outcomes (Long and Jenkins, 2010).

2.9 Summary

The person-centred organismic growth process and actualising tendency is a theory of an innate drive and change where an individual grows towards greater wellbeing. However, the rate it happens is dependent on social environments and interactions that nourish growth (Rogers, 1964, 2004). Therefore, person-centred theory is not merely an individual endeavour but embedded intrinsically

within a social context (Rogers, 1951, 1964, 2004). Additionally, person-centred theory is based on the holistic concept that the change process is the 'sum of its parts' and does not progress in developmental stages but through psychological shifts, or moments of movement, that ultimately lead toward becoming more fully functioning (Rogers, 1962). To sum this up, the assumption or belief of the person-centred model is that individuals (organisms) exist in a continually changing world of experience (phenomenal field) and are fulfilling and protecting themselves as best they can at any given time and under the circumstances that exist in that time for them.

Person-centred theory is pertinent to the data collection and analysis of this study as it relates to the participants endeavours to live, exist, and even survive the environments and social conditions they find themselves inhabiting as young people who self-harm. The adoption of configuration of self in home, school/college or in their social world has a great deal to do with their self-concept in those environments where, for example they are endeavouring to hide their self-harm or to manage situations where their self-harm is known about. The adoption of the core conditions of empathy, acceptance and congruence are particularly appropriate in participant interviews, enabling participants to feel free to respond openly and honestly to questions.

Participants of this study will have received either person-centred therapy, integrative therapy (a combined approach to therapy that brings together different elements of other therapies) or CBT. Exploring the core tenets of these

modalities gives a greater insight to the therapeutic journey each participant has experienced.

Chapter 3 - Review of Literature

3.1 Introduction

It was important to discover what had already been recorded about expectations and experiences of therapy of young people who self-harm in order to provide context, prevalence and to inform the scope of this study. Pertinent research questions were adopted with the intention of not only linking with the topic of this current study, but to identify any gaps in the literature in this subject area. The research questions employed for this review were:

> What is already known as to why young people who self-harm seek therapy, what they wanted as an outcome of therapy and whether they experienced therapy as helpful or hindering?

3.2 Methods

This review is concerned with the reported experiences of young people after they have accessed and undergone one-to-one therapy and as a result, the literature included in this review is predominately qualitative in nature although quantitative or mixed methods studies have not been excluded. McLeod (2011) emphasises that qualitative data allows us to understand how therapy is seen by clients and what can be done to make therapy more successful. Qualitative data of client accounts are often viewed with some unease in some academic and professional fields due to inference of bias, yet they provide one of several perspectives and have a validity of their own (Strupp, 1996). Thomas and Harden (2008) state that it is frequently suggested that qualitative research is not generalisable and is only specific to an individual setting, time and participants. Conducting a systematic review of quantitative studies can lead

to accusations of de-contextualising data and a misguided assumption that the data of the review can be measured by the same criteria (Campbell, 2003; Sandelowski and Barrow, 2007). This review concentrates on client's perspectives and no attempt is being made to form a generalisable theory or hypothesis therefore, these arguments are not relevant.

Initial scoping suggested there was a large amount of published literature reporting on client experiences of therapy across all age ranges and mental health presentations. Consequently, the framework of PICOC was adopted to define clearly the scope of this review (Sutton, 2016). Table 3.1 details the specific criteria for each element. This literature review was undertaken as a systematic qualitative evidence synthesis (QES) to identify and evaluate literature relating to the review question in order to appraise, synthesise and summarise the evidence (Mays et al., 2005; Grant and Booth, 2009; Gough et al., 2010; Bryman, 2016; Booth et al., 2018). The literature was reviewed through the theoretical lens of the humanistic psychology of Abraham Maslow (1908-1970) and the person-centred theory of Carl Rogers (1902-1987) as described in Chapter 2.

Table 3.1 PICOC criteria

Population	Anyone aged between 16 and 20 who has undergone therapeutic treatment where self-harm was a factor
Intervention	Talking Therapy for any non-psychotic mental health condition where self-harm was a factor.
Comparison	No specific comparison is being made.
Outcome	Young people who have undergone therapy and have dropped out or to conclusion, with no specific expectation that self-harming behaviours have changed
Context	Completed Talking Therapy treatment.

In order to determine the appropriate method for QES, a seven-stage process was utilised adopting the RETREAT framework to determine what is possible in this literature review (Booth et al., 2018). Table 3.2 details the RETREAT criteria. This QES is not intended to contribute to existing theory but seeks to gather data on existing evidence to inform this current study and future practice. The choice of method for this QES, based on the RETREAT criteria, was Narrative Synthesis (Popay et al., 2006). Narrative Synthesis adopts a word-based approach to synthesising evidence from contrasting studies of different methods and research questions to describe and summarise the evidence. (Popay et al., 2006). For that reason, Narrative Synthesis is apposite for this study where a corpus of mainly qualitative studies is included.

Table 3.2 RETREAT criteria

Review question	What is already known about young people who self-harm and their experience of therapy.
Epistemology	Interpretivist/constructivist.
Timeframe	One year in accordance with agreed PhD timetable.
Resources	Single reviewer working on a part-time basis.
Expertise	Limited experience of conducting qualitative reviews and research. Access to experienced PhD supervisors.
Audience and purpose	Primarily as an academic qualification for a specialist academic audience to achieve a PhD qualification.
Type of data	Qualitative and quantitative studies.

3.2.1 Search strategy

Literature was obtained from published works located through a search of online databases were undertaken in September 2018, July, and September 2019 and updated in September 2020. The databases accessed were Lancaster University OneSearch, PsycARTICLES, PsycINFO, PubMed, Web of Science, and Google Scholar. The topic of young people who self-harm is a multi-disciplinary topic including psychology, public health, sociology, and nursing amongst others therefore, these databases were considered suitable. Additionally, they have been used in similar reviews for example see Rowe et al. (2014); Bresin and Schoenleber (2015).

After consultation with Lancaster University Faculty Librarian and Library guides, the research questions were divided into four key areas: age,

interventions, presentation, and outcome in order to generate search terms. Additionally, search alternative terms were selected from those discussed in the definition of terms detailed in chapter one. The search terms adopted were age - teen* OR adolescent* OR young people* OR emerging adult*, interventions - therap* OR counsel* OR CBT, presentation - self-harm OR self harm OR self-injury OR DSH OR NSSI and outcome – help* OR unhelp* OR hinder*.

A snowballing search method was also adopted by examining reference lists and bibliographies of included literature. This method was adopted to bring to light additional literature that potentially addressed the review question and met the inclusion criteria which may not have been uncovered in the database searches.

3.2.2 Inclusion criteria

The literature included in this review was refined to focus on the literature obtained to that published from 1978 onwards. This date range was adopted because it is acknowledged that it was not until the late 1970s that significant literature on self-harm was produced (Millard, 2015). Quantitative and qualitative studies were included in this review. Longitudinal and cross-sectional studies were also included. However, the majority of the research included in this review is cross-sectional analyses. In addition to journal articles reporting on empirical studies papers, texts and books detailing theoretical approaches and ideas in the subject areas have been considered. Details of the inclusion criteria are contained in Table 3.3.

3.2.3 Exclusion criteria

Literature that reports on group therapy or single, individual therapy sessions were not included in this review because the aim of this study is to understand participant's individual experience of the whole, one to one therapy process. Details of the exclusion criteria are contained in Table 3.4.

Table 3.3 Literature inclusion criteria

Inclusion Criteria	
Types of Literature	Any literature written in English and published from 1978 onwards.
	Longitudinal and cross-sectional studies.
	Literature that explores help-seeking behaviours and therapeutic interventions for self-harm
	Studies adopting methods to record and describe patterns or themes that seek to understand participant experience through interviews and/or observation. This includes original studies, secondary qualitative analysis and mixed methods study.
	Meta analyses and systematic reviews
	Literature that explores helpful and unhelpful aspects of therapy.
Types of Participants	Research where the sample age range included some or all participants aged 16 to 20.
	Participants report self-harm behaviours.

Table 3.4 Literature exclusion criteria

Exclusion Criteria	
Types of Literature	Studies using methods to gather data that do not involve recording participant's motivations and experiences.
	Literature that relates to group therapy or single session therapy.
Types of Participants	Sample age range for all participants was entirely less than 16 or entirely greater than 20.

3.2.4 Evidence synthesis and quality assessment

Narrative synthesis was adopted as the method of synthesis for this systematic review. The use of narrative synthesis was registered with the Division of Health Research, Faculty of Health and Medicine at Lancaster University and the protocol (Appendix A) was followed and complied with.

Popay et al. (2006) specify four elements to narrative synthesis. These are:

- Developing a theory of how the intervention works, why and for whom
- Developing a preliminary synthesis of findings of included studies
- Exploring relationships in the data
- Assessing the robustness of the synthesis (p.11)

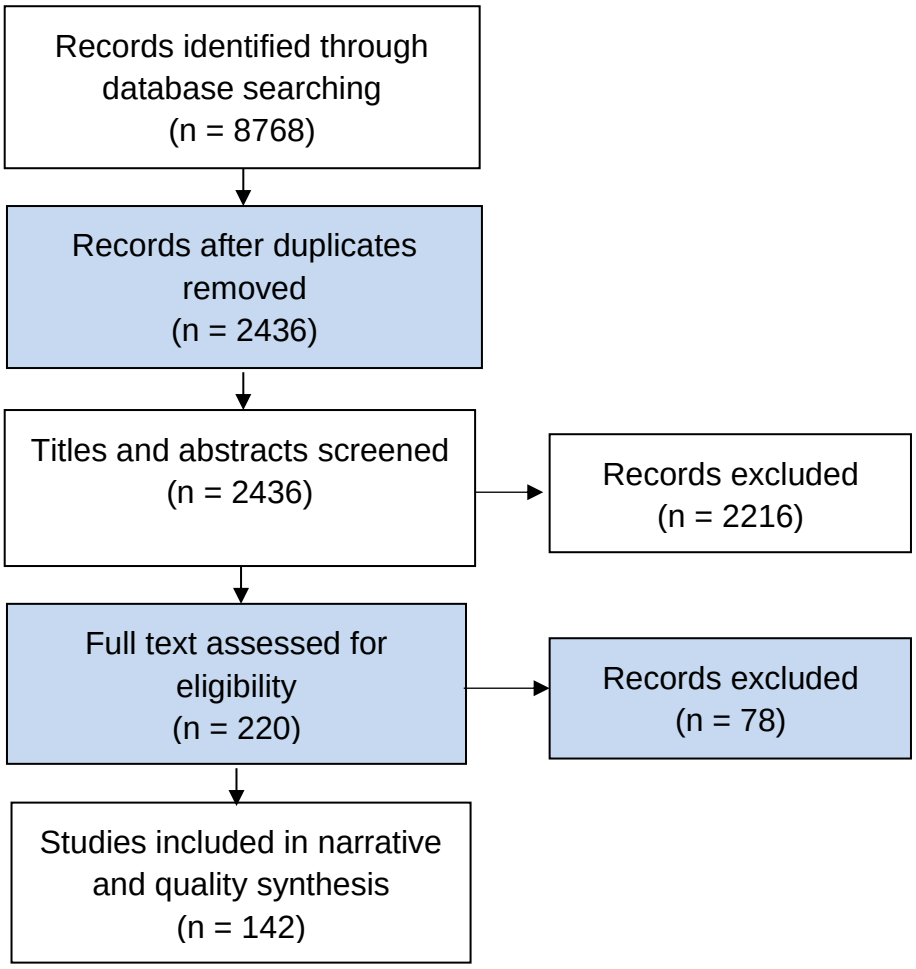
The components of the narrative synthesis framework were conducted in an iterative manner as opposed to being employed prescriptively in a linear way (Popay et al., 2006). This included conducting a primary synthesis of the included studies, discovering data connections within and between studies, evaluating the rigour of the synthesis of the data (Popay et al., 2006).

3.2.5 Assessment, appraisal, and results

Table 3.5 is a Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart to show the steps taken to the final selection of papers for the review. The literature was assessed and appraised by the author only who also undertook selection, extraction of information and quality assessment. A total of 8768 records were sourced from the six databases searched. After initial scrutiny for duplicate records, 2436 records remained. The initial assessment for suitability was made by evaluating the title and the abstract or introduction of literature identified against the inclusion and exclusion criteria. If there was uncertainty on the relevance of the study, then the articles were included for full-text eligibility screening. As a result 2016 records were excluded because they did not meet the inclusion criteria. The predominant reason for rejections were research that did not include participants of the inclusion criteria age range, reports based on single therapy sessions, or records that did not report on understanding young people's experiences. The full text of the remaining literature was then critically reviewed and appraised using a quality assessment against how fully it focuses on the review question (Hawker et al., 2002; Hannes, 2011; Greenhalgh and Brown, 2014).

As a result of the full text scrutiny and quality assessment of the remaining literature, 78 records were excluded. The main reason being that the literature did not report on young people's experiences of self-harm or therapy or were based on single therapy sessions.

Table 3.5 Prisma flow chart



The quality of the literature included in this review was assessed for internal validity and relevance, not for external validity and whether the results could be extrapolated to other situations (Petticrew and Roberts, 2006). The quality of the literature uncovered was assessed adopting the Standard Quality Assessment Criteria (QualSyst) as it is considered suitable for evaluating literature from a variety of contrasting sources (Kmet et al., 2004). The QualSyst assessment contains two checklists for use with quantitative and qualitative studies. The checklist for qualitative studies includes 10 questions such as 'is the question/objective sufficiently described?', 'sample size

appropriate' and 'conclusion supported by the results'. The quality assessment score is obtained by rating each study according to the degree to which they met the 10 criteria. The quality scoring is 'yes'=2, 'partial'=1 and 'no'=0, the maximum score being 20. Further information on scoring or for a full description of the 10 criteria see Kmet et al. (2004).

Given time constraints of this study and the distribution of the scores, a minimum threshold score of 15 was adopted for inclusion in the review (Kmet et al., 2004). Of the 142 studies included, 78 recorded a quality evaluation score of 18 or more, 64 scored between 15 and 18. An example of a quality assessment for this review is located at Appendix B.

The 142 records were the subjected to a more meticulous interrogation of the results and an exploration of patterns and relationships between evidence (Popay et al., 2006). It was observed and noted that the 142 records fell into two thematic categories, 56 studies were uncovered relating to young people, self-harm and help seeking. 86 examples of literature were located that correlated to young people's experiences of therapy and theories of therapy. Further synthesis highlighted that the literature in the two themes fell into further distinct sub-groups of evidence. For the help-seeking theme, two sub-groups were identified: barriers to help-seeking and gender difference in help-seeking behaviours. For the experiences of therapy theme, two sub-groups were identified: helpful and unhelpful aspects of therapy. The sub-group of helpful aspect of therapy, in turn fell into two further sub-groups of therapeutic Alliance and therapist understanding. Sub-group analysis can aid in the evaluation of a

theory of change and can support assessment of what factors affected young people in different circumstances in therapy (Popay et al., 2006). The details of the qualifying papers are presented in Appendix C and in the synthesised themes of the following section.

3.3 Synthesis Findings

3.3.1 Young people and help-seeking

Help-seeking is the activity carried out by an individual who recognises they need professional or informal structures to access support for mental health, physical health or social difficulties (Barker, 2007; Michelmore and Hindley, 2012; Lynch et al., 2018). Another factor in help-seeking behaviour is a more rational one based on a systematic reasoning of the benefits or personal costs of seeking and accessing help (Henshaw and Freedman-Doan, 2009). Help-seeking is triggered when the individual experiences the helping activity as being safe or their emotional or psychological distress exceeds the individual's personal resources and capacity to cope with the existing emotionally distressful situation (Chan, 2013; Lynch et al., 2018). For example, a study by Bury et al. (2007) indicated that young people, despite fears of how professionals may behave towards them, sought help when they were facing difficulties with mental health that had led to them experiencing high levels of despair and desperation.

Literature and a priori perceptions of therapy services, schools, and parents suggests that young people seek help to stop self-harming as a specific goal or desired outcome for therapy. To some extent, this is because of the strong

suggestions in the literature and belief in professional mental health spheres that self-harm is a precursor to suicide and perceived as taking up significant and disproportionate amounts of physical and mental health resources (Shaw and Shaw, 2007; Hawton, Saunders, et al., 2012; Cleaver et al., 2014; Grandclerc et al., 2016). This can lead to the perception that the focus of the therapy should be to stop self-harm or repeat self-harm in order to prevent the young person's mental health deteriorating to the point where they take their own life (Stanley et al., 2001; Cooper et al., 2005; Laye-Gindhu and Schonert-Reichl, 2005; Shaw and Shaw, 2007; Cleaver et al., 2014).

3.3.2 Barriers to help-seeking

Presentation at A&E in an emergency situation is commonly the first time that young people will have contact with professional health services for their self-harm injuries (Royal College of Psychiatrists, 2010; Doyle et al., 2015). Every person presenting at hospital for emergency treatment after harming themselves should receive a psychosocial assessment after medical treatment but before discharge (NICE, 2004). This assessment can lead to a number of options being accessed by the young person from hospitalisation to referral to psychological or social services (Bennewith et al., 2004; Hunter et al., 2012). One study reported that none of the participants found that the being admitted to hospital as part of a hospital assessment was helpful. Instead, it was recalled as a frightening, disempowering experience (Sinclair and Green, 2005).

Low rates of young people who self-harm and subsequently going on to seek professional help are reported in some studies, for example see Nada-Raja et

al. (2003); Madge et al. (2008); Watsford and Rickwood (2014). Between 10 and 13% of young people who are known to have self-harmed have then gone on to seek help from hospitals (Hawton et al., 2002; Morey et al., 2008; Ystgaard et al., 2009). However, the attitudes of young people who self-harm towards seeking or not seeking help are not entirely clear (Michelmore and Hindley, 2012; Klineberg et al., 2013). Literature suggests that young people appear to initially seek informal help from peers and family before they contact formal support services (Fortune et al., 2008; Michelmore and Hindley, 2012; Klineberg et al., 2013; Rowe et al., 2014). However, there is a strong correlation between such disclosures and an increase in thoughts and incidences of self-harm by friends or peers, especially if they have witnessed the self-harm (Whitlock et al., 2006; Fortune et al., 2008; O'Connor et al., 2014; Doyle et al., 2015). Conversely, a longitudinal study in New Zealand reported that accessing non-professional support from friends and family was associated with higher incidences of young people who self-harm then going on to access formal mental health services (Nada-Raja et al., 2003). The family relationship factor in the cessation of self-harm is supported by a study of 1973 young people aged 12 to 18 years in Australia that recorded that those individuals who had ceased harming themselves reported an increase in perceived family support over time (Tatnell et al., 2013). On the other hand, lower perceived family and social support and connections have been linked with self-harm (Rotolone and Martin, 2012).

Almost all studies on young people report that the onset of self-harm behaviours is in early adolescence, for example see Nock and Prinstein (2004). One study

by Moran et al. (2012) supports the proposition that self-harming resolves in early adulthood, sometimes without help-seeking or therapeutic interventions thus indicating that not seeking help is not entirely detrimental to the young person. Young people use self-harm to feel in control and alleviating emotional pain so that the individual can function and not be overwhelmed by the intensity of emotional pain, to survive and not end one's life (Sutton, 2007). What is often overlooked is that young people often report that self-harm has positive or adaptive functions and has even been described as enjoyable and comforting by some young people (Edmondson et al., 2016). Edmondson et al. (2016) proposed that self-harming to achieve a sense of control could be a positive experience. Self-harm can serve the function for some young people of controlling how they feel by taking control of their emotions and self-soothing through the release of endorphins particularly Dopamine (Sutton, 2007; Hicks and Hinck, 2008; Burton, 2019). The self-soothing aspect of self-harm is not always acknowledged or considered as a constructive characteristic, helping individuals to cope with their distress (Hicks and Hinck, 2008). Literature records young people describing the acts of self-harm as getting relief, calming, cleansing, to take my mind off, keeping bad memories away, to control feelings, to physically feel again, stopping me killing myself, coping with…, for example see Briere and Gil (1998); Laye-Gindhu and Schonert-Reichl (2005); Klonsky (2009); Martin et al. (2010); Brown and Kimball (2013); Edmondson et al. (2016). When self-harm is considered as a positive experience and helpful to their emotional difficulties, young people would not necessarily seek help (Polk and Liss, 2009). This notion is supported by Fortune et al. (2008) explored why young people who self-harmed did not seek help. The study revealed that

young people felt their self-harm was not serious or important, or they were exercising self-determination believing it was their choice to self-harm and only sought help in the spur of the moment. This aligns with other studies that reported that a barrier to help-seeking was that young people who self-harm do not always perceive self-harm as a problem (Mojtabai et al., 2002; Oliver et al., 2005; Freedenthal and Stiffman, 2007; Fortune et al., 2008). Young people's resistance or reluctance to seeking help can be considered a part of adolescent development as independence and autonomy is sought by them (Bury et al., 2007).

Studies also show that barriers to help seeking include stigma, culturally influenced social complications, lack of knowledge of where to seek help from, negative previous experiences of disclosing self-harm to others and poor experiences of mental health services i.e. perceived as not being beneficial (Vanheusden et al., 2009; Klineberg et al., 2011; Hunter et al., 2012; Watsford and Rickwood, 2014; Lynch et al., 2018; Wadman et al., 2018; Jones et al., 2019). Stigma is a frequently identified barrier young people help seeking with research suggesting that adolescents fear disclosing their difficulties due to anticipated rejection (Gulliver et al., 2010). Stigma can be thought of as problems in attitude, behaviour and knowledge and is experienced as prejudice, discrimination and ignorance, with adolescents who self-harm at risk of experiencing stigma due to their self-harming behaviour (Mitten et al., 2016).

Some of the reticence to seek help comes from the portrayal of self-harm as a negative phenomenon with critical statements such as, self-harm takes up too

much of physical and mental health resources and that self-harm is a precursor to suicide. These beliefs or attitudes contribute to the stigma around self-harm and to the negative experiences some young people have undergone when engaging with health professionals (Shaw and Shaw, 2007; Hawton, Bergen, et al., 2012; Cleaver et al., 2014; Grandclerc et al., 2016; Rayner et al., 2019). Young people who self-harm have reported negative previous experiences of services or professionals who focus on stopping the self-harming, or even demand that young people stop self-harming rather than helping them overcome the emotional difficulties that have led to them self-harming, the corollary of this is a reticence to access such services again (Waldorf, 2005; Shaw and Shaw, 2007; Cleaver et al., 2014; Grandclerc et al., 2016; Rayner et al., 2019).

Previous negative experiences of directive therapist can lead to resistance to therapy, leading to them not wanting to access therapy again or if they do engage, not being open to successful therapy interventions (Bischoff and Tracey, 1995). However, Cleaver et al. (2014) reported that the immaturity of some young people who self-harm engenders a more favourable attitude towards them by practitioners. Young people have expressed that an obstacle to them seeking help for self-harm is a fear of losing control to others and this loss of control can result in an increase in their self-harm (Mental Health Foundation, 2006; Royal College of Psychiatrists, 2010). Believing that they cannot trust others to keep their problems confidential is a significant factor in why young people do not disclose self-harm to others, including professionals (Royal College of Psychiatrists, 2010).

3.3.3 Gender and help-seeking for self-harm and mental health difficulties

It is not fully known how many young people self-harm, but it is widely reported that more young females self-harm than young males (Madge et al., 2008; Hill and Dallos, 2011; Moran et al., 2012; Bresin and Schoenleber, 2015; Clements et al., 2015; Cipriano et al., 2017; The Chidren's Society, 2018). The ratio of young females to young males who self-harm has been reported as being as high as 6:1 and a low as 2:1 (Madge et al., 2008; Hawton, Bergen, et al., 2012; Hawton, Saunders, et al., 2012; Gilman, 2013; Diggins et al., 2017). A study by McManus et al. (2014) reported that one in four 16 to 24 year old women reported having self-harmed at some point; over twice the rate for men in the sample age group. On the other hand, equal proportions of self-harm between the females and males have been reported in other studies, for example Briere and Gil (1998), Stanley et al. (2001), Lloyd-Richardson et al. (2007), Kaess et al. (2013). Of those young people who seek professional help for emotional difficulties involving self-harm, it is reported that females are more likely than males to do so (Oliver et al., 2005; Vanheusden et al., 2009; Klineberg et al., 2011). The reason a greater number of females than males seek help for self-harm difficulties could be explained by the greater ratio of reported instances of self-harm by young females than males. A further rationale for the reported gender difference in help seeking could also be explained by studies that demonstrate that males are less open and more avoidant of help seeking than females (Neighbors and Howard, 1987; Addis and Mahalik, 2003; Chan, 2013; Sullivan et al., 2015; Lynch et al., 2018). Social research over the past five decades, has studied differences in the help seeking between males and

females for physical and mental health difficulties. The findings are noticeably consistent and show that males of different ages, nationalities and backgrounds seek help less frequently than females for example, see Neighbors and Howard (1987); Ashton and Fuehrer (1993); Favazza (1996); (Galdas et al., 2005); Gilman (2013); Wendt and Shafer (2016).

3.3.4 Young people's experiences of therapy

Studies into significant helpful events in therapy changed substantially with the work of Robert Elliott (1983, 1984, 1985). Elliott (1983) introduced an in-depth method of measuring and understanding events in therapy called Comprehensive Process Analysis (CPA). CPA involves multidimensional analysis including data from observers and participants. Llewelyn et al. (1988) developed the Helpful Aspects of Therapy (HAT) form, a post-session self-report questionnaire where clients are asked open-ended questions to record their experiences of helpful and hindering events in their therapy sessions (Elliott, 2012). Research into client's encounters in therapy is dominated by questionnaires that have been designed to gather the client's experience, some expectations and preferences, and rating the success or failure of the therapy (McLeod, 2012). Timulak (2010) undertook a meta-analysis of client and therapist accounts of helpful and unhelpful events in therapy and concluded that more studies concentrated on helpful experiences than unhelpful ones. Bury et al. (2007) reported that the young people had little knowledge of the therapy process except from expectations influenced by media portrayals of therapy. However, other research indicates that young people begin therapy with a good indication of what they want from therapy and may even have agency in guiding

the therapist towards what is helpful for them (Rennie, 2001; Hoener et al., 2012; McLeod, 2012). Bohart and Tallman (2010) assert that client agency is critical in the therapeutic encounter contributing greatly to a successful outcome.

Everall and Paulson (2002) established that young people's goals for therapy can be predetermined either by parental influence or the referral source (GPs, Schools, Colleges etc.) leading to hindrance to the therapeutic alliance and the therapeutic outcome. Young people do not always engage in therapy with goals or even knowing what to expect (Cooper and Law, 2018). It is not until the therapy process has been completed can they reflect on what worked or was helpful or unhelpful for them. Nonetheless, Booth et al. (1997) reported that at the completion of therapy, on average participants considered they had mostly or partly achieved their goals for therapy. Diamond et al. (1999) showed that therapists who helped adolescent clients aged 13 to 17 develop personally important goals based on the client's desires for therapy resulted in a more positive therapeutic alliance and hence greater positive outcomes in therapy.

Castonguay et al. (2010) brings into question the reliability of client self-reports in studies and postulates that the therapy sessions reported on by nonparticipant observers would illicit different results in terms of the rating of helpful and/or hindering events. Client's perception of helpful or hindering events in therapy can be limited because the data is collected retrospectively. The client may not fully recall all of the moment by moment significant and important events in the sessions (Swift et al., 2017). However, Strupp (1996)

asks the question as to how can the client's own personal experience of the helpfulness or unhelpfulness of therapy be invalidated? Cooper and McLeod (2015) affirm the validity of accounts by clients of their helpful or unhelpful experiences in therapy.

Studies that adopt client post-therapy reports which rate session events as helpful and unhelpful may reveal indications of what the client hoped for and thus found helpful, or conversely if they did not get what they hoped for, they would rate the therapy as unhelpful (McLeod, 2012). Lindhiem et al. (2016) suggest that the setting of goals is important to the success of therapy but also provides a more specific test of improvement and outcome than standardised measures of treatment outcomes which do not allow for the assessment of the unique and individualised progress. Adopting a wide-ranging measure of client change and effectiveness of therapy, including achievement of goals would balance the client who does not fit in easily with standard outcome measures. This would especially be so where therapeutic change or improvement in client's mental health is based on achieving goals to cope with symptoms rather than overcome symptoms which may be chronic in nature and untreatable i.e. long-term health conditions (Kazdin, 1999; Donald and Carey, 2017).

Studies inform us that one predominant factor in client experience of therapy as being positive is when therapists provide a safe space to talk freely without judgement, explore and develop new ways of managing situations, and increasing awareness, new perspectives and knowledge (Dunne et al., 2000; Bury et al., 2007; Binder et al., 2011; Watson et al., 2012). Hindering or

unhelpful aspects of therapy are reported by clients as recollections of painful or threatening memories, and unwanted thoughts leading to difficult experiences in sessions (Dunne et al., 2000). Young people need to be able to access facilitative interactions in therapy where they can process past difficult events that have led to emotional difficulties including self-harm (McLeod, 2012). If the therapist cannot exhibit empathy, congruence and acceptance, the client will not experience the therapist as safe and understanding or grasping their feelings and their difficulties (Mearns et al., 2013). This resounds with the person-centred principle that therapist empathic responding and unconditional positive regard towards the client is a significant factor in effective therapy (Mearns et al., 2013). Paulson et al. (1999) found that the therapist facilitative interpersonal style combined with the client's own resources, gaining new perspectives, having the space for emotional release, self-disclosure and gaining knowledge all contributed to them considering that their therapy was helpful. Castonguay et al. (2010) observed that client helpful events fell into three specific areas: self-awareness, problem clarification, and problem solution. Enhanced self-understanding has also been recorded as being significantly helpful with new strategies and learning new ways of dealing with situations being highly valued as helpful (Paulson and Everall, 2003). These studies highlight that no single expectation or experience of therapy can be identified from a heterogeneous client group. There are many varied possibilities for helpful or unhelpful aspects of therapy to be experienced, some psychological, some practical. For example, Paulson et al. (1999) reported that clients considered the affordability of the counselling was an important factor to them.

3.3.5 Helpful aspects of therapy – hope

Across all modalities, one of the factors in therapy being successful is the presence of hope in the client (Hanna, 2002; Coppock et al., 2010; O'Hara, 2010). The efficacy of the client having hopeful expectations for therapy is further supported by a recent meta-analysis of 46 studies of over 8000 clients observed a considerable correlation between hopeful expectations of therapy and positive outcomes (Constantino et al., 2019).

The expression of goals for therapy points to participants having hope and an anticipation that these would be achieved (Glass et al., 2001; Watsford and Rickwood, 2014). Some of these hopes are lightly held, others are more strongly held, embedded in the core of the client's need for a move forward (McLeod, 2012). Hope is also considered as a goal-focused perspective where hope can be understood as a combination of identified goals, pathways, and agency towards achieving them, supporting self-motivation, positive attitude and is considered a strong source of resilience (Snyder, 1995; Gallagher, 2018).

Hope is specifically relevant in person-centred theory which emphasises human potential for actualisation. Hope is one of the client conditions that facilitates changes and movement towards the lived experience they wish to have (Koehn and Cutliffe, 2010; Miller and Rollnick, 2012). It should also be taken into account that therapists also may have hope for therapy. They too hope for a successful resolution to the client's difficulties and that the interaction between them and their clients will lead to positive change for the client (O'Hara, 2010). Client's and therapist's hope are intrinsically connected and when a client

becomes disengaged or the therapeutic alliance seems to the therapist to be failing, they can find it difficult to maintain their hope (O'Hara and O'Hara, 2012). There is a phenomenon of hope being communicable between client and therapist and that the hope of one of the therapeutic partnership can be influenced by the other, an interaction between the two (Farran et al., 1995; Hanna, 2002; Koehn and Cutliffe, 2010). This is further corroborated by Larsen et al. (2013) who reported that therapists hope was greatly associated to the sense of connection that they felt with their clients.

3.3.6 Helpful aspects of therapy – the therapeutic alliance

Studies have demonstrated that therapies provide approximately the same amount of therapeutic effect and no single therapy model or intervention is effective for all clients and all presentations and a 'one size fits all' model of therapy is not possible (Luborsky, 1995; Cooper, 2008; Barth et al., 2013; Lambert, 2013; Norcross and Lambert, 2018). It is evident that a range of effective therapeutic approaches are required in order to meet the diverse requirements of clients at different times in their lives (Norcross and Wampold, 2019). However, the evidence shows that regardless of therapeutic approach all models have common factors, and that all effective therapists have common identifiable elements (Lambert, 2013; Wampold, 2015; Norcross and Lambert, 2018). Regardless of the modality of therapy, clinical experience and research findings report that the relationship between client and therapist is understood and acknowledged as being helpful in enabling the therapeutic process to be effective (Horvarth, 2001; Lambert and Barley, 2001; Levitt et al., 2006; Horvath et al., 2011; Wampold, 2015; Norcross and Lambert, 2018). Therapy is a

complex mutual relationship, a relationship greatly influenced by context and dynamics of the therapeutic relationship and accumulated evidence continues to suggest that the relationship or therapeutic bond between client and therapist is central to the progression and efficacy of therapy (Martin et al., 2000; Horvarth, 2001; Everall and Paulson, 2002; Thompson et al., 2007; Day, 2015; Wampold, 2015). For example, Martin et al. (2000) examined the relationship between the therapeutic alliance and outcome. They identified 79 studies (58 published, 21 unpublished) that demonstrated that the therapeutic alliance was related to outcome. The authors concluded that if a therapeutic alliance was properly established between therapist and client, the relationship might be therapeutic in and of itself, regardless of the psychological modality underlying the relationship. However, the therapeutic alliance is more than therapy sessions with a facilitative therapist (Norcross and Lambert, 2018; Norcross and Wampold, 2019). Therapist qualities such as experience, personality, and warmth as well as the ability to convey an insight into the client's difficulties contribute to the ability to create an effective therapeutic relationship, a safe therapeutic space, and therefore positive outcomes (Black et al., 2005; Binder et al., 2011; Hill and Dallos, 2011; Klineberg et al., 2011; Klineberg et al., 2013; Levitt et al., 2016). Ghaemian et al. (2020) reported on reasons for client's dropping out of therapy with an IAPT service in the Solent NHS Trust area. Reported reasons for drop out of therapy included therapeutic alliance breakdown as well as a general dissatisfaction with the service and inconvenient appointments.

Studies looking at therapy from the client's perspective confirm that clients believe that the relationship with the therapist was the most helpful aspect of therapy and supports the person-centred theory of the core conditions engendering a psychological move forward for the client, for example see Bury et al. (2007); Cahill et al. (2013). The therapeutic or working alliance is dependent on therapist qualities or traits and these are identified as factors in young people finding therapy helpful or hindering (Horvath et al., 2011; Palmstierna and Werbart, 2013; Gurpinar-Morgan et al., 2014; Swift et al., 2017). Therapist attributes of respectfulness, gentleness, attentive listening skills and allowing the participants space to exercise individuality and autonomy were the most frequently reported helpful aspect of therapy (Paulson et al., 1999; Dunne et al., 2000; Levitt et al., 2006; Binder et al., 2011; Palmstierna and Werbart, 2013). For example, Binder et al. (2011) observed that therapist qualities featured often in the client responses. When the therapist demonstrated a professional role with the ability to protect the client in the therapeutic space, being non-intrusive and able to manage strong emotions, this was highly valued by participants. There can be many other factors that promote the therapeutic alliance, for example Paulson and Everall (2003) found that therapist attitudes such as being respectful, gentle, kind, and easy to talk with rated highly with suicidal adolescents. Clients have stated that empowerment facilitated by the therapeutic relationship has been helpful in their therapeutic encounter (Timulak, 2010). It is also inescapable that the effectiveness of therapy is greatly influenced by client engagement and contributions, and this is facilitated by a good therapeutic alliance. Estimates of the client effect vary from 30% to as much as 75% if clients' context, attitudes,

and positive expectations are taken into account (Cooper, 2008; Norcross and Lambert, 2018, 2019). Yet, the therapeutic alliance is not always the entire reason for therapy being helpful to clients. Paulson and Everall (2003) suggest that a collaborative focus on self-development within the chosen modality of therapy is the most facilitative approach.

An interesting and different dynamic to the therapeutic relationship and whether participants found therapy helpful or hindering comes from an exploration of young peoples' experiences of mobile telephone counselling where visual clues and body language are not present (Gibson and Cartwright, 2014). Participants in this study reported in interviews that they valued the privacy, anonymity, and control of text counselling. Another reported helpful aspect of text counselling was that the young people felt at home with texting, and this mitigated the power imbalance between the therapist and themselves more to their side. They reported that having an element of control over when and how to respond helped them balance their needs for autonomy and connection with a therapist. Additionally, text or, for that matter, telephone counselling may offer a safer encounter for the client as it obviates face to face contact and satisfies the need in some clients to feel safe in order to better make use of the therapy and grow psychologically (King et al., 2006; Gibson and Cartwright, 2014). Studies by Dunn (2012) and Fang et al. (2018) support the perception that asynchronous text-based online therapy provides young people a sense of security, safety and agency, and contributed to a strong therapeutic relationship. However, the success of asynchronous text-based counselling is also connected to the

therapist skill in using the technology and working without being able to assess and respond to non-verbal communications.

3.3.7 Helpful aspects of therapy – therapist understanding

Young people often perceived therapy as helpful if the therapist offers a facilitative style and demonstrates an understanding of their difficulties (Elliott and James, 1989; Paulson et al., 1999; Dunne et al., 2000; Timulak, 2010; Binder et al., 2011; Swift et al., 2017). Klineberg et al. (2013) reported that young people that did seek help from therapy hoped for understanding and were seeking to address the factors that led to them self-harming.

A lack of understanding especially about their self-harm, especially as their way of coping, is particularly hindering and unhelpful to young people in their emotional and cognitive processes in therapy (Hill and Dallos, 2011; Klineberg et al., 2013). Studies have indicated that young people find a lack of understanding about their self-harm engenders a wider sense of feeling misunderstood or not being listened to (Sutton, 2007; Jones, 2009). Binder et al. (2011) noted that participants described how they wanted the therapists to connect with them at a deep level and demonstrate an interest in understanding their feelings and experiences. If they did not experience these conditions, it was felt the therapy was unhelpful and disappointing and leads to early termination of therapy by the client (Roe et al., 2006). Using the HAT questionnaire (Llewelyn et al., 1988; Elliott, 1993) and Brief Structured Recall (BSR) interviews (Elliott and Shapiro, 1988) the study reported that clients found the most helpful aspect of therapy occurred when the therapist communicated

that they understood their story. They described how this allowed them to discover and expand on new aspects of their story that had not previously come into their awareness.

3.3.8 Therapy aimed at stopping self-harm

Some services and therapists try to invoke a no-harm contract with their clients and these have been described as a joke by some clients (Craigen and Foster, 2009). These situations can potentially lead to young people self-harming covertly and lying to the therapist, telling them that they have stopped when they have not, leading to a rupture in the therapeutic alliance. Therapists may consider that failing to stop their clients from self-harming breaches their duty of care and therapy service protocols (Ernhout and Whitlock, 2014). Mental Health service policies tend to lean towards supporting this position (Sullivan, 2017). However, the sense of control engendered by self-harming is something which is valuable in young people's efforts to cope in their distress (Mental Health Foundation, 2006; Royal College of Psychiatrists, 2010; Edwards and Hewitt, 2011). Nice guideline CG16 recommend the where repeat self-injury is predicted, clinical staff, service users and carers may consider discussing harm minimisation issues/techniques but does not specify what these techniques are. Instead, they signpost to voluntary organisations (NICE, 2004). NICE guideline CG16 considered harm minimisation strategies for individuals who have self-harmed by poisoning are not appropriate; there being no safe limits in self-poisoning (NICE, 2004).

3.4 Conclusion

This chapter has reviewed a broad selection of literature reporting on self-harm, why young people seek therapy, what they wanted as an outcome of therapy and whether they experienced therapy as helpful or hindering. A number of key themes have been identified, with findings being varied within themes and were even contradictory. The clearest evidence was found for the helpful aspects of therapy and help seeking behaviours of young people. Under the theme of help-seeking behaviours, the literature review indicates that a number of factors influence the help seeking behaviours of young people. These include gender, an intrinsic awareness that external help is required, and the level of psychological distress experienced. The most compelling evidence of a barrier to seeking help was negative and poor previous experiences of mental health services. Other barriers to a young people seeking help are reported as not perceiving they need professional help and not knowing where to get help from. These factors are often idiosyncratic and sometimes sociocultural in nature, making them difficult to promote or mitigate in young people.

Another theme highlighted in this review is an acknowledgment that for young people to feel that therapy had been successful, a number of factors need to be experienced by them. The strongest evidence uncovered for a young person to experience therapy as helpful came from a sense of being understood and feeling safe in the therapy session to speak openly. Additional common factors for the young person experiencing therapy as helpful were recorded as experiencing a facilitative therapeutic alliance leading to them gaining knowledge about themselves or their situation.

There is a large body of literature relating to self-harm and also the helpfulness or effectiveness of therapy. While numerous studies have been published into the epidemiology of self-harm and the efficacy of therapy, no studies uncovered in this literature review have combined the two subjects in one exploration of therapy with young people who self-harm from the young person's perspective. This affords an opportunity and rationale for this study to explore young people's experiences of therapy where self-harm is a factor. Identifying and understanding helpful or unhelpful events in therapy can give an indication of what was hoped for by the young people. Young people may in fact be looking for certain aspects or attributes of therapy to help support their process, to meet their needs to stop self-harming, and promote an experience of agency in the therapeutic encounter and in their lived experience.

Chapter 4 - Methodology and Methods

4.1 Locating the researcher – A first person reflexive statement

Rigorous research necessitates a researcher to be reflexive, demonstrating an awareness of the experiences, contexts and internal motivations that may influence interpretation whilst recognising pre-existing knowledge and theoretical influences that inform the development, execution and interpretation of this inquiry; and an awareness of the socioeconomic context in which the research is being undertaken (Finlay, 2002; Green and Thorogood, 2018; Braun and Clarke, 2019, 2020; Hennink et al., 2020)

This section is intended to more fully inform the readers of the epistemological and ontological beliefs, filters and lenses through which I view the world, born out of my life experiences, to help readers recognise what influence this has had on the inquiry (Ahern, 1999; Finlay, 2002). An examination of the position I have adopted can increase understanding of the underlying constructs that guide this research and thereby support increased validation of this research (Etherington, 2004).

I am a white Christian, heterosexual, cis gender male born in 1960. From a childhood background of a large council estate in Blackpool, Lancashire and after serving for over 31 years as an aircraft engineer in the Royal Air Force (RAF) until October 2008, I came into the counselling profession late in life. The motivation for the change from engineering to therapy came from personal experiences in the RAF, life events, and in 2000 as the result of divorce, becoming a single parent of a teenage boy. I trained as a Person-Centred

Counsellor, finding that the tenets and ethos of the Person-Centred Approach matched my own personal values, beliefs, and philosophy. After qualification as a counsellor, I began to work with young people aged 11 to 24 with a youth charity. It was while working there, I began to encounter for the first time, young people who self-harmed. In this work, I became increasingly aware of not only of their narratives of what led them to harm themselves, but also the way they felt they had been regarded or mis-treated by professionals and others in their world. My own Continuing Professional Development (CPD) and training became more focussed on self-harm as I sought to develop my own skills in working with this client presentation. Moving to working in an NHS environment in 2014, counselling young people aged 16 to 25, led me into more therapeutic encounters with young people who harmed themselves as a coping behaviour for extremely emotionally difficult circumstances. I became increasingly aware of client accounts of being advised to seek help through therapy but ultimately not being helped either because of therapist's lack of understanding of self-harm or by therapists that appeared to focus on stopping the self-harm behaviour rather than giving attention to the underlying difficulties that led them to self-harm in the first place. The evidence of my therapeutic contacts led me to seek ways to develop approaches to help fellow therapists gain greater understanding not only of the aetiology and functions of self-harm, but also client-led ways of engendering a stronger therapeutic alliance with young people who self-harm. Additionally, I considered it would be apposite to explore ways in which potentially negative therapist behaviour could be recorded to inform both myself and others to mitigate the unconstructive impacts therapist's lack of understanding has on young clients in therapy who self-harm.

At the time of the data gathering for this study, I was a Clinical Supervisor and Youth Counsellor working for an NHS Improving Access to Psychological Therapies (IAPT) service delivering primary care mental health interventions in the East of England to people aged 16 and over who are experiencing depression and anxiety related difficulties. During the analysis and writing up phases, I moved to working as a Student Counsellor for the University of East Anglia.

4.2 Methodology

To further the integrity, validity, and rigour of research, it is important to clarify the ontological and epistemological standpoints, and the rationales behind the methods adopted. These positions and assumptions will directly influence the decision-making process and is integral to understanding the underlying beliefs of this research. In order for research to be useful it must be well thought out and follow a coherent ontological (what can be known) and epistemological (how it can be known) route through the research questions and methods adopted (Bryman, 2016).

4.2.1 Ontology

This study embraces a constructionist/relativist ontology. Constructivism acknowledges that there is no shared reality but that different realities are constructed and interpreted, based on human interactions, social insights, and awareness, and are in a constant state of adjustment (Carter and Little, 2007; Rubin and Rubin, 2011; Ormston et al., 2014; Bryman, 2016). A relativist viewpoint holds that the reality experienced by individuals is also influenced by

the context in which they experience a given phenomenon (Blaikie, 2007). This position lies in opposition to objectivism where reality exists as a truth externally of individuals waiting to be discovered (Carter and Little, 2007; Ratner, 2012; Bryman, 2016).

4.2.2 Epistemology

The epistemological position of this study is a social constructivist-interpretivist one. Interpretivism considers that knowledge originates from experiences, perceptions and interpretations of the social world (Sikes, 2004; Bryman, 2016). Social constructionism shares the interpretivist standpoint that that knowledge is created in humans by their experiences and understanding of their interactions with their environment (Crotty, 1998). However, social constructionism is unlike some versions of interpretivism in that it emphasises that knowledge is dependent upon interaction between human beings and their world, and is developed and communicated in a cultural and social context through language (Crotty, 1998; Burr, 2003; Andrews, 2012). In essence, the position adopted in social constructivism is in principle that human beings construct and interpret meaning as they engage with the world in which the inhabit and it is through language they confer meaning (Crotty, 1998; Burr, 2003; Andrews, 2012). Willig (2013) emphasises that individuals can describe the same phenomenon in different ways, thereby creating different perceptions, understanding and language to portray a given phenomenon.

Social constructivism research tends to avoid rigid structural frameworks and adopt paradigms that are flexible and more interpersonal that are effective in

capturing the meanings attached to human interactions and make sense of what individual perceived as reality in a given context (Kecskes, 2014). In a social constructivism epistemology, the researcher will undoubtedly begin the study with some prior understanding of the topic. However, this knowledge is not sufficient to formulate a complete research outcome because of the complex and idiosyncratic nature of what is the reality of others. The researcher continually remains open to and embraces new knowledge in the course of the research. Social constructivism gives emphasis to the principle that knowledge is a human construct and thus can be interpreted in a variety of ways, knowledge about participants' experience of therapy and what they found helpful can only be sought by exploring their lived experience and perspectives (Burr, 2003). However, social constructivism also emphasises that knowledge generated in a research study is also co-constructed between participant and researcher during the process of research (Creswell, 2003). Co-constructed knowledge is developed, interpreted and given form during interviews and in the subsequent data analysis (Kvale, 1996; Creswell, 2003; Bryman, 2016).

4.2.3 Rationale for adopting qualitative methodology

A qualitative methodology was chosen because it allows for an opportunity to study the perspectives and experiences of participants in a more fluid, emergent, and dynamic way than the rigid and structured methods of a quantitative study (Corbin and Strauss, 2008; Bazeley, 2013; Bowling, 2014; Bryman, 2016). Qualitative research is more concerned with words than numerical values, employing a thorough systematic examination of recording and analysis of participant accounts (McLeod, 1999, 2014). Employing a

qualitative framework for this study facilitates a more in-depth understanding of the therapy process as experienced by the participants, fully grounded in the participants' distinctive lived experience, something which is not possible using quantitative methods (Braun and Clarke, 2013a; Denzin and Lincoln, 2017a; Mason, 2017).

A further rationale for selecting qualitative methodology is influenced by the exploratory, inductive nature of this study and the requirement to better understand the complexity and depth of participants' narratives, their social worlds, experiences of self-harm and outcomes for therapy. (Fossey et al., 2002; Denzin and Lincoln, 2017a). This aspect of this study is particularly relevant as the desired outcomes of therapy for young people who self-harm is not a highly studied area, with all the studies uncovered in the Literature Review centring on either self-harm or therapy outcomes, not a combination of both.

4.2.4 Rationale for employing semi-structured interviews

Different interview paradigms were considered including structured, semi-structured and in-depth interviews (Britten, 1995; Wengraf, 2001; DiCicco-Bloom and Crabtree, 2006; Rubin and Rubin, 2011). Semi-structured interviews were selected as the data gathering medium because they are conducted with a looser configuration than structured interviews, allowing the participants to bring more of themselves in order to share what is meaningful and significant to them without being overly inhibited by a series of predetermined, fixed questions (Wengraf, 2001; Dearnley, 2005; Rubin and Rubin, 2011). Additionally, by adopting a semi-structured approach,

unforeseen themes or topics may emerge in the participant responses which the researcher had not previously envisaged and can be explored further in the interview (Dallos and Vetere, 2005; Denzin and Lincoln, 2017b).

Semi-structured interviews offer an active listening space in a less formal environment which allows participants to develop their own narrative and is essential as the subject matter may stimulate strong emotional reactions (Wengraf, 2001). However, this stance adopts a basic presumption that there is something difficult in the participants' experience of self-harm and therapy. Therefore, assuming a looser structure without presuming an emotional response or that self-harm was seen as a problem, but an act of self-determination was important in order to gain full and authentic data from participants.

4.2.5 Rationale for using reflexive thematic analysis method

Braun and Clarke (2006, 2013b, 2014); Braun et al. (2018); Clarke and Braun (2018); Braun and Clarke (2019) assert that reflexive thematic analysis is theoretically independent and flexible. Reflexive thematic analysis provides the ability to encapsulate individual participant experience as well as cross-sectional similarities and variances, and to identify unanticipated features in the data in an adaptable yet structured way (Boyatzis, 1998; King, 2004; Braun and Clarke, 2006, 2013a; Braun et al., 2018). Reflexive thematic analysis emphasises the importance of researcher subjectivity as analytic resource, and their interpretive reflexive engagement with theory, data and interpretation (Braun and Clarke, 2020). Additionally, reflexive thematic analysis is suited to

a constructionist interpretation of language, data and meaning utilising the researcher's role in the generation of knowledge (Braun and Clarke, 2019). Joffe (2012) contends that thematic analysis aligns to a phenomenological methodology given that it is effective in illuminating the specific nature of a phenomenon as conceptualised by a given sample under study. Given that the purpose of this study is to do exactly that, to understand the phenomenon, the shared meaning that young people who self-harm have on the subject of therapy, reflexive thematic analysis is ideally suited for this research study. The reflexive thematic analysis method enables the researcher to answer the research question by staying close to the experience of the participants as an insider (counsellor) but also an outside researcher (McLeod, 2011; Braun et al., 2018). By endeavouring to see therapy from the point of view of the participant who self-harms, to step into their shoes, maintaining an Rogerian 'as if' quality allows the researcher to closely explore elements of their story which are particularly relevant to the participant, leading to data that encapsulates the meaning of the experience (Rogers, 1975; Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006; Braun et al., 2018).

Other analytical methods were considered including Interpersonal Phenomenological Analysis (IPA) and Grounded Theory. Both IPA and Grounded Theory seek out patterns in the data but are theoretically bound (McLeod, 2011; Bryman, 2016). IPA is aligned to a phenomenological epistemology, Grounded Theory had positivist origins, but some developments of Grounded Theory incorporate constructivist methods and questions, but still seeks to generate a theory that is grounded in the data (Smith and Osborn,

2003; Charmaz, 2006a; Smith et al., 2009; McLeod, 2011). The generation of a theory is not the aim of this research. This study, in part, seeks to understand the experiences of its participants and the conditions that triggered the motivation to seek help based on past events, histories or on a social aspect, something IPA is criticised as not being able to support (Willig, 2013; Tuffour, 2017).

The aim of thematic analysis is to identify patterns of meaning in data through a rigorous process of familiarisation, coding, and theme development to provide an answer to a research question (Braun and Clarke, 2006, 2013a; Braun et al., 2018). A theme is a reoccurring pattern of meaning identified in data analysis which is unified around an area of the data that communicates to the reader something about the shared meaning in it, and provides the researcher with the basis for a theoretical understanding of the data (Braun and Clarke, 2006; Bryman, 2016; Braun et al., 2018)

There are a number of different approaches to thematic analysis, including coding reliability and codebook framework. Coding reliability is conducted by data being collected qualitatively but analysed quantitatively and themes are developed early in the study before data analysis. The codebook method adopts a structured coding framework and are often domain summaries of the most frequently occurring topics (Braun et al., 2018; Braun and Clarke, 2020). The reflexive thematic analysis model adopted in this study emphasises the active role of the researcher as a reflexive individual within the process (Braun et al., 2018; Braun and Clarke, 2019). Reflexive thematic analysis adopts a six phase

approach to data analysis in a distinctive way of working with qualitative data offering a ‘structured scaffolding’ to generating knowledge by developing descriptive codes and themes which make sense of the meanings which participants bring to the research and includes researcher subjectivity as valid and a resource (Braun and Clarke, 2006; Braun et al., 2018; Braun and Clarke, 2020). The six phases are not considered as a linear process, where one phase is completed before the next, but a fluid contextual process which may move backwards as well as forwards through the phases (Braun and Clarke, 2006, 2013a; Braun et al., 2018; Braun and Clarke, 2020).

Reflexive thematic analysis can either be theoretically driven using a ‘deductive’, top-down approach which is driven by existing theory, or it can be data-driven using an ‘inductive’, bottom-up approach not trying to fit into a pre-existing theoretical framework (Braun and Clarke, 2019). This research employed a predominately inductive rather than a deductive approach to identify themes on both a latent and semantic level (Braun et al., 2018; Braun and Clarke, 2019, 2020). A sematic approach to the data identifies the explicit surface meaning and enables the emphasis to be on the words said by the participants. A latent approach to analysis endeavours to examine underlying meanings, assumptions, and concepts articulated in the data and is concerned with explaining the shape and form of the data (Braun and Clarke, 2006, 2013a; Braun et al., 2018). A mix of latent and semantic investigation meant that the analysis was led by the data itself as opposed to any predetermined theoretical notions as to what might be generated from the data (Braun and Clarke, 2006; Braun et al., 2018). Braun and Clarke (2006, 2020) note that there is a potential

in thematic analysis, when conducted in an inductive way, for there to be an element of 'top down', deductive analysis because of the researcher's epistemological and ontological assumptions which will be a lens through which data are coded and inform the analysis to some deductive level (Braun and Clarke, 2020). They also observe that some themes may be anticipated by the researcher based on viewing previous literature and in the cognitive processes of the researcher from the creation of links and understanding the data (Braun and Clarke, 2006, 2020). It is also important to bear in mind that this analysis cannot be considered as purely latent for the same reasons. It is the nature of reflexivity that it is dependent on the researcher being fully immersed in the data whilst maintaining a willingness to recognise and acknowledge the subjectivity of the researcher and transparency about the circumstances in which theory influences analysis (Braun and Clarke, 2019).

4.2.6 Possible criticisms of the reflexive thematic analysis method

Despite the benefits of thematic analysis previously highlighted, there are also a number of criticisms levelled against it. Although, thematic analysis is adopted across different paradigms, it can compromise the continuity and cause ambiguities with participant accounts (Holloway and Todres, 2003). Holloway and Todres (2003) further emphasise that in thematic analysis context in the data can be lost by fragmenting data into codes and themes.

It has been suggested that in thematic analysis a minimum number of participants should be interviewed in order to seek patterns across data. The more specific the sample is, the larger the sample should be to capture a

relevant number of instances of a theme (Fugard and Potts, 2015). It could be argued that this study using reflexive thematic analysis of 10 participant interviews does not employ a satisfactory number for the creation of cross-sectional themes. However, Braun and Clarke (2016) contend not only that the guidance of Fugard and Potts (2015) should be treated with caution but argue that theme relevance and numbers of instances may not have weight in a study such as this where the focus is on the participant's voice, the depth and richness of the data and its relevance to addressing this type of research question. Ethical considerations, the availability of participants and the timescales of this study also influenced the sample size, aspects which Fugard and Potts (2015) fail to account for but are considered of importance in time limited studies such as a PhD.

4.3 Methods

4.3.1 Participant recruitment

Suitable participants were located from clients who had received therapy from an Improving Access to Psychological Therapies (IAPT) Service in the east of England. Participants of any gender identity or ethnicity aged between sixteen and twenty years old were identified using a convenience sampling strategy from the patient record database (IAPTus). Participants were only included if they had been discharged from treatment and were discharged within six months of the date of the database search. These conditions were necessary to avoid any potential harm and disruption to any ongoing therapeutic process, to avoid potential coercion and to capture the young person's experiences while still fresh in their recollection (Mitchels, 2019). A further criterion for inclusion in

the study were that the clients must have completed a minimum of two one to one therapy sessions and had not received the entirety of their therapy through group work interventions. Any potential participants who were identified as having received therapy from the researcher were excluded from the study. The remaining client records were examined more closely to identify young people for whom self-harm was a factor in their presentation. This was done by scrutinising outcome measure results and case notes. Details of the inclusion and exclusion criteria are contained in Tables 4.1 and 4.2. Table 4.3 is a PRISMA style flow chart detailing the participant search of the IAPTus database.

Table 4.1 Participant inclusion criteria

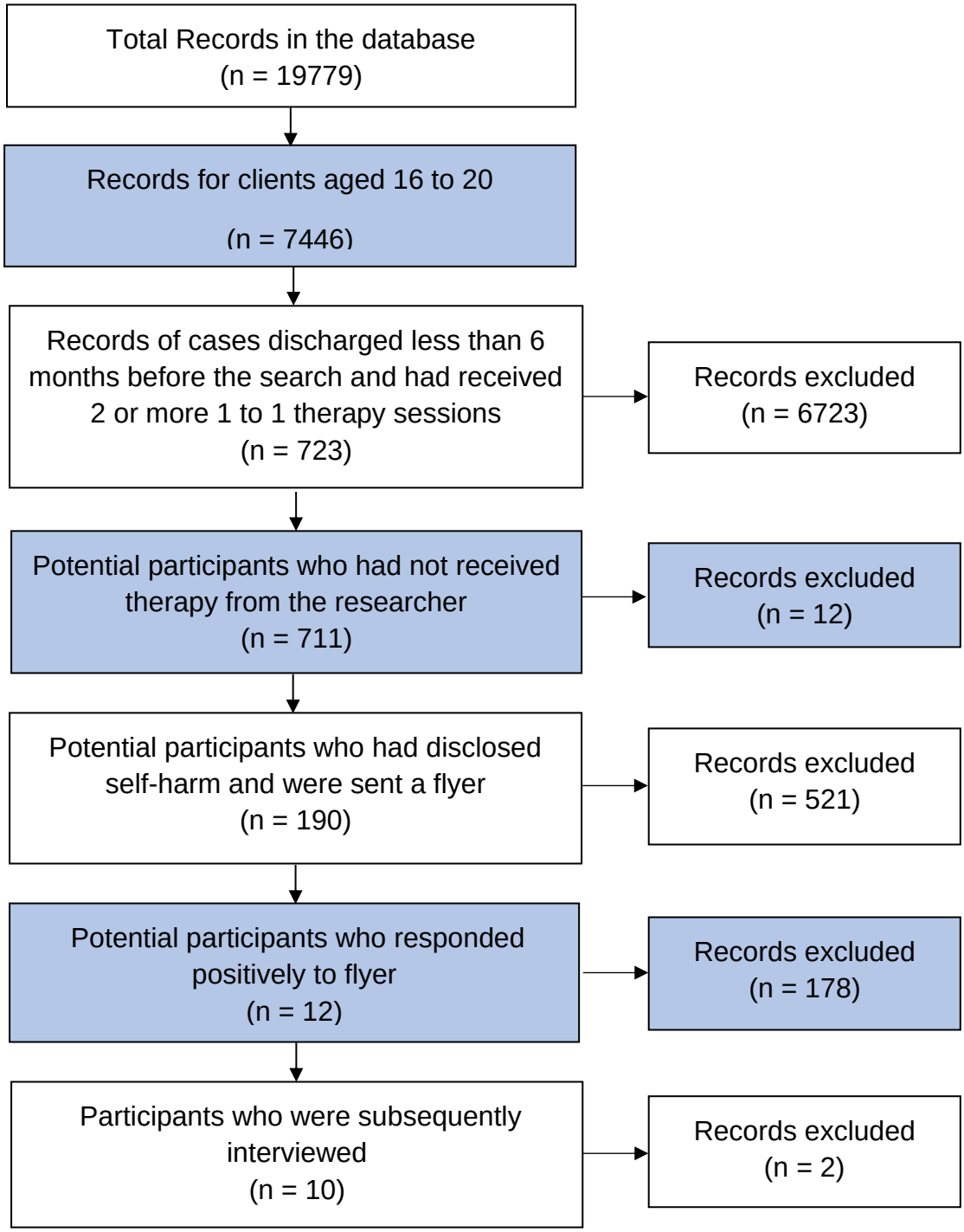
Inclusion Criteria	
1.	Clients aged between sixteen and twenty.
2.	Any mental health presentation where self-harm has been a factor.
3.	Discharged from therapy within six months at the time of the database search.
4.	Completed at least two, one to one therapy sessions.

Table 4.2 Participant exclusion criteria

Exclusion Criteria	
1.	Currently active in therapy or discharged from treatment in excess of six months at the time of the database search.
2.	Completed less than two therapy sessions or received therapy entirely thorough group interventions.
3.	Received therapy from the researcher.

A flyer was created and sent in the post to potential participants along with the standard post treatment letter routinely sent at the end of therapy. Flyers were also posted on the notice boards of the IAPT Service venues. Participants who responded to the flyer were sent an NHS Research Ethics Committee (NHS REC) approved Participant Information Sheet (PIS) (Appendix F) either electronically or in paper format. Participants were also asked whether they would prefer to be interviewed face to face or via Skype. Those potential participants that responded positively to being interviewed were also given an NHS REC approved consent form (Appendix G) to be completed at the interview stage where verbal clarification of the PIS was given according to what each participant required.

Table 4.3 Participant recruitment flow chart



4.3.2 Ethical considerations

The ethics of the design and implementation of this study were guided by the standards and frameworks of the Research Ethics and Research Governance at Lancaster: A Code of Practice, UK Policy Framework for Health and Social

Care Research (Health Research Authority, 2017), BACP Guidelines for Research in the Counselling Professions (Mitchels, 2019). The study was reviewed and given ethical approval by the Lancaster University Faculty of Health and Medicine Research Ethics Committee and the NHS Research Ethics Committee IRAS Project ID 210492, NHS REC Ref 17/LO1360 (Appendix D).

Researchers have a responsibility to protect participants from harm by mitigating or minimising risk and seeking informed consent where participants are made aware of any risk and ensuring that their right to withdraw from the study is clearly stated (Braun and Clarke, 2013a; Mitchels, 2019). Some of the participants are legally classified as children being aged sixteen and seventeen in accordance with the Children Act 1989 section 105. There is no specific law relating to consent to participate in research for this age group however, it is commonly accepted that the principle of 'Gillick competence' can be applied to consent to participate in research as well as to medical treatment (Health Research Authority, 2019; NHS, 2019). For all participants, a competency assessment was made which considered participants' capacity to understand the details of the research and what was being asked of them (Health Research Authority, 2019). Before interviews were undertaken, steps were taken to ensure the participants were clear about what would happen during interviews and to their information and interview transcripts.

A Participant Information Sheet (PIS) (Appendix F) was provided in a format that was understandable to all participants, this being verified in an unstructured assessment by young people of the same age range not involved in the

research. PIS were given to and discussed with participants prior to interviews being scheduled. This discussion also included confirmation that the participants understood that the interviewer was also a Counsellor and Supervisor employed by the service from which they received therapy. It was clarified that the interviewer would not know who their therapist was, nor would any details of the information given be conveyed to the therapist they received therapy from. Having been informed of this, confirmation was sought from the participants were happy to continue to be part of the research before interviews were scheduled. Potential implications of the interviewer/researcher also being an employee of the service from which the participants were drawn is discussed at chapter 6.7.2 and 6.7.3. The participant agreement was reconfirmed before the interview commenced, thus ensuring they had the opportunity to ask questions and to confirm they fully understood what was being asked of them before they signed a consent form. The interviews were scheduled at a time that the participants specified and in a venue of their choice or via Skype in accordance with the NHS REC approval criteria. All the interviews were audio-recorded and transcribed verbatim only by the researcher. To afford participants' anonymity, they were assigned pseudonyms for the transcripts. All participants were asked if they would like to choose their own pseudonym, although none chose to do so and were allocated pseudonyms by the researcher. To further ensure anonymity, the service from which participants received therapy and the main towns and cities in the area have also been anonymised in the transcripts.

One of the main criteria for the interviews was to ensure that the participants were supported in being able to be as honest and open as possible in their responses. During the interviews, sensitive and difficult subject matter could have been disclosed and appropriate measures were adopted to ensure that participants felt safe and supported during and after interviews. These measures included pausing the interview or stopping and rescheduling the interview should the participants become distressed or uneasy. However, during the interviews, none of the participants experienced high levels of distress or discomfort. The PIS contained information about support and counselling organisations available to the participants should they experience any emotional distress after the interview, and this was reaffirmed at the end of each interview.

4.3.3 Data collection

Data was gathered by semi-structured interviews over a ten month period between March 2018 and January 2019. The interviews lasted between 25 and 40 minutes depending on the depth of responses the participants offered. An interview schedule was created to act as a guide so that all the participants received the same initial questions. To allow for the refinement of interview questions and ensure they were clear and reasonable, it was hoped that a pilot interview would be carried out prior to interviews with participants (Robson, 2011; Bryman, 2016). However, due to difficulties recruiting participants and time restrictions, a specific pilot interview was not conducted. The first interview doubled as a pilot and a main interview.

The interviews were conducted adopting a person-centred approach style of active listening. Initial or starter questions were asked, and the participants were free to answer as they felt appropriate. A collaborative approach was used with the intent of following the participants rather than leading them unnecessarily to achieve fruitful data by responding to what the participants bring in a similar style of a television interviewer (Davies, 2007; Rubin and Rubin, 2011). Summarising and reflecting answers and follow-up questions based on participant responses was used to clarify information and to illicit greater detail about the essence of what the participant was trying to convey. Additionally, appropriate silences were held so that further self-expression by participants could be fostered through attentive silence and other non-verbal as well as verbal means (Wengraf, 2001). A relaxed style of interviewing was adopted as it was important to try to minimise some of the inherent power dynamic between interviewer and participant through building rapport, a considerate relationship and mutual trust, especially for those participants who were nervous (Karnieli-Miller et al., 2009). However, it is almost impossible to eliminate the interviewer/interviewee effect altogether and in the context of the subject of the interview, it is not necessarily desirable as both the interviewee and interviewer bring their own power which is a valuable component of the relationship (Karnieli-Miller et al., 2009). It was therefore useful to try to understand how the researcher influenced the discussions and to take note of how the researcher is positioned as an interviewer and a counsellor for the service from which the participants were drawn. Rather than seek to reduce the significance of the interaction between the interviewer and interviewee, an

awareness of the inter-personal dynamics was considered both in the interview and in later analysis of the data.

4.3.4 Data analysis

The interview recordings were transcribed using an orthographic methodology i.e. exactly as it was spoken and not ‘cleaned up’ (Braun and Clarke, 2013a; Willig, 2013). The audio recordings were listened to on a further two occasions in conjunction with reading the transcript for the specific purpose of verifying the thoroughness and quality of the transcriptions (Braun and Clarke, 2013a). Analysis of the data was conducted manually only by the researcher using a mix of both the latent and sematic content of the data adopting the six phase analytical model of reflexive thematic analysis (Braun et al., 2018). It was considered that analysing the data manually as opposed to utilising Computer Aided Qualitative Data Analysis Software offered the opportunity to be sensitive to individual participants’ use of language, pause and non-verbal communication. Additionally, manual analysis of data allowed for any in-depth meaning of particularly poignant, interesting, or relevant data that could be analysed in the process of repeated re-reading, cross referencing and comparison with other data. Furthermore, manual coding of the data sharpens the ability of the coder to combine ideas and coding, and gives the researcher a better idea of how to best organise data (Bright and O'Connor, 2007).

Although the thematic analysis phases are recorded here in a linear way, it is important to note that the process was iterative and moved backwards as well as forwards between the entire dataset, the coded extracts of the transcripts,

the emerging categories/themes and the research notes (Braun and Clarke, 2006; Fereday and Muir-Cochrane, 2006; Braun and Clarke, 2013a; Vaismoradi et al., 2013; Braun et al., 2018). It is vital in thematic analysis for the researchers to immerse themselves in the data to the extent that they are familiar with the depth and breadth of the content (Braun and Clarke, 2006; Braun et al., 2018; Braun and Clarke, 2019). The process of familiarisation with the data started during the data collection process. As the interviewer and researcher, initial analytic interests or thoughts had begun to be formulated during the interviews and the in the interview transcription phase. Collecting and analysing data were conducted simultaneously, thus adding to the depth and quality of data analysis (Vaismoradi et al., 2013). Each interview recording was listened to alongside reading the transcript in order to become familiar with the depth and span of the data. Informal notes were made to record what was of interest in all aspects of the data and not only those relating to the research question (Braun et al., 2018). Attention was paid to the potential impact of the researcher's position as an insider practitioner and so the focus was on subjectivity, remaining truthful to the participants' meaning but considering alternative meanings or interpretations (Braun and Clarke, 2006; McLeod, 2011; Willig, 2013; Braun et al., 2018).

Codes were generated using an inductive emphasis to analyse the dataset without introducing any preconceived theories or formulations (Braun and Clarke, 2013a; Braun et al., 2018). At this phase, codes were generated adopting a complete coding methodology to record interesting features that captured meaning in the data that were noteworthy and relevant to the research

question but not ignoring other distinctive patterns or interesting data that may not directly relate to the research question (Braun and Clarke, 2013a). Initial codes and corresponding segments of text were recorded using tables in Microsoft Word to enhance the exploration of connections and relationships and to aid analytic thinking. The coded segments of text varied in length in order to capture the full essence of the data and its characteristics (Braun and Clarke, 2006; Braun et al., 2018).

The goal of the third phase of reflexive thematic analysis is to re-focus the examination of the wider level of categories and themes by merging related codes (Braun and Clarke, 2006; Braun et al., 2018). Candidate themes were shaped by identifying significant patterns in closely related and interconnected codes across the dataset (DeSantis and Ugarriza, 2000; Braun and Clarke, 2013a; Braun et al., 2018). Initial candidate themes were developed based on codes relating to outcome or goals for therapy. The next set of candidate themes were generated from codes connecting what participants felt helped them achieve or stopped them achieving their goals for therapy. Finally, candidate themes were generated for codes that did not specifically relate to the research question. A practical procedure was adopted where each code and a brief description were written in a Microsoft Word document table creating diagrammatic thematic map. Thematic maps provided a visual presentation of themes, codes, and their relationships, involving an account and description of each theme, their criteria, examples, and similar details in the data.

The candidate themes recorded in a thematic maps and discussion with supervisors helped with analytic thinking and to facilitate a review of the candidate themes and ensure that it was an accurate representation achieving the aim of identifying coherent but distinctive contents (Richie and Spencer, 2002). The validity of candidate themes to dataset was undertaken by re-reading all the transcripts and coding, re-coding where necessary (Braun and Clarke, 2013a; Braun et al., 2018). It was also in this phase that the relationships between candidate themes was considered, leading to association of some candidate themes and codes into different themes and the potential for themes to be subthemes or an overarching theme (Braun and Clarke, 2006, 2013b; Braun et al., 2018).

In this phase, in conjunction with discussions with supervisors, a fuller sense of the core of a theme or sub theme was developed and what quality of the data it captured. Additionally understanding was sought as to how it fits into not only the research question but the overall participants' story (Braun and Clarke, 2013a; Braun et al., 2018). It was also at this point, the themes were reviewed and examined for internal homogeneity and external heterogeneity i.e. that data relating to a theme corresponds meaningfully, while ensuring that themes are distinct from each other (Braun and Clarke, 2006, 2013b; Braun et al., 2018). Names for themes arose from further immersion in the data and especially in the candidate themes. To aid clarity, candidate themes, sub themes and theme names were transferred onto a thematic chart where data extracts were also recorded alongside the relevant theme.

Drafting and writing up the Findings Chapter offered a final opportunity to test how well the themes stay close to the data and how well they reflect the research question (Braun et al., 2018). The interlacing of existing literature and quotations from participant transcripts into theme descriptions along with supervisor inputs, a concise, coherent and accurate presentation of the findings of the themes capturing the narrative of the data and demonstrate the validity of the analysis was produced (Braun et al., 2018).

Trustworthiness and validity of the coding was enhanced by engaging in review of codes and research diary, and in supervisor meetings. Additionally, trustworthiness of the analysis was established by engaging in peer debriefing and peer validation through feedback from fellow PhD students on Palliative Care, Public Health, and Organisation Health and Wellbeing cohorts. This aspect of trustworthiness is discussed further in chapter 6.7.3.

Chapter 5 – Findings

5.1 Chapter overview

The aims of this research are to establish what goals participants had for therapy, whether they achieved them and what helped or hindered them in achieving those goals. In this chapter, the findings of the data analysis are reported in four sections by theme. The first theme, 'Hope of feeling more in control' relates to the element of the research question concerning participant's goals for therapy. The second and third themes, 'Therapy changed the way I see things' and 'Therapist enabled a positive therapeutic space', are associated with the element of the research question that looks at what participants thought helped or hindered them in the achievement of their goals for therapy. The fourth theme is 'There are consequences to admitting to self-harming'. This theme is derived from participant responses which were unanticipated, but nonetheless contributes a significant and interesting theme which developed from the data showing participant's fears about disclosing that they self-harm. It concerns their thought processes about being honest about their self-harm and it was a factor in helpful outcomes and has links with a diminished sense of control whilst undergoing therapy. The final section chronicles the findings from an element of the research question which covers what the participants considered hampered them in achieving their goals.

This chapter presents participant quotations to illustrate and evidence the key findings and themes. Congruent with the social constructivist paradigm and Reflexive Thematic Analysis, the themes illustrate shared meaning of the

experience of the participants, rather than aligning with a framework based on an existing theory (Yardley, 2017; Braun et al., 2018).

5.1.1 Introduction of Participants

Not all potential participants who expressed an interest to participate in a research interview and received the PIS subsequently agreed to be interviewed. In total 10 participants were interviewed. All of the participants were white, the majority were British citizens, and the majority were University or College students. Not all of the participants were cis gendered.

5.2 Theme 1 – Hope of feeling more in control

Participant's responses that contributed, as candidate themes and subthemes, to the realisation of the main theme of hope of feeling more in control centred on what they wanted in order to be able to experience life in a better way, gain some resolution to the way they feel or at least know some improvement in their lived experience. Rachel for example specifically stated that therapy would make things better by helping her by "*feeling more in control*".

None of the participants felt that there would not be any benefit from therapy, even though some had previously had poor experiences of receiving therapy. For example, Rachel had a previously poor experience of receiving therapy from a youth charity. However, despite this experience, she sought therapy with a different organisation, remaining hopeful of a better outcome. She hoped that the new set of therapy sessions would "…*help me sort of like ground myself*". Others were not certain about what therapy would do for them but still

there was a sense of hope in their responses. For example, Esther said "*it* (therapy) *was the only option before the option I really, really didn't want to take* (medication) *and so I just wanted to give it a go and whatever came out of it, fingers crossed it was a positive"*.

The expression of goals for therapy, whether it be for greater understanding, feeling better, or gaining a sense of being more in control points to participants having hope and an anticipation that these goals would be achieved. The hope some of the participants held was about achieving a different way or new way of having some sense of control rather than using self-harm to achieve this.

Table 5.1 Theme 1 - Hope of feeling more in control

Candidate Theme	Subtheme	Theme
Therapy can help me understand why I feel this way	I can gain understanding from therapy	Hope of feeling more in control
Understanding will help me		
Therapy can help me make sense of things		
Therapy can change things for me	Therapy can make things better and help me to feel more in control	
Getting better will stop people worrying about me.		
Therapy can stop me self-harming		
Therapy can help me be more in control.		

5.2.1 Subtheme – I can gain understanding from therapy

Five participants communicated that their hope for therapy was to be found in gaining understanding. Participants were unclear about what sort of understanding they sought, yet their responses provided evidence that understanding would be helpful to them to overcome their current situation and feeling more in control. Adam did not give a specific area of understanding he wanted to gain but in his assessment of the success of achieving this goal he said "*…since I've had more understanding of all the different things going on, it* (urge to self-harm) *hasn't been able to build up and get to me so much because I know what's happening*." This candidate theme was also supported by David who was a more distinct about what understanding he sought. He said "…*seeing how other people could kind of just help me with that where either I couldn't help myself or medication couldn't at a certain point*." Deborah clarified her rational by saying that she hoped to gain "*…understanding, like clarity out of it*". Keziah simply reported that "*… helped me understand my thoughts properly*" without expanding in more detail on what that meant for her.

The candidate themes of 'Therapy can help me understand the way I feel', and 'Therapy can help me make sense of things' are derived from participant responses that expressed a hope that the way they felt would be validated or why they felt that way would become clearer. Deborah conveyed that to understand that what she was thinking, and feeling was natural or OK would be helpful to her "*I just wanted to see from another perspective if it, if I was right, or if I was normal or something like that*." Hannah articulated the desire for understanding by wanting to have "*closure or validation for how I felt*" and to

discover "…*that I was allowed to feel a certain way so If I was allowed to feel guilty about the way, not liking someone because they did something to me*."

5.2.2 Subtheme - Therapy can make things better and help me to feel more in control

All the participants hoped that therapy would lead to a more tangible, yet still ambiguous experience of feeling better. Whilst 'better' is a generalised and subjective statement, it speaks to the participant gaining a sense, or a perception of positive change in their lives and feeling more in control.

Some participants were slightly more specific than others as to what 'better' meant. For instance, for David "*…generally having a better mental health*". Ruth stated, "*I suppose I just wanted to, to get better 'cause I, all my life I'd, I knew something was wrong with me*" and Keziah articulated that "*"…it to just get better or just go away…It was like, that's, that's what I wanted to happen, for it to just stop or it just go away".* Deborah described a numerical scale to define how she wanted to feel better *"…I guess that was it or at the end of it I could say that I don't know, when I started it maybe I was feeling a 4 out of 10 and now at the end of it I'm feeling an 8 out of 10*." Whilst Esther quantified her hope of getting better without the need to use medication "*I didn't want to go on medication because I saw, I've seen my mum and dad both on it and it's, it's quite a rocky road to get to a good place and I didn't, I felt bad enough. I didn't want to go on that rocky road to get to the good bit and I just thought therapy was the best option for me*." Eve said that better for her meant "…*I guess it*

always was just like the main thing of being happier and not being so down as much all the time, because it was rather constant".

Of interest in this study is the fact that only one participant, Abigail, openly stated that getting better for her would be to stop herself from self-harming. She wanted to learn "*…what I could do instead, just not wanting to self-harm*." This also suggests that she wanted to feel more in control in order to feel better. Although stopping self-harming was not specifically verbalised by other participants, latent coding of the data points to unspoken hope of change or a greater sense of control in their lives leading to them no longer feeling the need or desire to self-harm.

Based on the evidence of this study, in stating that their goals for therapy were something other than stopping self-harm, it gives weight to the argument that a helpful way to support young people is not directly confronting or challenging self-harming behaviours but helping young people to resolve their emotional difficulties and alleviating the situations they were experiencing. This is notion is further supported by Esther's response "*I wasn't being unsafe, and the actual self-harm wasn't the problem*". To force Esther to stop, take her way of having control, would have most likely led her to disengage from therapy. Without pressure to stop self-harming, Esther went on to say when asked if she had stopped self-harming and how she felt therapy helped "*I have not self-harmed in, I'm gonna say, in about eight months, which is incredible bearing in mind I did it multiple times a day and that's down to therapy 100%".*

Participant's difficulties which led them to therapy also had an impact on family members and others who were close to them. A number of participants hoped that therapy would make them better or feel more in control of their emotions so that others would not worry about them any longer or end conflicts with parents (candidate theme getting better will stop people worrying about me). Eve said exactly that "*I kinda hoped that I would get better enough, so that people wouldn't be worrying too much about me anymore*."

Adam's mother had encouraged him to seek formal help, suggesting she was aware of his difficulties which consequently affected her "*it got to the point like where my mum also suggested and I thought about er, going to the doctors*". Esther had received a very negative reaction for her mother on finding out that she self-harmed "*…she found out, yeah not great way and I got a quite bad reaction…*" It is plausible that her underlying hope was that her self-harm would stop as a result of therapy and hence the negative reactions she had received from her mother would stop as a result. Keziah wanted to get better to be able to stop conflict with her parents because occasionally she could not make it to therapy appointments because of her anxiety. "*…my parents got angry with me because I'm, they know I need to go to them* (therapy appointments) *and I couldn't…*" Abigail's motivation to stop self-harming came in part from the fear that "…*knowing that if I did it again I'd likely be well, either taken out of Uni by my parents, or kicked out of Uni by Uni*". This evidence demonstrates that parental strategies to help their child are sometimes an indication a level parental distress at knowing their child self-harms. Parental attempts to help their child can often be in the form of threats of punishment which can also

engender in the young person a sense of losing an element of control in their lives.

5.3 Theme 2 – Therapy changed the way I see things

Participant's assessment of what helped them in therapy to achieve their goals came from a change of viewpoint or reframing of problems or difficulties. The changes brought about through therapy had powerful effects on some participants for example, Eve reflected that at the end of therapy "*it actually, it helped me so much that honestly, I don't think that I'm the same person as I used to be anymore*". Ruth's interview was four months after her therapy finished and she said that "*I still think back to what I've learned and things, so it has had a long-lasting effect so to speak*."

Table 5.2 Theme 2 - Therapy changed the way I see things

Candidate Theme	Subtheme	Theme
Helped me understand	Learnt to see things differently	Therapy changed the way I see things
Helped me to think differently		
Greater awareness of things		
Seeing things more clearly		
What I can do to help myself	Learned new strategies	
Learning to question myself		

5.3.1 Subtheme – Learnt to see things differently

There were different examples given in the data of how therapy changed participant's perspective and ways of thinking. Adam said that as a result of his therapy "*I've been able to get my head around it instead of, because it was often*

when things got too much that, that would be the sort of release. So, being able to understand helped sort of clear that." David illustrated how he could now "…*see things more clearly, understand everything.*" Deborah described how her therapist helped her to 'see things differently' and 'what she could do to help herself' through his approach to therapy. She recalled he said "…*let's talk about what went wrong this week, why it went wrong and what you can do next time…"*

'Seeing things differently' and gaining a 'Greater awareness of things' were also demonstrated by David who considered that *"I became kind of aware of things I suppose*." Ruth also contributed to these candidate themes with her assertion that "*The thing that was most helpful is questioning why I was thinking something*". Deborah also thought that her therapist helped her to not only gain understanding but also to question what she was thinking. She related how her therapist would challenge her by asking "…*why are you thinking this but you don't need to do but you don't need to do that or he was like all of my rational thinking he was actually someone that would just say well no that*".

Although it was not a specified goal for therapy, Deborah did feel she had learnt something "*...in a way it almost felt like I wasn't receiving CBT, I was learning about CBT. So, in my head that's kind of how I felt.*" Esther did not trust her own thoughts "*so, having someone that I can offload everything onto and either agreeing with me or telling me, actually you're being a bit silly or, (pause) you have every right to feel that way and let's, let's try and strategise what we can do to sort it that was good*." Keziah became more aware of her thinking and to question it through the therapy which helped her to "*realise that, that your*

thoughts is not what you want to be thinking". Ruth deemed that the process of CBT helped her by "…*putting what's in your brain onto paper and challenging it. It won't always work but eventually you'll start to think I don't need to think that because that's, that's wrong*". Ruth felt that the most helpful aspect of her therapy was to think differently by her therapist by "…*questioning why I was thinking something*".

5.3.2 Subtheme – Learned new strategies

Participants communicated that they achieved their goals through learning to question themselves and learning what they can do to help themselves. Abigail felt that "…*my therapist, she was just like OK you can do this specific thing in order to worry less, and that was just a lot more helpful*". David was given information that helped him to develop new strategies from "…*getting what I needed from someone's professional opinion, also just different perspective*…" This subtheme evolved from not only from Abigail's therapist helping her with what she could do next time she worried, but also from Esther who described how her therapist helped her to "…*strategise what we can do to sort it*…". Eve found therapy offered her "…*positive advice things that they could do to help you get through it*" which gave her understanding of new ways of thinking and how to deal with things. David felt that as the result of therapy he could now "… *just know what things I can actually do to help myself and just continue with a better mental state really*".

5.4 Theme 3 – Therapist enabled a positive therapeutic space

In their assessment of how therapy helped them achieve their goals, participants reported that the therapist's qualities and the environment of the therapy room contributed to helping them achieve their goals for therapy. Table 5.3 presents the candidate and subthemes for this theme. Participants that believed a combination of the personal qualities of the therapist, the words they used, or the facilitation of a safe environment enabled them to talk about their difficulties freely and without fear of judgement.

Table 5.3 Theme 3 - Therapist enabled a positive therapeutic space

Candidate Theme	Subtheme	Theme
Non-critical responses	Therapist's helpful responses	Therapist enabled a positive therapeutic space
Accepting attitude		
Supportive manner		
Challenging thoughts		
Helpful prompting		
Therapist self-disclosure		
Safe space to talk	Safe environment.	
Built trust		

5.4.1 Subtheme – Therapist's helpful responses

The data demonstrates for the most part that therapists were accepting and empathic towards young people who self-harm. All except one participant felt that the therapist responses, the way they spoke, had a beneficial influence on them feeling better and moving towards achieving their outcome for therapy. Supportive and non-critical attitudes were reported most frequently. Abigail for

example said "*She was, she was very friendly. She took everything like, she took things seriously, she didn't you know, downplay anything*…" Adam felt that the therapist questioning him helped him achieve his goal of understanding "…*how they would ask you something and you'd come out erm, with whatever the reply would be, but it was able to then have a smaller question maybe around that that then helped you to think for yourself*.". Deborah had a poor previous experience of CBT but this time "…*he actually seemed interested, enthusiastic like he wanted to know, he wanted to understand and help*" which in turn helped her engage more fully in the therapy. Eve felt that *"…the way they behaved towards me about it* (self-harm)*. Like they weren't being shocked by it, or they didn't say oh I'm so sorry that happened to you and all this other stuff that you hear from everyone else. It was just mainly saying like positive advice things that they could do to help you get through it and just be really calming about it.*" Hannah compared her therapist's acceptance and supportive manner when talking about self-harm with other professionals. It seemed to her that "…*my doctor really didn't care as much but the person that I saw definitely did. She was very helpful to me*." Keziah deemed it was the therapist's attitude and what they said that was facilitative for her "*Just the way they spoke, like their manners and stuff like that. Because they, one of them, one of them said, she's like, I don't, I don't know what you are going through because I have never been through it before, but I will help you understand and I will like, you know, it's, she was really, really helpful*." An example of therapist unconditional positive regard, and it being received by the client comes from David, who is transgender. David recorded that he felt that he received non-critical responses and an accepting attitude of his gender identity from the therapist "…*I had*

started to feel much better as far as I remember. I think just kind of, it more or less kind of, acceptance, the therapist had no particular bias was helpful."

For Hannah, the most helpful aspect of her therapy was when her therapist challenged her thoughts "*The thing that was most helpful is questioning why I was thinking something*". Therapist self-disclosure was also beneficial for Hannah in achieving her goals "…*she always used an example of herself and she would always say when she was training as a mental health nurse and how she struggled, and putting it, hearing it from someone else's perspective and I wasn't the only one struggling*".

Of particular interest is Esther's experience of acceptance and empathy from her therapist was that "*I remember clearly the first thing he ever said to me was that he was not going to tell me not to do it* (self-harm) *and nobody had ever said that to me before, and we focused on why I wanted to do it not the fact I was doing it*". This established a positive therapeutic bond which from then on contributed to a successful outcome for this young person. In her own words "… *just that they're absolutely incredible, and they saved my life*". This is powerful evidence of the effectiveness of therapists taking the approach of not concentrating on stopping their client self-harming but focusing more on the underlying reasons that lead to the client self-harming and giving the young person a sense of keeping some level of control in line with client hopes and goals for their therapy sessions.

Only Adam gave an account of using harm minimisation techniques suggested to him by the therapist "*I did try most of the different ones. It's only been more recently I've stopped erm, wearing the sort of you know, the elastic band around my wrist*". When asked if this information was valuable, he replied "*I wouldn't have known other ways if not*" indicating he felt the information was useful to him and helped him to gain ways to feel in control instead of self-harming.

5.4.2 Subtheme – Safe environment

For some participants having trust and feeling safe to talk was important and this required certain conditions to be present in the therapy room. In part, it was the room but mostly it was the atmosphere of trust created by the therapist. Adam felt the whole atmosphere in the therapy room was conducive to helping him achieve his goal *"… it was always calm and, yeah it's er, (pause) there was just little things, more of it, it being relaxed and er, always in the same room. I always sat in the same chair (laugh) because, you know, always being able to look out the window was more relaxing.*" Hannah explained that it was feeling safe to talk was important *"…definitely being like feeling comfortable to talk about how I felt or the past situations"*. Trust building by therapists came in the form of just how they were in sessions. Rachel felt that the space was "…*a comforting environment." I mean we moved offices like every single day, we never spent two sessions consecutively in the same office, but the en, the environment and how he presented both himself and everything around him was very comforting, it was very, like you are in a safe place here*." Yet later she added that sometimes the therapist attitude was unhelpful "*It really kind of depended on the session*" because of her therapist directing the content

towards her family, a subject she did not want to talk about. Ruth found her therapist's character helped her feel safe and to be able to talk freely "*she was very easy to, that nature about her, she's very easy to just talk to. It's really hard to describe."* Another example for the candidate theme of building trust came from Esther's assessment of her therapist was "*I think, when I first met him he was really, he didn't know how to be around me but as we got to know each other better they adapted themselves to suit me better and we got a really good relationship*."

For some participants it was the attributes of the room that therapy was conducted in that helped them. Adam particularly felt that because his therapy sessions were "…*always in the same room. I always sat in the same chair (laugh) because, you know, always being able to look out the window was more relaxing*". Further intrigue comes from Rachel who found her therapist's focus in the sessions as unhelpful but found the rooms "*…a comforting environment. I mean we moved offices like every single day, we never spent two sessions consecutively in the same office, but the en, the environment and how he presented both himself and everything around him was very comforting...*" Literature confirms that the room in which therapy is conducted is a factor in clients positive experience of therapy (Pressly and Heesacker, 2001; Pearson and Wilson, 2012).

5.5 Theme 4 – There are consequences to admitting to self-harming

This theme was conceptualised from the differing participant expectation and experiences expressed at being asked directly in their initial therapy

assessment if they are self-harming. It links partially to the section of the research question relating to what helped in achieving their goals in that being open and honest had a value in helping them to move towards reaching their goal.

There was a mix of responses from participants about being asked directly about whether they self-harmed with number of participants expressing concerns over disclosing they self-harmed because of previous negative experiences of disclosure or misconceptions of what would happen if they disclosed self-harm. Four participants said they expected to be asked about self-harm or were not bothered by being asked, the remaining six had reservations about answering honestly. Whether they expected to be asked or not, the participants all believed there would be a consequence to them confirming that they are self-harming, be it a positive or a negative one. Keziah described how she felt when asked if she self-harmed "…*oh I wasn't expecting to be asked like, this sort of question*". Eve said she was "*shocked*" at being asked as she was not expecting to be. She believed the assessment would concentrate on "*…more just oh how has your mood been kinda thing."* As she contemplated whether to admit to self-harming she initially thought "*…I'm going to be sent off somewhere, I'm going to get in trouble or someone's going to come 'round my house and talk to me about it*". The fear of someone coming "*'round my house*" alludes to a fear her parents would find out about her self-harm. Rachel conveyed how "*I felt very put on the spot. It was really kind of off putting that that was there straight off, like straight off the bat. It was one of the first few things they asked you about*".

Table 5.4 Theme 4 - There are consequences to admitting to self-harming

Candidate Theme	Subtheme	Theme
Felt put on the spot - not expecting to be asked directly	It is risky to admit to self-harm	There are consequences to admitting to self-harming
Anxious because of previous bad experience		
Concerned about who they would tell		
Scared because I might get in trouble		
Shocked at being asked		
Expected to be asked	It is ok to be honest about self-harming	
Not bothered by being asked directly		
Had to be honest to get help		

Her fear of the possible consequences was that "*if I put the wrong answer, they were gonna, I don't know, phone someone else and it was all gonna like get thrown up into the air*." Again, this suggests that divulging self-harm could lead to problems with parents and an increased level of attention to something which young people who self-harm see as a personal subject. Ruth did divulge to the therapist that she self-harmed but in doing so "*I was worried if I said too much, they would refer me and then my parents would find out that or they would (pause). Yeah, I'd worry that, this is totally daft because I know how hard it is for someone to be sectioned… it was just that I didn't want my parents to find out because I was very much to keep it to myself and things."* As the next

sections will show, participants who initially felt there could be negative outcomes underwent an internal dialogue or decision-making process that persuaded them that being open and honest was the best policy to make ensure a positive outcome was achieved.

5.5.2 Subtheme – It is ok to be honest about self-harm

The data demonstrates the participants believed that ultimately being honest with the therapist about self-harm was key to them having a positive therapy outcome. This was applicable to all almost all the participants regardless of whether they were initially reluctant to admit to self-harming or not afraid to say that they were. Some participant's dialogue showed a process of evaluation for instance, Eve "*…I kind of just went and, went through a process of saying oh if I lie about this, I'm not going to get the help*". Once Eve had begun talking in the sessions about her self-harm "*I kinda couldn't stop because it was just really helpful to talk about it*." Keziah expressed how she felt that "*I didn't think it would come up but you got to be honest haven't you, and so it's just, you just answer it properly like*" pointing to an understanding the being honest is helpful to her feeling better. Deborah delayed being open about her self-harm but eventually after a few sessions, felt secure enough to tell the therapist that she self-harmed. Rachel, despite initially being nervous about disclosing she self-harmed, realised that honesty is the best policy and in doing so "*…it helped me like, sort of like, sort it out in my head of this is why I'm here."*

5.6 What hampered the achievement of goals for therapy

Every participant expressed a goal for therapy however Deborah, Keziah and Rachel did not achieve the goals they hoped for, each for differing reasons and judged different aspects of the therapy as unhelpful. Deborah felt she had not fully achieved her goals for therapy because "*I'm not fully OK or I haven't, it hasn't necessarily helped with some of the things I initially went there with … So, I guess it probably helped with certain things but maybe not the main reasons I was there.*" Deborah expressed her goal for therapy was to see from another perspective if the way she felt was 'normal' or 'right'. She did not quantify which aspects of her goals she achieved or did not achieve. The evidence points to her not having a sense of feeling fully better, or as better as she hoped. It can be hard for clients to identify goals for therapy and in Deborah's case, more work on goal setting at the outset of therapy might have been beneficial.

Keziah was not able to realise her hopes for therapy as a result of her therapy sessions being ended before she had begun to see any improvements in the way she felt. Keziah was not able to attend more than 2 therapy sessions due to her having to travel the long distance from her home for appointments. The service through which she was accessing therapy stipulates a maximum number of missed appointments and so because she missed too many appointments she was discharged from the service "*I was meant to go to one in (*city name*) but obviously I live in (*town name*) so I've no way of getting to (*city name*) and I don't earn a lot of money so I've missed the last couple of them so they've just took me off the system now because I couldn't make them."*

She said that when she was discharged for non-attendance "*It, it made me feel pretty crap. It's like, because obviously I, my parents got angry with me because I'm, they know I need to go to them and I couldn't, and I had no one to go with me and I can't travel to city name on my, on my own. So, it's like, it's hard as well. I always have to have someone with me when I go somewhere*." This experience will most likely have resulted in Keziah's mental health deteriorating or at best stagnating. Additionally, this experience could become a barrier to her accessing services in the future.

Rachel's first encounter with a therapist left her feeling that when she talked about self-harm "*They just kind of, they didn't tell me to like stop or anything, they just, they kind of just dismissed it*." This may well have established some resistance to changes through therapy in Rachel. Furthermore, Rachel felt that her CBT therapist hampered her achievement of her goals by overly directing the sessions to a specific topic about her family "*…he would often like start the day, or start the session by, he would like offer a question that would go down a very, almost specific path.*" This caused her not to engage fully in the therapy as "*It just kinda got tedious after a while, like talking about the same thing over and over again, when nothing was changing.*" Her therapist told her that CBT was not going to work for her, and the sessions came to an end. Rachel stopped going to her therapy sessions after completing 4 and was subsequently discharged for not turning up for sessions arranged by her therapist. Rachel did finally achieve what she hoped for from therapy through the support of friends who "…*didn't dismiss me, they didn't treat me like I was just another*

statistic or that I was just a kid." This points to how she felt she was treated in the therapy sessions.

5.7 Conclusion

One of the more significant themes to emerge from the data analysis is that of participant's hope of feeling more in control. This appears to be a significant element to their goals for therapy. Greater understanding and affirmation of feelings and difficulties was sought by participants seeking to feel more in control. Hope of feeling more in control in the context of these participants was for a better life experience, changes in the way they can interact with others and their environment.

Gaining or regaining autonomy or control in their lives as a hope for therapy is rarely referred to directly in the participants' narratives. Where participants did not directly express that they wished to feel more in control, the descriptions they gave of their goals for therapy imply or point to a desire for a greater sense of being more in control. Some of these hopes for feeling more in control were lightly held, others were more strongly held, embedded in the core of their need for a move forward. Explicitly stated or not, participants hope for the outcome of therapy is also an expression of wanting to regain a level of control where they feel they do not have control in their lives. This is both a cognitive and somatic experience and demonstrates the person striving to meet their needs of belonging, connectedness and esteem through therapy; the motivation to move towards greater self-actualisation. The term 'feeling better' was frequently used by participant. 'Better' had different meanings for different

participants and this mix of participant interpretations of what better means, points to the goal of feeling better being an individualistic, subjective sensing particularly relevant to each young person at a particular point in time.

No consistent reason for participants not achieving their goals for therapy was clear. One participant completed the allocated number of sessions but did not feel they had achieved what they hoped to achieve. Another participant was unable to achieve her goals because she was not able attend more than 2 sessions because of difficulties in accessing the therapy venue and was discharged from the service. The third participant dropped out because she felt the therapist was directing the sessions to an area that she did not want to discuss.

Chapter 6 – Discussion

6.1 Chapter overview

In this investigation, the aim was to explore the association between the therapeutic goals of young people and the ways in which the therapist facilitated their achievement of those goals. The research questions are:

> What outcome goals do young people aged 16 to 20 who self-harm have for therapy and what in therapy helped or hindered them in achieving these goals?

In this chapter the themes identified in the analysis are considered against the research question, theories and existing evidence base as set out in the literature review. The inferences drawn from this study are situated in its social constructionist paradigm, its methodological design, and its accounts from ten participants. Through exploring the relationship of the themes to the existing literature and theories, this chapter supports, as well as challenges, some assumptions in practice and in the literature. The analysis of participants' accounts offers some new insights into outcomes and helpfulness of therapy from a different context to previous studies namely, from the perspective of young people who self-harm receiving therapy through an IAPT service.

6.2 Hope and feeling more in control

This study has generated knowledge which advances the existing evidence base by the insight it contributes that for young people who are presenting with a behaviour that is a strategy for having a sense of control (self-harm) enabling them to be in control of their therapy is particularly important. From the evidence

of the data and from the systematic literature review, it can be seen that whatever the function of self-harm is for a young person, having control is a factor. If the function of self-harm is to punish for example, then the young person has control over when, how much and for how long this punishment is administered. If the function is to experience a manageable pain or to overcome numbness, again the young person has control over when, how much and for how long. Thus in the act of self-harm, they are exercising a level of control over a part of their lives which they might not otherwise feel they have regardless of what they feel the function self-harm serves. This connects to the data of this research that demonstrates that at the forefront of the young person who self-harms goals for therapy are hopes that therapy will guide them to feeling more in control of their lives and to gain a resolution to the difficulties they are experiencing. The hope or desire to feel in control, feeling that one has agency to act independently, to make free choices, and not be overly influenced by external forces is consistent with the drive of the actualising tendency (Rogers, 1962, 1980, 2004). Therapy that has a focus on the presenting visible problem (self-harm) can threaten the sense of control young people have over the process of therapy.

Analysis of the data of this study showed that gaining an increased sense of control comes from gaining a greater understanding of the situations that lead the young people to seek help. Understanding comes from the young person, with the therapist to assist them, appreciating how their difficulties evolved, how their experiences and social situation led them to where they are now, why they might feel the way they do, and how they attach meaning and language to their

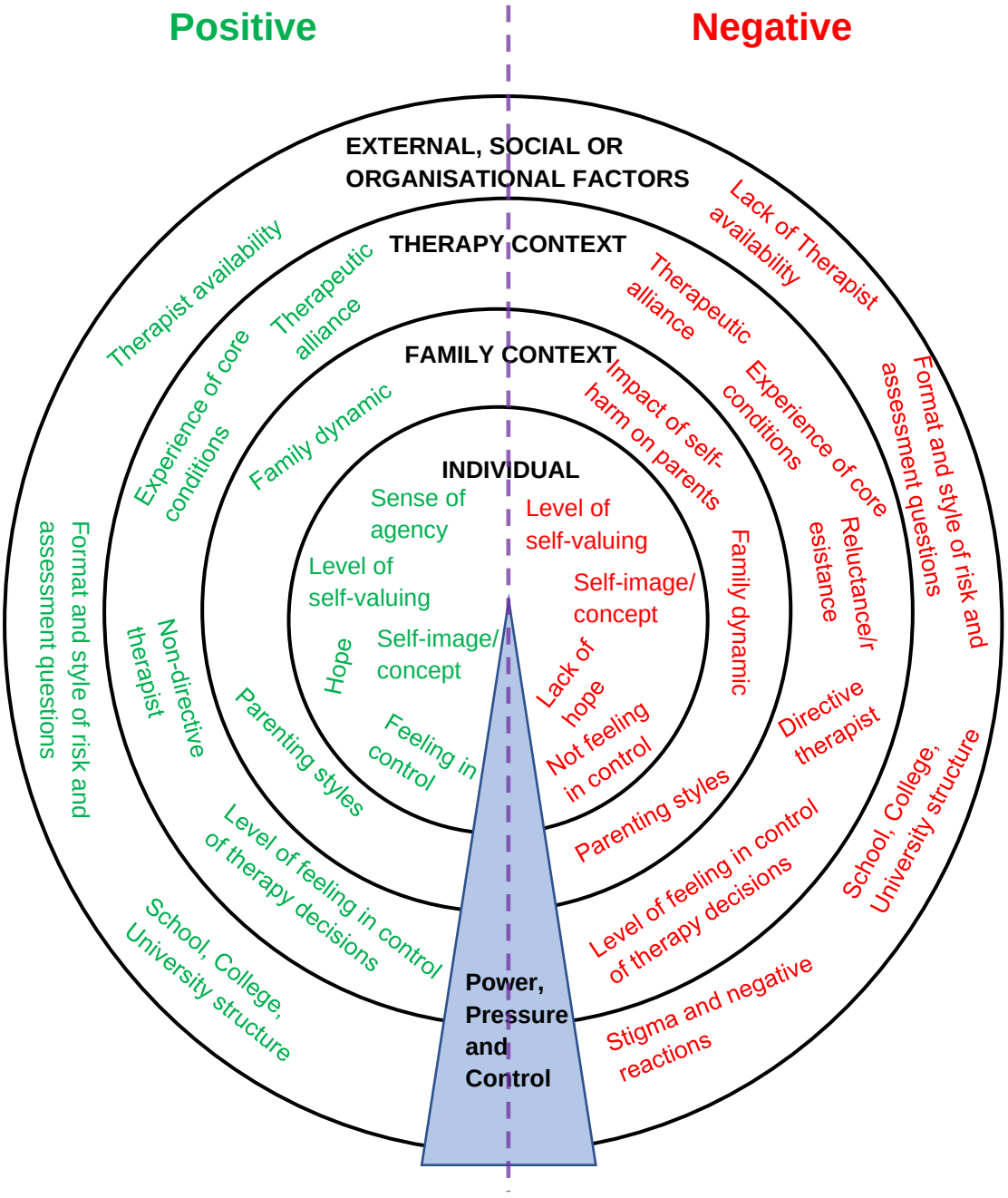
feelings and difficulties. Understanding can also be in the form of recognising unhelpful ways of thinking or behaviour. Understanding leads to clarification, explanation and change in thinking or awareness so that the young person can have control over the resolution of their difficulties and move closer to having the life they hope to have. The findings of this study suggest that an increased understanding of situations promotes self-confidence in young people and the choices they have made or will make in the future. Self-confidence is an indication of feeling in control in a given situation.

6.3 When young people do not feel in control in their lives

The theoretical model derived from this study (Figure 2) indicates that there are four main factors that affects a young person's sense of their ability to exercise control or agency. Figure 2 maps the actors in an individual's experience of control, highlighting where positive and negative influences on the young person's sense of control lies. The model, not previously demonstrated in literature, helps us to understand where positive and negative influence are experienced which affects the young person's sense of control and emotional distress and hence impacts their self-harming behaviours. The negative influences on the individual can be a source of emotional distress. Additionally, negative influences in the family context, therapy context and external social factors can perpetuate the emotional distress and hence the self-harm behaviours. Conversely, the positive influences that lead to the young person feeling more in control reduce the young person's emotional distress and as a consequence reduce or stop self-harming behaviours. This current study reinforces the view that an individual's positive sense of hope, self-image and

perception of their own agency and control are significant factors in experiencing their world as safe and affirming (Offer et al., 1989; Jørgensen, 2004).

Figure 2 Theoretical Model – Factors affecting young people's sense of being in control and the actualising tendency in an individual



The learning of this study, connected to the young person sense of agency and control, also demonstrates an added implication that Maslow's Hierarchy of Needs should be viewed as being achieved or deficient concurrently rather than sequentially. What is clear for both of the literature and the research is that lower needs can be partially achieved and at the same time higher needs can begin to be met before the lower needs are fully satisfied. Conversely, higher needs can be partially met, and lower needs can become deficient again due to life events or new circumstances the young person may be encountering, albeit temporarily.

This study has shown that a young person who self-harms will potentially be aware of the effect on their parents and others to a greater or lesser degree but possibly not all the intricacies of the impact. This can lead the young person to experience increased feelings of guilt, shame, stress, and feeling less in control if parents or significant others become aware of their self-harm. This then contributes to them harming themselves to further express their increased distress (Amoss et al., 2016; Palmer et al., 2016). There is considerable impact on their own self-worth and on family and friends that physical reminders in the form of scars have results in guilt, shame, and compulsion to hide the scars. This is a complex situation as the act of hiding the scars can serve to draw attention to the fact the young person is self-harming rather than hiding the fact i.e. wearing long sleeved clothing in hot weather (Gelinas and Wright, 2013). This is where the young person often adopts a configuration of self that hides both the scars and the emotional distress they are experiencing in order to avoid or protect the parents or friends from experiencing their own emotional distress

as a result of the young person's self-harm being noticed or seen. This study has also highlighted the difficulties a young person experiences when trying to avoid parental knowledge of their self-harm and the impact this has on the young person i.e. secrecy and fear of being found out, and the consequences of what such a discovery would bring for example, punishment or increased parental control, thus diminishing the young person's sense of agency and control.

Evident from the analysis of participant narratives in this study is that the young person's hope of 'getting better' through therapy has the expectation that it will not only ease their own difficulties but also assuage family difficulties, distress or concern. Thus end threats of disciplinary or punitive actions from overly controlling behaviours of parents and significant others in the young person's life. It is understood that young people who live with parents with mental health difficulties, alcohol or drug dependence or where there is domestic abuse, worry about their parents and this worry may well progress to feelings of guilt that they will have made things worse with their own difficulties and by self-harming (Ferrey et al., 2016b; Palmer et al., 2016). The fact that the young person has sought professional help, or have gone to therapy when advised to, is part of the process in young person's attempt at alleviating their worries but also the worries of family and friends and speaks to the actualising tendency in action. It can also address conditions of worth that have been placed on them whereby the young person will only experience acceptance from parents or significant others if they seek help and stop self-harming. Therefore, in therapy, it is vital to help the young person to be able to experience better-quality relationships

with family and friends and enable them to share their thoughts and feelings with them. Helping a young person experience what control they can have and what it feels like in therapy and the therapeutic relationship can ultimately improve the relational dynamic they have with family and friends. Existing research establishes the benefits of combining family support, including parents, siblings, and extended family where possible and appropriate, in interventions aimed at reducing self-harm. An increased sense of connection increases family support and is a factor in young people ending self-harming behaviours (Amoss et al., 2016; Palmer et al., 2016; Cottrell et al., 2018). A young person who self-harms becoming distressed at the impact their self-harming behaviours has on family and friends, can be a motivation to resist self-harm as well as accessing professional help (Tatnell et al., 2013; Mummé et al., 2017). Overall, an improved sense of control, greater connection and improved communication with family and friends affords individuals the opportunity to process difficult thoughts and emotions in more constructive ways (Baron and Cobb-Clark, 2010).

Therapy has a focus on the individual and the relationships between the individual and others, including the therapist within the therapeutic setting. This study has shown that having greater control may be wanted by the young person but outside the therapy environment, control is limited by their age, their circumstances, and the social and ethnocultural environment they inhabit. There are other factors that are important to the individual's sense of control which are outside the possibility of what therapy can offer (Figure 2). Therapy alone cannot give individuals control over all aspects of their lives. What

literature and this study has demonstrated is that therapy can offer is a positive space and opportunity for young people to experience being in control and that in itself is therapeutically valuable (Horvarth, 2001; Everall and Paulson, 2002; Feller and Cottone, 2003; Horvath et al., 2011).

6.4 When young people do not feel in control in therapy services

This study has identified how young people can have their sense of control diminished or blocked when they access mental health services. Evidence of not allowing an element of control runs through all the participant narratives of their journey through therapy with an IAPT service. One of the important contributions of this study is to highlight that in circumstances where a sense of control is therapeutically important, systems that reduce the young person's sense of being in control are problematic. This understanding can contribute knowledge beyond the settings of this study for example in other statutory mental health services and third sector services aimed at supporting young people.

6.4.1 Sense of control - therapy service process

The data and the systematic literature review investigated in this study illustrates that there are different reasons why young people do not access formal help and support including having had previous negative experiences of mental health services. As this study demonstrates, drop-out of therapy can occur because young people have not felt in control in these services. The process of accessing therapy in itself has layers that can diminish the young person's sense of control or thwart their achievement of a greater sense of

control and even limit their actualising tendency. From initial engagement with the therapy service through to the therapy sessions and the therapeutic relationship, the pressure that young people feel to meet other's demands and relinquish control is evident in the data of this study.

The administration of the service determines that several aspects are out of the control of young people. For example, the number of sessions offered, the modality of therapy they are to receive, who the therapist will be, and the location of the therapy session. There is evidence in the data of this study of the negative impact not having control over where the therapy sessions were held. For one participant, there were therapy sessions available at a Medical Centre in the same town as the participant's home and she had requested to attend them there. However, the service insisted she travelled over 30 miles for her therapy sessions. There may be some factors in this decision not known to the participant or this study including therapist availability or room availability. Ultimately, the young person failed to attend all the sessions offered to her and was discharged from the service as a result. Clearly this was an aspect which was out of the young person's control and was a significant obstacle to them accessing therapy, achieving their goals, and completing therapy.

The findings of this research provide insights in to how the structure and environment of the therapy service has an effect on the young person being in control. A service which engenders sense of acceptance and valuing and not just another patient to be cured, goes a long way to facilitating the individual to feel valued accepted and hence more able to access their actualising tendency.

A complex and onerous referral process which centre on asking questions which the individual could find difficult to answer, or that forces them to divulge information they may not feel ready or willing to disclose at that time, can shut down the individual's help-seeking drive. The data of this study draws attention to the fact that a sense of control can feel diminished in the initial assessment for therapy in the IAPT service the participants were drawn from. In a 45 minute information gathering assessment appointment, they are asked whether they have self-harmed in the past two weeks. These assessments including a risk assessment for self-harm or suicide, or harm to others, are carried out at the first contact with an IAPT service to, amongst other things, to ensure the individual understands whether they have been accepted by the service, how their difficulties are defined and the rationale for treatment intervention. Data from this study shows, in the experience of the participants, the risk questions came too early in the assessment and left young people in a situation of having their control over when or if they disclosed whether they self-harmed being taken away from them. In the assessment, participants perceived negative experiences of therapist indifference and a sense that the person they were speaking to were only interested in gathering information and not particularly showing any interest or empathy towards them. There is no definitive statement about the importance of the timing for sharing information on risk or self-harm in literature. However, it is accepted that an engaging, trusting and supportive relationship should have developed before these questions are asked: for example see, The Tavistock & Portman (2019).

The characteristics of therapy provision demonstrate to the young person that right from the outset they do not have control over what is going to happen to

them in therapy. Most therapists try to give their clients some level of control, especially those that practice non-directive therapy, but the evidence of this study shows that whatever this IAPT service believe they are doing, the structures around therapy can lead to young people not feeling in control.

6.4.2 Sense of control in therapy sessions

In the literature, exercising control is reported as one of the functions of self-harm and there is reference to the detrimental outcomes of being compelled to stop self-harming, for example see Sutton (2007); Nock (2009); Polk and Liss (2009); Edmondson et al. (2016). This current study highlights that whilst not openly expressing a desire to stop self-harming in their hopes for therapy, young people having or gaining a greater sense of being in control through therapeutic interventions can be a route to them lessening and ultimately replacing self-harm as a way of taking control or exercising autonomy. This is demonstrated in the data where participants stopped self-harming of their own volition as a result of what they felt was successful therapy where the therapist did not insist or compelling them to stop self-harming.

The findings of this study highlight an important issue in that preventing a young person from self-harming completely and not resolving the underlying difficulties or advocating alternatives that do not engender the same sense of control, takes away the young person's coping strategy and can lead to greater distress and emotional harm. Concentrating solely on affect regulation and developing strategies to manage emotions more effectively in therapy becomes ultimately less useful unless the idea of feeling in control through self-harm is explored in

depth with the individual. This was no more clearly demonstrated in the evidence of this study where the therapist, in the eyes of the participants, did focus on the underlying issues and not the self-harm leading to successful outcomes for therapy.

The value to young people of not directly confronting or challenging self-harming behaviours in therapy has clearly been shown in this study. Based on the evidence it is possible therefore, that helping clients to resolve their emotional difficulties, engendering a greater sense of control, and alleviating the emotional difficulties they were experiencing is a more therapeutically effective position to adopt by therapists and can lead to a reduction or cessation of self-harming behaviours. The strongest examples of this were shown in the narratives of the nearly all the participants where the therapist did not focus on stopping their self-harm but instead concentrated on their difficulties and goals for therapy. In these cases, alignment between the young person and the therapist's approach was important and effective, and matched the mindset, attitude towards self-harm, goals and hopes for therapy of the participants.

The results of this research support the idea that a principal feature of client's experiencing therapy as being helpful is when the therapist makes available a space in which they feel they have a measure of control, that to them feels safe to explore their issues and talk openly, increase their self-awareness, and develop new ways of coping with difficult situations. The therapeutic relationship has been explored extensively in literature, for example see Goldfried and Davila (2005); Long and Jenkins (2010); Gurpinar-Morgan et al.

(2014). In this study, the diversity of the therapeutic relationship and ways in which this relationship fosters a sense of control in the young person has been demonstrated in a different context to those discussed in the literature i.e. in a service provision which offers time limited therapy to the standards of IAPT.

There is no one size fits all element to the therapeutic relationship although there are elements of it that are common in all circumstances, specifically empathy and acceptance demonstrated by the therapist. This study adds to the existing literature in highlighting that in therapy delivered under the IAPT provision when a young person who self-harms experiences empathy, acceptance, and valuing, perceiving the therapeutic relationship as positive, this engenders a greater sense of hope of psychological change in the individual, and promotes their actualising tendency. Besides the person-centred modality, other theoretical models of therapy consider that empathy and acceptance in therapy sessions are facilitative to therapeutic change, indicating they are necessary; for example, see Feller and Cottone (2003); Watson (2016); Elliott et al. (2019); Farber et al. (2019). However, factors external to the young person such as parental influence, therapy service structure and stigma have an effect on the outcome of therapy (see figure 2). These external factors can impact the young person's engagement in therapy, the depth of the therapeutic alliance, and their commitment to change through therapy. Therefore, it cannot be the case that Rogerian therapeutic conditions alone are entirely sufficient for therapeutic change, regardless of the therapeutic modality employed.

The data from this study confirms that the therapeutic relationship with young people who self-harm is nuanced and multifaceted. There are elements of the therapeutic relationship with young people who self-harm which are unique to each therapeutic connection. For example, the data of this study reveals that the therapist who told their client that they were not going to tell them to stop self-harming connected to the young person in a unique and specific way. This was relevant to that young person at that specific time and on a level that met her own mindset. This was a purposeful and empathic response to the feelings that the young person was experiencing and the reason for those feelings as expressed by them in a way that was distinctive to that young person. This therapist's approach, for this young person, also reinforced that they remained in control over whether she self-harmed or not. This approach ultimately cemented a stronger therapeutic relationship between the young person and the therapist which led to a successful outcome. As a result of their therapeutic experience the young person declared that the therapist was "absolutely incredible, and they saved my life".

This study has shown that when young people feel they are being directed to an agenda of the therapist's making, they will disengage or not make progress in therapy sessions; strengthening the evidence that the breakdown of a therapeutic relationship occurs when the young person feels they are not in control. In the data of this study, the cause of therapeutic relationship breakdown was most often centred around a perceived lack of empathy and understanding of the sensitivity of disclosing self-harm. In one case the participant dropped out of therapy because the therapist directed the sessions

to a topic the young person did not want to explore. Therapists taking away the client's sense of having control can be responsible for creating client resistance or reluctance to change. Resistance is a result of a conflict between clients and therapists due to client negative reaction to the therapeutic process sparked by the therapist's manner and delivery of therapy. Reluctance is defined as an unwillingness to engage fully in the therapy process (Egan, 2017; Ucar, 2017). Resistance and reluctance are reported as negatively associated with client satisfaction and improvement, and positively associated with premature endings in psychotherapy. This study has shown that resistance and reluctance can be present to some extent before sessions begin but can be amplified by the therapist approach in sessions. Resistance and reluctance were clearly demonstrated by one participant who had the specifically stated goal of wanting to feel more in control but felt not in control in therapy sessions. Her account of the therapy sessions strongly points to her feeling the therapist had taken control of the sessions by leading the topic and direction of the therapy sessions. The participant's narrative also shows the impact the young person's resistance and reluctance had on the therapist who perhaps felt some frustration with the situation, leading to his proclaiming that CBT was not going to work for this participant. Resistance and reluctance to change has been demonstrated as a hindrance which can prevent the expression of what is important to the young person. The findings of this investigation support earlier studies, albeit in different therapeutic environments, which illustrates resistance hampering engagement in therapy and the making of progress within the therapy process (Worrell, 1997; Beutler et al., 2002; Ucar, 2017).

6.4.3 Sense of control - stopping self-harm

This study supports the notion that solely focusing on the potential of further self-harming behaviours or the injuries themselves by having an emphasis on stopping or preventing clients from self-harming is experienced as ignoring what the young person wishes, taking away their autonomy and what they hope for from therapy. Stopping a young person from self-harming can have the motivation of satisfying and mitigating risk to assuage the therapist's own feelings about self-harm. This in turn can also lead to therapy drop out by the young person or unsuccessful outcomes of therapy. The corollary can be that the young person adopts more destructive behaviours and possibly involving engaging in substance abuse or increased suicidal thoughts, planning and intent to act (Skegg, 2005). Alternatively, when support and a genuine effort to understand the underlying reasons for the young person self-harming occurred, a stronger therapeutic alliance was established and subsequently a positive outcome of therapy for the young person is accomplished leading to self-harming behaviours and any suicidal thoughts, stopping (Gelinas and Wright, 2013; Wadman et al., 2018; Hetrick et al., 2020; Royal College of Psychiatrists, 2020).

Harm minimisation has been shown to be a constituent part of the initial assessment process and initial therapy sessions of the participants of this study. Harm minimisations methods can often be the option given to young people to assuage risk management concerns and do not have the young person's reasons for self-harming as the root consideration i.e. a sense of control. Encouraging young people to stop self-harming or use safer alternatives has

some advantages as it can be seen as demonstrating that they are important, do matter and to help young people grow in self-esteem. In spite of this, some alternatives for self-harm are not actually alternatives but substitutes as they can cause damage of their own and could be considered as self-harming acts in themselves for example, snapping an elastic band onto one's wrist hurts and leaves a mark, using ice cubes inflicts cold burns. Alternatives to self-harm do not resolve the underlying issues that led the young person to self-harm in the first place and can perpetuate the same self-harming mindset; it is essentially self-harm in a different form. Alternatives should serve as safe distractions, not substitutes, which will help a young person move away from the immediate desire to self-harm into a place where emotions can be expressed in a less destructive way. However, this evidence of study does conclude that advocating alternatives to self-harm is apposite in many cases as long as it this is something the young person is seeking, and the method adopted still allows the young person to retain a level of control and mitigate the danger of skin or tissue damage i.e. infection or permanent disfigurement. Cases where alternatives for self-harm are not appropriate will be unique and relevant to each individual's sense of control and need to exercise that control.

6.5 Implications for clinical practice and service provision

One clinical recommendation to arise from this study is that the practice of gathering data for the purpose of risk assessment and management, and to determine what type of therapy the young person receives is something that merits greater consideration by mental health services. In particular it is important to consider how data gathering is managed. It should not be used to

predict future behaviour and that assessment and treatment decisions should be considered as part of a wider assessment process. In addition, risk assessment could be conducted later in the therapy process, possibly with the therapist once a therapeutic alliance has been formed as part of unforced progression in the early stages of therapy sessions. It can then be conducted in a more effective manner which is positive, empathic, sensitive, and compassionate with a greater understanding of the impact that such risk assessment has on young people who self-harm rather than at the beginning of the therapy process where it can appear impersonal and mechanistic.

Service providers and therapists should keep in mind that young people who self-harm can have their sense of being in control denied to them by the very nature of the structure of the therapy service they access. The loss or lack of control is important to recognise and address if young people who self-harm are to be understood, advance in their sense of being in control and achieve good therapeutic outcomes. Therapists and therapy services should keep in mind that it is crucial that young people are presented with opportunities to gain a greater sense of control and be guided towards feeling that it is safe and acceptable to make choices of their own as they journey through therapy. There is undoubtedly scope in therapy services and in therapy to offer young people a level of control through informed consent as to the therapeutic modality (i.e. Counselling or CBT), day and time when they are seen and where they are seen. These decisions taken by the young person will contribute to them feeling more in control and therefore engage more thoroughly with therapy. It is the case that approaches aimed at helping young people develop a greater sense

of control in their lives are of great benefit in the light of the important role gaining control appears to play in some young people's self-harm behaviours (Hill and Dallos, 2011; Brown and Kimball, 2013).

Given that the evidence of this study and the systematic literature review highlights the link between a young person self-harming and their relationship with their parents and family, any therapeutic intervention would benefit from trying to increase the young person's connectedness with their parents and family. One way in which this could happen would be for therapists to identify what is important to the young person regarding their relationship with their parents and family and help them move towards interactions and behaviour with their family members which is in line with their hopes for therapy. Similarly, the present study, combined with existing research demonstrates the importance of engendering family support in reducing self-harm, possibly by engaging in joint therapy or psychoeducation sessions (Palmer et al., 2016; Mummé et al., 2017). This of course will require careful consideration and need to be in collaboration with the young person, but it is something that therapists need to consider as part of therapy with young people who self-harm. However, very careful consideration must also be given to the potential that the family is the source of the problem for example, in situations where self-harm is a response to abuse. In these cases, the therapist must consider other options including safeguarding and not engage in any therapeutic activities that would increase the safeguarding risk to the young person.

Greater emphasis should be given to assisting parents and carers who discover their child is experiencing self-harm. Education establishments, family support organisations, and medical practitioners could ameliorate the negative responses and reactions to self-harm experienced by young people from their parents or carers through offering them better education and dissemination of support information. Helping parents and carers to understand that they have not failed and that they and their child are not alone. Understanding the causes and functions of self-harm, and the need to give support with the underlying emotional difficulties are paramount. Helping parents or carers to understand that different things will help, and this is very dependent on what emotions and feelings the young person is trying to cope with. Encouraging the parents to talk with their child and encouraging them to seek professional help (not forcing them), while giving the young person space to find their own ways of coping and figure out what works for them is vitally important for the young person. It is essential medical professionals, school staff, family support organisations and social services offer parents resources and assistance to help them understand and support their child when they discover their child is self-harming. Information is available through organisations such as YoungMinds (www.youngminds.org.uk) but these could be much more widely disseminated through education, family support organisations and medical establishments in the form of signposting, training, or publications.

The role of self-harm alternatives must be considered in clinical practice in the light of how it either perpetuates self-harming mindset or merely replaces one

form of self-harm with another. Alternatives to self-harm need to be measured to respect the young person's attitude towards self-harm and sense of control. Consideration should be given to not overly focusing on the self-harm and trying to stop it to the detriment of helping the young person regain a sense of being in control and overcome the underlying difficulties that have led to the self-harm behaviours. Services and therapist may consider or even accept that some young people will continue to self-harm until they feel they are moving towards a greater sense of achieving their hopes for therapy. It is entirely appropriate in these circumstances to encourage self-care when young people self-harm and engender a greater compassion towards themselves.

Services need to assist young people to engage in support, for example by reviewing potential engagement barriers at the start and/or after a missed appointment. Additionally, understand why young people drop out of therapy or do not feel that it is successful should be explored by services in order to correct errors and to improve service delivery. Young people are rarely asked why they dropped out of therapy, possibly due to pressure on services with a long waiting list or due to the difficulty and uneasiness of asking young people why they have rejected services. This is especially so in the culture of IAPT services being rated by the Care Quality Commission as outstanding, good, requires improvement, or inadequate and thus retaining or gaining service provision contracts. It is important to acknowledge the challenges of following up young people who have been discharged from the service, despite it being potentially labour intensive. The benefits of developing services based on negative as well as positive feedback should not be underestimated, nor the

constructive impact this would have on the provision of future services. It is clear from this study and other literature that it is important to listen to the voices of young people who self-harm, their families, and therapists who work with them to develop services that are effective and inclusive. This will need a shift in current service provision and management culture.

6.7 Strengths and limitations of research

This study has expanded on the current knowledge base of providing therapy to young people who self-harm. However, as with all research there were limitations to the study which are reflected in the following sections.

6.7.1 Sample

Research of this nature is limited to its context and therefore inferences cannot be removed from the socio-economic environment that impact participants' accounts. Consequently, these conclusions reflect the prevailing social climate of therapy within a single IAPT service. The ten participants who agreed to take part in the research were from the database of an IAPT service in the East of England. This limits the sample to those who have accessed therapy through this service and not others, for example CAMHS or third sector therapy services. A wider, more diverse group of young people would have most likely generated more data and themes. Notwithstanding the relatively limited sample, this work offers valuable insights into young people who self-harm and their experiences of therapy under an IAPT provision.

An additional limitation is that the participants were only white and mostly cis gendered. A mix of varied ethnic heritage, gender identities, and sexuality were not specifically sought in the recruitment of participants. This was a deliberate and pragmatic choice to enable sufficient young people to be recruited to the study. Whilst theme saturation was achieved with this number of participants, clearly more participants of a greater mix of ethnicities, gender identities, and sexualities may have elicited additional or different themes. That being said, the study managed to recruit 10 young people from a cohort where recruitment is challenging. The study has drawn out some important learning and does highlight the processes and experiences of young people who self-harm occurring in a particular setting, with theoretical insights having relevance beyond this setting. A further limitation of the sample was that participants for the most part had largely positive experiences of the service. Recruitment of participants with a greater diversity of views and experiences may possibly have generated different topics and themes.

6.7.2 Retrospective accounts

It is valuable to keep in mind that the participants are reflecting on their therapy from a standpoint that is different from the time when they were in therapy. The data of the interviews can never be anything other than a reflection coloured by the emotional and social context of the young person at the time of the interview. The interview data is the young person's construct of what was happening for them in therapy at the time. There is no guarantee that their recall was complete as one can only have partial awareness and not complete access to every nuanced part of that experience. Therefore, the knowledge gained through

these interviews is knowledge that is constructed in that particular time and place between the participant and interviewer/researcher interacting, identities which are themselves partly created through that interaction (Dexter, 2006). Rather than a limitation per se, taking a social constructionist approach to research necessitates acknowledging that subjectivity applies to both the participant and researcher.

The process of the interviews provided some epistemological dilemmas for the researcher. The identity of the researcher as a counsellor for the IAPT service being known to the participants posed an evident limitation for the research process (Lowes and Hullatt, 2005; Blaikie, 2007; Millera and Boulton, 2007). It is useful to take into account that the young people, when reflecting on their experiences of a therapist, may have made sense of their experience of the service and therapy in a different way if they had been interviewed by someone who was not employed by the service they received therapy from. Additionally, the style and manner of the interviewer would have had an influence on the responses the participants gave. The interviewer felt they had made a good, relaxed connection with the participants. This style may have allowed some participants to be open, others perhaps more cautious in their answers to the questions. As a result, the researcher was only able to interpret, analyse, and develop themes from the data provided by participants (Charmaz, 2006b). In recognising this, it is clear that this distinct aspect of the data has some impact on the ability to apply these findings beyond the immediate context of this study.

6.7.3 Rigour

A criticism of a lack of rigour has been levelled against almost all qualitative methods, including thematic analysis (Morse, 2018). Rigour has been demonstrated in this study by promoting consistency and explicit coherent epistemological underpinning (Holloway and Todres, 2003). Rigour has also been demonstrated in this research by embracing the concepts of credibility, dependability, confirmability, and transferability (Lincoln and Guba, 1985).

Commitment to rigour has also been demonstrated in this study through a deep engagement with the subject data which encompasses all aspects of this study (Yardley, 2017). In order to sustain objectivity, rigour, and thus plausibility of findings, throughout the time of this study there has been constant reflecting upon the values, beliefs, attitudes of the researcher. The researcher was resolute in endeavouring not to impose understanding, conceptions, and values, integrated from their own experiences, work history and theoretical interests on the interpretation of data. This was undertaken whilst reflecting on the relationship between analytical systems, including quality practices, and the ontological, epistemological, and theoretical foundations of the research, using reflexive thematic analysis purposefully and reflexively (Braun and Clarke, 2020). Self-critiques and self-appraisal, reflexivity, and the appraisal of supervisors have highlighted aspects which may have affected the interpretation of not only data, but also the research processes employed, including the emphasis that may have been placed upon findings.

It is important to point out that researcher bias can never be completely excluded (Braun et al., 2018). Throughout this research process, an awareness that the researcher's own personal values and perspectives could influence the research through choice of research question, methodology, and analysis. These impose a bias on the research, which cannot be discounted. Steps such as ensuring that the participants had not received therapy from the researcher were taken to reduce bias and influence, and to avoid potential coercion of participants.

The clinical experience of the researcher was incredibly valuable in giving insights that a researcher without such a background would not have. On the other hand, as an insider researcher, combined with the researcher's own life experiences, there may be an unconscious influence on the data and analysis. Participants were aware, via the recruitment information and informal discussions, that the researcher was a Counsellor and Clinical Supervisor with the IAPT service from which the participants had received therapy. In the reflective log it was noted that an awareness of this was present in the researcher:

> *"I am aware that I could possibly have some foreknowledge of these participants cases through peer or group supervision. However, confidentiality and boundaries in peer and group supervision precludes my knowing which young person is being discussed and therefore, it is extremely unlikely that I would know which of the participants may have been discussed in supervision groups when I was present."*

Reflexivity explored in Chapter Four has been useful in not only guiding the researcher to an understanding of what impact this had on this research and the positions taken but would also informs the reader as to the underlying influences that generated different points of view. The reflexive process and the contribution of two PhD supervisors allowed for the challenges of validity and rigour to be addressed, which in turn enabled the production of this research and improvement in the quality of the findings.

To mitigate the impact of bias and develop rigour in this study, peer debriefing and peer validation was adopted. Peer debriefing is a process where the researcher attains feedback from peers outside the field of the study. A presentation was made whereby peer's view was considered and established into constructive feedback; this brought a fresh perspective to the research which helped to enhance its validity. This was done with fellow PhD students on Palliative Care, Public Health, and Organisation Health and Wellbeing cohorts. This approach gave the researcher different perspectives and a more impartial view of the study (Russell and Kelly, 2002). Peer debriefing can be seen as a method through which to enhance the credibility of a study (Nguyên, 2008).

From a social constructionist perspective validity, was ascertained through a continual process of review, analysis, and an interrogation of values (Denzin and Giardina, 2009; Kvale, 2016). This critical stance was evidenced in the continual reflexive process from the beginning to the end of this study that the researcher, the research questions, and participants' accounts were subject to

in conjunction with inputs from two PhD Supervisors (Kvale, 2016; Yardley, 2017). Additionally, the strength of this research and its external validity comes from the sample. Participants were drawn from a currently operational NHS IAPT service and the described experiences that are drawn from what is still current everyday service delivery.

Chapter 7 – Concluding observations

7.1 Overview of thesis

This study was developed from an initial curiosity of the experiences of young people who self-harm had of accessing therapy. The researcher's curiosity was stimulated after negative experiences were reported by young people to the researcher in his role as a counsellor for an NHS IAPT service. An empirical exploration of the lived experience of young people who self-harm had of therapy would give a distinctive insight from the individual's perspective. There are several reasons why understanding how therapy with young people who self-harm, their sense of feeling in control and the impact on their actualising tendency is important. These include understanding the effect of service administration, therapy relationships, and therapy processes in order to see what, if any, improvements could be made to enhance the experience and therapeutic outcomes of young people who self-harm.

The systematic literature review and empirical studies were rooted in the epistemological, person-centred principle that individuals have an innate knowing what they need and construct their own ideas and interpretations of reality (Rogers, 1962, 1980). The methods of synthesis and analysis selected were intended to value individual accounts and idiosyncratic interpretations by developing incremental knowledge from data. While there have been numerous studies separately aimed at understanding why young people self-harm and what works in therapy. This study has explored first-hand accounts of young people who self-harm who have accessed therapy in order to better understand their unique experiences.

7.2 Summary of evidence

The evidence from this study suggests that it is still the case that young people who self-harm have poor experiences of empathy and understanding from family members, educational establishments and mental health services, including IAPT services. The findings of this investigation complement those of earlier studies which show that previous experiences of disclosing self-harm to others and poor experiences, including not feeling in control of the process, are a barrier to young people seeking professional help later in their lives. This thesis has provided a deeper understanding of the consequences experienced by young people when they disclose self-harm to others and lose control over when to disclose self-harm.

The empirical findings in this study provide a new understanding of a greater sense of how feeling in control over their lives is a common goal for therapy for young people who self-harm. Learning and greater understanding which has become apparent from this study is that having a sense of control or agency is a significant part of self-harming behaviours and in hopes for therapy for those who self-harm. The language used in participant narratives regarding their goals for therapy are often describing a state of being or feeling which signifies being in control without actually articulating that greater control is desired. The results of this investigation show that gaining understanding or reclaiming a sense of being in control results in the young person experiencing the therapy in a positive light and assessing it as successful. The results also show that an increased sense of being in control is sometimes overlooked and a missing aspect of therapy with young people who self-harm. It should also be kept in

mind that the loss or desire to experience greater control in life is not specific to young people who self-harm or indeed just to young people.

The findings also suggest that connected to a sense of control is the realisation in the young person that their behaviours impact others. What is clear from this investigation is that in some cases the motivation to seek professional help and hope for the outcome of therapy as being to 'get better' is driven by concern for how self-harm impacts significant others over and above the young person's need to decrease their own emotional difficulties. This could be connected to an attempt to ameliorate conditions of worth experienced by the young person because of their self-harm behaviours.

One realisation of this research project is that as a society, parents, carers, and therapists we should stop thinking that therapy alone is going to stop young people self-harming in every case as it is unrealistic, and not a helpful one to bring into therapy sessions. The underlying causes and functions of self-harm are varied are for the most part, external to the therapy room but do encompass an element of lack of or exerting a level of control. Therapy can only ever be part of the answer. Changes and new perspectives, recognised in the therapy room, need to be adopted outside the therapy room in order for a better lived experience to be realised. However, control over some aspects of young people's lives cannot be changed because of circumstances and socioeconomic demands of the world they inhabit. In these cases, therapy can only offer a greater understanding and acceptance of where control can or cannot be exerted.

7.3 Summary

Whilst it has taken longer to complete than anticipated, the journey from research proposal to NHS ethical permission, interviews, data analysis, and writing up has been both challenging and rewarding. Ultimately, the result of this thesis builds on existing knowledge by adding incrementally to what is known by bringing new learning from a new context of therapeutic interventions for young people who self-harm. It has looked at the causes of loss of feeling in control and looked at ways in which the young person's sense of control can be maintained and nurtured within the therapy process. Continuing to further our understanding of therapy and outcomes of therapy for those who self-harm adds to and furthers the existing literature which then informs not only therapists and service providers but also social awareness.

7.4 Suggestions for future research

Further exploration of young people's experiences of help-seeking and therapy, not only where self-harm is a factor, continues to be both valuable and important. With the acknowledgement that mental health difficulties in adults can often have foundations in teenage years and with the rising numbers of young people experiencing mental health difficulties, greater knowledge about what is effective is vital. Studies based 20 years or more ago, whilst giving a substantial underpinning to today's therapeutic services and therapeutic modalities, cannot encompass the greater ethnic, gender identity, sexuality, and socioeconomic diversity that prevails in the present day. This will be an ever-changing ethic and cultural diversity of the UK population of young people as

each generation passes into adulthood; a factor in why we need to continue to explore barriers to help-seeking and efficacy of therapy.

Studies into therapy for young people who self-harm who have accessed IAPT services in less rural locations or urban settings would provide a useful comparison to this study. In other demographic setting, a young person's sense of being in control may be more limited or possibly more accessible. Furthermore, participants of different ethnic, sexual and gender identities may contribute different knowledge. Additionally, research into outcome goals of young people who self-harm and what in therapy helped or hindered them in achieving these goals from clients who have access non-IAPT services would also provide an appealing comparison to this study.

Studies into the efficacy of the pluralistic approach with young people who self-harm, especially with relevance to their sense of control will be an invaluable endeavour. Pluralistic counselling and psychotherapy approach holds that there is no right or best way of delivering therapy because different clients need different things at different times, and to find out the best way of helping clients is to ask them about it. The latter principle supports the idea of giving the client some control over what happens in therapy.

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Appendices

Appendix A - Narrative Synthesis Protocol Summary

Extracts from Popay et al., 2006 to provide a summary of the Narrative Synthesis protocol:

'Narrative synthesis' refers to an approach to the systematic review and synthesis of findings from multiple studies that relies primarily on the use of words and text to summarise and explain the findings of the synthesis. Whilst narrative synthesis can involve the manipulation of statistical data, the defining characteristic is that it adopts a textual approach to the process of synthesis to 'tell the story' of the findings from the included studies. As used here 'narrative synthesis' refers to a process of synthesis that can be used in systematic reviews focusing on a wide range of questions, not only those relating to the effectiveness of a particular intervention.

CHAPTER 2: THE SYSTEMATIC REVIEW PROCESS – AN OVERVIEW

The process of undertaking a systematic review has been well documented and there is broad agreement about the main elements involved. Six main elements are identified here including the process of synthesis, the focus of this guidance. The other five elements of a systematic review are not described in detail. References to detailed methodological advice on systematic reviewing are included in Appendix 2. This chapter provides a framework to aid understanding of where the synthesis occurs in the systematic review process.

2.1 Identifying the review focus, searching for and mapping the available evidence

Getting the question(s) 'right' is critical to the success of the systematic review process overall. The review question has to be both relevant to potential users of the review and in theory at least answerable. In some instances the question is clearly formulated at an early stage. More often, however, whilst an initial focus for the review is identified, a 'mapping' of the available relevant evidence needs to be carried out before the specific question(s) for the review can be clearly specified.[6]

The mapping exercise can be used to assess the need for a systematic review and/or to guide and refine the scope of the review. It is especially useful in situations where a broad question is of interest, such as "how effective are interventions to prevent unintentional injuries?" By mapping the available literature addressing this topic it is possible to:

- Describe the types of interventions that have been evaluated • Describe the sorts of study designs used in these evaluations and
- Assess the volume of potentially relevant literature.

Based on this initial mapping the scope of the review can be refined, so that the questions to be addressed are both answerable and relevant. The search for studies should be comprehensive and appropriate to the question posed so a mapping exercise may also help to refine a search strategy.

2.2 Specifying the review question

It will take time to get the review question right. In the context of reviews of the effectiveness of interventions, there is general agreement that a well-formulated question involves three key components: the people (or participants) who are the focus of the interventions, the interventions, and the outcomes. Sometimes a fourth component that relates to type of study design is also included. If the review intends to focus on the factors shaping the implementation of an intervention then the question will also have to include components related to this, such as aspects of the context in which the intervention was implemented.

2.3 Identifying studies to include in the review

Once the precise review question has been agreed, the key components of the question form the basis of specific selection criteria, each of which any given study must meet in order to be included in the review. It is usually necessary to elaborate on the key components of the review question so as to aid process of identifying studies to include in the review and make sure that decisions made are transparent to users of the review. These might include, for example, being more precise about the age groups of participants to be included in the review or about aspects of the intervention design.

2.4 Data extraction and study quality appraisal

Once studies are selected for inclusion a process of study quality appraisal and data extraction takes place. Decisions about which data should be extracted from individual studies should also be guided by the review question. In the context of a systematic review addressing a question about the effect of a particular intervention, for example, the data to be extracted should include details of: the participants, the interventions, the outcomes and, where used, the study design. For reviews focusing on implementation, it would be important to extract detailed data on the design of the intervention, the context in which it was introduced and on the factors and/or processes identified as impacting on implementation. The specific data and/or information to be extracted and recorded are usually those which could affect the interpretation of the study results or which may be helpful in assessing how applicable the results are to different population groups or other settings. This may be referred to as applicability, generalisability or external validity.

Study appraisal - also called validity assessment, assessment of study quality and critical appraisal - usually refers to a process of assessing the methodological quality of individual studies. This is important as it may affect both the results of the individual studies and ultimately the conclusions reached from the body of studies - although ‘quality’ in general and validity in particular are defined differently in relation to different types of study designs. In the context of effectiveness reviews study quality is often used as a criterion on which to base decisions about including or excluding particular studies, although this does depend on the approach taken by the reviewers. Whatever the focus of the review, reviewers may choose to exclude studies from the synthesis on grounds of methodological quality; others may opt to

include all studies, but in this case it is important to differentiate clearly between more and less robust studies. There are many different appraisal tools available for use in relation to both quantitative and qualitative study designs…

2.5 The synthesis

The key element of a systematic review is the synthesis: that is the process that brings together the findings from the set of included studies in order to draw conclusions based on the body of evidence. The two main approaches are quantitative (statistical pooling) and narrative, and sometimes both approaches are used to synthesise the same set of data. One approach - narrative synthesis - is the focus of detailed attention in this guidance.

2.6 Reporting the results of the review and dissemination

Once the review is complete the findings need to be disseminated to potential users, although communication needs to be considered from the start often with the involvement of policy, practice and end point users and throughout the review process.

Copy of Email Confirmation and Conditions of Use

From: Chadburn, Hannah <h.chadburn@lancaster.ac.uk>

Sent: Friday, 26 October 2018, 11:59

To: Clamp, Mark <m.clamp@lancaster.ac.uk>

Subject: RE: Request for a copy of the Narrative Synthesis Guidance document

Dear Mark,

Please find attached a copy of the ESRC-funded guidance on the conduct of narrative synthesis. We are happy to provide this free of charge, but would ask you to have regard to the following conditions on its use:

1. Do not distribute this to anyone else – if anyone asks for a copy please get them to contact us via the website:

https://www.lancaster.ac.uk/shm/research/nssr/research/dissemination/publications.php

The website has an up-to-date email link and also lists the information required and explains why it is being recorded.

2. If you use the guidance, or any part of it, we would be grateful if you would please:

- acknowledge the authorship team;
- send copies of any reports/papers that are produced to Professor Jennie Popay (using the address at the bottom of this e-mail); and
- let us have any comments/suggestions that you feel might improve the guidance so that your experience can be incorporated into subsequent updates.

Many thanks

Division of Health Research | Faculty of Health & Medicine | Furness

Building | Lancaster University | Lancaster LA1 4YG | United Kingdom

Appendix B – Example of Quality Assessment

Paper		Cutting to Live: A Phenomenology of Self-Harm, Brown & Kimball, 2013		
Criteria		Yes (2)	Partial (1)	No (0)
1	Question / objective sufficiently described?	✓		
2	Study design evident and appropriate?	✓		
3	Context for the study clear?	✓		
4	Connection to a theoretical framework / wider body of knowledge?	✓		
5	Sampling strategy described, relevant and justified?	✓		
6	Data collection methods clearly described and systematic?	✓		
7	Data analysis clearly described and systematic?	✓		
8	Use of verification procedure(s) to establish credibility?	✓		
9	Conclusions supported by the results?	✓		
10	Reflexivity of the account?			✓

Reproduced from Kmet et al. (2004) page 6

Appendix C - List of Papers for Literature Review

Reference (a)	Title (b)	Participants (c)	Design (d)	Main Focus (e)	Themes & Findings (d)
Addis & Mahalik, 2003	Men, Masculinity, and the Context of Help Seeking.	N/A	Literature Review	Identify obstacles that limit understanding of the ways that men do or do not seek help from mental and physical health care professionals.	Men's difficulty is attributed to a mismatch between available services and traditional masculine roles emphasizing self-reliance, emotional control, and power.

(a)	(b)	(c)	(d)	(e)	(d)
Ashton & Fuehrer, 1993	Effects of Gender and Gender Role Identification of Participant and Type of Social Support Resource on Support Seeking.	359 American Undergrad-uate students	Questionnaire, long form of the Bem Sex-Role Inventory	Gender-typed and androgynous, white, middle to upper middle-class males and females given scenarios describing situations in which help was needed.	Males are less likely to seek support than females, and more specifically, males, and gender-typed males, would be less likely to seek emotional support.
Barker, 2007	Adolescents, Social Support and Help-Seeking Behaviour	N/A	Literature Review	Literature review and programme consultation with recommendations for action	Identified barriers to help seeking and promoting help seeking in organisational settings.

(a)	(b)	(c)	(d)	(e)	(d)
Barth et al., 2013	Comparative Efficacy of Seven Psychotherapeutic Interventions for Patients with Depression: A Network Meta-Analysis	N/A	Meta-analysis	To re-examine the comparative efficacy of seven psychotherapeutic interventions for adult depression	Results are consistent with the notion that different psychotherapeutic interventions for depression have comparable benefits.
Bennewith et al., 2004	Variations in The Hospital Management of Self Harm in Adults in England	Hospital staff administering admissions for self-harm	Observational Study	Key emergency and psychiatric staff were interviewed about service structures. An audit of the processes of care was undertaken.	Variation across hospitals in levels of psychosocial assessment, variation in the proportion of attendances leading to admission.

(a)	(b)	(c)	(d)	(e)	(d)
Binder et al., 2011	Meeting an Adult Ally on the Way Out into The World: Adolescent Patients' Experiences of Useful Psycho-therapeutic Ways of Working at an Age When Independence Really Matters	14 aged 16 to 19 years	Qualitative, hermeneutic-phenomenological approach	To explore how adolescents in ongoing psychotherapies prefer their therapists to interact with them when they are establishing a therapeutic bond	Adolescent patients experienced the need for certain therapist behaviours and attitudes to establish a working relationship with trust and autonomy
Bischoff and Tracey, 1995	Client Resistance as Predicted by Therapist Behavior: A Study of Sequential Dependence	N/A	Book	Examine the relation of client resistant behavior to therapist directive behavior	Therapist directive behavior slightly increasing the probability of subsequent client resistance

(a)	(b)	(c)	(d)	(e)	(d)
Black et al., 2005	Self-Reported Attachment Styles and Therapeutic Orientation of Therapists and Their Relationship with Reported General Alliance Quality and Problems in Therapy	491 Psycho-therapists working with young people	Qualitative, Attachment Style Questionnaire	To explore the relationship between therapists' self-reported attachment styles and therapeutic orientation with the self-reported general therapeutic alliance and therapist-reported problems in psychological therapy	Secure attachment style was positively correlated with therapist-reported general good alliance. Anxious attachment styles were negatively correlated with good alliance, and positively correlated with the number of therapists reported problems in therapy.
Bohart and Tallman, 2010	Clients: The Neglected Factor in Psychotherapy	N/A	Book	Client contributions to therapy continue to be neglected in most theoretical models of change, with a few exceptions	Clients' active involvement in the therapeutic process is critical to success.

(a)	(b)	(c)	(d)	(e)	(d)
Booth et al., 1997	Counselling in General Practice: Clients' Perceptions of Significant Events and Outcome	51 aged from 16 to 65 years	Quantitative, Helpful Aspects of Therapy, Quality of Life and Goal Attainment questionnaires	An investigation of clients' perceptions of the change process and outcome of counselling in primary care	Results showed that 'reassurance', 'problem solution', 'insight' and 'involvement' impacts were reported most frequently by clients.
Bresin and Schoenleber, 2015	Gender Differences in the Prevalence of Nonsuicidal Self-Injury: A Meta-Analysis	N/A	Meta-Analysis	To better conceptualize the presence and size of gender differences in the prevalence of NSSI.	No significant relation between age and effect size. Women were more likely to use some methods of NSSI compared to men.

(a)	(b)	(c)	(d)	(e)	(d)
Briere and Gil, 1998	Self-Mutilation in Clinical and General Population Samples: Prevalence, Correlates, and Functions	72 aged 18 to 90 years	Quantitative adopting Logistic Regression Analysis.	To explore the connection between self-harm and suicide	Significant associations between self-harm and sexual abuse, but no evidence for the role of several other variables
Brown and Kimball, 2013	Cutting to Live: A Phenomenology of Self-Harm	Aged 19 to 39 years	Phenomeno-logical	Explore the overall experiences of individuals who self-harm	Data suggested three categories that described the participants' experiences: Self-harm is misunderstood; Self-Harm has a role.

(a)	(b)	(c)	(d)	(e)	(d)
Burton, 2019	Suicide and Self-Harm: Vulnerable Children and Young People	N/A	N/A	Explores both the differences between self-harm and suicidal behaviour, and how they are connected.	Self-harming behaviour is often negatively referred to as ‘attention-seeking’. Looked after children and young people have an increased risk of self-harm and suicide and are highly vulnerable.
Bury et al.,2007	Young People’s Experiences of Individual Psychoanalytic Psychotherapy	4 young women and 2 young men aged 17 to 21 years	Interpretative Phenomenological Analysis	Develop an in-depth understanding of service users’ perspectives and the way in which young people had made sense of their experience.	Young people experience negative portrayals of psychotherapy which induces fears and reluctance to engage. Resistance to help-seeking is part of adolescent development

(a)	(b)	(c)	(d)	(e)	(d)
Cahill et al., 2013	What do Patients Find Helpful in Psychotherapy Implications for the Therapeutic Relationship in Mental Health Nursing	61 aged 20 to 60 years	Quantitative adopting Helpful Aspects of Therapy (HAT) questionnaire.	This study examined client perception of the therapeutic impact of two models of therapy delivered by mental health nurses and clinical psychologists respectively	Patients reported minimal significant differences between the therapies in terms of what they found helpful and from the patient's point of view, the relationship is the most important factor
Castonguay et al., 2010	Helpful and Hindering Events in psychotherapy: A Practice Research Network Study	121 adolescents and adults	Practice Research Network Study	Present the findings of a psychotherapy process study conducted within the Pennsylvania Psychological Association Practice Research Network.	Clients and therapists perceived the fostering of self-awareness, the therapeutic alliance, and other significant interpersonal relationships as helpful.

(a)	(b)	(c)	(d)	(e)	(d)
Chan, 2013	Antecedents of Instrumental Interpersonal Help-seeking: An Integrative Review	All ages	Integrative Review	An integrative review of the antecedents of interpersonal help-seeking behaviour.	Proposes a framework that organises and integrates extant research on the antecedents of interpersonal help-seeking behaviour.
Cipriano et al., 2017	Nonsuicidal Self-injury: A Systematic Review	N/A	PRISMA Systematic Review	Present an up-to-date overview on nonsuicidal, self-injurious behaviours	NSSI is most common among adolescents and young adults, and the age of onset is reported to occur between 12 and 14 years. Comorbidity with borderline personality disorder (BPD) and eating disorders is often reported

(a)	(b)	(c)	(d)	(e)	(d)
Cleaver et al., 2014	Attitudes Towards Young People Who Self-Harm: Age, an Influencing Factor.	143 staff members of 4 A&E departments	Mixed Methods.	To determine the attitudes of emergency care staff towards young people (aged 12–18 years) who self-harm and to gain an understanding of the basis of attitudes that exist	Age is a factor in shaping practitioners' attitudes; age also directs and influences a young person's journey through emergency care, although there is inconsistency ambiguity for those aged 16–17 years of age
Cooper and Law, 2018	Working with Goals in Psychotherapy and Counselling	N/A	Book	Recent evidence has shown that the successful setting of goals brings about positive outcomes in psychological therapy.	Goals help to focus and direct clients' and therapists' attention in therapeutic work. They also engender hope and help energise clients.

(a)	(b)	(c)	(d)	(e)	(d)
Cooper and McLeod, 2015	Client Helpfulness Interview Studies: A Guide to Exploring Client Perceptions of Change in Counselling and Psychotherapy	N/A	N/A	To provide an accessible and practical introduction to conducting Client Helpfulness Interview (CHI) studies.	The CHI method provides a means of conducting research that can make a genuine contribution to the development of the counselling profession

(a)	(b)	(c)	(d)	(e)	(d)
Clements et al., 2015	Rates of Self-Harm Presenting to General Hospitals: A Comparison of Data from the Multicentre Study of Self-Harm in England and Hospital Episode Statistics (HES	Data on Self-harm across 5 hospitals in Oxford, Manchester, and Derby.	Quantitative	This study aimed to compare national and local estimates of the incidence of self-harm using data collected as part of the Multicentre Study of Self-harm in England, and routinely collected hospital data available from HES.	There was a consistent underestimation of presentations for self-harm recorded by HES emergency department data, and fluctuations in year-on-year figures.

(a)	(b)	(c)	(d)	(e)	(d)
Constantino, 2019	Expectations	N/A	Book	Identify elements of effective therapy relationships and determine efficacious methods of customising psychotherapy to the individual patient.	Practitioners are encouraged to routinely monitor patients' satisfaction with the therapy relationship, comfort with responsiveness efforts, and response to treatment.
Cooper et al., 2005	Suicide after Deliberate Self-harm: A 4-Year Cohort Study	7968 aged 10 to 92 years	Quantitative	To estimate suicide rates up to 4 years after a deliberate self-harm episode, time-period effects on the suicide rate and to examine potential sociodemographic and clinical predictors of suicide within this cohort.	The results highlight the importance in a suicide prevention strategy of early intervention after an episode of self-harm.

(a)	(b)	(c)	(d)	(e)	(d)
Cooper, 2008	Essential Research Findings in Counselling and Psychotherapy: The Facts are Friendly	N/A	Book	Provide trainees, students, practitioners, and researchers with a comprehensive introduction to the latest findings in the field.	Sets out the evidence for the effectiveness of therapy. Clearly laying out the factors associated with positive therapeutic outcomes.
Coppock et al., 2010	The Relationship Between Therapist and Client Hope with Therapy Outcomes	43 clients aged 18 to 57 years and 10 therapists.	Naturalistic Study	Examine whether clients' perceptions of hope and therapists' hope in their clients were associated with therapy outcomes.	Client-rated hope at any point in therapy was not significantly related to therapy outcomes. Therapists' hope in their clients after the first and last sessions was significantly related to client outcomes.

(a)	(b)	(c)	(d)	(e)	(d)
Craigen & Foster, 2009	"It Was like a Partnership of the Two of Us Against the Cutting": Investigating the Counseling Experiences of Young Adult Women Who Self-Injure.	1110 women aged 18 to 23 years	Phenomenology	Explored the counseling experiences of 10 young adult women with a history of self-injurious behavior	The quality of the counseling experience was primarily related to the counseling relationship. Many of the women felt that their counsellors were unable to meet their unique needs.
Day, 2015	Field Attunement for a Strong Therapeutic Alliance: A Perspective from Relational Gestalt Psychotherapy	N/A	N/A	Address the basis for the centrality of the therapeutic relationship in effective therapeutic outcomes, especially as distinct from technique.	Relational Gestalt psychotherapy has developed the concept of field to have evolved principles for working with the felt effects of the field. .

(a)	(b)	(c)	(d)	(e)	(d)
Diamond et al., 1999	Alliance-building Interventions with Adolescents in Family Therapy: A Process Study.	Ten families including young people aged 13 to 17 years	Case based Process Research Study	Identify, articulate, and measure therapist behaviours associated with improving initially poor therapist adolescent alliances in multidimensional family therapy	By session three, therapists were attending to the adolescent's experience, formulating personally meaningful goals, and presenting as the adolescent's ally.

(a)	(b)	(c)	(d)	(e)	(d)
Diggins et al., 2017	Age-related Differences in Self-Harm Presentations and Subsequent Management of Adolescents and Young Adults at the Emergency Department	2559 people aged 12 to 25 years	Quantitative using SPSS version 22	Investigate how Emergency Department (ED) presentations and management of self-harm differ through adolescence and early adulthood	The female to male ratio was 6.3:1 at 12–14 years old, decreasing with successive age groups to 1.2:1 at 22–25 years old
Donald and Carey, 2017	Improving Knowledge About the Effectiveness of Psychotherapy	N/A	N/A	To address the limitations of qualitative differences in treatments being masked beneath quantitatively equivalent outcomes.	Extending the criteria of the current criterion used to evaluate the efficacy and effectiveness of psychotherapy to include the magnitude, efficiency, rates, and reliability of change.

(a)	(b)	(c)	(d)	(e)	(d)
Dunne et al., 2000	Adolescent Males' Experience of the Counselling Process	11 males aged 14 to 18 years	Mixed Methods	To Study 23 counselling sessions to identify what was found helpful and unhelpful during key moments in the therapeutic process.	The experience of emotional support and relief appears to be highly significant for adolescent males, who give significantly lesser importance to cognitive task factors.
Edmondson et al., 2016	Non-Suicidal Reasons for Self-Harm: A Systematic Review of Self-Reported Accounts	N/A	Systematic Review	A Systematic Review of the literature reporting first-hand accounts of the reasons for self-harm other than intent to die.	Summarised self-harm as a positive experience and defining the self. These self-reported “positive” reasons may be important in understanding and responding, especially to repeated acts of self-harm.

(a)	(b)	(c)	(d)	(e)	(d)
Elliott, 1983	That in Your Hands	200 therapy session with client of all ages	Comprehensive Process Analysis (CPA)	Analysis of significant therapy events.	Illustrating new methods for describing significant change events in therapy.
Elliott, 1984	A Discovery-oriented Approach to Significant Change Events in Psychotherapy: Interpersonal Process Recall and Comprehensive Process Analysis	N/A	N/A	Study of significant events in therapy that lead to change in the client.	Interpersonal therapy events were distinguished by links to themes from previous sessions and led to awareness of painful emotions. Cognitive therapy events were externalizing reattributions given to more clinically distressed clients.

(a)	(b)	(c)	(d)	(e)	(d)
Dunne et al., 2000	Adolescent Males' Experience of the Counselling Process	11 males aged 14 to 18 years	Mixed Methods	To Study 23 counselling sessions to identify what was found helpful and unhelpful during key moments in the therapeutic process.	The experience of emotional support and relief appears to be highly significant for adolescent males, who give significantly lesser importance to cognitive task factors.

(a)	(b)	(c)	(d)	(e)	(d)
Edmondson et al., 2016	Non-Suicidal Reasons for Self-Harm: A Systematic Review of Self-Reported Accounts	N/A	Systematic Review	A Systematic Review of the literature reporting first-hand accounts of the reasons for self-harm other than intent to die.	Summarise as self-harm as a positive experience and defining the self. These self-reported “positive” reasons may be important in understanding and responding, especially to repeated acts of self-harm.

(a)	(b)	(c)	(d)	(e)	(d)
Edwards & Hewitt, 2011	Can Supervising Self-harm be part of Ethical Nursing Practice?	N/A	N/A	Discusses, and evaluates from an ethical perspective, three competing responses to self-harming behaviours: to prevent it; to allow it; and to make provision for supervised self-harm	It is argued that of these three options the prevention strategy is the least plausible. A tentative conclusion is offered in support of supervised self-harm.
Elliott, 1983	That in Your Hands	200 therapy session with client of all ages	Comprehensive Process Analysis (CPA)	Analysis of significant therapy events.	Illustrating new methods for describing significant change events in therapy.

(a)	(b)	(c)	(d)	(e)	(d)
Elliott, 1984	A Discovery-oriented Approach to Significant Change Events in Psychotherapy: Interpersonal Process Recall and Comprehensive Process Analysis	N/A	N/A	Study of significant events in therapy that lead to change in the client.	Interpersonal therapy events were distinguished by links to themes from previous sessions and led to awareness of painful emotions. Cognitive therapy events were externalizing reattributions given to more clinically distressed clients.
Elliott, 1985	Helpful and Nonhelpful Events in Brief Counseling Interviews: An Empirical Taxonomy.	24 students from UCLA and University of Toledo, Ohio	Quantitative adopting the Helpfulness Rating Scale (HRS)	What types of events matter in counseling?	The taxonomy of nonhelpful events offers a set of empirically derived counsellor errors.

(a)	(b)	(c)	(d)	(e)	(d)
Elliot, 2012	Qualitative Methods for Studying Psychotherapy Change Processes	N/A	Qualitative	To encourage the use of a broader range of options for qualitative data collection and analysis in Change Process Research (CPR).	The range of qualitative CPR methods currently being employed in the published literature is gradually broadening beyond Grounded Theory analysis,
Elliot and James, 1989	Varieties of Client Experience in Psychotherapy: An Analysis of the Literature	N/A	Literature Review	To analyse the main themes in the research literature to better understand the process and action of psychotherapy	Nine domains of client experience appear in the existing empirical literature including sense of progress, the therapist, changes in experienced therapy

(a)	(b)	(c)	(d)	(e)	(d)
Elliott and Shapiro, 1988	Brief Structured Recall: A More Efficient Method for Studying Significant Therapy Events	N/A	Case Study	To develop a more efficient method of identifying significant therapy events and a more structured interview schedule	The most common predominant impact of therapy was Problem Clarification, followed by Personal Insight and Problem Solution.
Ernhout & Whitlock, 2014	Bringing Up Self-Injury With Your Clients. Ithaca, NY: Cornell University.	N/A	N/A	Therapists, counsellors, and medical professionals alike report difficulty broaching the subject of self-injury with their clients	Find out about the “why” of self-injury. What is the function of the self-injury? What is happening internally (and externally) for the client directly before and after they injure

(a)	(b)	(c)	(d)	(e)	(d)
Everall and Paulson, 2002	The Therapeutic Alliance: Adolescent Perspectives	Eighteen young people aged 12 to 18 years	Qualitative Semi-Structured interviews with Thematic Data Analysis	This paper presents a conceptualisation of the therapeutic alliance from the adolescent perspective and discusses implications for practitioners.	Three major themes were identified: therapeutic environment, uniqueness of the therapeutic relationship and therapist characteristics.
Fang et al., 2018	Undergraduate Student Experiences with Text-Based Online Counselling	Online counselling session involving 33 undergraduate clients	Qualitative Content Analysis	To understand the benefits, challenges, and user experiences of a text-based online counselling programme for undergraduate students	Analysis identified advantages (increased accessibility, flexibility, and immediacy; allowing room for reflections; increased sense of safety)

(a)	(b)	(c)	(d)	(e)	(d)
Farran et al., 1995	Hope and Hopelessness in Critical Clinical Constructs	N/A	Book	To provide a synthesis of current knowledge about the physical effects of hope and hopelessness	Analysis of the causal relationship between psychological and physical well-being and exploring the key conceptual and theoretical issues
Favazza, 1996	Bodies Under Siege: Self-mutilation and Body Modification in Culture and Psychiatry	N/A	Book	Beliefs about self-mutilation, clinical cases of self-mutilation, and assessment and treatment of self-mutilation cases.	Classification of self-injurious behaviours, cultural aspects, and clinical information.

(a)	(b)	(c)	(d)	(e)	(d)
Freedenthal and Stiffman, 2007	“They Might Think I was Crazy” Young American Indians’ Reasons for Not Seeking Help When Suicidal	101 American Indians aged 15 to 21 years	Mixed methods adopting scales and measures as well as interviews for data gathering.	To determine the barriers to seeking formal and informal help while suicidal of American Indian people	Most frequently reasons for not seeking formal help were perceiving no need for help, avoiding stigma, and turning to friends or family. Reasons for not seeking informal help were avoiding stigma, feeling alone, and fearing consequences of disclosure.

(a)	(b)	(c)	(d)	(e)	(d)
Fortune et al., 2008	Help-seeking Before and After Episodes of Self-Harm: A Descriptive Study in School Pupils in England.	Aged 15 and 16 years in 41 secondary schools in Oxfordshire, Northampton shire, and Birmingham	Qualitative research methods to identify key themes. Open coding scheme adopted.	The vast majority of episodes of self-harm do not result in presentation to hospital and relatively little is known about to whom or where adolescents who harm themselves go for help.	Friends and family were the main sources of support. Fewer sought help from formal services. Barriers to help seeking include perceptions of self-harm as something done on the spur of the moment and therefore not serious or important or to be dwelt upon.
Galdas et al., 2005	Men and Health Help-Seeking Behaviour: Literature Review	N/A	Literature Review	Review the key research literature regarding men's health-related help seeking behaviour.	Studies comparing men and women are inadequate in explaining the processes involved in men's help seeking behaviour.

(a)	(b)	(c)	(d)	(e)	(d)
Gallagher, 2018	Introduction to the Science of Hope	N/A	Book	Although historical perspectives on hope were mixed, decades of research have now demonstrated that hope can be reliably measured	Develops the dominant model of hope that emphasizes agency and pathways thinking as the two core components of hope
Ghaemian et al., 2020	Therapy Discontinuation in a Primary Care Psychological Service: Why Patients Drop Out	818 aged 16+ years	A qualitative approach adopting thematic analysis of semi-structured interviews	To explore patients' experience with an Improving Access to Psychological Therapies (IAPT) service, and to investigate the reasons for discontinuing their treatment.	The study uncovered a wide range of reasons for people who had dropped out from their treatment. The findings mainly emphasised general dissatisfaction and inconvenient appointments.

(a)	(b)	(c)	(d)	(e)	(d)
Gibson and Cartwright, 2014	Young People's Experiences of Mobile Phone Text Counselling: Balancing Connection and Control	21 aged 15 to 18 years	Thematic Analysis	Explore what aspects of text counselling young people perceived as valuable.	Participants appreciated the accessibility of text counselling and felt comfortable communicating through text.
Gilman, 2013	From Psychiatric Symptom to Diagnostic Category: Self-Harm from the Victorians to DSM-5	N/A	Literature Review	History of self-harm and what defines 'self-harm' historically and culturally?	Literature records instances of self-harm as early as the 19th Century. The definition and causality to mental health difficulties of self-harm has developed greatly since that time.

(a)	(b)	(c)	(d)	(e)	(d)
Glass et al.,	Expectations and Preferences	N/A	Literature Review	Definitions and methods of assessment of clients' expectancy for therapeutic gain; expectations about the roles they and their therapists will play; and their preferences for therapy roles, type of psychotherapy, and demographic features of the therapist.	Clients' expectations for therapeutic gain are related to outcome although no causal conclusions can be drawn. The literature on role expectations is equivocal, and the relatively few studies on client preferences yield primarily negative or mixed results.

(a)	(b)	(c)	(d)	(e)	(d)
Grandclerc et al., 2016	Relations between Nonsuicidal Self-Injury and Suicidal Behavior in Adolescence: A Systematic Review	Aged 11-25 years	Narrative Systematic Review	To explore the views of relations between nonsuicidal self-injury and suicidal behaviours during adolescence and young adulthood expressed in the literature.	It is difficult to conceive an intention to die during adolescents' acts of self-injury.
Gulliver et al., 2010	Perceived Barriers and Facilitators to Mental Health Help-Seeking in Young People: A Systematic Review	N/A	Systematic Review	To summarise reported barriers and facilitators of help-seeking in young people using both qualitative research from surveys, focus groups, and interviews and quantitative data from published surveys	Young people perceived stigma and embarrassment, problems recognising symptoms (poor mental health literacy), and a preference for self-reliance as the most important barriers to help-seeking.

(a)	(b)	(c)	(d)	(e)	(d)
Gurpinar-Morgan et al., 2014	Ethnicity and the Therapeutic Relationship: Views of Young People Accessing Cognitive Behavioural Therapy	5 aged 16 to 18 years	Interpretive Phenomenological Analysis	To examine BME adolescent service users' perceptions of how ethnicity featured in the therapeutic relationship and its relevance to their presenting difficulties	This research furthers an understanding of the views and experiences of BME service users regarding ethnicity and the therapeutic relationship and illustrates the complexity and variety of views held by this small heterogeneous sample.
Hanna, 2002	Therapy with Difficult Clients: Using the Precursors Model to Awaken Change.	N/A	Book	Explore the active ingredients of therapeutic change	Precursors appear to regulate the speed and intensity of the therapeutic change process.

(a)	(b)	(c)	(d)	(e)	(d)
Hawton et al., 2002	Deliberate Self Harm in Adolescents: Self Report Survey in Schools in England	6020 aged 15 and 16 years	Quantitative utilising the χ^2 and Mann Whitney tests, and logistic regression	To determine the prevalence of deliberate self-harm in adolescents and the factors associated with it.	Self-harm is common in adolescents, especially females. School based mental health initiatives are needed.
Hawton et al., 2012	Epidemiology and Nature of Self-Harm in Children and Adolescents: Findings from the Multicentre Study of Self-Harm in England	Data from six Hospitals	Quantitative $\chi 2$ test using Microsoft Office Excel 2003, SPSS v15.0, and Stata v10.0.	Examine epidemiology and characteristics of self-harm in adolescents and impact of national guidance on management.	Of 5,205 individuals (7,150 episodes of self-harm), three-quarters were female.

(a)	(b)	(c)	(d)	(e)	(d)
Hawton et al., 2012	Self-Harm and Suicide in Adolescents	N/A	Meta-Analysis	Discuss self-harm and suicide in adolescents in terms of epidemiology, developmental aspects of self-harm, including short-term and long-term outcomes; factors that contribute to the behaviour; and treatment and prevention	There is little evidence of effectiveness of either psychosocial or pharmacological treatment, with particular controversy surrounding the usefulness of antidepressants.

(a)	(b)	(c)	(d)	(e)	(d)
Henshaw and Freedman-Doan, 2009	Conceptualizing Mental Health Care Utilization Using the Health Belief Model	N/A	Literature Review	Health Belief Model (HBM) as a framework for explaining what factors might encourage or inhibit an individual from utilizing mental health services.	Mental health treatment can be facilitated by accurate information to answer basic decision-making questions regarding: (a) severity, (b) benefits, (c) barriers and (d) self-efficacy
Hill and Dallos, 2012	Young People's Stories of Self–Harm: A Narrative Study	6 aged 13 to 18 years	Narrative Analysis	Explore the way in which adolescents who have engaged in self-harm make sense of their self-harm and its relationship to the events in their lives	Adolescents perceive a severe lack of understanding from others about self-harm. They also found it difficult to discuss and integrate the difficulties behind their self-harm.

(a)	(b)	(c)	(d)	(e)	(d)
Hicks and Hinck, 2008	Concept Analysis of Self-Mutilation	N/A	Systematic Review	A report of a concept analysis to define and describe self-mutilation.	A release of endorphins after the physical damage that contributes to the feeling of relief supports an addictive maladaptive coping cycle of pain, relief, shame and self-hate
Hill and Dallos, 2012	Young People's Stories of Self–Harm: A Narrative Study	6 aged 13 to 18 years	Narrative Analysis	Explore the way in which adolescents who have engaged in self-harm make sense of their self-harm and its relationship to the events in their lives	Adolescents perceive a severe lack of understanding from others about self-harm. They also found it difficult to discuss and integrate the difficulties behind their self-harm.

(a)	(b)	(c)	(d)	(e)	(d)
Hoener et al., 2012	Client experiences of agency in therapy	11 aged 18 to 23 years	Grounded Theory	To seek an understanding of clients' experiences with psychotherapy from clients' own points of view	Agency was consistently salient and highly valued by the participants
Horvath, 2001	The Therapeutic Alliance: Concepts, Research and Training	N/A	N/A	Examine the role of the relationship between the therapist and the client as a core concept in therapy.	The alliance appears to play an important role in all helping efforts, although it is likely that different helping contexts, types of therapy offered, and the goals of the process generate unique alliances.

(a)	(b)	(c)	(d)	(e)	(d)
Horvath et al., 2011	Alliance in Individual Psychotherapy	N/A	Meta-Analysis	Report on a research synthesis of the relation between alliance and the outcomes of individual psychotherapy	The positive relation between the quality of the alliance and diverse outcomes for many different types of psychological therapies is confirmed in this meta-analysis.

(a)	(b)	(c)	(d)	(e)	(d)
Hunter et al., 2012	Service User Perspectives on psychosocial Assessment Following Self-Harm and its Impact on Further Help-seeking: A Qualitative Study	Age 18 or over	Interpretative Phenomenolog-ical Analysis	Exploration of service user experiences of psychosocial assessment following hospital attendance for self-harm.	When participants felt able to talk about what had happened, they felt hopeful for change. Participants disengaged from services when they felt judged for their actions, ignored by staff, or hopeless about the possibility of change.
Jones, 2009	Rethinking Childhood: Attitudes in Contemporary Society	N/A	Book	Focus is placed on opposing the processes by which children are made to be 'other': the ways in which children are separated and segregated by adults	Rethinking childhood is essential for those for those working with children in any field, from education to health, from play to law.

(a)	(b)	(c)	(d)	(e)	(d)
Jones et al., 2019	Barriers to Help-Seeking in Suicidal Men: A Systematic Literature Review	N/A	Systematic Literature Review	To provide an overview of the research into two thirds of males who had taken their own lives and had not been in contact with mental health services.	The current literature revealed that males with suicidality when help-seeking experience specific barriers. as personal failure.
Kaess et al., 2013	Adverse Childhood Experiences and Their Impact on Frequency, Severity, and the Individual Function of Nonsuicidal Self-Injury in Youth	125 inpatients aged 13 to 26 years	Quantitative adopting t-tests, chi-square tests and logistic regression	To investigate a relationship between nonsuicidal self-injury (NSSI) and a variety of adverse childhood experiences (ACEs) over and above childhood abuse and their impact on frequency, severity, and functions of NSSI	Forty-eight patients,64.0%of those engaging in NSSI, reported at least one type of ACEs. This compared with only 17 patients (34.0%) from the non-NSSI group.

(a)	(b)	(c)	(d)	(e)	(d)
Kazdin, 1999	The Meanings and Measurement of Clinical Significance	N/A	N/A	There are ambiguities regarding the meaning of current measures of clinical significance	A number of measures of clinical significance are available, but researchers do not have a clear idea of the meaning of results that are clinically significant.
King et al., 2006	Online Counselling: The Motives and Experiences of Young People who Choose the Internet Instead of Face to Face or Telephone Counselling	39 young people who access Kids Help Line for ages 5 to 18 (ages of participants not reported in the study)	Consensual Qualitative Research Methodology	To explore the motivations and experiences of young people who utilise the Internet for counselling over other counselling media	This study revealed that factors such as privacy and lack of emotional exposure attracted adolescents to online environment, while inhibiting factors such as time availability

(a)	(b)	(c)	(d)	(e)	(d)
Klineberg et al., 2011	Symptom Recognition and Help Seeking for Depression in Young Adults: A Vignette Study	1125 aged 16 to 24 years	Data gathering by postal survey. Data Analysis using Strata (version 10), Chi-square tests, kappa statistic and logistic regression.	To explore whether young adults recognised depressive symptoms in a vignette, and how they thought a young person might respond to these symptoms.	The majority of young people recognised symptoms of severe depression. The sociodemographic groups at greatest risk of suicide are the least likely to recognise depression

(a)	(b)	(c)	(d)	(e)	(d)
Klineberg et al., 2013	How Do Adolescents Talk About Self-Harm: A Qualitative Study of Disclosure in an Ethnically Diverse Urban Population in England	30 Aged 15 and 16 years (24 females, 6 males),	Framework Approach	Study aims to increase understanding about how adolescents in the community speak about self-harm; exploring their attitudes towards and experiences of disclosure and help-seeking.	Participants reluctant to talk about self-harm, had difficulty understanding self-harm in others. Some did not wish to accept offers of help, if their self-harm had been secretive and 'discovered'.
Klonsky, 2009	The Functions of Self-Injury in Young Adults Who Cut Themselves: Clarifying the Evidence for Affect-Regulation	39 young adults, mean age of 19.4 years	Structured Interview.	Consequences, affect-states, and reasons associated with self-injury assessed.	Self-injury is associated with improvements in affective valence and decreases in affective arousal

(a)	(b)	(c)	(d)	(e)	(d)
Koehn and Cutcliffe, 2010	The Inspiration of Hope in Substance Abuse Counseling	10 counsellors	Grounded Theory	To explore how counsellors inspire hope in clients struggling with substance abuse.	Hope inspiration occurred in 3 phases and consisted of several categories of hope-inspiring processes.
Lambert and Barley, 2001	Research Summary on the Therapeutic Relationship and Psychotherapy Outcome	N/A	N/A	Explore the research that indicates that the provision of therapy as an interpersonal process in which a main curative component is the nature of the therapeutic relationship.	The improvement of psychotherapy may best be accomplished by learning to improve one's ability to relate to clients and tailoring that relationship to individual clients.

(a)	(b)	(c)	(d)	(e)	(d)
Lambert, 2013	The Efficacy and Effectiveness of Psychotherapy	N/A	Book	Explore meta-analytic reviews that suggest patients undergoing many diverse kinds of psychotherapy for depression surpass no-treatment and wait-list control patients.	Many formal, theory-driven psychotherapies have demonstrable effects on a variety of clients. Those clients that undergo formal treatment have better outcomes than individuals who are on a wait list or who receive no treatment

(a)	(b)	(c)	(d)	(e)	(d)
Larsen et al., 2013	'It's important for me not to let go of hope': Psychologists' In-Session Experiences of Hope	5 female psychologists	Case Study	We may speak as if hope is in ready supply for psychologists, available to be easily dispensed. However, research on psychologist burnout and compassion fatigue calls this assumption into question	In this study, psychologists' reflections highlighted that their in-session experiences of hope and hopelessness were strongly tied to their ability to envision a good future for the client and for their work together.
Laye-Gindhu and Schonert-Reichl	Nonsuicidal Self-Harm Among Community Adolescents: Understanding the "Whats" and "Whys" of Self-Harm	424 young people aged 13 to 18 years	Quantitative Self-Report Questionnaire	Identify the prevalence and types of self-harm, the nature and underlying function of self- harm.	Self-harm is associated with maladjustment, suicide, and other health behaviours indicative of risk for negative developmental trajectories.

(a)	(b)	(c)	(d)	(e)	(d)
Levitt et al., 2006	What Clients Find Helpful in Psychotherapy: Developing Principles for Facilitating Moment-to-Moment Change	26 aged 18 to 79 years	Grounded Theory	Define a list of principles was constructed to guide the moment-to-moment process of psychotherapy practice	Clients in this study spoke of their therapeutic relationship in excess of any other factor and emphasized the importance of the experience of care within that relationship.
Levitt et al., 2016	A Qualitative Meta-Analysis Examining Clients' Experiences of Psychotherapy: A New Agenda	N/A	Meta-Analysis	Psychotherapy practitioners and researchers should be informed by the qualitative evidence that has been gathered to represent clients' own experiences of therapy	When therapists demonstrated authentic care and acceptance, clients reported safety to explore threatening themes.

(a)	(b)	(c)	(d)	(e)	(d)
Lindhiem et al., 2016	A Meta-analysis of Personalized Treatment Goals in Psychotherapy: A Preliminary Report and Call for More Studies	N/A	Meta-Analysis	To explore the hypothesis that psychotherapy has larger effect sizes for personalised treatment goals than for symptom checklists.	Estimates of the effectiveness of psychotherapy that are based on symptom checklists perhaps underestimate the true benefit of psychotherapy.
Llewelyn et al., 1988	Client Perceptions of Significant Events in Prescriptive and Exploratory Periods of Individual Therapy	40 clients who received 8 sessions of psychotherapy	Correlation Research	Comparison of the impact of helpful and hindering events as perceived by clients.	Introduction of Helepful Aspects of Therapy (HAT) Form. Therapeutic impacts as reported by clients do not reflect treatment outcomes.

(a)	(b)	(c)	(d)	(e)	(d)
Lloyd-Richardson et al., 2007	Characteristics and Functions of Non-Suicidal Self-injury in a Community Sample of Adolescents	633 adolescents from the southern or mid-western United States of America	Quantitative adopting surveys and analysis by $\chi 2$ test and SPSS version 13.0	To assess the prevalence, associated clinical characteristics, and functions of NSSI in a community sample of adolescents.	Adolescents reported high rates of NSSI, engaged in to influence behaviours of others and to manage internal emotions.
Luborsky, 1995	Are Common Factors Across Different Psychotherapies the Main Explanation for the Dodo Bird Verdict That 'Everyone Has Won So All Shall Have Prizes'?	N/A	Systematic Review	Common factors across psychotherapies, comparison of psychotherapy outcomes and nonsignificant difference effect.	There is no significant evidence to suggest one form of therapy is more effective than another. Differences between psychotherapies are often attributable to extra-treatment effects

(a)	(b)	(c)	(d)	(e)	(d)
Lynch et al., 2018	Young Men, Help-Seeking, and Mental Health Services: Exploring Barriers and Solutions	Men aged 18 to 24 years	Thematic Analysis	Explored barriers and solutions to professional help seeking for mental health problems among young men living in the North West of Ireland	Young men can be encouraged to seek help if services and professionals actively address barriers.
Madge et al., 2008	Deliberate Self-Harm Within an International Community Sample of Young People: Comparative Findings from the Child & Adolescent Self-Harm in Europe (CASE) Study	30000 aged 14 to 17 years	Quantitative	A seven-country comparative community study of deliberate self-harm among young people	Self-harm was more than twice as common among females as males and, in four of the seven countries, at least one in ten females had harmed herself in the previous year.

(a)	(b)	(c)	(d)	(e)	(d)
Martin et al., 2000	Relation of the Therapeutic Alliance with Outcome and Other Variables: A Meta-Analytic Review	N/A	Meta-Analysis	To identify underlying patterns in the alliance literature that relate alliance to outcome.	The relation of alliance and outcome does not appear to be influenced by other moderator variables.
Martin et al., 2010	Self-Injury in Australia: A Community Survey	12 006 aged 16 to 85 years	Cross-Sectional Analysis	To understand self-injury and its correlates in the Australian population.	Self-injury may begin at older ages than previously reported. Self-injurers are more likely to have mental health problems and are at higher risk of suicidal thoughts and behaviour than non-self-injurers, and many self-injurers do not seek help.

(a)	(b)	(c)	(d)	(e)	(d)
McLeod, 2012	What do Clients Want from Therapy? A Practice-Friendly Review of Research into Client Preferences	N/A	Literature Review	To provide a practice-friendly review of research into client preferences for therapy that has the potential to guide the work of pluralistically oriented therapists	The research suggests that clients arrive in therapy with a capacity to make reference to a complex set of ideas around what will be helpful for them

(a)	(b)	(c)	(d)	(e)	(d)
McManus et al., 2014	Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014	Age 16+	Survey	The Adult Psychiatric Morbidity Survey (APMS) series provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population	39 per cent of adults aged 16-74 with conditions such as anxiety or depression, surveyed in England, were accessing mental health treatment, in 2014. This figure has increased from one in four (24 per cent) since the last survey was carried out in 2007.
Mearns et al., 2013	Person Centred Counselling in Action	N/A	Book	Exposition of the theory and practice of the person-centred approach.	Exploration of Relational Depth, Actualising Tendency, and counsellor′s use of self

(a)	(b)	(c)	(d)	(e)	(d)
Mental Health Foundation, 2006	Truth Hurts – Report of the National Inquiry into Self-Harm Among Young People	N/A	Report	At the time of this report being produced there was relatively little research or other data on the prevalence of self-harm among young people in the UK or on the reasons why young people self-harm.	The research, personal testimony and expert opinion submitted to the Inquiry has demonstrated how far-reaching the issue of self-harm is for young people.
Miller and Rollnick	Motivational Interviewing: Helping People Change	N/A	Book	Authoritative presentation of motivational interviewing (MI), the powerful approach to facilitating change	Elucidates the four processes of MI--engaging, focusing, evoking, and planning--and vividly demonstrates what they look like in action

(a)	(b)	(c)	(d)	(e)	(d)
Mitchelmore & Hindley, 2012	Help-Seeking for Suicidal Thoughts and Self-Harm in Young People	Literature relating to participants up to the age of 26 years	Systematic Review	Investigating published studies examining help-seeking for suicidal thoughts or self-harm	All included literature demonstrated that the majority of young people who have self-harmed do not seek professional help.
Mitten et al., 2016	The Perceptions of Adolescents Who Self-Harm on Stigma and Care Following Inpatient Psychiatric Treatment	12 aged 14 to 19 years	Cross-Sectional adopting open-ended interviews	To explore youths' perceptions of stigma	Results indicated that youth reported experiences of stigma from both clinicians and other patients, and some of these youth reported stigmatizing others with mental health disorder

(a)	(b)	(c)	(d)	(e)	(d)
Mojtabi et al., 2002	Perceived Need and Help-Seeking in Adults with Mood, Anxiety, or Substance Use Disorders	1792 aged 15 to 54 years	Quantitative adopting Binary Logic Regression for data analysis	To better understand why a majority of adults with common mental disorders do not seek professional help.	Severity of mental disorders associated with impairment of role functioning or suicidality are strong predictors of perceived need and decisions to seek help and where to seek help from.
Moran et al., 2013	The Natural History of Self-Harm from Adolescence to Young Adulthood: A Population-Based Cohort Study	1943 aged 14 to 29 years	Longitudinal	To describe the course of self-harm from middle adolescence to young adulthood.	A substantial reduction in the frequency of self-harm during late adolescence was recorded.

(a)	(b)	(c)	(d)	(e)	(d)
Morey et al, 2008	The Prevalence of Self-reported Deliberate Self Harm in Irish Adolescents	3881 pupils aged 15-17 years across 39 schools in southern area of Ireland	Quantitative cross-sectional survey	To determine the prevalence of deliberate self-harm in adolescents and the methods, motives and help seeking behaviour associated with this behaviour.	A lifetime of self-harm was reported by 9.1% of the adolescents. Self-harm was more common among females than males. Self-cutting and overdose were the most common methods.
Nada-Raja et al., 2003	A Population-Based Study of Help-Seeking for Self-Harm in Young Adults	965 participants from a cohort of 1037 involved in a longitudinal health study from birth to age 26 years	Semi-structured interview data analysed by adopting Chi-square or Fisher's exact tests	Examine help-seeking for self-harm in a population-based sample of young adults.	Those who self-harmed either sought no help, accessed informal and/or formal help. Those who sought informal help-seeking were significantly more likely than those who did not to also seek formal help-seeking.

(a)	(b)	(c)	(d)	(e)	(d)
Neighbors and Howard, 1987	Sex Differences in Professional Help Seeking Among Adult Black Americans	2107 18 years old or older member of the black community in the United States of America	Quantitative methodology adopting bivariate and multivariate analysis recorded as Confidence Intervals	To provide baseline data on sex differences in help-seeking behaviour among black adults	There is a very strong relationship between gender and the reporting of a serious personal problems. Although this does not test the proposition that women recognize problems more readily than men.
NICE, 2004	Self-Harm in Over 8s: Short-term Management and Prevention of Recurrence	N/A	N/A	Guideline to cover the short-term management of self-harm in people aged 8 and over in the first 48 hours of an act of self-harm	People who have self-harmed should be treated with the same care as any other patient. At triage they should be offered a preliminary psychosocial assessment.

(a)	(b)	(c)	(d)	(e)	(d)
Nock and Prinstein, 2004	A Functional Approach to the Assessment of Self-Mutilative Behavior	108 aged 12 to 17 years	Quantitative	To apply a functional approach to the assessment of self-mutilative behavior (SMB) among adolescent psychiatric inpatients.	Most adolescents engaged in SMB for automatic reinforcement. A sizable portion endorsed social reinforcement functions as well.
Norcross and Lambert, 2018	Psychotherapy Relationships the Work III	N/A	Meta-Analysis	What, specifically, is effective in the powerful psychotherapy relationship?	Experts deemed nine of the relationship elements as demonstrably effective, seven as probably effective, and one as promising.

(a)	(b)	(c)	(d)	(e)	(d)
Norcross and Wampold, 2019	Personalizing Psychotherapy: Results, Conclusions and Practices	N/A	Book Chapter	Responsiveness, what, specifically, is effective in the powerful psychotherapy relationship?	Summarizing what works and what does not in psychotherapy responsiveness and treatment adaptations.
O'Connor et al., 2014	Adolescent Self-Harm: A School-based Study in Northern Ireland	School pupils in secondary years 11 and 12 - 90% were aged 15–16 years	Observational Study	To determine the prevalence of self-harm in Northern Irish adolescents and the factors associated with it, including exposure to the Northern Ireland (NI) conflict	Exposure to the NI conflict was associated with self-harm alongside bullying, alcohol use, drug use, physical and sexual abuse, sexual orientation concerns, anxiety and impulsivity were additional risk factors. The internet/social media and the self-harm of others were also key influences

(a)	(b)	(c)	(d)	(e)	(d)
O'Hara, 2010	Hope – The Neglected Common Factor	N/A	Journal Article	Of the four factors generally accepted to be common across all therapeutic approaches, hope is the least researched.	Engendering hope is one of the essential tasks of therapy. Working with hope is a balancing act between a passive holding and an active engaging with clients on the topic.
O'Hara and O'Hara, 2012	Towards a Grounded Theory of Hope	76 trainee and experienced therapists	Qualitative questionnaires and semi-structured interviews	To identify and explore (i) how therapists conceptualise hope and (ii) how they operationalise and work with hope in therapy	Hope is not a conscious aspect of therapy work but none the less very present. A number of hope focussed strategies are discussed.

(a)	(b)	(c)	(d)	(e)	(d)
Oliver et al., 2005	Help-Seeking Behaviour in Men and Women With Common Mental Health Problems: Cross-Sectional Study	10842 aged 16 to 64 years	Cross-Sectional Study	To investigate patterns of lay and Professional help-seeking in men and women in relation to severity of symptoms and sociodemographic variables.	Males, young people, and people living in affluent areas were the least likely to seek help. The preferred source of help was friends or relatives
Palmstierna and Werbart	Successful Psychotherapies with Young Adults: An Explorative Study of the Participants' View	134 aged 18 to 25 years	Grounded Theory	Explore experiences of therapeutic process and outcome that fulfilled the rigorous quantitative criteria for long-term therapeutic success	The experience of a growth-promoting and secure therapeutic relationship within the therapeutic frames, the patients and the therapists could overcome obstacles to their collaboration.

(a)	(b)	(c)	(d)	(e)	(d)
Paulson et al., 1999	Client's Perceptions of Helpful Experiences in Counseling	36 aged between 18 and 56 years	Mixed Methods	To clarify the scope and interrelations among elements of the retrospective experience of helpfulness of clients who had completed counselling.	5 themes, consistent with previous research were identified. 4 New themes were also identified – Emotional relief, Gaining knowledge, Accessibility and Client resolutions.
Paulson and Everall, 2003	Suicidal Adolescents: Helpful Aspects of Psychotherapy	17 aged 13 to 18 years	Concept Mapping	To investigate suicidal adolescents' perceptions of helpful experiences in psychotherapy	The findings suggest that participants found 5 aspects of therapy to be helpful: Enhanced Self-Understanding, Communication, Creative Expression, Therapeutic Relationship, and Therapeutic Strategies.

(a)	(b)	(c)	(d)	(e)	(d)
Polk and Liss, 2009	Exploring the Motivations Behind Self-Injury	154 aged 18 to 47 years	Questionnaire	To explored self-described motivations for self-injuring behavior.	The most frequently endorsed reason for self-injury was to obtain emotional release. The second most common intent was to resolve dissociation and feel alive or real. Individuals also revealed that they self-injured in order to gain a sense of control, to punish themselves, to distract themselves, and to avoid suicidal or homicidal actions.

(a)	(b)	(c)	(d)	(e)	(d)
Rayner et al., 2019	Emergency Department Nurse's Attitudes Towards Patients Who Self-Harm: A Meta-Analysis	N/A	Meta-Analysis	Examine the attitudes of Emergency Department nurses towards patients who self-harm, based on currently available evidence	Results demonstrated limited empathy and negativity towards patients who self-harm
Rennie, 2001	The Client as a Self-aware Agent in Counselling and Psychotherapy	Not indicated in the text	Grounded Theory	How clients respond to counsellors' operations depends on what clients desire and what they feel they can say safely	In desiring to take their own wants into account, clients also desire to meet what they perceive as being the practitioner's wants.

(a)	(b)	(c)	(d)	(e)	(d)
Roe et al., 2006	Clients' Reasons for Terminating Psychotherapy: A Quantitative and Qualitative Inquiry	84 aged 20 to 40+ years	Mixed Methods	To study private-practice clients' perspective on reasons for psychotherapy termination and how these are related to demographic and treatment variables and to satisfaction with therapy.	The most frequent reasons for termination were accomplishment of goals, circumstantial constraints and dissatisfaction with therapy, the client's need for independence and the client's involvement in new meaningful relationships.
Rotolone and Martin, 2012	Giving up Self-Injury: A Comparison of Everyday Social and Personal Resources in Past Versus Current Self-Injurers	Aged 16 to 65 years	Logistic Regression	to identify social and personal resources that may aid in cessation of self-injury	Self-injurers could be distinguished from non self-injurers on self-esteem, social connectedness and resilience.

(a)	(b)	(c)	(d)	(e)	(d)
Rowe et al., 2014	Help-seeking Behaviour and Adolescent Self-Harm: A Systematic Review	Studies that included participants aged 11 to 19 years	Systematic Review	To determine (a) the sources of support adolescents who self-harm access if they seek help, and (b) the barriers and facilitators to help-seeking for adolescents who self-harm.	A small proportion of adolescents who seek help for their self-harm, informal sources are the most likely support systems accessed. Interpersonal barriers and a lack of knowledge about where to go for help may impede help-seeking.

(a)	(b)	(c)	(d)	(e)	(d)
Royal College of Psychiatrists, 2010	Self-Harm, Suicide and Risk: A Summary	N/A	Report	Examines issues of self-harm, suicide and risk.	Government, NHS Trusts and commissioners, professional bodies and the third sector ought to be aiming to improve the care for people at risk of suicide and self-harming behavior
Royal College of Psychiatrists, 2010	Self-Harm, Suicide and Risk: Helping People Who Self-Harm	N/A	Report	Enquire into and report on why people harm and kill themselves and to consider the role that psychiatrists and other mental healthcare professionals play in their care and treatment.	There are variations in the standard of care for people who harm themselves. The majority of self-harm remains invisible until a crisis occurs.

(a)	(b)	(c)	(d)	(e)	(d)
Shaw and Shaw, 2007	A Dialogue of Hope and Survival	N/A	Book chapter	Exploring functions, family dynamics and psychological treatment of self-harm	Listening to the voices of people who self-harm, their partners and families, and staff who care for them and developing services based on these narratives is important and will need a shift in current service culture

(a)	(b)	(c)	(d)	(e)	(d)
Sinclair and Green, 2005	Understanding Resolution of Deliberate Self Harm: Qualitative Interview Study of Patients' Experiences	20 participants from an original cohort of 150 who had had not self-harmed in the past 2 years.	In-depth interviews analysed by Thematic Analysis	Explore the accounts of those with a history of deliberate self-harm but who no longer do so, to understand how they perceive this resolution and to identify potential implications for provision of health services	Young people report difficulties in engaging with unfamiliar secondary service staff. Abstinence from alcohol was a factor in the resolution of self-harm.
Snyder, 1995	Conceptualizing, Measuring and Nurturing Hope	N/A	Journal Article	Theoretical models of hope summarised. Usefulness of measuring hope discussed.	Hope is counterproductive and therapist should help clients think in more hopeful ways of developing more hopeful environments.

(a)	(b)	(c)	(d)	(e)	(d)
Stanley et al., 2001	Are Suicide Attempters Who Self-Mutilate a Unique Population?	53 people aged 18 to 65 years who had attempted suicide with or without a history of self-harm	Quantitative adopting Two-tailed t tests for continuous variables and chi-square analysis for categorical variables	To determine differences between suicide attempters with and without a history of self-mutilation.	Subjects with and without a history of self-mutilation did not differ by age, gender, ethnicity, marital status, religious affiliation, education level, or employment rate
Strupp, 1996	The Tripartite Model and the Consumer Reports Study	N/A	N/A	To study the framework of the tripartite model of mental health and therapeutic outcomes	The literature on psychotherapy outcomes supports the claim that all forms of therapy tend to reduce the patient's presenting symptoms or complaints.

(a)	(b)	(c)	(d)	(e)	(d)
Sullivan et al., 2015	Masculinity, Alexithymia, and Fear of Intimacy as Predictors of UK Men's Attitudes Towards Seeking Professional Psychological Help	Aged 18 to over 65 years	Cross-sectional online survey subjected to regression analysis	Male gender role socialization and male development may be important in accounting for men's underutilization of mental health services in the United Kingdom.	Men who score higher on measures of traditional masculine ideology, normative alexithymia, and fear of intimacy reported more negative attitudes towards seeking professional psychological help
Sullivan, 2017	Should healthcare professionals sometimes allow harm? The case of self-injury	N/A	N/A	Considers the ethical justification for the use of harm minimisation approaches with individuals who self-injure.	It is argued that healthcare professionals sometimes have a moral obligation to allow harm to come to their patients.

(a)	(b)	(c)	(d)	(e)	(d)
The Children's Society, 2018	The Good Childhood Report 2018	N/A	Report	Children's happiness with their lives had risen steadily in the 15 years from 1995 to 2010. But this progress has now been reversed and children's well-being is now as low as it was two decades ago.	Between 2009 and 2016, children's happiness with friends and life as a whole dropped, while their happiness with schoolwork increased. There was no change in happiness with family, school, or appearance.
Thompson et al., 2007	Treatment Engagement: Building Therapeutic Alliance in Home-Based Treatment with Adolescents and their Families	19 families which included children aged 12 to 18 years	Qualitative interviews and content analysis	Explore the process of engaging high-risk youth and their parents in a unique home-based family therapy intervention	Findings support previous research suggesting that a strong therapeutic alliance significantly predicts outcomes, over and above the type of therapy administered.

(a)	(b)	(c)	(d)	(e)	(d)
Sutton, 2007	Healing the Hurt Within	N/A	Book	Insight into the lives and minds of those who self-injure.	Offers direction to those who self-injure; guidance to family and friends supporting a loved one who self-injures; and guidelines to professionals and voluntary caregivers on how to respond to clients that self-injure.

(a)	(b)	(c)	(d)	(e)	(d)
Swift et al., 2017	Understanding the Client's Perspective of Helpful and Hindering Events in Psychotherapy Sessions: A Micro-Process Approach	16 aged between 19 and 70 years	Micro-process Research	To bridge the methodologies of significant events and micro-process research to gain a better understanding of clients' perceptions of helpful and hindering events in psychotherapy.	Results suggest that clients perceive both specific treatment and common factors techniques as being helpful. Further, some of the same therapist actions were rated as both helpful and hindering.
Tatnell et al., 2013	Longitudinal Analysis of Adolescent NSSI: The Role of Intrapersonal and Interpersonal Factors	1973 students aged 12 to 18 years	Longitudinal Analysis	To understand onset, maintenance and cessation of NSSI	A combination of interpersonal and intrapersonal variables contributes to the onset, maintenance and cessation of NSSI in adolescence.

(a)	(b)	(c)	(d)	(e)	(d)
Timulak, 2010	Significant Events in Psychotherapy: An Update of Research Findings	N/A	Meta-analysis	Provide an overview of the significant events research conducted, the methodology used together with findings and implications.	The impacts of helpful events reported by clients are focused on contributions to therapeutic relationship and to in-session outcomes. Hindering events focus on some client disappointment with the therapist or therapy.

(a)	(b)	(c)	(d)	(e)	(d)
Vanheusden et al., 2009	Beliefs About Mental Health Problems and Help-seeking Behavior in Dutch Young Adults	830 young adults aged 19 to 32 years	Cross-sectional survey adopting a multivariate logistic regression analysis.	To examine the beliefs about mental health problems and help-seeking behaviour of young adults with self-perceived mental health problems	Young adults often do not seek help because they do not believe that treatment can help and because they believe that their mental health problems do not have adverse consequences.

(a)	(b)	(c)	(d)	(e)	(d)
Wadman et al., 2018	An Interpretative Phenomenological Analysis of Young People's Self-Harm in the Context of Interpersonal Stressors and Supports: Parents, Peers, and Clinical Services	14 females ages 13 to 18 years	Interpretative Phenomenological Analysis	Multiple psychological, social, and clinical factors contribute to self-harm, but it remains a poorly understood phenomenon with limited effective treatment options.	Parents and peers play a key role in both precipitating self-harm and in supporting young people who self-harm.
Waldorf, 2005	Clinical Implications of the Paradox of Deliberate Self-Injury	N/A	N/A	Explore the aetiology, functions, and treatment of young people who self-harm.	The relationship between the nurse and young people is important and will help ensure a smooth treatment process.

(a)	(b)	(c)	(d)	(e)	(d)
Wampold, 2015	How Important Are The Common Factors in Psychotherapy? An Update	N/A	Book	To understand the evidence supporting them as important therapeutic elements, the contextual model of psychotherapy is outlined	The evidence supports the conclusion that the common factors are important for producing the benefits of psychotherapy
Watsford and Rickwood, 2014	Young People's Expectations, Preferences, and Experiences of Therapy: Effects on Clinical Outcome, Service Use, and Help-Seeking Intentions	228 young people ages 12 to 25 years	Quantitative prospective research utilising SPSS 19 statistical Package for data analysis.	Examining the relationships between young people's expectations, preferences, and actual experience of therapy on their clinical outcome, mental health care service use, and help-seeking intentions.	Young people's initial expectations of therapy may not be well formed and appear not to be relevant to their engagement or outcomes and are less important than motivation and actual experiences.

(a)	(b)	(c)	(d)	(e)	(d)
Watson et al., 2012	Helpful Therapeutic Processes Client Activities Therapist Activities and Helpful Effects	10 aged 20 to 47 years	Thematic Analysis	To explore helpful processes in therapy, focusing on the specific client and therapist activities that can lead to helpful effects.	Talking about emotions and experiences are the most helpful activity. The most helpful contributions from therapists were questioning, direction and the therapists' specific relational qualities.
Wendt and Schafer, 2016	Gender and Attitudes about Mental Health Help Seeking: Results from National Data	927 of adult age	Quantitative adopting Confirmatory Factor Analysis (CFA)	Focusing on help seeking endorsement on the basis of mental health diagnosis and the characteristics of individuals with such a diagnosis.	Men and women have largely similar attitudes about informal help seeking for mental health problems.

(a)	(b)	(c)	(d)	(e)	(d)
Whitlock et al., 2006	The Virtual Cutting Edge: The Internet and Adolescent Self-Injury	Aged 12 to 47 years	Quantitative	To explore and document adolescent use of online message boards to share, solicit, and receive information and advice on self-injurious behaviour.	Internet message boards provide a powerful vehicle for bringing together self-injurious adolescents.
Ystgaard et al., 2009	Deliberate Self-Harm in Adolescents: Comparison Between those who Receive Help Following Self-harm and Those who do not	1660 pupils aged 14 to 17 years from Australia, Belgium, England, Hungary, Ireland, The Netherlands, and Norway.	Quantitative utilising Lifestyle and Coping questionnaire. Data analysis employed Self-Concept Scale, Plutchik Impulsivity Scale and $\chi 2$ or F-tests	International comparative study addresses differences between adolescents who engage in deliberate self-harm (DSH) and who receive help following the DSH episode versus those who do not.	Nearly half (48.4%) of the participants had not received any help following self-harm, 32.8% had received help from their social network only and 18.8% from health services.

Appendix D – NHS REC Favourable Opinion Letter

Health Research Authority

London - Riverside Research Ethics Committee

Level 3 Block B
Whitefriars Lewins Mead
Bristol BS1 2NT

Telephone: 02071048044

Please note: This is the favourable opinion of the REC only and does not allow

you to start your study at NHS sites in England until you receive HRA Approval

15 September 2017 Mr Mark Clamp
9 The Oaks
Ashill, Thetford Norfolk
IP25 7AN

Dear Mr Clamp

Study title:	**What Outcomes Do Young People Who Self-Harm Expect from Talking Therapies and Did They Achieve Them?**
REC reference:	**17/LO/1360**
IRAS project ID:	**210492**

The Research Ethics Committee reviewed the above application at the meeting held on 04 September 2017. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request.
Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below. .

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

1) **Changes to the PIS and Consent form**

a) Please state clearly that the following; If you wish to withdraw from the study then please telephone the Chief Investigator on …'

2) **Changes to the Participant Invitation letter**

a) Please remove the lower limit of 3 days so that the sentence reads as follows; 'If you agree I would kindly ask you to complete the consent form and return it using the SAE enclosed within 14 days of the date of this letter.'

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion” below).

Summary of discussion at the meeting

The Committee welcomed you to the meeting and stated that they were very interested in the study design and stated that it was a worthwhile project to undertake.

The Committee asked you if you will be based in Norfolk and you confirmed that you would be.

The Committee accepted this response.

Social or scientific value; scientific design and conduct of the study

The Committee noted that this is a qualitative study involving semi-structured interviews to gather data about the therapy the participants have received. The interviews can be conducted via Skype if this is what the participant wants.

The study has been well thought through.

The Committee asked you how many of patients form Norfolk have been referred for counselling or CBT aged between 16-20 years old.

You responded to say that in the last funding year there have been 4,500 NHS referrals for counselling or CBT (Cognitive Behavioural Therapy), two thirds of which are patients under the age of 21 years old. You added that 80% of referrals have one to one sessions. In East Anglia there are 30 therapists.

The Committee accepted this response and explained that the reason for asking this question is because there is a risk that participants may disclose incidences of malpractice by the therapist.

You acknowledged that there is a risk of this type of disclosure and responded to say that there is a safeguarding policy operating within the Norfolk and Suffolk NHS Foundation Trust which NHS staff will follow if there is a report of malpractice. If a complaint is raised by the participant then the NHS complaints policy will be adhered to.

The Committee accepted this response.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity

The data obtained from the interviews will be stored on the Chief Investigator's home computer which the Committee stated was not necessarily an ethical issue but it is not good practice to use a home computer to store sensitive patient data. Furthermore, most NHS organisations would insist on patient data being stored on NHS premises using a local NHS computer. It was noted that you will have an office in the NHS.

The Committee informed you that they were ethical issues concerning the storage of highly sensitive patient data on a home computer and recommended that the data is stored on NHS premises.

You responded to say that you own a NHS laptop and use a dedicated computer at home for your PhD work. The information stored will be password protected. You continued to say that you work for the IAPT department and you have a hot desk in the NHS office which you use routinely and use your NHS laptop to store patient notes.

The Committee was satisfied with this response.

It is unclear to the Committee if you will know when the participant is becoming distressed during the Skype interview and how this will be managed appropriately. It was noted that the participant's parent can be present during the Skype interview.

You responded to say that there are alternative venues available if the participant does not want to be interviewed via Skype. Participants may choose to be interviewed via Skype if they live in a remote area with limited public transport services or cannot drive. If the participant becomes distressed during the interview then the interview will be stopped and alternative arrangements will be made. The participant can chose to be interviewed face-to- face instead.

You added that patients can be interviewed in the therapy rooms at Providence Street Community Centre in King's Lynn or Hellesdon NHS Hospital which the participants will be familiar with. Participants will not be interviewed in their own home or at school.

The Committee accepted this response and asked you would consider visiting the participant in their own home.

You responded to say that this could be done if the NHS Trust allows it, however this will present more safeguarding risks to consider and it would be dependent on the time available. If it is not possible to conduct a face-to-face interview with the participant then Skype will be the last option.

The Committee was satisfied with this response.

Recruitment arrangements and access to health information, and fair participant selection

Participants will be aged between 16-20 years old and recruited using an advertising flyer. The Committee commented that this form of recruiting may not be successful. The Committee queried why younger participants are not included in the study and concluded that it would be difficult to obtain parental consent from children under the age of 16 years old.

The Committee asked you if the recruitment posters will be useful.

You responded to say that a flyer will be used that can be included in the participant invitation letter. The flyer will be seen by patients attending their routine therapy session.

The Committee was satisfied with this response.

The sample size range is between 6 and 12 participants. It was stated by the Committee that recruiting less than 6 participants would still yield worthwhile results.

Informed consent process and the adequacy and completeness of participant information

The PIS states that participants can withdraw from the study up to 14 days after the interviews have taken place. However, it is not clear in the PIS how participants can withdraw.

You were advised by the Committee that there are some minor administrative changes required to the PIS and consent form that will be outlined in the ethical opinion letter.

You agreed to amend the PIS accordingly.

Suitability of supporting information

The Participant Invitation letter states that participants are required to complete the consent form within 3-14 days of the date of the letter. The Committee stated that the consent form should be revised to remove the lower limit of 3 days.

You were advised by the Committee that there are some minor administrative changes required to the participant invitation letter that will be outlined in the ethical opinion letter.

You agreed to amend the participant invitation letter accordingly.

The Committee asked you if you had any questions for the Committee to which you replied you did not. You were advised by the Committee advised that you would receive the ethical opinion letter within 10 working days of this meeting.

The Committee thanked you for attending the meeting and you left the meeting room.

Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [Flyer]	3	15 June 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Lancaster University Insurance Certificate - Professional Negligence]		30 June 2017
Interview schedules or topic guides for participants [Interview Guide]	4	16 June 2017
IRAS Application Form [IRAS_Form_20072017]		20 July 2017
IRAS Checklist XML [Checklist_07082017]		07 August 2017
Letter from sponsor [Sponsorship Letter]	1	16 May 2017
Letters of invitation to participant [Participant Letter]	3	17 June 2017
Other [NSFT Research Committee Review]		16 June 2017
Other [PR Invalidity Report]		19 June 2017
Other [Lancaster University Insurance Certificate - Public Liability]		30 June 2017
Other [Covering Letter - Changes]	1	31 July 2017
Participant consent form [Consent Form]	6	15 June 2017
Participant information sheet (PIS) [Participant Information Sheet]	6	15 June 2017
Research protocol or project proposal [Research Protocol]	7	15 June 2017
Summary CV for Chief Investigator (CI) [CI CV]	1	17 May 2017
Summary CV for supervisor (student research) [CV - 1st Academic Supervisor]	1.2	04 August 2017
Summary CV for supervisor (student research) [CV - 2nd Academic Supervisor]	August 2017	04 August 2017

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the- hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/LO/1360 **Please quote this number on all correspondence**

With the Committee's best wishes for the

success of this project. Yours sincerely

Pp

Dr Margaret Jones Chair

E-mail: nrescommittee.london-riverside@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*

"After ethical review – guidance for researchers"

Copy to: *Dr Diane Hopkins*
Mr Tom Rhodes, Norfolk & Suffolk Foundation Trust Research & Development

London - Riverside Research Ethics

Committee Attendance at Committee

meeting on 04 September 2017

Committee Members:

Name	*Profession*	*Present*	*Notes*
Miss Tina Cavaliere	REC Manager	Yes	
Dr Marina Cecelja	Centre Career Establishment Fellow	Yes	
Dr Irina Chis Ster	Senior Lecturer In Biostatistics	Yes	
Ms Stephanie Ellis BEM	Former Civil Servant	Yes	
Dr Nuria Gonzalez-Cinca	Clinical Study Manager	No	
Ms Alison Higgs	Lecturer in Social Work	Yes	
Dr Matthew Hyde	Research Scientist	Yes	
Dr Margaret Jones (Chair)	Retired General Practitioner	Yes	
Ms Alexandra Mancini	Pan London Lead for Neonatal/Palliative Care	No	
Ms Fanny Mitchell	Retired NHS Manager	Yes	
Dr Lorraine Murphy	Pharmaceutical Consultant	Yes	
Mr Kamen Shoylev	Lawyer	No	
Mrs Dinah Smith	Retired Head Teacher	Yes	
Ms Julia Williams	Senior Producer	Yes	

Appendix E - Example of NHS IAPT Service Wellbeing Tracker

wellbeing
Helping you live your life

Please ask a member of staff if you would like this questionnaire in a larger print format

Date ……Name ……..……..……Date of Birth ...../……./……

On the Mood Tracker and the Anxiety Tracker below add a number against each of the statements;
0 = not at all 1 = several days 2 = more than half the days 3 = nearly every day

1. This is the **Mood Tracker**; using the scale above tell us how often over the last two weeks you have been bothered about any of the following:		2. This is the **Anxiety Tracker;** using the scale above tell us how often during the last two weeks the following might have given you concerns.	
	Little interest or pleasure in doing things		Feeling nervous, anxious or on edge
	Feeling down, depressed or hopeless		Not being able to stop or control worrying
	Trouble falling/staying asleep or sleeping too much		Worrying too much about different things
	Feeling tired or having little energy		Trouble relaxing
	Poor appetite or overeating		Being so restless that it is hard to sit still
	Feeling bad about yourself – or that you are a failure or have let yourself or your family down		Becoming easily annoyed or irritable
	Trouble concentrating on things, such as reading the newspaper or watching television		Feeling afraid as if something awful might happen
	Moving or speaking so slowly that other people could have noticed? Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual		**Your Total Score (Optional)** GAD-7, Pfizer
	Thoughts that you would be better off dead or thoughts of hurting yourself in some way	3. Are you currently taking any prescribed medication to help you with your mood or anxiety? **Yes / No**	
	Your Total Score (Optional) PHQ-9, Pfizer		

IMPORTANT: People often get thoughts of hurting themselves or of being better off dead when they are depressed and this is normal. However it is more of a concern if you are thinking about acting upon these thoughts.

If you have any current intent/plans to harm yourself, please tick this box ☐
If you have any current intent/plans to end your life, please tick this box ☐

If you have ticked one or both of these boxes please speak to a staff member prior to leaving. If you have not ticked a box we will assume you feel able to keep yourself safe currently.

4. Choose a number from the scale below to tell us **how much you would avoid** each of the situations or objects listed below.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Always

☐ **Social situations** due to a fear of being embarrassed or making a fool of myself

☐ Certain situations because of a fear of having a **panic attack** or other distressing symptoms (such as loss of bladder control, vomiting or dizziness)

☐ Certain situations because of a **fear of particular objects or activities** (such as animals, heights, seeing blood, being in confined spaces, driving or flying)

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5. **Tell us about your ability to do certain day-to-day tasks** – look at each statement and write the number that represents how you think your problem affects your ability to carry out each task.

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very severely

	Work - if you are retired or choose not to have a job for reasons unrelated to your problem, please leave box blank.
	Home Management – cleaning, tidying, shopping, cooking, looking after home/children, paying bills etc.
	Social Leisure Activities - with other people, e.g. parties, pubs, outings, entertaining etc.
	Private Leisure Activities – done alone, e.g. reading, gardening, sewing, hobbies, walking etc.
	Family And Relationships – form and maintain close relationships with others including the people that I live with

6. Employment Status

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Self-employed
- ☐ Receiving benefits
- ☐ Retired
- ☐ Unemployed (seeking work)
- ☐ Student full-time
- ☐ Homemaker or carer
- ☐ Unemployed
- ☐ Student part-time
- ☐ Volunteer

7. Are you currently receiving Statutory Sick Pay?

☐ Yes ☐ No ☐ Unknown ☐ I don't wish to say ☐ N/A

8. If you are employed, what is your current Employment Attendance Status?

☐ Employed and in work ☐ Employed and off work due to sickness leave
☐ I don't wish to say

9. What is the average number of hours you typically work in a week?

☐ 1-4 ☐ 5-15 ☐ 16-29 ☐ 30+ ☐ I'm not employed ☐ I don't wish to say

10. **Are you currently receiving benefits?**

☐ Yes
☐ No
☐ Not stated
☐ Unknown☐ N/A

11. **Are you receiving Jobseekers Allowance?** ☐ Yes ☐ No ☐ Not stated ☐ Unknown ☐ N/A

12. **Are you receiving Employment and Support Allowance?**
☐ Yes ☐ No ☐ Not stated ☐ Unknown ☐ N/A

13. **Are you receiving Universal Credit?** ☐ Yes ☐ No ☐ Not stated ☐ Unknown ☐ N/A

14. **Do you currently receive Personal Independence Payment?**
☐ Yes ☐ No ☐ Not stated ☐ Unknown ☐ N/A

15. Are you currently receiving other Benefits that are not listed above?
☐ Yes ☐ No ☐ Not stated ☐ Unknown ☐ N/A

For office use only:	
Risk checked by facilitator	

Appendix F – Participant Information Sheet

Participant Information Sheet

What outcomes do young people aged 16 to 20 who self-harmed want from therapy and how did talking therapies help or impede them achieving these outcomes.

My name is Mark Clamp and I am conducting this research as a student studying for a PhD in Mental Health at Lancaster University, Lancaster, United Kingdom.

What is the study about?
The purpose of this research is to find out what young people who self-harm hoped would be the outcome of therapy and whether they achieved what they hoped for and how did the therapy help them achieve these outcomes.

Why have I been approached?
You have been approached because the study requires information from young people who have completed Counselling or CBT based interventions with Wellbeing in the past 6 months who were self-harming before, during and possibly after the therapy.

What will I be asked to do if I take part?
If you decide you would like to be a part of this research, you would be asked to undertake a one to one interview. There will be one or two initial questions with follow-up questions based on the replies you have given. The interview will last between 30 and 60 minutes at a date and time of your choosing at a mutually agreed Youth Wellbeing venue or via Skype. The interview will be audio recorded and transcribed This will allow patterns to be identified against other young people who are part of the study.

Do I have to take part?
No. It's completely up to you to decide if you want to take part. If you decide to take part, you are completely free to withdraw at any time up to 14 days after you have been interviewed without giving any reason, without criticism or recrimination. If you wish to withdraw from the study then please telephone the Chief Investigator on 01760 440493.

Will I be Identifiable from the research report?
All your personal information will be kept anonymous and no one will know you have taken part. Your interview would be recorded and the recording will be typed out. The typed version of your interview will be made anonymous by removing any identifying information and your name will be changed. Your personal information will be stored securely and kept separate from your interview recording and transcript. Direct quotations from your interview may be used in reports or publications from the study, so your name will not be attached to them.

There are some limits to anonymity: if what is said in the interview makes me think that you, or someone else, is at significant risk of harm, I will have to break confidentiality and share this information with Safeguarding Team of Norfolk and Suffolk NHS Trust and your identity may be revealed as a consequence. If at all possible, I will tell you if I have to do this before I contact the Safeguarding Team.

The information collected for this study will be stored securely. Only the researcher conducting this study and the supervisors of the study will have access to it. The audio recordings of your interview will be transferred to a computer. The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them). Backup copies will be made and saved on two encrypted USB memory sticks. The saved recordings on the PC will be deleted after the project has been submitted for publication/examined and award given. The copies on the encrypted USB memory sticks will be retained for 10 years in accordance with Lancaster University guidelines.

Hard copies of transcripts and data analysis will be kept in a locked cabinet. At the end of the study, hard copies of will be kept securely for ten years. At the end of this period, they will be destroyed.

For further information about how Lancaster University processes personal data for research purposes and your data rights please visit our webpage: www.lancaster.ac.uk/research/data-protection

What will happen to the results?
The results will be reported in a thesis which will be submitted to Lancaster University Faculty of Health and Medicine to be assessed and marked for the award of a PhD in Mental Health. The outcomes of this research will be shared with other mental health organisations by publication in academic or professional journals to help other therapists work with similar clients in a more effective way. Additionally, the knowledge gained in this research will be combined with other information to create resources to support parents, carers and partners of young people who self-harm.

Are there any risks?
There are no risks anticipated with participating in this study. However, if you experience any distress during or following participation you are encouraged to inform the researcher and contact the resources provided at the end of this sheet. In the unlikely event of any harm being caused to you, Lancaster University legal liability cover applies to this study. Further details can be obtained from either the researcher or from Lancaster University contacts below.

Are there any benefits to taking part?
Although you may find participating interesting, there are no direct benefits to you in taking part. However, future young people accessing therapeutic services may benefit from the outcomes of this research.

Who has reviewed the project?
This research has been reviewed by the NHS Research Ethics Committee, the Faculty of Health and Medicine Research Ethics Committee and the University Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?
If you have any questions about the study, please contact the main researcher:
Mark Clamp
Email: m.clamp@lancaster.ac.uk Tel: 01760 447486

Or alternatively you can contact the research supervisors

Dr Mark Limmer
Email: m.limmer@lancaster.ac.uk Tel: 01524 593015

Professor Steven Jones
Email: s.jones7@lancaster.ac.uk Tel: 01524 593382

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

Professor Bruce Hollingsworth
Title: Head of the Division of Health Research
Faculty of Health and Medicine
Lancaster University
Lancaster
LA1 4YG
Email: b.hollingsworth@lancaster.ac.uk
Tel: 01524 594154

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

Professor Roger Pickup
Title: Associate Dean for Research
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG
Email: r.pickup@lancaster.ac.uk
Tel: 01524 593746

Resources in the event of distress
Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance:
Wellbeing at 0300 123 1503 or www.wellbeingnands.co.uk
MIND 0300 123 3393 or info@mind.org.uk
Alternatively, you can contact your GP who will be able to refer you to a Crisis Team.

If as a result of participating in this research you feel you are in crisis, experiencing feelings of despair or are suicidal, contact the Samaritans on 116 123 or 08457 90 90 90

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

Appendix G – Consent Form

Study Title: What outcome goals do young people aged 16 to 20 who self-harmed want from therapy and how did talking therapies help or impede them achieving these goals.

We are asking if you would take part in a research project which will look at your experiences of the therapy you received. Before you consent to take part in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Mark Clamp.

Please initial each statement

1.	I confirm that I have read the Participant Information Sheet version 8 dated 15/09/2017 and fully understand what is expected of me within this study.	
2.	I confirm that I have had the opportunity to ask any questions and to have them answered.	
3.	I understand that my interview will be audio recorded and then made into an anonymised written transcript.	
4.	I understand that audio recordings will be kept for 10 years after the completion of the research	
5.	I understand that my participation is voluntary and that I am free to withdraw up to 14 days after my interview has been recorded without giving a reason.	
6.	I understand that once my interview has been recorded, I will have 14 days to withdraw it from the study. If you wish to withdraw from the study then please telephone the Chief Investigator on 01760 440493	
7.	I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published	
8.	I consent to information and quotations from my interview being used in reports, conferences and training events.	
9.	I understand that the researcher will discuss data with their academic supervisor as needed.	
10.	I understand that any information I give will remain anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with Safeguarding Team of Norfolk and Suffolk NHS Trust.	
11.	I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished	
12.	I understand the relevant section of my Patient Health Record (IAPTus) and data collected during the study may be looked at by individuals from Lancaster University, from regulatory authorities or from Norfolk & Suffolk NHS Foundation Trust, where it is relevant to my taking part in this research. I give my permission for these individuals to have access to my records.	
13.	I consent to take part in the above study.	

Name of Participant _____ **Signature** _____ **Date** _____

Name of Researcher _____ **Signature** _____ **Date** _____

Appendix H – Interview Schedule

Stage 1

Put the participant at ease ensure the participant feels in control and allay any fears or anxieties.

Stage 2

Reaffirm anonymity and confidentiality. Reaffirm permission to record interview. Answer any questions.

Stage 3

Obtain background information:

- Participant's status – school, college, work etc.
- How long ago the participant completed therapy and how many sessions they had.
- Were those sessions with a counsellor or a CBT practitioner, or both.

Stage 4

Describe the general principals of the interview, reiterating that the study is looking for experiences of the therapy not the reasons for undergoing therapy. Explain how each subject will be explored in depth with follow-up questions and probes

Stage 5

The questions below are a guide. The interviewer is a highly qualified and experienced youth counsellor. Should the participant find it difficult to respond to the questions, the interviewer will utilise acquired skills to adapt and modify the questions through reframing or rephrasing. Further questions will be formulated by the interviewer based on the responses given by the participants.

1st Question:

How did your referral come about, did you seek it or did someone tell you to come?

2nd Question:

I wonder if you could tell me how you felt about being asked, quite early on, about have you self-harmed, are you self-harming, how did that feel?

3rd Question:
I am interested in hearing about if you had any hopes, goals, ambitions, or desires about what you wanted to get from therapy.

4th Question:

Did you achieve the outcome you wanted?

5th Question:
Can you tell me what was it in the therapy sessions that stands out as being helpful to you achieving the outcome you wanted?

6th Question:
Can you tell me what if anything it in the therapy sessions that stands out as being unhelpful and hindered you in achieving the outcome you wanted?

7th Question:
This next question you do not have to answer, it, it's not compulsory for you to answer it.

Could you, if you feel able to, tell me whether your self-harming has reduced or stopped since you had therapy?

8th Question:
Is there anything, any question you would have liked to have been asked that I haven't asked you? Anything you'd like to talk about, but you haven't been asked?