

Challenges to frontline professionals in care for adolescents who self-harm

Challenges encountered by frontline professionals in care for adolescents who self-harm.

A qualitative study conducted on an inpatient unit implementing
Adolescent Mentalization-Based Integrative Treatment (AMBIT)

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A thesis submitted for the degree of Professional Doctorate in Clinical Psychology

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September 2015

Declaration by Candidate

This thesis is submitted as part of the requirement for the University of Essex Professional Doctorate in Clinical Psychology.

I declare that this is my own work, under the supervision of Professor Alessandra Lemma and Dr Frances Blumenfeld and contributions made to this study are consistent with normal supervisory practice. Other sources of information cited here have been acknowledged and referenced appropriately.

This thesis has not been submitted for examination at any other institution, nor for publication in advance of the submission for examination. Considerations regarding publication will be taken once the thesis has been passed and the Professional Doctorate awarded.

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Signature:



Date: 21/09/2015

Acknowledgments

The completion of this project would have not been possible without the support received from a number of people.

First of all, I owe my deepest gratitude to the twelve participants who volunteered to participate in the study for their time and valuable contributions. Without you, this research would not have been possible.

On this journey, I was in the privileged position of being given guidance by two very experienced supervisors. My first supervisor, Professor Alessandra Lemma, supported me to deal with the theoretical ideas underpinning this thesis. I am also grateful to my second supervisor, Dr Frances Blumenfeld, for her support in the development of the study, continued guidance and encouragement throughout the challenges of conducting this thesis.

Further thanks must go to Dr James Fairbairn for his generosity in giving me time, space and support in order that I could carry out this thesis. The enthusiasm and warmth of those in the service from which I recruited the participants made this particularly demanding task easier.

I would also like to thank my husband, Jonathan, for his unlimited support and belief in me over the last three years. Your love and support allowed me to undertake this work.

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Abstract

Research: The prevalence rate of self-harm among adolescents is high and rising. This is a worrying trend, considering that self-harm is associated with poor mental health and an increased risk of suicide. However, research literature suggests that adolescents rarely seek help and that caring for them is a complex task. Furthermore, the existing research indicates that healthcare professionals' views and responses to working with this patient group may be influenced by interplay of individual, interpersonal and institutional processes. Those working on the frontline in inpatient settings seem to be most affected by these processes. It was proposed that to support frontline healthcare professionals in caring for this patient group theory-driven therapeutic models need to be developed. It was also proposed that psychoanalytic theories were best positioned to manage the impact of the processes posing challenges to care for adolescents who self-harm.

Research aims: This thesis aimed to investigate the challenges experienced by frontline professionals caring for adolescent patients who self-harmed whilst being treated on an inpatient unit, and frontline professionals responses to these challenges, including their use of Adolescent Mentalization-Based Integrative Treatment (AMBIT), a psychodynamically-oriented approach to care for adolescents with complex needs.

Method: Qualitative methods were employed in this study. Twelve participants were recruited from an adolescent inpatient unit implementing AMBIT. Data were generated with semi-structured interviews and analysed with descriptive inductive thematic analysis.

Findings: Four overarching themes were generated. The first three themes informed on the challenges in care for adolescent patients associated with patients' and frontline professionals'

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unhelpful relationships on the unit; and the impact of frontline team professionals' responses to self-harm on their practices. The fourth theme elucidated frontline professionals' use of AMBIT.

Discussion: The findings provided new insights into the processes influencing frontline professionals' work with adolescent patients who self-harmed whilst being treated on an inpatient unit. The opportunities and challenges related to the frontline professionals' use of AMBIT were discussed.

Chapter 1: Introduction

This thesis explores the challenges inpatient frontline professionals encounter when caring for adolescents who self-harm. It also investigates frontline professionals' responses to these challenges, with particular attention paid to healthcare professionals' application of Adolescent Mentalization-Based Integrative Treatment (AMBIT) implemented on the inpatient unit participating in this research project. The thesis draws upon both research in healthcare professionals' views and responses to adolescents' self-harm; and psychoanalytic perspectives on the psychological processes influencing healthcare professionals providing care to adolescents who self-harm.

Chapter Overview

The chapter begins with a literature review in the field of healthcare professionals' views and responses to adolescents' self-harm and adolescent patients who engage in it. The chapter continues with relating the literature review findings to psychoanalytic perspectives that describe the unconscious individual, interpersonal and institutional processes hypothesised to pose challenges to healthcare professionals' working practices. This leads into a presentation of Adolescent Mentalization-Based Integrative Treatment (AMBIT), AMBIT's theoretical underpinnings and the potential benefits of its application for addressing some of these challenges. The chapter concludes with a rationale for the study and research questions.

Study Background: Adolescents' Self-harm

Self-harm is internationally recognised as a major healthcare problem in adolescents (Greydanus & Shek, 2009). However, the term "self-harm" lacks clear nomenclature and its meaning varies across different countries, cultures and historical times (Ougrin, Ng, & Zundel,

2009). This project follows the National Institute for Health and Care Excellence (NICE) guideline (2011) and considers self-harm to be a behaviour that involves “any act of self-poisoning or self-injury carried out by an individual irrespective of (his or her) motivation” (p. 4).

Self-harm is a common clinical problem in adult patients (Hawton, Bergen, Casey, Simkin, Palmer, & et al., 2007) and the number of adolescents who self-harm was reported to be twice as high as that in adults (Ferrara, Terrinoni, & Williams, 2012). However, the prevalence of self-harm among young people is difficult to determine as its estimates vary according to the classification systems and research methodologies used (Muehlenkamp, Claes, Havertape, & Plener, 2012) and unsurprisingly different sources report different prevalence rates.

A comparable epidemiological study ‘Child and Adolescent Self-harm in Europe’ (CASE) (Madge, Hewitt, Hawton, de Wilde, Corcoran, & et al., 2012) conducted in seven European countries found the following prevalence estimates of self-harm in adolescents aged 14-17 years old: lifetime prevalence of 4.3% in boys and 13.5% in girls; 12-month prevalence of 2.6% in boys and 8.9% in girls. Data gathered by the CASE study in England reported an estimated lifetime self-harm prevalence of 4.8% in adolescent boys and 16.7% in adolescent girls, and a 12-month self-harm prevalence of 3.2% in adolescent boys and 11.1% in adolescent girls. Similarly to the current study, the CASE study used the following definition of self-harm: any self-injurious act with or without intent to die.

Self-harm is associated with an increased risk of suicide and poor mental health, and research data reports that after self-harm the risk of suicide increases fifty times (Owens, Horrocks, & House, 2002). In the United Kingdom, self-harm was reported to be in the top five

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reasons for admission to hospital for emergency medical treatment (Hawton & Fagg, 1992; Gunnell, Brooks, & Peters, 1996).

The high self-harm rates in young people and the associated risks of self-harm were recognised in the National Suicide Prevention Strategy for England (Department of Health, 2012) and guidance for prevention and management of self-harm in this patient group was developed (NICE, 2004; NICE, 2011).

Unfortunately, research data indicate that only a small proportion of adolescents who self-harm seek help from healthcare services (Hawton, Rodham, Evans, & Weatherall, 2002; Madge et al., 2008) and that some young people who sought help had negative experiences linked to healthcare professionals' negative attitudes (Rissanen, Kylma, & Laukkanen, 2009).

Literature Search Strategy, Review and Synthesis

In order to explore some of the barriers to accessing healthcare services affecting adolescents who self-harm, healthcare professionals' views, attitudes and responses to working with this patient group were investigated. This chapter provides a report of a literature review conducted to achieve this aim. The review was carried out in respect to the following question:

‘What are healthcare professionals' views of and responses to adolescents' self-harm and adolescents who engage in it?’

Literature search strategy

A systematic search was conducted to identify relevant literature. An adaptation of the PICO format was employed (Needleman, 2002) and four major concepts were identified:

‘healthcare professionals’; ‘views and/or responses’; ‘adolescent’; ‘self-harm’.

Consideration was given to the definitional boundaries of the generated concepts. The concept of ‘healthcare professionals’ included all registered and unregistered healthcare professionals working within the healthcare system in the given country. The concept ‘views and/or responses’ included all views, opinions, attitudes, beliefs, experiences and affective responses healthcare professionals may have reported in relation to caring for adolescents who self-harm. Special consideration was given to the definition of the major concept of ‘self-harm’ due to its lack of clear nomenclature (Ougrin, Ng, & Zundel, 2009). This review applied the definition of self-harm proposed by the NICE guideline (2011) which stated as: “every act of intentional self-poisoning or self-injury, irrespective of motivation” (p. 4) and employed the term to signify a spectrum of self-injurious behaviours with no suicidal intent on one end and driven by a wish to end one’s life on the other end (Hill, 1995).

Search terms within the identified major concepts were identified by a review of research literature in the field and complemented with a use of the ‘CINAHL Headings’ facility. The reviewed literature reported a mixture of terminology for each major concept; therefore multiple search terms were included.

The primary search was conducted using the following electronic databases: CINAHL Completer; E-Journals; MEDLINE with Full Text; PsychARTICLES, PsycINFO, PEP Archive, Psychology & Behavioral Sciences Collection, and the Cochrane Library. They were all accessed through the electronic resources at the University of Essex and Tavistock and Portman NHS Foundation Trust’s libraries. Research literature was located by searching in “Abstracts”. The body of identified literature was then refined with the following limiters: age (all child: 0-18 years; adolescence: 13-17 years; adolescent: 13-18 years; young adult: 19-24 years); major concept (self-mutilation; self-inflicted injury; self-injurious behaviour; attempted suicide; suicide).

Of the 444 articles identified the following inclusion and exclusion criteria were applied.

Inclusion criteria:

- The research specific to healthcare professionals' views and responses to adolescents' self-harm and adolescents who engage in it;
- Participants were healthcare professionals who had worked with adolescents who self-harmed;
- Full text was available;
- Published in the English language;
- All years.

Exclusion criteria:

- Research that only related to healthcare professionals' attitudes to adult patients who presented with self-harm;
- Research that did not focus on healthcare professionals (e.g. research on teachers);
- Research in healthcare professionals' attitudes to self-neglect, eating disorders, etc.;
- Non English literature.

The inclusion and exclusion criteria initially identified eleven relevant articles.

References were screened and researchers who had contributed to the investigated field were contacted via email to ask about relevant published literature. By these methods, three further articles and two unpublished doctoral dissertations were identified. Unfortunately, attempts to access the unpublished dissertations failed. In total, fourteen articles dating from 2000 were identified and were subject to the literature review (Appendix A).

Appraisal of research rigour in reviewed research literature

The review consisted of fourteen papers reporting on nine research projects. Four papers reported on different stages and aspects of a mixed-methods study investigating healthcare professionals' attitudes to and views on adolescents' suicidal behaviours. These reported on findings generated in: a pilot study (Anderson, Standen, Nazir, & Noon, 2000); an extended study which reported its qualitative (Anderson, Standen, & Noon, 2003, 2005) and quantitative (Anderson & Standen, 2007) findings separately. One mixed-methods study explored inpatient nursing team professionals' attitudes to adolescents' self-harm and reported its quantitative and qualitative findings separately (Dickinson & Harley, 2012; Dickinson, Wright, & Harrison, 2009; respectively). Finally, one qualitative study on Finnish nurses' views on adolescents' self-harm reported its findings in two papers (Rissanen, Kylma, & Laukkanen, 2011, 2012).

An initial appraisal of the identified literature was conducted with the Critical Appraisal Skills Programme tools criteria (CASP; Public Health Resource Unit, 2006). Its outcome indicated a significant heterogeneity of the research design, method and quality.

Research design and methods

Within the nine research projects identified by the research literature review, two utilised quantitative methods, three utilised qualitative methods and four employed mixed-methods. The strength of the reviewed literature was linked to the appropriate application of research design. More information about the limitations and strengths of the reviewed studies is presented below.

Mixed-design studies

A mixed-methods design was employed in four studies (Anderson, Standen, Nazir, & Noon, 2000; Anderson, Standen, & Noon, 2003, 2005; Anderson & Standen, 2007; Crawford,

Geraghty, Street, & Simonoff, 2003; Dickinson, Wright, & Harrison, 2009; Dickinson & Harley, 2012; Cleaver, Meerabeau, & Maras, 2014).

All studies referred to their exploratory character when providing the rationale for the use of mixed-methods. Only one study reported the measures taken to integrate findings generated with different methods (Cleaver et al., 2014). The remaining three studies lacked this information; therefore appraisal of their rigour was conducted separately for quantitative and qualitative findings.

Quantitative studies

All quantitative studies employed a cross-sectional questionnaire-based survey design.

Measures

Reviewed studies employed a range of questionnaires with varied psychometric qualities. The Suicide Opinion Questionnaire (SOQ; Alston & Robinson, 1992) was used in Anderson and colleagues' study (Standen, Nazir, & Noon, 2000; Anderson & Standen, 2007). This questionnaire was designed to measure general attitudes to suicidal behaviours, not specifically to measure attitudes to adolescents' suicidal behaviours; therefore the findings generated with its use were excluded from this review.

Different adaptations of the 'Staff Attitudes to Adolescent Self-harm' scale, developed by Crawford, Geraghty, Street, and Simonoff (2003), were used in three studies (Crawford et al., 2003; Wheatley & Austin-Payne, 2009; Timson, Priest, & Clark-Carter, 2012). This scale measures levels of negative attitudes, worry and subjective sense of effectiveness with three subscales: 'Negativity', 'Worry' and 'Effectiveness'. The scale shows factorial validity (Crawford et al., 2003). The 'Effectiveness' and 'Negativity' subscales showed acceptable

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internal consistency (Cronbach's $\alpha = .735$ and Cronbach's $\alpha = .723$; respectively) whereas the 'Worry' subscale showed unacceptable internal consistency (Cronbach's $\alpha = .313$; Timson, Priest, & Clark-Carter, 2012).

The 'Attitudes towards Young People who Self-harm' (AYPSH) scale was used in Cleaver, Meerabeau, and Maras' study (2014). It showed factorial validity and acceptable internal consistency (Cronbach's $\alpha = .63$).

The 'Self-harm Antipathy Scale' (Patterson, Whittington, & Bogg, 2007) was used in Dickinson and Harley's (2012) study. It showed good internal consistency and some evidence of good test-retest reliability (Patterson et al., 2007). The 'Attribution Questionnaire' administered by Wheatley and Austin-Payne (2009) was derived from a range of measures (Peterson, Semmel, von Baeyer, Abramson, Metalsky, & et al., 1982; Mackay & Barrowclough, 2005). It showed evidence of acceptable validity and reliability (Peterson et al., 1982; Mackay & Barrowclough, 2005).

Data analysis and presentation

A limited appraisal of the appropriateness of data analysis methods employed in the identified quantitative studies was possible. Only two studies (Timson, Priest, & Clark-Carter, 2012; Cleaver, Meerabeau, & Maras, 2014) reported running tests for the appropriateness of use of parametric tests, and only one study (Cleaver et al., 2014) reported full descriptive statistics calculated from data generated with Likert scale coding systems.

Research quality

Overall, the rigour of the six quantitative studies was weakened by the following limitations. All studies used self-report questionnaires to generate their data which introduced the

self-report bias. Only one study (Wheatley & Austin-Payne, 2009) controlled for the recruitment selection bias and only one study (Cleaver, Meerabeau, & Maras, 2014) reported frequencies in its descriptive statistics required for interpretation of data generated with a Likert type coding system.

Qualitative studies

Qualitative studies used a range of designs.

Methodology

The use of in-depth semi-structured interviews, focus groups and written extracts was considered appropriate for generation of rich data needed for exploration of novel areas (Smith, 2008), which all studies aimed for. Two mixed-design studies (Crawford, Geraghty, Street, & Simonoff, 2003; Dickinson, Wright, & Harrison, 2009, Dickinson & Hurley, 2012) used open-ended survey questionnaires, inviting study participants to express their views in a brief written form, which was less appropriate for producing rich data.

Grounded Theory was used by Anderson, Standen and Noon (2003, 2005) and Dickinson and colleagues (2009). Interpretative Phenomenological Analysis was used by Sandy (2013). These three studies and the study conducted by Rissanen, Kylma, and Laukkanen (2011, 2012) reported a clear rationale for their choices of methodology and methods of analysis. All qualitative studies reported using different variations of thematic analysis, with the exception of two studies which did not provide information about their analysis methods (Crawford et al., 2003; Dickinson & Hurley, 2012).

Research quality

A range of measures was put in place to increase the quality of the reviewed studies' findings. With the exception of two studies (Crawford, Geraghty, Street, & Simonoff, 2003; Dickinson, Wright, & Harrison, 2009), all studies gave fairly detailed audit trails. With one exception (Sandy, 2013), all studies used some sort of triangulation (e.g. of recruitment setting, of respondent group, of data collection method). Members' checks of interview transcriptions were used by Anderson, Standen, Nazir and Noon (2000). Co-researchers checks of analysis were used by Rissanen, Kylma and Laukkanen (2011; 2012) and Medina, Kullgren and Dahlblom (2014). Quotes were included in the findings of all reviewed studies, with the exception of Crawford and colleagues' (2003).

Only two studies reported theoretical frameworks employed (Anderson, Standen, & Noon, 2003, 2005; Sandy, 2013) and only two studies (Crawford et al., 2003; Medina et al., 2014) provided fairly detailed descriptions of their context. These limitations, where present, made the appraisal of the quality of the research findings problematic.

Sample and recruitment

Sampling and recruitment strategies employed in the current study are reported below.

Sample

Sampling strategies employed in the reviewed quantitative and qualitative studies (opportunistic census sampling and purposive criterion sampling, respectively) were appropriate. However, with the exception of Wheatley and Austin-Payne's study (2009), none of the studies evidenced controlling for the selection bias.

The sample sizes varied considerably across the quantitative studies from 69 to 179. The lowest sample sizes were reported in studies recruiting from inpatient settings (n = 76, Wheatley & Austin-Payne, 2009; n = 69, Dickinson & Hurley, 2012). All sample sizes offered reasonably high probabilities in detecting statistically significant results (Field, 2014).

The response rates in the quantitative studies varied from 12% to 85%, with a mean of 48.37%. Low response rates were reported in studies recruiting from inpatient mental health and secure adolescent settings (12%, Wheatley & Austin-Payne, 2009; 46%, Dickinson & Hurley, 2012). The remaining quantitative studies showed reasonably high response rates ranging from 50% to 79%.

The sample sizes in the qualitative studies ranged from 8 to 126 and were appropriately employed to generate rich data required for exploration of the researched phenomena (Braun & Clarke, 2014).

Professional role and affiliation

For the needs of this review only professional role and affiliation are included from the range of demographical data recorded. The reviewed literature included research projects which recruited the following professional groups: psychiatrists and non-psychiatrist medical doctors (three); psychiatric and non-psychiatric nurses (eight); healthcare assistants (two); paramedics and ambulance technicians (one); and other professions (one).

Recruitment setting

The reviewed literature included research projects which recruited from across a range of settings. These included accident and emergency departments (A&E) (four); inpatient units (six);

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child and adolescent mental health services (CAMHS) (three); paediatric wards (one); ambulance services (one) and primary healthcare services (one).

Geographical area

Most of the reviewed studies (seven) were conducted in the United Kingdom (UK). One study was carried out in Finland (Rissanen, Kylma, & Laukkanen, 2011, 2012) and another in Nicaragua (Medina, Kullgren, & Dahlblom, 2014). The dominance of studies conducted in the UK increases generalisability and transferability of the research findings to populations in the UK, but limits it for populations with different social, cultural and economic characteristics.

Narrative Synthesis Procedure

The reviewed literature showed significant heterogeneity; therefore the Narrative Synthesis Guidance (Popay, Roberts, Sowden, Petticrew, Arai, & et al., 2006) was followed. The review incorporated four elements recommended by this framework: developing a preliminary synthesis of findings; exploring relationships in the data; generating models of relationships between the data; and assessing the robustness of the synthesis.

The following procedure was employed. Initially, quantitative and qualitative design categories were generated and all studies were grouped according to their design. For mixed-design studies, findings obtained with quantitative and qualitative methods were separated and reviewed with other studies utilising the same methods. All studies in the two categories were tabulated and research findings were extracted within the two categories. Then, the research findings were translated to textual descriptions and were clustered across the two categories. The generated clusters were subjected to within-case and across-case thematic analysis. Reciprocal and reputational relationships in the data were investigated within the generated themes. The

outcome of the thematic analysis was a descriptive synthesis of the literature findings. An evaluation of the robustness of the synthesis was carried out and reported. Finally, a descriptive model outlining the themes captured in the data and the hypothesised relationships between these themes was presented.

Findings

Three overarching themes were generated. Within these themes, quantitative and qualitative studies are reported separately.

Adolescents' self-harm, its function and causes

Findings from four qualitative studies shed light on healthcare professionals' perceptions of adolescents' self-harm, its functions and causes.

Conceptualisations

Adolescents' self-harm was described as dangerous and aggressive impulsive attacks on one's body (Anderson, Standen, Nazir, & Noon, 2000; Rissanen, Kylma, & Laukkanen, 2011) and was perceived as contagious, dangerous not only to the self but also to others (Anderson, Standen, & Noon, 2003, 2005; Rissanen et al., 2011; Sandy, 2013). Additionally, adolescents' self-harm and those who engage in it were given pejorative labels by participants in a study which recruited from nursing teams in secure services (Dickinson, Wright, & Harrison, 2009).

Furthermore, adolescents' self-harm was conceptualised as a manifestation of individual and/or interpersonal processes in which aggression, hatred or punishment were directed at the self or at others (Anderson et al., 2000; Rissanen et al., 2011; Sandy, 2013). It was seen as both a

manifestation of ill mental health and of a social trend (Anderson et al., 2000; Rissanen et al., 2011; Rissanen, Kylma, & Laukkanen, 2012).

Although in Anderson and colleagues' study (2000, 2003, 2005), healthcare professionals refrained from passing moral judgement on those who resorted to self-harm, 'moral sensitivity' was noted by the researchers in the quotes reporting study participants' views on this phenomenon. Anderson and colleagues (2005) proposed a theoretical model to explain the presence of 'moral sensitivity' in participants' speech about adolescents' self-harm. The model posits that healthcare professionals' views on adolescents' self-harm are shaped by societal constructions of adolescents and self-harming behaviour. Accordingly, the model proposes that groups of adolescents and people who self-harm threaten the norms of the modern society (Aldridge, 1998; Shucksmith & Hendry, 1998); and that to manage these threats, both groups are subject to moral scrutiny, their behaviours are signified as 'deviant' (Downes & Rock, 1998) and described as immoral, harmful or insane.

Functions and causes

Healthcare professionals recruited in the reviewed qualitative studies reported a range of views on functions and causes of self-harm.

The identified functions were: the communication of a complex and difficult to understand message (Anderson, Standen, & Noon, 2005); dealing with unbearable states of mind (Anderson, Standen, Nazir, & Noon, 2000; Rissanen, Kylma, & Laukkanen, 2011, 2012; Sandy, 2013); and eliciting care and attention, sometimes through the means of manipulation (Anderson et al., 2000; Anderson et al., 2005; Anderson & Standen, 2007; Dickinson, Wright, & Harrison, 2009; Rissanen et al., 2012; Sandy, 2013; Cleaver, Meerabeau, & Maras, 2014).

The identified causes included: individual factors (high level of distress, poor affect regulation, anxiety, substance misuse, poor solution building skills and past experience of trauma and neglect; Anderson et al., 2000; Rissanen et al., 2011; Sandy, 2013); systemic factors (poor quality of social support within family and wider community systems; exposure to violence and deprivation, and to self-harm in immediate and wider social systems; Anderson et al., 2000; Anderson, Standen, & Noon, 2003, 2005; Rissanen et al., 2011, 2012; Sandy, 2013); and institutional factors (such as being admitted to an inpatient psychiatric service; Anderson et al., 2005; Sandy, 2013).

Attitudes and feelings towards adolescents' self-harm

Reviewed literature showed a complex picture of healthcare professionals' attitudes and affective responses towards adolescents' self-harm.

Attitudes and affective responses

Quantitative and qualitative findings shed light on healthcare professionals' attitudes and responses to adolescents' self-harm.

Qualitative studies

Qualitative findings presented in the previous section suggested a presence of 'moral sensitivity' in healthcare professionals statements about adolescents' self-harm. Additionally, two qualitative studies reported that healthcare professionals experience frustration and feelings of powerlessness when caring for adolescents who self-harm (Anderson, Standen, & Noon, 2003; Medina, Kullgren, & Dahlblom, 2014).

Quantitative studies

All quantitative studies investigated healthcare professionals' attitudes and affective responses to adolescents' self-harm. Three studies (Crawford, Geraghty, Street, & Simonoff, 2003; Wheatley & Austin-Payne, 2009; Timson, Priest, & Clark-Carter, 2012) attempted to measure attitudes towards adolescents' self-harm among a range of professionals working in emergency, child and adolescent mental health services, and inpatient services. Their findings showed that healthcare professionals scored relatively low on the levels of negative attitudes towards adolescents' self-harm and on the levels of worry about working with adolescents who self-harm, and relatively high on the levels of subjective sense of effectiveness in this area of clinical practice, as measured by the 'Staff Attitudes to Adolescent Self-harm' scale (Crawford et al., 2003). Dickinson and Hurley's (2012) study showed reasonably low levels of antipathy amongst inpatient nursing team healthcare professionals to adolescents who self-harm. The limitations of the reviewed quantitative studies (the use of self-report data; the lack of a detailed report of descriptive statistics derived from data generated with Likert type coding systems) significantly undermined the validity of their findings.

Determinants of attitudes and responses

The review of quantitative studies showed a mosaic-like picture of determinants of healthcare professionals' attitudes and affective responses to adolescents' self-harm.

Professional background and clinical setting

Three studies paid attention to the relationship between participants' professional background, and their attitudes and affective responses. In Crawford, Geraghty, Street, and Simonoff's (2003) study, psychiatrists reported more worry than non-psychiatric medical

doctors, and psychiatric and non-psychiatric nurses. In Wheatley and Austin-Payne's (2009), study conducted in inpatient services healthcare assistants reported significantly more worry and negative attitudes than nurses. In Dickinson and Hurley's (2012) study, non-psychiatric nurses reported significantly higher levels of agreement with the statement that self-harm was manipulative and they had a significantly lower level of acceptance for people who engaged in it than psychiatric nurses.

Three studies attempted to determine whether there was a difference in the attitudes and affective responses among healthcare professionals working in different settings. No significant difference between levels of negative attitudes and worry was found between nursing staff working in adolescent and adult services (Wheatley & Austin-Payne, 2009). A significant difference was found between the levels of antipathy amongst nursing team professionals working with inpatient adolescents in secure settings and healthcare professionals working with adult patients in community teams, with inpatient nursing team professionals reporting more antipathy (Dickinson & Hurley, 2012). Finally, accident and emergency healthcare professionals reported significantly more negative attitudes towards adolescents who self-harm than professionals working in community-based child and adolescent mental health services (Timson, Priest, & Clark-Carter, 2012). The above findings suggest that healthcare professionals working on the frontline in acute settings may show higher levels of negative attitudes and responses to adolescents who self-harm.

Knowledge and effectiveness

Three studies explored a relationship between factual knowledge about self-harm and healthcare professionals' attitudes (Crawford, Geraghty, Street, & Simonoff, 2003; Wheatley & Austin-Payne, 2009; Timson, Priest, & Clark-Carter, 2012). A significant negative correlation

between these variables was found only in one of those studies (Timson et al., 2012). Two studies explored the relationship between knowledge about self-harm and the levels of worry experienced by healthcare professionals working with adolescents who self-harm (Crawford et al., 2003; Wheatley & Austin-Payne, 2009), and again, only one study found a non-significant trend indicating a negative correlation between these two variables (Crawford et al., 2003). Finally, Dickinson and Hurley (2012) identified that previous education and training on how to work with adolescents whose self-harm was significantly associated with a reduction in antipathy in nurses working with inpatient adolescents in a secure setting. In light of the above, negative attitudes and responses among healthcare professionals seemed to be more related to their education and training in working with self-harm rather than to their factual knowledge about this behaviour.

Three studies looked at the relationship between a subjective sense of effectiveness and negative attitudes ('Negativity') to self-harm (Crawford et al., 2003; Wheatley & Austin-Payne, 2009; Timson et al., 2012). Two of those studies also looked at the relationship between a subjective sense of effectiveness and affective responses ('Worry') (Crawford et al., 2003; Wheatley & Austin-Payne, 2009). Where measured, evidence was found for a negative relationship between healthcare professionals' negative attitudes and their subjective sense of effectiveness; and between healthcare professionals' worry and their subjective sense of effectiveness (Crawford et al., 2003; Wheatley & Austin-Payne, 2009; Timson et al., 2012). Additionally, healthcare professionals' positive self-appraisal of their skills was positively associated with the level of sympathy for patients in a study recruiting nursing team professionals working with inpatient adolescents (Wheatley & Austin-Payne, 2009).

Interestingly, where measured, the association between healthcare professionals' knowledge and their subjective sense of effectiveness was not found (Crawford et al., 2003;

Timson et al., 2012). Conversely, in a study which recruited from nursing team in a secure inpatient setting, healthcare professionals' specialist education and training in working with adolescents who self-harm was associated with higher levels of self-appraisal of their competence and lower levels of their beliefs about care futility (Dickinson & Hurley, 2012).

Other determinants

Two studies examined the relationship between healthcare professionals' negative attitudes and worry about working with adolescents who self-harm. A significant positive correlation was found between these two variables for inpatient nursing professionals (Wheatley & Austin-Payne, 2009), whereas it was not found in a study recruiting participants representing different professional groups working in emergency and inpatient settings (Crawford, Geraghty, Street, & Simonoff, 2003).

Finally, a relationship between general attitudes to adolescents and attitudes to adolescents who self-harm among emergency and ambulance service healthcare professionals was investigated by Cleaver, Meerabeau, and Maras (2014). A correlation between these two variables was found, with higher levels of negative attitudes to adolescents found to be associated with higher levels of negative attitudes to adolescents who self-harm.

Caring for adolescents who self-harm

Findings from qualitative studies shed light on healthcare professionals' experiences of providing care to adolescents who self-harm. These studies identified skills that healthcare professionals identified as required in work with this patient group, and some of the institutional barriers impacting healthcare professionals' practices.

Required competencies

Caring for adolescents who self-harm was seen as a complex task requiring a range of specialist skills. The ability to foster therapeutic relationships was identified as one of the most important skills (Anderson, Standen, & Noon, 2003; Dickinson, Wright, & Harrison, 2009; Rissanen, Kylma, & Laukkanen, 2012). Good listening skills were needed to help adolescent patients manage distress and build an understanding of their difficulties (Anderson et al., 2003; Sandy, 2013).

Taking on a reflexive stance was required for professionals to gain an awareness of their responses to caring for this group of patients and to prevent reactive actions (Rissanen et al., 2012; Sandy, 2013). Also, professionals needed to have competencies in attending to physical and mental health problems (Rissanen et al., 2012). Finally, healthcare professionals needed to develop skills in negotiating adolescent patients' needs for dependency and autonomy (Anderson et al., 2003).

Institutional barriers

Two studies identified limited resources and the busy nature of healthcare environments as barriers to providing care to adolescents who self-harm (Anderson, Standen, & Noon, 2003; Medina, Kullgren, & Dahlblom, 2014). Risk management procedures in inpatient settings were seen as potentially non-therapeutic and contributing to an increase in patients' distress and feelings of powerlessness (Sandy, 2013). Also, professionals who identified with the role of a 'preserver of life' found adolescents' self-harm to challenge their values which, in turn, impacted on how they related to this patient group (Anderson, Standen, & Noon, 2005; Medina et al., 2014).

Insufficient training was identified as a barrier to providing good quality care to adolescents who self-harm in five studies (Anderson et al., 2003, 2005; Crawford, Geraghty, Street, & Simonoff, 2003; Dickinson, Wright, & Harrison, 2009; Medina et al., 2014). Moreover, feeling incompetent in caring for adolescents who self-harm was linked to healthcare professionals becoming reluctant to work with this patient group (Medina et al., 2014).

All of the above not only posed barriers to healthcare professionals' care for adolescents who self-harm but also prevented them from gaining experience required for developing skills in this area of clinical practice (Anderson et al., 2003).

The Quality of the Narrative Synthesis

The trustworthiness of the above synthesis is strengthened by a clear and detailed record of the steps undertaken to conduct the systematic search and research literature review. Consideration needs to be given to the significant limitations of the generated synthesis. As research in the investigated field was scarce, all identified studies which met the inclusion criteria and employed appropriate methods were included. The synthesis was generated from studies which showed considerable heterogeneity in their methodological quality. Another limitation was related to the fact that the synthesis consisted only of literature published in the English language.

Summary

This section reported the outcome of the narrative synthesis of research literature in the area of healthcare professionals' views and responses to adolescents' self-harm. Figure 1 illustrates two parallel sets of themes captured in the quantitative and qualitative findings, and the hypothesised relationships between them.

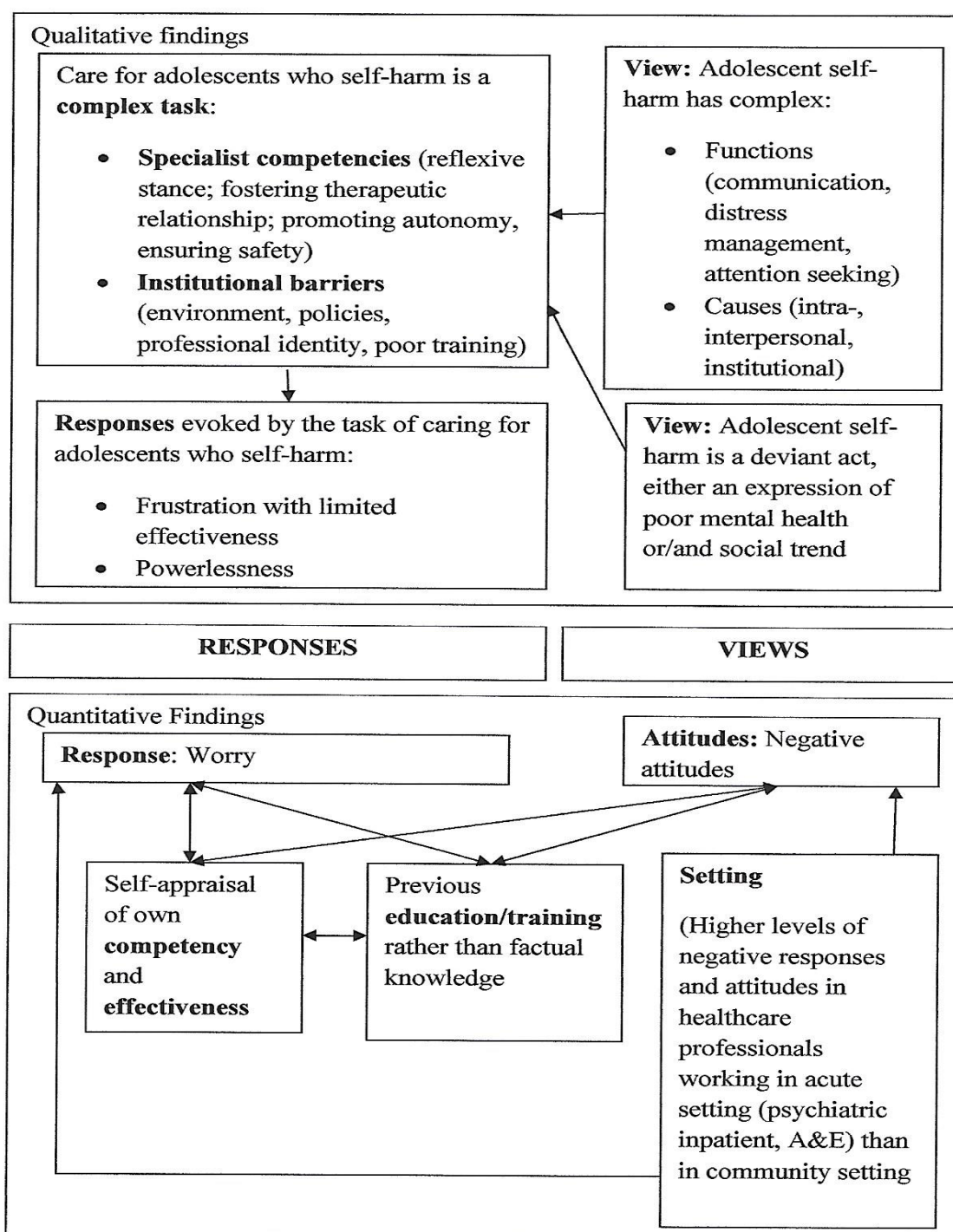


Figure 1. Model of the relationship between the quantitative and qualitative findings of the reviewed research literature

The review of the qualitative findings indicated that healthcare professionals consider adolescents' self-harm to have complex functions and causes. Also, some of the qualitative findings suggested that 'moral sensitivity' in healthcare professionals' speech about adolescents'

self-harm was perhaps indicative of healthcare professionals holding negative views and attitudes to this behaviour and this patient group. The task of caring for adolescents who self-harm was seen as complex and requiring specialist competencies. Institutional barriers were reported to negatively impact healthcare professionals' attempts to care for this patient group.

Based on the review of the research findings, the researcher hypothesised that healthcare professionals' negative views on adolescents' self-harm, and the complexity of adolescents' self-harm behaviour contribute to the difficulty of working with adolescent patients who self-harm. The researcher hypothesised that the complexity of the task of working with this patient group may generate negative affective responses among healthcare professionals.

The reviewed quantitative findings suggest that healthcare professionals' negative attitudes, negative affective responses, their self-appraisal of their competency and effectiveness, and their past specialist training are interrelated. These findings also indicate that healthcare professionals working in acute settings, such as emergency and inpatient services, may be more likely to report higher than healthcare professionals in other settings levels of negative attitudes and responses to adolescents' self-harm.

There is a need for institutional support for healthcare professionals who provide care to this patient group. The measures recommended to achieve this were: education, training, challenging and modifying healthcare professionals' attitudes, and an application of theory-driven treatment models which recognise the impact of professionals' views and emotions on their capacity to relate to their patients (Anderson, Standen, & Noon, 2003, 2005; Crawford, Geraghty, Street, & Simonoff, 2003; Anderson & Standen, 2007; Rissanen, Kylma, & Laukkanen, 2011; Dickinson, Wright, & Harrison, 2009; Wheatley & Austin-Payne, 2009; Dickinson & Hurley, 2012; Rissanen, Kylma, & Laukkanen, 2012; Timson, Priest, & Clark-Carter, 2012; Sandy, 2013; Medina, Kullgren, & Dahlblom, 2014).

Conducting research on modifying healthcare professionals' views and responses, and on implementing new theory driven therapeutic models were recognised as a significant tool in achieving this task (Anderson et al., 2003, 2005). It would be of particular importance to gain insight into the processes contributing to formation of views and responses to adolescents' self-harm and into how these processes are related to healthcare professionals' capacity to provide care to adolescent patients who self-harm.

In the following section, the presented literature review findings are related to psychoanalytic perspectives. These perspectives provide a conceptual frame for thinking about the presented findings and the hypothesised relationship between them.

Contribution of Psychoanalytic Perspectives to Understanding of the Literature Review Findings

This section starts with presenting a descriptive model of the hypothesised relationships between the data derived from the reviewed above research findings. This model is then related to relevant psychoanalytic perspectives with particular attention paid to the unconscious processes hypothesised to influence inpatient nursing teams. This has been done because the reviewed findings suggested that the highest levels of negative views and affective responses were reported by healthcare professionals positioned on the frontline in hospital settings.

Developing theoretical conceptualisations of the processes that may shape healthcare professionals' views and responses to adolescents who self-harm and other challenges impacting healthcare professionals' work with this patient group is required to identify interventions improving healthcare professionals' practices.

Relationships in the reviewed findings

The reviewed qualitative and quantitative findings were combined to generate a descriptive model mapping the relationships in the data. Figure 2 presents the generated model. It is hypothesised that healthcare professionals' views and responses to adolescents' self-harm are related both to adolescents' self-harm complex causes and functions; and to the institutional barriers affecting those who care for adolescents who self-harm. It is hypothesised that these challenges will impact on healthcare professionals' practices, and healthcare professionals' self-appraisals of their competency and effectiveness.

Healthcare professional's negative self-appraisals of their competency and effectiveness were found in the reviewed quantitative studies to be directly correlated with high levels of negative attitudes and worry about work with adolescents who self-harm. The developed model follows this finding and suggests that specialist training in work with adolescents' self-harm was linked with an increase in healthcare professionals' self-appraisal of their competency and effectiveness, and with a decrease in both their negative attitudes to adolescents who self-harm and their worry about working with this patient group.

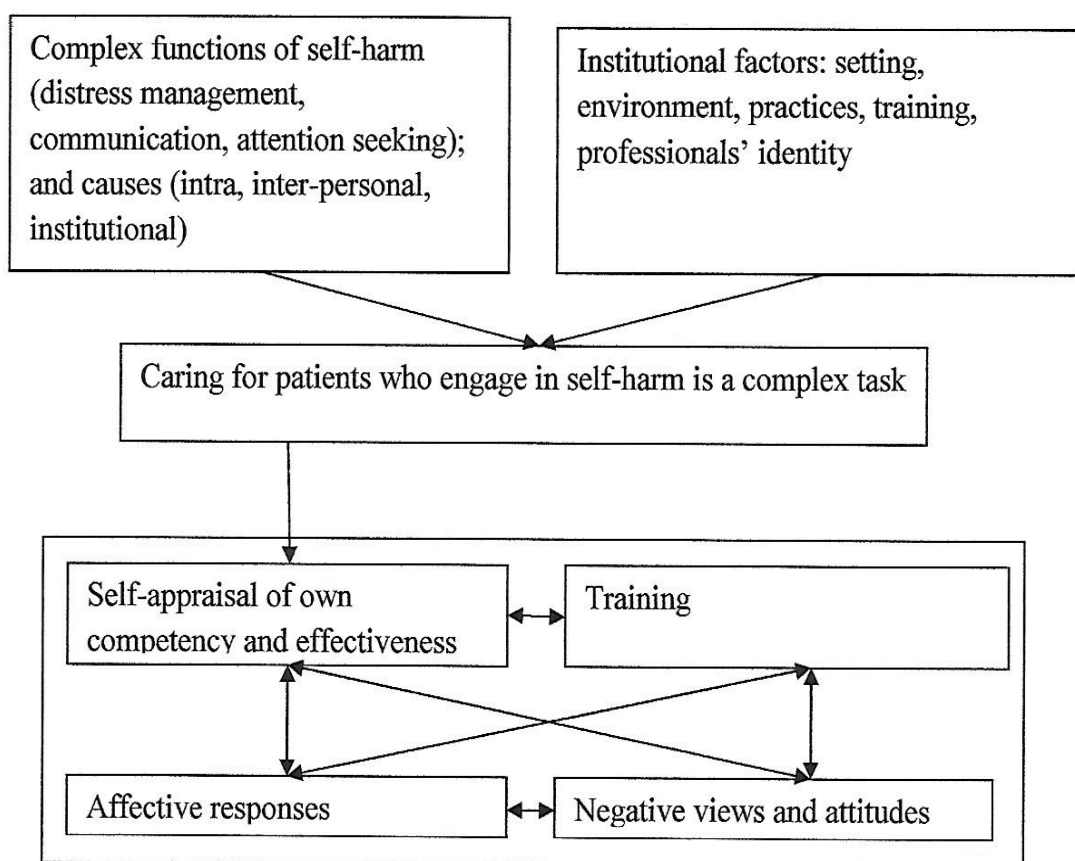


Figure 2. Reviewed model of the relationship between the quantitative and qualitative findings in the reviewed data

The above findings may be thought about in relation to a number of psychological and sociological theories. For example, adolescents' propensity to self-harm to cope with distress can be thought about in relation to neuro-developmental perspectives, which posit that developmental processes taking place in adolescence may manifest themselves with deteriorating mental health and increased impulsive behaviours, including self-harm (Blackmore, 2007). Systemic perspectives (Dallos & Draper, 2010) help to relate healthcare professionals' views and experiences to their contexts. Every perspective inadvertently explores one aspect of the investigated findings at the expense of the other, such that investigating individual determinants means that the systemic factors are neglected and vice versa.

The reviewed literature indicate the existence of complex and multi-layered processes impacting the task of caring for adolescents who self-harm. Psychoanalytic perspectives accommodate this complexity and allow for thinking about the emergence of negative attitudes and responses to adolescents' self-harm in healthcare professionals in relation to the interplay of individual, interpersonal and institutional unconscious processes.

Psychoanalytic conceptualisations of the causes and functions of self-harm in adolescents are largely consistent with the findings of the reviewed literature. The theoretical concepts of counter-transference (Winnicott, 1949) and projective identification (Klein, 1946) can be drawn on in thinking about the processes which may shape healthcare professionals' views and responses to adolescents' self-harm. Theoretical perspectives developed by Menzies-Lyth (1960) and Main (1975a) may also be helpful when thinking about the institutional barriers to care for adolescents who self-harm found in the reviewed research literature. Finally, Bion's (1962) concept of container-contained is presented as an example of a possible application of psychoanalytic perspectives for responding to the challenges faced by healthcare professionals.

Causes and functions of adolescents' self-harm

This section links psychoanalytic perspectives to the reviewed research literature indicating that healthcare professionals view adolescents' self-harm as aggressive and dangerous behaviour that has complex functions and causes.

The Object Relations Theory provides an exploratory model of how one's interactions with the external reality are mediated by his or her inner phantasy world and helps to understand the link between self-harm and the developmental changes taking place in adolescence.

The theory posits that adolescence is a turbulent developmental stage, often set in train by the onset of puberty (Waddell, 2002). The theory further proposes that during this stage, psychic energy is employed in the negotiation of the task of forming an identity that can provide resilience, a capacity for independent functioning and forming intimate relationships outside the family system (Waddell, 2002).

The adolescent's identity formation is conceptualised as a psychological process taking place against the backdrop of multiple losses. These losses are: the loss of a child's body and self, the loss of idealised and powerful parents, and the loss of safety from instinctual desires directed towards one's parents (Anderson, 1998). The psychoanalytic perspectives hypothesise that these changes result in increased internal tensions and a reactivation of the anxieties and defences belonging to an early developmental stage called by Klein the paranoid-schizoid position (1946).

The perspectives propose that the regression to the paranoid-schizoid position results in the adolescent's loss of the capacity to tolerate ambivalence towards his or her internal objects and an emergence of anxiety about causing damage to his or her internal world (Anderson, 1998). The object relations perspectives propose further that in order to deal with this anxiety, the adolescent employs primitive defence mechanisms of splitting in his or her internal world into 'good' and 'bad'; and of projection of the 'bad' aspects of their internal world (e.g. aggressive impulses, hostile objects) onto the other (Anderson, 1998; Lemma, 2003). By disowning and expelling the 'bad' aspects of one's internal world on the other, the adolescent protects its 'good' objects. Klein's model of development (1946) proposes that this psychic solution gives rise to internal 'persecutory anxiety' that the 'bad' aspects of the internal world, now located in the other, will retaliate (Lemma, 2003). The emergence of 'persecutory anxiety' decreases the adolescent's ego strength, his or her capacity to manage distress and to test reality

(Lemma, 2003). In the Theory of Object Relations, it is hypothesised that the above described processes increase the adolescent's propensity to manage his or her psychic pain by 'not thinking' and by enacting (Waddell, 2005). Self-harm is thought about as one of many forms of managing distress thought action employed by adolescents.

Psychoanalytic perspectives also explain the relevance of past and present relationships to the adolescent's increased propensity to self-harm. The quality of current external relationships is seen to determine the adolescent's capacity to deal with individual tension (Anderson, 1998) and the quality of past relationships with significant others, as represented in the inner world of object relations, is considered to determine the adolescent's psychological resilience (Seager, 2008). The combined quality of the internal and external worlds of relations is seen as determining whether the adolescent defends against anxiety in a healthy or a self-destructive way (Waddell, 2002). In line with the above perspectives, individuals with poor social support and a history of trauma and/or neglect are at a higher risk of engaging in self-harm.

Psychoanalytic perspectives consider self-harm and suicidal behaviours as enactments governed by specific processes which are outlined below. In the Theory of Object Relations, one is more likely to engage in enactments when he or she regresses to the paranoid-schizoid position and his or her ego strength is weakened (Klein, 1946; Seager, 2008). It is proposed that self-harm is a form of enactment in which the individual unconsciously manages his or her high level of anxiety with the primitive defences of splitting (separating the internal hostile and hateful 'bad' objects from the 'good' objects) and projecting the 'bad' objects into his or her body. Maltzberger (1993) proposed that under the operation of those defences, the individual may act out the relationship between 'good' and 'bad' objects by attacking the 'badness' projected into his or her body. Maltzberger (2004) proposed that self-harm is a form of enactment where the

self attacks its body to punish the ‘bad’ aspects of the self and that suicidal behaviour is a form of enactment where the self aims to eradicate them.

The above outlined psychoanalytic perspectives on the psychological processes contributing to the adolescent’s increased propensity to engage in self-harm and suicidal behaviours are largely consistent with and further elaborate healthcare professionals’ conceptualisations of adolescents’ self-harm, its causes and functions found in the reviewed research literature.

In summary, this section outlined psychoanalytical conceptualisations relevant to the reviewed research findings on healthcare professionals’ views on adolescents’ self-harm. The reviewed findings are largely consistent with the presented psychoanalytic perspectives.

Caring for adolescents who self-harm

This section focuses on the psychoanalytic perspectives on the processes which may contribute to healthcare professional forming negative views about adolescents who self-harm, negative responses to working with this patient group, and negative self-appraisals of their competency and effectiveness in this area of clinical practice. Finally, the interplay between healthcare professionals’ negative responses to and views on adolescents’ self-harm and their views of their effectiveness are considered.

The concepts of counter-transference and projective identification are useful in thinking about the themes found in the reviewed literature. Winnicott (1946) proposed that the task of caring for distressed patients evokes difficult states of mind in healthcare professionals, and that the severity of these states of mind depends on the severity of patients’ mental health disturbance. Winnicott (1949) focused on a particular aspect of this experience, the counter-

transference, which he defined as “the analyst's love and hate in reaction to the actual personality and behaviour of the patient, based on objective observation” (p. 69). He suggested that through the vehicle of counter-transference, all healthcare professionals experience how they are experienced by their patients. He also thought that the way patients experience their carers is determined by their internal world and the feelings and intentions they attribute to their internal objects (Winnicott, 1949).

The concept of projective identification, introduced by Klein (1946), provides another model of thinking about how healthcare professionals may experience their patients' internal worlds. Klein (1946) coined the term projective identification to name a primitive mechanism originating from the paranoid-schizoid position employed to defend against persecutory anxiety. It was proposed that through this defence mechanism the individual frees himself or herself from the unbearable states of mind by projecting them onto the other who then unconsciously identifies with these expelled states as if they belonged to his or her own internal world (Lemma, 2003).

In line with this theoretical conceptualisation, those who care for patients who rely on the defence of projective identification find it difficult to remain in the more mature, reflective states of mind that are required for providing support to their patients (Menzies-Lyth, 1960). Similarly, following the theoretical conceptualisation of counter-transference, healthcare professionals acting on their counter-transference may cause harm to their patients (Winnicott, 1949). Both of these theoretical models provide explanations of the mechanisms by which healthcare professionals may engage in harmful actions originating from their identification with their patients' inner worlds.

To predict forms of unhelpful or even harmful actions of healthcare professionals who work with adolescents who self-harm, it is important to consider the types of inner objects populating the internal worlds of those young people. Maltzberger (1993) proposed that the internal worlds of the individuals who engage in self-harm are populated by hostile, hateful and punishing objects and that self-harm has a function of defence against the unbearable pain caused by getting into contact with those objects. Maltzberger (1993) hypothesised that self-harm is a form of enactment of punishment and/or riddance of the hostile inner object by the mechanism of splitting and projection of these objects into the body.

Harmful practices may occur when through the process described as projective identification (Klein, 1946) healthcare professionals identify with the hostile aspects of their patients' experiences or when through the process of counter-transference (Winnicott, 1949) they get in contact with how they are experienced in their patients' inner world. In line with these conceptualisations, it is possible to hypothesise that healthcare professionals working with patients who self-harm may be recipients of unbearable aspects of their patients' internal worlds. These theoretical concepts can be used to explain the processes by which healthcare professionals' negative views about adolescents who self-harm are formed. It could be hypothesised that healthcare professionals' negative views are formed by a repeated experience of identifying with the negative aspects of the inner worlds of these patients.

Furthermore, the above model can be used to explain the processes by which healthcare professionals have negative affective responses to adolescent patients who self-harm. Feelings such as worry, frustration and powerlessness could stem from healthcare professionals' identifications with aspects of their patients' experience. In this vein, healthcare professionals' low self-appraisal of their effectiveness and competency could be thought about as a result of their identification both with their patient's hostile and critical inner objects and with their

patients' unbearable experience of feeling criticised and powerless. Finally, the above outlined theoretical models can be of use to attempt to explain why healthcare professionals' viewed adolescents' self-harm as manipulating and eliciting care. It could be hypothesised that these views are formed through healthcare professionals' identifications with their patients' unbearable experience of being manipulated and feeling out of control.

The concepts of counter-transference and projective identification provide theoretical explanations of the processes contributing to healthcare professionals forming negative views about adolescent patients who self-harm and negative responses to caring for this patient group. These perspectives can be used in thinking about interventions aimed at supporting healthcare professionals to manage the negative impact of the unconscious processes on their practices.

The following practical implications may be considered in providing support to healthcare professionals. Promoting reflection on the responses evoked in the care for adolescents who self-harm to free healthcare professionals from the grip of unconscious processes that impair reality testing. This is somewhat consistent with the literature review findings indicating that it was education and training rather than factual knowledge that were associated with a reduction in the levels of negative views and responses to adolescents' self-harm and in negative self-appraisals of competency and effectiveness in healthcare professionals.

Institutional factors

The above sections linked the findings of the literature review with psychoanalytic perspectives on self-harming behaviours in adolescents and on healthcare professionals' responses to this patient group. Next section will present psychoanalytic perspectives on institutional unconscious processes hypothesised to impact healthcare professionals and their patients.

Theory of Social Defences against Anxiety

The reviewed literature suggested that the task of caring for adolescents who self-harm was complicated by a range of institutional barriers. Menzies-Lyth's (1960) theory of Social Systems as a Defence against Anxiety proposes a theoretical model of thinking about the role of unconscious processes in the generation of institutional barriers. The theory posits that organisational defences, such as an increase in bureaucratic procedures, are unconsciously constructed and maintained by organisations in order to protect their workers from the anxieties stirred by attending to the organisation's primary task, the task the organisation was created to accomplish (Bion, 1961).

Menzies-Lyth (1960) described the anxiety that healthcare professionals experience when caring for their patients by drawing on Klein's (1946) concepts of the paranoid-schizoid and depressive position anxieties. Following this theoretical standpoint, organisational preoccupation with risk prevention and effectiveness may be thought about as a manifestation of institution's anxiety either about survival (paranoid-schizoid) or about causing harm to their patients (depressive).

In line with the above outlined theoretical model, environmental factors (e.g. busy wards, insufficient training) and cultural factors (e.g. risk-oriented practices and inflexible professional identities) may perform a function of protecting healthcare professionals from experiencing painful anxieties by creating emotional and physical distance between healthcare professionals and their patients; however, the theory posits, these defences prevent healthcare professionals from forming therapeutic alliances with their patients. This is of particular importance when thinking about healthcare professionals working with adolescents who self-harm, whose inner worlds, as hypothesised by psychoanalytic perspectives, are populated with hostile and depriving

objects. This is because healthcare professionals' defensive practices maintaining emotional distance may trigger anxiety in their patients.

These theoretical perspectives can be used to consider measures which can be taken to support healthcare professionals in managing high levels of anxiety and reducing their need to resort to defensive practices.

Challenges in psychiatric residential institutions

The literature review showed that healthcare professionals considered admission to an inpatient unit to be associated with an increase in self-harm. This finding can be related to theoretical perspectives on unconscious processes impacting healthcare professionals and their patients in inpatient settings. The application of psychoanalytic theory for understanding of processes that negatively impact patients placed in psychiatric institutions was initiated by Bion and Rickman (Harrison & Clarke, 1992) and was further developed by Main (1975) and his colleagues in their work on the therapeutic community approach (Hinshelwood, 2001). In line with these theoretical conceptualisations, an increase in patients' self-harm can be thought about as an outcome of a complex interplay between healthcare professionals' and patients' internal realities in the context of the psychiatric hospital institution (Main, 1975). Main (1975) proposed that this interplay leads to a mutual projective process between healthcare practitioners and their patients, whereby, patients project healthy aspects of their self onto healthcare professionals caring for them, and healthcare professionals project their vulnerable and 'mad' aspects of their self onto their patients. In this process, both patients and healthcare professionals identify with the projected aspects of the other.

These psychoanalytic perspectives on the unconscious processes present in inpatient services posit that healthcare professionals' motivations to "come to terms with unresolved

issues from their past” (Roberts, 1994, p. 110) and patients’ searches for “magically helpful others to restore them to health from death and madness” (Griffiths & Hinshelwood, 1997, p. 3) prepare the ground for the unconscious processes both groups become affected by when they enter the relationship of care. As a result of the double projective processes, patients and healthcare professionals become stuck in the identities of the ill, needing help (“ultimate helpless”) and the healthy and providing care (“ultimate helpers”; Main, 1975, p. 103). These identities are formed and maintained through the process of projective identification, therefore ill patients and caring professionals cannot exist without each other (Main, 1975).

The psychoanalytic perspectives presented here suggest that the patient, having projected onto professionals his or her own strength, agency and health, is left with the identity of an ill beneficiary within a caring and controlling institution. He or she does not have to face reality, and the institution he or she sought treatment from becomes a refuge, a place of safety where uncomfortable aspects of the self and of the external world do not have to be faced (Skogstad, 2001). Thus the patient can get stuck in a state of “psychic retreat” (Steiner, 1993), out of reach of the pain caused by contact with reality.

Additionally, the perspectives presented here suggest that subjecting patients to care and control in residential settings may lead to their regression (Skogstad, 2001), often manifested as a deterioration in their symptoms, to healthcare professionals’ frustration and guilt about the lack of improvement in their patients (Griffiths & Hinshelwood, 1997). Healthcare professionals may respond to this by modifying and/or intensifying treatments which may be enactments of their anger and aggression stirred by unrealised frustration and guilt (Main, 1957). Main argued that these responses are more likely to emerge in caring for patients whose difficulties are linked to what he called a ‘masochistic nature’, that is those patients who may have a tendency to project their negative and sadistic inter objects onto the other (Main, 1957). These psychic processes are

reminiscent of those hypothesised to determine self-harm. Needless to say, these processes may be detrimental to patients and those who care for them.

The above theoretical conceptualisations go some way to explain the increase in adolescents' self-harm in inpatient units and healthcare professionals' development of negative views and responses to adolescent patients who self-harm. Therapeutic practices which prevent and manage the challenges related to the unconscious processes described above need to be developed.

Application of psychoanalytic perspectives to designing services and treatments for adolescents who self-harm

The discussed psychoanalytic perspectives provided a theoretical explanation of the processes captured by the research review findings. The need for the development of theoretically driven models of treatment to meet the needs of adolescents who self-harm was identified. The outlined psychoanalytic perspectives indicate that there is also a need for the development of theoretically-driven models which will consider the impact of unconscious processes on healthcare professionals' practices in the care of adolescents who self-harm. Ideally, these models would consider the impact of unconscious processes on all of the discussed levels (individual, interpersonal and institutional). Finally, there is a need for the development of theoretically-driven models aimed at reducing the impact of anxiety on patients and healthcare professionals in psychiatric inpatient settings.

Seager (2008) suggested that psychoanalytic theory may perform a containing function in planning and delivering services to patients who self-harm, as it offers a robust conceptual framework for thinking about this task. For example, Bion's concept of container-contained (1962) can be used in thinking about measures increasing mental health care services' capacity

to manage anxieties stirred by caring for their patients. This model of psychological development posits that a child develops their capacity to manage his or her anxieties when their mental states are digested and returned to them in a meaningful form by their caregiver. When this is not provided, the child's ability to manage his or her unconscious mental life is compromised. In this model, the child whose mental states are digested and returned to them is thought about as the 'contained' and the caregiver who performs this functions is thought about as the 'container'. Following this theoretical model, institutions unable to contain the anxiety of their staff and patients are considered to have lower capacity to manage the anxieties stirred by attending to their primary task (Bion, 1961) and to be at a higher risk of relying on the use of unconscious defensive processes to manage these anxieties (Menzies-Lyth, 1960).

Some of the critics of contemporary NHS highlight the risks of a target/performance-based culture, accompanied by the survival anxiety, and argue that contemporary services do not provide a containing function for their staff and push anxiety down into frontline teams (Seager, 2008; Evans, 2015). This helps to understand one of the review findings, suggesting that healthcare professionals working in acute frontline services experience the highest levels of anxiety.

Summary

In this section, the findings of the research review were related to psychoanalytic perspectives.

Institutional barriers were seen as a possible manifestation of social defences employed to protect healthcare professionals from the anxiety stirred by the task of caring for adolescents who self-harm. Healthcare professionals' views and responses to adolescents' self-harm were

related to the concepts of counter-transference and projective identification, and the risks of carrying out actions born out of the unrealised unconscious processes were hypothesised.

Theoretical perspectives on the psychological processes at play in adolescence and self-harm were delineated to propose an explanation of the complexity of the task of providing care to this patient group. The psychoanalytic perspectives presented here support the recommendation made by many authors of the reviewed literature about the need to develop theoretically-driven models appropriate to the needs both of adolescents who self-harm and those who work with this patient group. It is hoped that such models may support healthcare professionals in reflecting on the processes outlined above and can provide the containing function (Bion, 1962). Seager (2008) argues that psychoanalytic theory is best positioned to meet these needs.

In the following section, a novel psychodynamic model developed to meet the above specified needs is presented.

Adolescent Mentalization-based Integrative Treatment and its Possible Use to Address Challenges to Caring for Adolescents who Self-harm

This section provides an overview of mentalization-enhancing therapeutic models developed to address the needs of young patients with poor mentalization capacity, such as those who self-harm. The theoretical assumptions underlining these psychodynamic models are outlined.

Mentalization-enhancing models and approaches utilised for work with adolescents who self-harm are presented. Particular attention is paid to Adolescent Mentalization-Based Integrative Treatment (AMBIT), an innovative treatment approach for work with ‘hard to reach’

young people (Bevington & Fuggle, 2012). AMBIT's possible use for reducing of the impact of the unconscious processes outlined in the previous section is explored.

Theoretical model of mentalization

The theoretical model of mentalization provides a conceptual framework for thinking about psychic processes and personality organisation linked to self-harm.

Mentalization is defined as a “form of (mostly preconscious) imaginative mental activity that enables us to perceive and interpret human behaviour in terms of intentional states” (Fonagy & Allison, 2012, p. 11). Mentalizing involves an observation of the self and others and a capacity to reflect on the content of these observations in terms of cognitions and feelings (Fonagy & Luyten, 2009; Lieberman, 2007). Such mental activity is proposed in this model to lead to the development of an ability to represent one's own psychic experiences, infer psychic experiences in others, and relate these to feelings, behaviours and contexts (Fonagy & Allison, 2012). The emergence of mentalization capacity paves the way for the development of an ability to read one's own mind and the minds of others; and for the development of a coherent sense of self and the ability to relate to others. Furthermore, mentalizing allows for distinguishing inner psychic events from those based in external reality, including the mental life of others. This developmental achievement lays the foundation for affect regulation and attentional control (Fonagy, Gergely, Jurist, & Target, 2002; Fonagy & Allison, 2012).

The emergence of mentalizing is thought to be determined by early childhood experiences and to take place in the relational space between the child and his or her caregiver (Fonagy et al., 2002). For mentalizing to emerge the caregiver needs to recognise the existence and separateness of the child's mental world and his or her intentionality (Bateman & Fonagy,

2004). Caregivers are able to attend to this task when they can mentalize themselves (Fonagy & Allison, 2012).

Secure attachment is seen as a prerequisite for the emergence of mentalizing, and for the development of a representational system of the core self and a mentalizing model of the world (Fonagy & Allison, 2012). Disorganised attachment endangers mentalization development (Fonagy & Allison, 2012; Lyons-Ruth & Jacobitz, 2008). Attachment disorganised by maltreatment may lead to partial mind-blindness, and to difficulties with inferring causal relationships between mental states and actions, representing one's own mental events, and establishing one's sense of agency and separateness. It impairs the individual's capacity for incorporating a representation of a caregiver into the self representation and may lead to a formation of the alien self, a self organisation furnished with an internalisation of an abusive and/or mis-attuned caregivers (Fonagy, 2000).

In a disorganised self-structure, the individual's ability to manage affect is impaired as mental states cannot be represented. Furthermore, the development of the alien self leads to unbearable psychic pain and high affect, accompanied by poor mentalization capacity. The high level of distress caused by this may be managed by identification with an aggressor (Freud, 1936), where one identifies with the aggressive and mis-attuned caregiver and directs the internalised hate and hostility outside the self or against the self (e.g. self-harm). Finally, the internalised representation of an abuser may be expelled through the use of projective identification which locates it in the other (Rosenfeld, 1971).

All of the three ways of managing psychic pain may be employed by an individual with a disorganised identity structure. Also, it is posited that a high level of distress in an individual and the consequent loss of mentalization may impact others, their affective states and may reduce

others' capacity to mentalize (Rossouw, 2012). A process of a systemic loss in mentalization capacity may be set in train when individuals' actions directed at managing their high level of affect impact others and their behaviours.

This conceptualisation of psychic processes leading to self-harm shows reasonably close resemblance to the unconscious processes governing the inner world described in the earlier presented psychoanalytic perspectives. Both theoretical conceptualisations suggest the presence of inner hostility which can lead to psychic pain and a need to manage it by the means of projection and enactment.

Mentalization-enhancing therapies for adolescents who self-harm

The developmental model of mentalizing (Mentalization-Based Therapy) was developed by Bateman and Fonagy (2006) for patients with the diagnosis of Borderline Personality Disorder, and is the precursor of all mentalization-enhancing therapy models. Since its inception, it has been adopted and modified to meet the needs of a range of clinical populations. Mentalization-Based Therapy for Adolescents (MBT-A) is a structured and manualized treatment model which aims at enhancing mentalization in adolescents (Rossouw, 2012).

The theoretical model of mentalization posits that improving mentalizing is crucial to decreasing the need for self-harm (Fonagy, 1998). The aim of mentalization enhancing is “improving understanding of mental states and processes that drive behaviour and relational patterns, as opposed to exploring the unconscious content driving these states or applying behaviourally derived management strategies to specific behavioural symptoms of distress” (Rossouw, 2012, p. 136-137).

In order to support patients in building their capacity for mentalization, healthcare professionals need to be able to promote secure relationships and recognise the separateness of their patients' mental life by adopting a not-knowing stance (Bevington & Fuggle 2012). It is also acknowledged that healthcare professionals' working with adolescents and families who struggle to mentalize are exposed to situations causing higher levels of arousal which endanger their own mentalization capacity (Bevington & Fuggle, 2012).

Adolescent Mentalization-Based Integrative Treatment

The theoretical model of mentalization has been employed in the service of improving clinical practice in multidisciplinary teams working with young people with severe and complex mental health needs. Adolescent Mentalization-Based Integrative Treatment (AMBIT) (Midgley & Vrouva, 2012) adapted the model to the needs of different clinical settings. Since its inception, AMBIT has been widely implemented in the field of adolescent mental health (Anna Freud Centre, 2015).

AMBIT is an integrative framework which offers a collaborative strategy for the development of treatment services for 'hard to reach' young people who find standard treatment provision inaccessible (Bevington & Fuggle, 2012). Its target group are those individuals who because of their complex needs, often including disorganised attachment styles, attract multi-agency support with which they struggle to engage with (Bevington & Fuggle, 2012). It also recognises that healthcare professionals' capacity to engage 'hard to reach' young people is constantly undermined by the high levels of anxiety they experience in their work, causing a loss in their mentalization capacity. As a result, 'hard to engage' young people slip through the gaps in the net of care services (Bevington & Fuggle, 2012). The interrelated processes described

above show some similarity to the impact of projective and counter-transference hypothesised to pose challenges in the care of patients admitted to psychiatric hospitals.

AMBIT attends to these challenges in the following way. It suggests a modification in the multi-disciplinary and multi-agency support for 'hard to reach' young people; it recognises that effective support requires engagement of young people and their surrounding systems. AMBIT also recognises that the disorganised attachment styles of 'hard to reach' young people contribute to their difficulty in forming therapeutic relationships. It proposes inter-agency collaboration efforts which involve delegating and supporting one healthcare professional to engage with the patient and manage his or her care. This relationship performs the function of a safe base necessary for the patient's development (Midgley & Vrouva, 2012). AMBIT also addresses the challenges to healthcare professionals' mentalizing capacity and advocates for the use of mentalization-enhancing interventions not only in work with patients but also in staff teams' supervision.

AMBIT is flexible and can accommodate the particular needs of the given service. It employs wiki manualisation for recording and sharing knowledge about its use in clinical practice (Bevington & Fuggle, 2012).

Challenges and opportunities

AMBIT provides a theory-based, innovative and flexible approach which can be of benefit for adolescents who self-harm and those who work with this group of patients. It offers a theoretical framework and interventions for addressing processes which are hypothesised to generate challenges to healthcare professionals providing care to adolescents who self-harm.

AMBIT may provide the function of containment (Bion, 1962) to organisations providing care to adolescents who self-harm. Specifically, it provides theoretical and practice tools for normalising healthcare professionals' negative responses to adolescents who engage in self-harm and for supporting healthcare professionals in reflecting and managing such responses. By providing a containing function and promoting healthcare professionals' reflection on their practices it may minimise the negative impact of acting on unrealised unconscious processes.

Unfortunately, research evidence supporting the effectiveness of mentalization-enhancing treatment models in work with young people, including those who self-harm, is scarce (Midgley & Vrouva, 2012). Furthermore, implementation of mentalization-based models is complex and challenging. For example, Hutsetbaut and colleagues (2012) study reported difficulties in the process of implementing Mentalization-Based Treatment adapted to the needs of inpatient adolescents with the diagnosis of Borderline Personality Disorder. There was a range of general and context specific organisational, team, therapist and patient factors identified. These included: the lack of familiarity with the theoretical model among nursing staff; limited provision of supervision; division between nursing and multi-disciplinary teams; and frustration as well as loss of confidence among healthcare staff. These difficulties were compounded by the complex needs of the young people being treated.

Bevington and Fuggle (2012) suggest two additional factors which may contribute to healthcare professionals' difficulties with implementing the approach. They thought that professionals may be reluctant to use manualized protocols recommended by AMBIT as they may experience these as imposed by higher management structures as well as being too rigid for use alongside clinical acumen (Addis & Krasnow, 2000). Furthermore, manualized treatment may be ill-equipped for guiding clinical practice in the everyday reality of healthcare services which have to contend with local and individual needs (Bevington & Fuggle, 2012).

AMBIT attempts to overcome some of the identified challenges. The approach stresses the importance of adherence to clinical governance procedures and respect for evidence. But, at the same time it recognises the importance of local expertise for designing services to meet the particular needs of 'hard to reach' patient populations (Dickenson & Fuggle, 2012).

Summary

This section outlined the theoretical underpinnings of mentalization-enhancing treatment models and their application for work with adolescents who self-harm. Adolescent Mentalization-Based Integrative Treatment (AMBIT), a psychodynamically-oriented approach to care for 'hard to reach' young people, was described. It is proposed that this treatment model could be employed to remedy the impact of the outlined earlier unconscious processes on healthcare professionals' work with adolescents who self-harm. However, it was envisaged that a healthcare professionals may encounter difficulties in applying this approach.

Rationale for the Study

Self-harm among adolescents is pervasive and its prevalence has been increased in recent decades (McDougall, Armstong, & Trainor, 2010). Adolescents who self-harm were reported to seek help reluctantly, and some of those who accessed help reported negative experiences related to healthcare professionals' negative attitudes (Crawford, Geraghty, Street, & Simonoff, 2003). This thesis sets out to investigate this issue which is seen here as a barrier to accessing care by adolescents who self-harm.

A literature review was conducted and its findings indicated that healthcare professionals' negative views and responses to adolescents' self-harm were linked to negative views on their effectiveness and competence in caring for this patient group, the complexity of

this task and by institutional factors. The data indicated that the highest levels of negative views and responses were reported by healthcare professionals working on the frontline in hospital settings.

These literature review findings were considered in light of psychoanalytic perspectives on unconscious individual, interpersonal and institutional processes affecting frontline teams in inpatient services. Adolescents' self-harm was related to perspectives on unconscious internal object relations and defence mechanisms. Healthcare professionals' negative views and responses to adolescents who self-harm, including views on their own competency and effectiveness, were related to concepts of counter-transference and projective identification. Institutional barriers were linked to the conceptualisation of social defences. The increase in self-harm in adolescent inpatient services was related to psychoanalytic perspectives on the impact of unconscious processes on patients and healthcare professionals.

Counter-transference and projective identification reactions, social defences and double collusive projective processes were hypothesised to pose significant challenges to healthcare professionals' capacity to care for their patients. Lack of containment in healthcare institutions was hypothesised to intensify the negative impact of these processes. It was proposed that the development and application of psychodynamically-oriented therapeutic models were needed to provide a conceptual framework and practice guidance for healthcare professionals who work with adolescents who self-harm.

In light of the above, healthcare professionals' negative views and responses to adolescents' self-harm were seen as one of many challenges encountered by healthcare professionals working with adolescent patients who engage in self-harm, particularly in inpatient services. For this reason the study aims to investigate the specific challenges faced by inpatient

frontline teams related to the processes hypothesised by the theoretical models of counter-transference, projective identification, social defences and patient-carer collusive projective dynamics.

It is hypothesised that psychodynamically-oriented theoretical treatment models may offer containment to frontline teams and reduce the impact of the above processes. Adolescent Mentalization-Based Integrative Treatment (AMBIT), a psychodynamically oriented approach to caring for ‘hard to reach’ adolescents, may remedy the above outlined challenges in the work of frontline teams caring for adolescents who self-harm. However, its complex theoretical underpinnings may pose challenges to frontline professionals’ attempts to use it.

The current research took place from a critical realist position, within which the advancement of knowledge is achieved by scientific evaluation of the validity of the existent theoretical perspectives. Therefore, it aimed to explore the researched phenomena and to investigate whether the generated data converge with the introduced theoretical perspectives and the hypothesised impact of psychodynamically-oriented interventions.

Therefore, this research aimed to investigate the challenges inpatient frontline professionals encountered in the care of adolescents who self-harm and how healthcare professionals responded to these challenges in an inpatient service which implements AMBIT. Particular attention was paid to frontline professionals’ application of this approach. Finally, the research aimed to attempt to conduct a “formative evaluation” (Weiss, 1994, p. 179) by investigating processes which shaped existing practices, including the application of AMBIT.

The research project questions were:

- What are the challenges inpatient frontline professionals encounter when caring for adolescents who self-harm in an inpatient unit which implements AMBIT?
- How do frontline team professionals respond to the identified challenges?
- How do frontline team professionals draw on AMBIT when caring for adolescents who self-harm?

Summary

This chapter started with a brief outline of the reasons for the development of good practice guidelines for working with adolescents who self-harm. This was followed by a presentation of a narrative synthesis of research in the area of healthcare professionals' views and responses to adolescents' self-harm. The reviewed literature was related to psychoanalytic perspectives to provide a theoretical framework for explaining relationships in the data. The impact of unconscious processes was hypothesised and the need for development of psychodynamically-oriented theoretical models was advocated for. The section continued with a brief introduction to mentalization-based models and their benefits for adolescents who self-harm and services which treat them. The chapter concluded with a presentation of research rationale, aims and research questions. In the next chapter, the methodology is presented.

Chapter 2: Methodology

Chapter Overview

This chapter outlines the design and methods employed in this study. It gives an account of the theoretical position taken and the rationale for its choice. This is followed by a presentation of sampling, recruitment, data generation and analysis procedures. The chapter continues with a discussion of relevant ethical issues and concludes with a description of the measures taken to increase the rigour of the study.

Qualitative Paradigm and Methods

The term ‘qualitative’ is used to refer to research methods and a wider paradigm, defined assumptions and practices shared by a given research society (Kuhn, 1962). The qualitative research paradigm provides a conceptual framework for designing research exploring people’s subjective worlds and meanings (Braun & Clarke, 2014). It rejects the positivist scientific model of research and its assumption of objectivity; instead, it assumes that research generates knowledge that is determined by its context and the researcher’s subjectivity (Silverman, 2013).

The qualitative paradigm offers a particular view of the world as a subject of research enquiry. In contrast to the quantitative approach, in which the object of enquiry is seen in terms of variables and the relationships between them, in qualitative research the world is seen as consisting of “people, situations, events, and the processes that connect these; explanation is based on analysis of how some situations and events influence others” (Maxwell, 2013, p. 29).

Qualitative research is a rich and diverse field (Madill & Gough, 2008) in which naturalistic collection methods are employed to generate real life data and to investigate people’s subjective worlds. It may explore different aspects of reality through investigating participants’

perspectives, meanings, experiences and actions. Depending on the aims of the given project, the focus may be placed on social phenomena understood either as a part of study participants' reality (affect, intentions, cognition) or participants' constructions (Maxwell, 2013). The former phenomena tend to be investigated with exploratory research and the latter with critical research (Reicher, 2000). In exploratory research the focus is placed on the elaboration and validation of participants' experiences. In critical research the emphasis is put on the interrogation of the processes involved in data generation. Notably, qualitative research often employs language as a tool for accessing the investigated researched phenomena (Braun & Clarke, 2014).

Qualitative research can be used for formative evaluation (Patton, 2001) by investigating processes which shape existing practices. It can achieve this aim by investigating how specific phenomena contribute to clinical outcomes and by exploring the processes by which that happens. Formative evaluation attempts to identify causality by attending to "the description of a visualizable sequence of events" (Weiss, 1994, p. 179). Identification of causality in the processes shaping investigated practices is required for practice improvement.

The choice of research paradigm and focus in the current study

The choice of qualitative methods in the current study was determined by the research aims. The first aim was to investigate the challenges frontline professionals encountered in caring for young people who self-harmed in an inpatient unit which implemented an innovative treatment approach. The project also aimed to investigate healthcare professionals' responses to the identified challenges. This involved identifying causal processes contributing to the observable phenomena. To achieve these aims exploratory qualitative methods were employed and descriptive data were generated to review relevant theoretical perspectives.

The second aim of the project was to provide aspects of formative evaluation (Weiss, 1994) of the processes and interventions which shape existing practices in the researched area. Exploratory qualitative methods were employed to generate descriptive data to capture the causal mechanisms shaping participants' practices in the participating service, particularly relating to the innovative intervention implemented.

Finally, qualitative methods were employed as the researcher aimed to explore the researched phenomena within its context.

Theoretical assumptions: Critical Realism

This section provides a brief outline of the theoretical assumptions employed in this study and the rationale for their choice.

It is crucial to establish a theoretical position with respect to the researcher's view of the nature of reality (ontology) and knowledge (epistemology) in order to justify the choice of the methodology and to establish the measures required for ensuring high rigour of the research study (Holloway & Todres, 2003).

Ontological and epistemological position

Theoretical views on the nature of reality and knowledge are subject to ongoing discussion in the world of social science (Denermark, Ekstrom, Jakobsen, & Karlsson, 2002). On one hand, there is a realist position which posits that there is a world (reality) which exists independently of humans' attempts to explore it, and that the pursuit of generating knowledge is restricted to collecting data on what can be empirically observed (Maxwell, 2012); on the other hand, there is a non-realist position, which argues that reality does not exist outside of the

construction of different individuals and societies, and that research can only attempt to generate knowledge about the generative mechanisms of these constructions (Maxwell, 2012).

None of the above theoretical positions accommodate on their own the view on the nature of reality and knowledge taken by the researcher in this investigation. The researcher considered the investigated phenomena to exist in reality; however she also recognised that the outcome of the generation of knowledge about the explored phenomena was going to be socially constructed. For this reason, this study takes a critical realist stance, which moves beyond the earlier presented dichotomy of view on the nature of reality and knowledge and “combines and reconciles ontological realism and epistemological relativism” (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998, p. xi). Such perspectives are presented below.

Theoretical perspectives on the nature of reality

A critical realist position uses the ontological realism premise in its view of reality and proposes that “there is a real world that exists independently of our perceptions and theories” (Maxwell, 2013, p. 43). Its unique theoretical conceptualisation of reality offers an ontological map consisting of three domains: the empirical (what we can experience empirically, it is theory-dependent and theory-laden); the actual (actual events which may or may not be experienced empirically); and the real (mechanisms which generate events taking place in the actual domain which cannot be directly accessed; Bhaskar, 1978).

This research project hopes to access the actual domain of reality (challenges and responses to the clinical practice of caring for adolescents who self-harm) and the real domain of reality (causal mechanisms underlying the challenges and responses to them) by gathering descriptive data in the empirical domain (healthcare professionals’ accounts of their experiences).

Theoretical perspectives on the nature of knowledge

This study employs a critical realist stance in how it views the process of generating knowledge in social sciences. This stance proposes that our understanding of the world is a social construction, not an objective perception, and that an investigation of the ‘real world’ is always altered by the researcher’s subjective reality (Denermark, Ekstrom, Jakobsen, & Karlsson, 2002).

Knowledge is seen as conceptually mediated, theory dependent and theory laden but not theory determined (Denermark et al., 2002). Knowledge is also seen as deeply influenced by social practices and these practices are a part of. In this vein, natural and social science ‘facts’ are seen as dependent on relevant contemporary theories available for the conceptualisation of researched phenomena, and on the researcher’s social and ideological position.

Finally, knowledge production within social sciences involves double hermeneutics. The social scientist’s task is to interpret other people’s interpretations of the investigated phenomena, and other people’s understandings are an inseparable part of the object of the study. Therefore participants’ contribution to the research is shaped by their active participation in the researched phenomena and by their participation in the process of production of knowledge (Denermark et al., 2002).

The researcher therefore considers the findings generated within double hermeneutics to be socially-dependent and socially-constructed facts.

Theoretical perspectives on science and the role of theory in knowledge advancement

Within a critical realist stance, knowledge is seen as fallible yet open to modification and development (Denermark et al., 2002). Its advancement depends on finding methods for the

identification of theories and conceptualisations which best inform about the external reality (Archer, Bhaskar, Collier, Lawson, & Norrie, 1998) and on conscious and systematic scrutiny of them (Sayer, 1992). Knowledge advancement can be achieved through scientific practice, which in critical realism is seen as one of many socially-determined practices that needs to be thought about in relationship to language, conceptualisation and meaning production (Denermark et al., 2002).

Scientific endeavour in a critical realist stance is conceptualised as having two dimensions, intransitive and transitive, the existence of which Bhaskar (1978) has referred to as the “central paradox of science” (p. 21). The intransitive dimension is never directly accessible by science. The transitive domain consists of contemporary theories describing researched phenomena which in themselves are objects of scientific practice. Scientific practice takes place in the transitive domain where existent theories are subject to systematic scrutiny and transformed in order to discover knowledge of a deeper reality which cannot be known directly (Denermark et al., 2002). Needless to say, the transformed theories are never seen as perfect but as the best possible approximations of a deeper reality determined by its current historical and cultural context. Scientific endeavour is aimed at refining these lenses. As a result science is seen as social practice which aims to get closer to the understanding of reality rather than to generate scientific knowledge.

Contemporary conceptualisations and theories which describe reality may be seen as constraints to accessing deeper reality; however, they provide interpretative frames of reference without which communication about deeper reality could not be meaningfully shared.

Methods of knowledge and advancement on the researched phenomena

Critical realism's ontological and epistemological positions' claims have direct implications on research practices. In this approach, it is not the surface level of reality (the empirical domain) but the deeper level of reality (the actual and the real domains) that are the objects of the research endeavour (Denemark et al., 2002). Those levels of reality can be uncovered by an analysis of the causal mechanisms generating the researched phenomena and knowledge about these allows research to make generalisable claims about its discoveries. However, as it is impossible to fully access deeper reality, critical realism takes on a pragmatic stance by establishing what is known already and by subjecting it to systematic scrutiny (Denemark, et al., 2002).

The rational for the use of critical realist stance in this study

This study aims to advance knowledge by subjecting current theoretical explanations of the studied phenomena to systematic scrutiny using the research methods detailed below. The actual and real domains of reality are uncovered through an analysis of the casual mechanisms in the researched phenomena. This is achieved by a systematic analysis of generated data.

In line with a critical realist perspective, the methods, social positioning and theoretical stance employed in this research endeavour are seen as influencing the researcher's viewpoint, and limit what the researcher is able to observe.

Thematic analysis

Different paradigms employing different philosophical assumptions about the nature of reality (ontology) and knowledge (epistemology) are employed to set foundations for research

design methods in quantitative and qualitative research. Abbott (2001, 2004) argued that those theoretical positions need to be considered in establishing study design.

Thematic Analysis (TA) is a pattern-based data analysis method for identifying, analysing and reporting themes across datasets. It is theoretically flexible and not tied to any particular collection method or set of ontological and epistemological positions. These qualities make it a very popular, although not always fully recognised data analysis method in psychology (Roulston, 2001). Although TA was first named in the 1970s (Merton, 1975), it had not been recognised as a distinctive research method until it was operationalised by Braun and Clarke (2006) in the last decade.

Braun and Clarke (2014) suggest that TA is a versatile research method which can be used at any point on the spectrum of qualitative research. It can be applied to descriptive and exploratory research, investigating semantic (descriptive, surface level) data. It also can be employed in interpretative research, which looks beyond the surface level of data and explores meaning at a deeper or latent level. TA may be conducted either inductively and apply data-driven, ‘bottom up’ analysis, or deductively and apply ‘top down’ theoretical analysis. Finally, depending on the ontological and epistemological assumptions employed, TA may be placed at any point on the realist–relativist spectrum (Braun & Clarke, 2006).

Application of thematic analysis in this study

The current study takes advantages of the versatility of TA as a pattern-based data analysis method to investigate the researched phenomena and their underlying generative processes. It is used in an inductive way to elucidate the deeper reality accessed through participants’ verbal reports of their experiences, cognitions and behaviours. The analysis attends only to the semantic level of the generated data; therefore language is treated as a way of

accessing participants' accounts of the researched phenomena and is not subjected to data analysis.

Sampling

The sampling size and strategy employed were determined by the research questions, methods and theoretical frameworks.

Sampling strategy and size

In line with the methodological guidance for qualitative design studies, the study was conducted in its natural setting “at the site where participants experience the [...] problem under study” (Creswell, 2012, p. 45).

Convenience purposive criterion sampling (Patton, 1990) was employed. Purposive sampling in respect to the setting and participants aimed to select participants who had witnessed the researched phenomena (Weiss, 1994). Their participation in the project was believed to offer high chances of generating “insight and in-depth understanding” (Patton, 2002; p. 230) relevant to the researched phenomena. Criterion sampling aimed to select participants according to whether they meet the inclusion criteria, as specified below. These needed to be extended in order to recruit a sufficient number of participants.

Convenience sampling was a necessity. This was because of the small size of the recruitment population and the low number of individuals interested in participation in the study. Nonetheless, convenience sampling had its benefits as it allowed for recruitment of participants whose interest in the study fostered a productive relationship required for generating rich data (Maxwell, 2013; McCosker, Barnard, & Gerber, 2001).

Inclusion and exclusion criteria

Initial inclusion criteria for participants' recruitment were defined as follows:

1. Frontline professionals (registered and un-registered);
2. Healthcare professionals who had an introduction to AMBIT and acquired the following experience after this introduction;
3. Healthcare professionals who had been involved in the prevention and management of adolescents' self-harm, understood as acts of self-cutting, self-mutilation, self-strangulation, head-banging, with or without intent to die, among inpatient adolescents on extended observations.

The recruitment based on the above criteria did not yield a sufficient sample size; therefore the second criterion was extended to:

Healthcare professionals who had experience of the prevention and management of self-harm among adolescent patients treated on the participating unit and acquired this experience after AMBIT was implemented in this setting.

The following exclusion criteria were applied:

1. Non-frontline healthcare professionals employed in clinical and non-clinical roles at the participating unit (e.g. consultant psychiatrists, clinical psychologists, social workers, etc.);
2. Healthcare professionals with no experience of prevention and management of self-harm among adolescent patients treated at the participating unit;
3. Healthcare professionals who had no experience of working at the participating unit after AMBIT was implemented;
4. Healthcare professionals who had limited understanding of the English language.

Recruitment site

Study participants were recruited from an adolescent inpatient Tier 4 psychiatric unit in a local NHS Trust. The unit offers assessment and treatment to young people (thirteen to seventeen years old, up to their eighteenth birthday) with severe mental health difficulties. The unit has places for fourteen young people. It offers a comprehensive range of assessments and treatments delivered by a multi-disciplinary team of psychiatrists, nurses, healthcare assistants, an occupational therapist, clinical psychologists, a family therapist, an art therapist, outreach workers, a dietician and teachers.

The frontline team provides nursing care to young people admitted to the unit twenty-four hours per day and is composed largely of mental health nurses and healthcare assistants with varied levels of responsibility.

The length of stay and the type of admission depends on the young person's needs and circumstances. Most young people stay for around eight to ten weeks, but shorter and longer admissions are offered according to the clinical need of the given patient. The inpatient unit implements Adolescent Mentalization-Based Integrative Treatment (Dickenson & Fuggle, 2012) introduced into the unit approximately one and an half year before the recruitment for this study started. The unit attempts to provide all newly employed frontline professionals with a brief introduction to the model which varies in length from a couple of hours to a day.

Sample size and characteristics

Following the recommendations made by Braun and Clarke for a medium size research project (2014), the sample size of twelve participants was considered as sufficient for the needs of the current project. All participants were recruited from the unit's frontline team. Ten

participants met the initially specified inclusion criteria and two were recruited following the reported extension to the inclusion criteria.

All study participants were female. Nine were in their twenties, one was in her thirties and two were in their fifties. Equal numbers of nurses and healthcare assistants were recruited. Only two participants reported having attended a full day introduction to AMBIT, eight attended an introduction session lasting from one to three hours and two did not attend a formal introduction. Participants reported varied levels of training and length of employment on the unit. Recruited sample demographic data are presented in the Table 1, below.

Table 1. Study participants' demographic data

Participant number	Gender/ Age	Professional role/level of responsibility	Educational background	Length of work at the unit (in years)	Training in AMBIT (in hours)
1	F/20-30	Healthcare assistant (HCA)/low	psychology (undergraduate)	1-3	2
2	F/20-30	HCA/low	psychology (master's); counselling	<1	7
3	F/20-30	HCA/low	psychology (undergraduate, master's)	<1	2
4	F/20-30	Nurse/high	mental health nursing	<1	7
5	F/30-40	HCA/low	n/a	3-5	3
6	F/50-60	HCA/low	n/a	1-3	3
7	F/20-30	Nurse/medium	psychology (undergraduate); mental health nursing	1-3	1
8	F/20-30	Nurse/medium	mental health nursing	<1	3
9	F/20-30	Nurse/high	mental health nursing	1-3	3
10	F/50-60	Nurse/medium	psychology (undergraduate); mental health nursing	1-3	3
11	F/20-30	HCA/low	psychology (undergraduate)	1-3	None
12	F/20-30	Nurse/medium	mental health nursing	<1	None

Recruitment Procedure

Data collection was completed over four phases.

Information sharing

Adhering to unit procedures, the researcher liaised with nursing management to promote the study at staff meetings. This involved disseminating information regarding inclusion criteria and the procedure for expressing interest. Information about the research was presented face-to-face by the researcher within the staff meetings and written copies of the 'Invitation Letter' and the 'Participant Information Sheet' (Appendices B and C) were distributed. In order to reach healthcare professionals unable to attend the meetings, an email was circulated among frontline professionals with an invitation to the study and with full information about it. Additionally, a poster was placed in the staff office (Appendix D).

The researcher informed potential study participants about their rights to retrospectively withdraw consent to participate, and outlined the strategies taken to protect their anonymity and procedures for managing the risk of harm to their professional and psychological lives. The 'Invitation Letter' summarised the above mentioned information and the 'Participant Information Sheet' detailed information about the project. The researcher's contact details were included in both documents.

Participants who expressed interest

Frontline professionals interested in participating in the study contacted the researcher. Following an expression of interest raised by a healthcare professional, the researcher checked with them that they met the inclusion criteria, and arranged a suitable time and place to meet.

Interviews

Willing participants were met at the agreed time and date, and consent to participate was sought after restating the participants' right to withdraw from the research, measures to protect anonymity, and professional and personal safety. Participants' consent was recorded on a Consent Form (Appendix E). The aims and procedures involved were reiterated, and after participants agreed to participate in the study, an interview commenced. Interview participants were offered a £10.00 gift token as an expression of the researcher's appreciation for their time and effort (Appendix F).

Data Generation

Rich qualitative data were generated from individual semi-structured open-ended interviews.

Qualitative data

Qualitative research uses words as its language data (Tolich & Davidson, 2003). In the current research, the 'words' data were generated from study participants' accounts which were audio recorded and transcribed. It was recognised that the transcripts were approximations of what the research participants had communicated and suffered inevitably from the 'selective arrangement' involved in the transcription process (Sandlerowski, 1994, p. 311). This was an outcome of the researcher's engagement with the audio data which required choices about content and presentation (Braun & Clarke, 2014).

Individual interviews

Face-to-face individual interviews were employed to gain access to participants' experiences relevant to the investigated area (Rubin & Rubin, 1995). Interviews lasted from forty five to ninety minutes. None of the participants volunteering in the study withdrew.

Materials

In-depth semi-structured interviews with open-ended questions were used to investigate the researched phenomena (Creswell, 2012). An interview guide was constructed to gather data relevant to the research questions (Appendix G). The schedule attempted to elicit event-centred stories in which study participants could comment on the researched phenomena. This story-telling strategy attempted to capture relevant material and psychological factors.

The guide was developed in consultation with inpatient unit staff, clinical practice and academic supervisors. The guide was applied flexibly to allow participants to discuss issues relevant to them which the researcher had not anticipated.

Interviewing procedure

All participants were asked the same questions to allow for "greater comparability in response, and increased simplicity in coding" (Potter & Wetherell, 2005, p. 163). General questions promoting rapport were asked before proceeding to questions about healthcare professionals' experiences, views and behaviours about the 'sensitive' object of the study (McCosker, Barnard, & Gerber, 2001). At the end of the interview participants were encouraged to add any other information and share their experience of the interview.

The importance of establishing good rapport and partnership with study participants was crucial. The researcher provided participants with full information about the aims of the study and the potential threats to their privacy, so they could make an informed choice about the level of disclosure they were comfortable with.

Data transcription

The orthographic transcription style was employed to represent the audio data in a written form as the focus of the study was on ‘what’ study participants said about the researched phenomena. This style was employed to ensure consistency and a high quality of transcription of audio data to written language (Braun & Clarke, 2014).

An adapted version of a notation system developed by Jefferson (2004) was employed. The transcription included all verbal utterances. To preserve the shape of the original data, limited punctuation was used. Reported speech was indicated with inverted commas and each speaker was identified with a number. New utterances (turns of talk) were recorded in a new line. Data that could compromise the anonymity of the research participants were not transcribed.

Method of Analysis

Descriptive pattern-based thematic analysis (Braun & Clarke, 2014) was used for qualitative data coding and analysis. The analysis focused on an exploration of the content of the accounts relevant to the researched phenomena.

Thematic analysis stages

The following stages of data analysis adapted from Braun and Clarke (2014) were followed.

Transcription

The first stage of the data analysis was the transcription process which allowed the researcher to become familiar with the data and start forming analytical ideas. This process resulted in a dataset incorporating all transcribed audio data (Braun & Clarke, 2006).

Reading and familiarisation

This stage involved the researcher familiarising herself with the dataset and making records of items which seemed relevant to the research questions. The textual data were read repeatedly and items of interests recorded.

Following Braun and Clarke (2014), the researcher recognised that familiarisation is an active process of analytic and critical engagement with the data with the goal of trying to make sense of what the data means.

Coding

Complete coding across the entire dataset was carried out to answer the research questions. The aim was to break the data into discrete fractures which could be used for the generation of categories and concepts (Maxwell, 2013).

Semantic (surface, data-driven) codes were generated from participants' accounts. This was followed by a generation of systems of codes of data potentially relevant to the research

questions. These systems of codes were analysed again and relevant research categories and clusters showing content or conceptual similarity were identified (examples of coding in Appendix H).

This initial stage of sorting data was required for further data organising and later identification of themes. This was the only stage of the data analysis conducted using the MAXQDA software programme and the additional use of the Microsoft Excel.

Searching for themes

Semantic categories were subjected to further analysis. Initial semantic themes (larger patterns of data) were identified. Braun and Clarke (2014) defined themes as broader, multifaceted patterns of data capturing ideas relevant to the research questions organised around a central concept. Where appropriate, a hierarchical system for organising themes was developed. Conceptual maps were produced for visual representation of the semantic themes and the relationships between them. Finally, tables recording all data were produced for further analysis aimed at reviewing the themes (examples of coding in Appendix I).

Similarly to coding, identifying themes was an active process susceptible to the researcher's frame of reference (Taylor & Ussher, 2001). And the interplay between the type of data collected and researcher's choices determined the outcome of this stage of analysis. This stage of the analysis was conducted using Microsoft Excel software.

Reviewing themes

A recursive analysis was conducted on the whole dataset to check the potential themes against earlier identified codes. The generated themes were confirmed, revised and excluded depending on how well they fitted the datasets and a coherent system of themes was generated.

Reviewing and naming themes

The themes were refined by producing names and definitions. The resultant system showed a map of generated patterns in the data providing answers to the research questions. Summaries of the themes were written. Text extracts were chosen. The outcome of this stage was a narrated interpretation of the generated themes and their relevance to the research questions. A final conceptual map was produced for visual representation of semantic themes and the relationships between them.

In the discussion, the generated themes were related to the relevant literature, theoretical frameworks and research relevant to the researched phenomena. Areas requiring further investigation were noted.

The last stage of analysis was conducted using Microsoft Word software.

The researcher reflected on the impact of her subjectivity on the process of analysis in the reflective journal. The theoretical stance taken in respect to the impact of the researcher's and study participants' subjectivities is described in the following section.

Reflexivity and Researcher's Position

In contrast to the positivist research tradition, where the researcher's bias is seen to interfere with the enterprise of research and something that needs to be eliminated, this research project followed a view that the researcher's perspective contributes to the research process but it needs to be recognised (Maxwell, 2013). This influence was not necessarily seen as unconstructive; however, it was recognised that the researcher's initial views and assumptions needed to be considered before the data were collected and analysed. Following Reason's (1994)

idea of critical subjectivity, the researcher considered her conceptual baggage to be a useful tool in the research project.

The researcher took a reflexive view on the impact of her experience, knowledge and beliefs (personal reflexivity) and wider contextual factors (functional reflexivity) on the research process (Wilkinson, 1988; Malterud, 2001). Following recommendations made by Lincoln and Guba (1985), the researcher recorded her reflections on the impact of these factors in the research in a reflective journal (Appendix I) which evidenced her analytic decisions.

The role of the researcher's experience, and her preconceptions and familiarity with particular theoretical frameworks were recognised as factors shaping the process of transcription and data analysis.

The researcher took on a reflexive stance with respect to negotiating entry to the unit (Marshall & Rossman, 1999), and to setting and negotiating relationships with study participants (Maxwell, 2013). The researcher thought about the role of context and the aim of the study in thinking about the level of rapport achieved in the interviews.

Finally, in line with a critical realist stance (Maxwell, 2012), the researcher acknowledged that the investigated phenomena could not be accessed directly. A double hermeneutic stance was employed and the researcher recognised that the generated data were shaped by participants' interpretations of the researched phenomena and by the researcher's interpretations of participants' accounts (Denermark et al., 2002).

Ethical Issues

In the process of designing this research project, the researcher reflected on the relevant ethical issues. As a result the following measures were taken to ensure high standard of ethical conduct.

Ethical approval

Ethical approval was gained from the Research and Development (R&D) service within the NHS Trust commissioning the services provided by the participating unit (Appendix K). The research project was also approved by the University of Essex (Appendix K).

Ethical considerations for recruitment

Following the Code of Human Research Ethics (BPS, 2010), all participants were informed in writing about the aims of the study, potential risks and benefits, limits of confidentiality and the right to withdraw from the project in the 'Invitation Letter' (Appendix B), the 'Participants Information Sheet' (Appendix C); and in person at the beginning of the interview process.

Also, potential participants were allowed to contact the researcher before they decided to take part in the study to clarify any relevant issues. This was done to support potential study participants to make an informed choice about participating (Barker, Pistrang, & Elliott, 1994). Written consent was obtained from frontline professionals who agreed to participate (Appendix E).

Convenience purposive sampling was employed to increase the chances of recruiting participants who felt confident about sharing their experiences, and who had high clinical

Challenges to frontline professionals in care for adolescents who self-harm

expertise and exposure to the researched phenomena. This sampling strategy was used to minimise the risk causing harm to participants' professional life.

The British Psychology Society Ethics Standards (BPS, 2010) were adhered to in the research selection process so that the potential study participants did not feel that they had fallen victim of favouritism. This was achieved by recruiting the first twelve participants who expressed an interest in the study and met the inclusion criteria.

Ethical considerations for data collection

Following guidance of the Code of Human Research Ethics (BPS, 2010) full consideration was given to maintaining research participants' anonymity and confidentiality during the data collection process.

To ensure participants' anonymity and privacy, the interviews were held in private meeting rooms in the inpatient service, separate from the adolescent inpatient ward. The interviews were audio recorded on a digital sound recording system. Limited personal information was collected to describe the participants sample.

Information generated in interviews did not raise concerns about the safety of the study participants and/or others. Similarly, the generated data did not raise concern about unethical practice. Therefore, the researcher did not need to make exceptions and the confidentiality of the obtained data was fully ensured.

Full consideration was given to the discomfort participants experienced in the interview procedure. To minimise the risk of emotional discomfort, a protocol for conducting interviews focusing on sensitive phenomena was employed (McCosker, Barnard, & Gerber, 2001), which detailed strategies reducing the psychological impact of the research (Appendix L).

The researcher recognised that her study was an intrusion into the worlds both of those who agreed to participate in it and of other healthcare professionals working on the inpatient unit participating in the study (Maxwell, 2013). Special consideration was given to how potential and actual participants perceived and responded to the project. The researcher took careful steps to minimise the power imbalance between the researcher and the participants by providing full information about the research and the limits of confidentiality.

Ethical consideration about data storage and data dissemination

In line with the Code of Human Research Ethics (BPS, 2010), participants' anonymity and confidentiality were protected in data storage and data dissemination.

Following the interview, the digital recordings were stored on a password protected computer in password protected and encrypted electronic files. Each recording was transcribed and given a unique identifying code. All names and places were anonymised and contextual identifiers were removed, or modified, within the presented quotations. The sample was described according to participant inclusion and exclusion criteria and minimal demographic data were reported.

The collected data were stored securely on the University of Essex computer system and, after being anonymised, on the private computer of the researcher. Only one of the academic research supervisors had access to anonymised digital records and the anonymised transcripts from the interviews. No other professionals and academic staff had access to the research data. The data were not transferred outside of the United Kingdom.

Research participants were advised about the relevant measures in the 'Invitation Letter' (Appendix B) and in the 'Participants Information Sheet' (Appendix C).

Research Rigour

The measures taken to increase the research rigour of the current study in respect to its validity, generalisability and transferability are detailed in this section.

Validity

The validity of the qualitative research is understood as “the correctness and credibility of a description, conclusion, explanation, interpretation or other sort of account” (Maxwell, 2013, p. 122) and it depends on the theoretical assumptions employed (Maxwell, 2013). In this research project identifying of the specific threats to validity and the appropriate measures to overcome these was done from a critical realist standpoint.

In qualitative research, measures to counteract threats to validity entailed of using research evidence for ruling out alternative interpretations of generated data (Huck & Sandler, 1979). In this project, the researcher identified a number of validity threats. These included: researcher’s bias, reactivity, participants’ bias; and more generic threats to validity, such as threats to the validity of data description, analysis and interpretation. This section follows with a description of the measures which were put in place to respond to the identified threats.

The researcher’s bias

The researcher took a reflexive stance in data generation and analysis, and sought feedback from her research and clinical supervisors to minimise the impact of the researcher’s bias on the process of project design, analysis, interpretation and theorising.

A clear data analysis procedure was generated to ensure that the analysis was conducted in a systematic manner. This helped the researcher to select not only the data which fitted her theories but also the data which did not stand out to the researcher (Miles & Huberman, 1994).

In qualitative research it is broadly recognised that it is impossible to eliminate the researcher's influence on the research study (Hammersley & Atkinson, 1995) and within the employed ontological and epistemological position it is clearly recognised that the researcher always influences the process of research. The researcher used a reflective diary (Appendix J) to promote her reflexive stance (Hammersley & Atkinson, 1995), to reflect on her theories and preconceptions, and on the potential impact she might have had on the research project. All these measures helped the researcher to gain an awareness of her own influence on the project.

Reactivity

The researcher also paid attention to how her conduct may have impacted the participants' reactions to the research study and shape their contributions. The researcher attempted to identify her own views about the researched phenomena and the research population by using a reflective diary (Appendix J) before she contacted the research site. The researcher also used a semi-structured interview with open-ended questions to minimise her impact on the process of data generation.

One of the validity threats related to the study participants' reactivity in the current research project was related to the limits of confidentiality. In order to mitigate this impact, the researcher actively fostered participants' sense of agency in respect to their participation in the process of generating knowledge. This was achieved by acknowledging study participants' expert roles, by providing study participants with detailed descriptions of the aims of the study and by maintaining transparency about the restrictions to confidentiality.

All these measures were taken to minimise, where possible, the impact of the researcher's views and of the frame of the study on participants and the data they generated.

Participants' bias

The validity threats related to participants' bias and poor openness in expressing their views was responded to by using opportunistic convenience sampling. This allowed for increased recruitment of healthcare professionals with reasonably high confidence in their practice and an interest in contributing to research in the explored phenomena. In turn, this measure presented threats to the validity of the research findings stemming from the selection bias. Another reason for not using non convenient recruitment was that it was predicted that such strategy stood low chances of recruiting a sufficient number of participants.

Threats to validity of description, analysis and interpretation

In order to prevent the threats to description validity, the full content of the interviews was audio recorded and transcribed. Also, extracts of data transcriptions were included in the findings. Analysis validity was strengthened by providing a considerably detailed audit trail of the process of data generation and analysis.

Theoretical validity was strengthened by paying attention to discrepant data/negative cases and by giving consideration to alternative interpretations. The generated rich data provided a reasonably detailed picture of the researched phenomena (Becker, 1970).

Members' checks were not used. Although this measure is often taken to ensure that the researcher's reading of data was accurate, within the theoretical position taken this would not eliminate threats to the interpretation validity. This is because it was considered that participants would not be able to comment on the researcher's interpretation of their views, as their views

would have undergone changes since their participation in the interviews. Therefore, seeking participants' feedback about the researcher's understanding of participants' responses was not seen as an effective strategy for ensuring an accurate understanding of the data.

All of the above measures were taken to increase the validity of the generated findings. The section continues with commenting on generalisability and transferability of the research findings.

Generalisability and transferability

Generalisation, in research, refers to extending research conclusions from a research study recruiting from a particular population in a particular context and time to other groups of people in other contexts (Polit & Beck, 2010).

Maxwell (2013) differentiates between external and internal generalisability. The former refers to the generalisability of research findings beyond the study population and setting, whilst the latter refers to the generalisation of research findings within the studied group and/or setting. Because of different sampling strategies, quantitative studies tend to show high external generalisability and qualitative studies tend to show high internal generalisability (Braun & Clarke, 2006).

For a qualitative study to achieve internal generalisability it needs to demonstrate a rich and varied dataset that shows a detailed picture of the studied phenomena. This aim was achieved by the use of semi-structured, open-ended interviews and by the recruitment of different professional roles within the study population. Nonetheless, the use of convenience sampling strategy was used here to increase participants' openness in sharing their views. However, it was recognised that this strategy limited the internal generalisability of the research

findings to those who shared characteristics with the recruited participants (Braun & Clarke, 2014).

Becker (1991) argues that a qualitative research project may also show external generalisability. This can be achieved when research outcomes capture mechanisms generating the researched phenomena. Becker (1991) proposed that captured generative processes may be present in other populations and settings, although the identified mechanisms may lead to different outcomes. The current research took a critical realist position to identify processes underlying the researched phenomena in the hope that its research findings would show external generalisability.

Another form of external generalisability, called flexible generalisability or, in other words, transferability understood as “the extent to which aspects of qualitative research can be transferred to other groups of people and contexts” (Braun & Clarke, 2014, p. 282) was strengthened by a detailed description of the recruitment strategy, sample and setting as well as the process of analysis. These measures were taken to inform the reader about the relevance of this study to their circumstances and settings (Lincoln & Guba, 1985)

Summary

The chapter provided an overview of the theoretical position and methods employed for data generation and analysis. Measures taken to ensure high ethical conduct and research rigour were detailed. In the next chapter, the generated findings are presented.

Chapter 3: Results

Chapter Summary

This chapter presents findings from the study in four sections, each section discussing an overarching theme that was generated in the analysis of the data. The following overarching themes emerged: “Adolescent patients’ relational positioning”, “Self-harm elicits care and attention”, “Affective and cognitive responses to self-harm” and “Frontline team’s use of Adolescent Mentalization-Based Integrative Treatment”.

The first overarching theme shed light on the challenges to providing care to adolescents who self-harmed posed by adolescent patients’ relational positioning on the unit. The second overarching theme evidenced frontline professionals’ concern over the possible negative impact of their responses to self-harm when it was viewed as eliciting care. The third overarching theme illustrated frontline professionals’ affective and cognitive responses to adolescent patients’ self-harm, failures to prevent it and caring for this patient group. The fourth overarching theme shed light on frontline professionals’ experiences and views about using Adolescent Mentalization-Based Integrative Treatment (AMBIT) in caring for adolescent patients who self-harmed. Each overarching theme is composed of various themes and subthemes. A summary of the overarching themes, themes and subthemes is presented in Table 2 below.

Whilst the researcher has distinguished between the content of the first three overarching themes, she also recognised that the themes’ areas overlap and interact with one another.

Table 2. Table presenting overarching themes, themes and subthemes

Overarching theme	Theme	Subtheme
1 Adolescent patients' relational positioning	1.1 Adolescent patients' positioning in relation to the inpatient peer group	
	1.2 Adolescent patients' positioning in relation to the frontline team	1.2.1 Frontline team being positioned as 'Social Police'
		1.2.2 Frontline team being positioned as an expert in ensuring patients' safety
	1.3 Counteracting the negative impact of adolescent patients' positioning	
2 Self-harm elicits care and attention	2.1 The view that self-harm elicits care and attention	
	2.2 Responses driven with the view that self-harm elicits care and attention	
3 Responses to self-harm	3.1 Affective and cognitive responses	3.1.1 Affective responses to witnessing self-harm
		3.1.2 Responses to a sense of limited effectiveness

		3.1.3	Determinants of affective responses
		3.1.4	Changes in information processing
	3.2 Risks associated with affective responses	3.2.1	Uncontained affect
		3.2.2	Reactive responses
	3.3 Responses to the challenges associated with the responses to self-harm	3.3.1	Measures taken to process affective responses
		3.3.2	Measures taken to manage uncontained affect and reactive responses
4	Frontline team's use of Adolescent Mentalization-Based Integrative Treatment	4.1	Mentalization and mentalization-enhancing interventions
		4.2	Individual key relationship
		4.3	Conscious and unconscious use of AMBIT
		4.4	Views on AMBIT

Overarching Theme 1: Adolescent Patients' Relational Positioning

The first overarching theme presents challenges related to adolescent patients' relational positioning on the inpatient unit. The first theme focuses on adolescent patients' positioning in relation to the inpatient peer group. The second theme focuses on the challenges stemming from adolescent patients' positioning in relation to the frontline team. The third theme sheds light on participants' attempts to overcome the challenges originating from adolescent patients' relational positioning on the unit.

Theme 1.1: Adolescent patients' positioning in relation to the inpatient peer group

This section illustrates the challenges in caring for adolescent patients who self-harmed related to them being placed in a group of peers treated on the same unit. Participants reported that admission to the inpatient unit sometimes led to young patients forming unhelpful relationships with their peers. In the following quote, one participant commented on this issue.

They're in a really forced environment, which is really intense. You have fourteen young people who wouldn't necessarily meet any other time. The age difference is huge, so you're looking at expected maturity for a seventeen year old compared to fourteen year old (...) We get friendships and relationships on the ward where it can be deemed unhelpful and that's a challenge because the young people can't see it (117- 122, Participant 4)

Participants observed that sometimes young people self-harmed after they had seen it done by other adolescent patients. And those who had not self-harmed sometimes started doing it after being admitted to the unit. Similarly, it was noted that those who had been engaging in self-harm before their admission were likely to increase their self-harming behaviour after being exposed to it on the inpatient unit. In the quote below, one participant suggested that the increase in self-harm among adolescents admitted to the inpatient unit was caused by adolescent patients copying each other.

Some young people do start to copy other young people (...) I don't see it all the time, but sometimes you do. They've shown no signs of any risk up to that point, and then you might find that they've started to do something, and you can't really make out the reasons as to why they've done it, all you can think is that they're trying to be like some of the others (517-522, Participant 6)

Two other participants suggested that an increase in self-harm may have been related to adolescent patients witnessing other patients receiving care. In the quote below one participant noted that witnessing another patient receiving care may have caused negative feelings of being deprived.

Using physical intervention the whole time, that does have an impact on the ward because the other young people will feel that they not getting the support, they're not getting the time (...) it does affect then other young people and sometimes that can cause ill feeling amongst the young people because they will be "oh well so and so just does this to get all the staff". Quite often I have heard comments from young people saying they (other patients) did that on purpose just so that they can get some staff support, (and they said) "we've been all left, we've got no staff to support us" (384-390, Participant 6)

In the next quote, another participant elaborated the processes which may be at work when young people observe others receiving care. She hypothesised that young people admitted to the unit often had an internalised sense of being rejected which became activated when they observed others receiving care; and that adolescent patients, whose internalised sense of being rejected got activated, resorted to self-harm to compete for attention.

You come into the inpatient unit and you learn (that) in order to get your needs met you have to increase the anti, and that does happen, and then a lot of people because they feel so rejected in themselves and they've got this like kind of internal filter that will make anything negative. They see another person get the attention, then they feel rejected so therefore they have to increase their anti to get their needs met (412-416, Participant 8)

In summary, adolescent patients' positioning in relation to other patients was seen as potentially harmful. It was noted that adolescent patients were forced into an artificial environment where they formed unhelpful relationships. Also, participants noted that a stay on an inpatient setting was related to an increase in self-harm among patients exposed to that

behaviour amongst their peers. Attempts to copy others and competing with others for care were identified as possible causes of self-harm.

Theme 1.2: Adolescent patients' positioning in relation to the frontline team

Adolescent patients' positioning on the unit in relation to the frontline team was noted to pose challenges to the care of adolescent patients who self-harmed. In the below section, the potential risks are reported.

Subtheme 1.2.1: Frontline team being positioned as 'Social Police'

Study participants reported that adolescent patients' relational positioning on the unit led to adolescent patients forming unhelpful relationships with the frontline team responsible for guarding their safety. These unhelpful relationships were seen as posing challenges to the frontline team's efforts to provide care for adolescent patients who self-harmed. Participants reported that this positioning contributed to a formation of a 'teacher-child' relationship between adolescent patients and the frontline team. It was hypothesised that adolescent patients experienced the frontline team as 'Social Police' that deprived them of their freedoms, including the freedom to self-harm. This made it difficult for the frontline team to engage young people in the process of therapeutic change. The quote below illustrates these processes.

What happens is you come into a kid unit, everything's removed from you, and so it becomes more of a treat to self-harm. You feel deprived, when you're deprived of something you want it (...) you want it more, and when you get it it's more of a treat, and it becomes this fight rather than actually being able to create a therapeutic alliance (...) it becomes the 'teacher-child' role (386-390, Participant 8)

When you've (the patient) taken something to school that you shouldn't have, i.e. a blade or a mobile phone, you (the healthcare professional) become this authority and they are authority, which is O.K., cos there has to be some authority, but that's not what our role is about, our role is try to find a space for these young people where they do feel safe to talk and then work through that, whereas often in that unit you become 'Social Police' (401-405, Participant 8)

A reversal of the described above power balance was reported by participants who cared for informal (voluntarily admitted) patients refusing treatment. Frontline professionals reported finding themselves particularly disempowered in their role of guarding the safety of informal patients whose form of self-harm was insertion. The quote below illustrates one participant's sense of disempowerment when witnessing an informal patient inflicting self-harm by insertion.

You see their fluctuation on that one decision, so "I'm not taking the items out and I'm not going to A&E" and "I want to die of the infection" and you've see them physically grey, lolling it in and out because their temperature's gone up (...) and you're just having a whiff, as a nurse it feels a bit disempowering because you've got to wait for a doctor to say, "yes, the capacity is gone." And you're thinking "for the last two hours I knew it was gone but I had to wait for you to actually say that even though I've watched their physiological obs (observations) go up and mental health decline" (464-470, Participant 4)

The above relationship is also evidenced in the below comment which reported that frontline professionals' actions pressurising patients to stop self-harming led to more harm.

What we found with particularly some young girls is if the pressure from the medical team is put on such as to remove the item, they're more likely to reinsert with something more dangerous, so ink, things like that (339-340, Participant 4)

In summary, the 'child-teacher' relationship, where the patient was positioned in the role of being deprived of his or her freedoms and the frontline team was positioned in the role of 'Social Police' was identified as an obstacle limiting the effectiveness of the frontline team in engaging their patients in treatment. It was also seen as potentially contributing to an increase in self-harm among patients inclined to fight with the frontline team responsible for restrictions of their liberty.

Subtheme 1.2.2: Frontline team being positioned as expert in ensuring patients' safety

Participants noted a relationship between an increase in patients' self-harm and patients' sense of safety fostered by access to specialist care provided by the frontline team preventing and

managing the potential harms caused by self-harm. In the quotes below three participants commented on a range of situations in which patients had access to the frontline team's support that coincided with their increased self-harm.

Sometimes they just start to self-harm because they know we're here and we can keep them safe. You might find that somebody's been on home leave and they'll come back here and take an overdose. You're asking yourself "well, why not take your overdose at home? Why come back to the unit to do that?" and the conclusion you come to is because you're surrounded by the nursing staff you can get sent to the hospital and you can keep safe. Maybe if they were at home their parents wouldn't know what to do, or there's no nursing equipment there and they potentially might do it just for "help me I need some support"; but actually they would not get that at home and they might actually kill themselves and they don't want to. But here they can do it knowing that they can be safe (528-533, Participant 6)

I often think that if the person self-harms they often feel safe in the environment to do it (195-196, Participant 8)

A lot of them tend to self-harm on intermittent observations because then they can do stuff in private; but they know that someone's going to come and made them safe again (118-119, Participant 5)

Interestingly, it was reported that self-harm may increase in patients who showed some form of improvement or moved towards discharge from the unit. This observation is evidenced in the following quotes.

Sometimes, you're sort of thinking "you're getting there" and get a discharge date and things are moving on. And you might find something that on the build up to discharge the young person might start self-harming again (79-82, Participant 6)

Sometimes here you find that the young person would do something and we feel that we're on top of that and then they move on to something else. It's like they raising the level, they're raising the level of severity and maybe what they're doing, they might not end up cutting, they might end up doing something else (58-60, Participant 6)

Although the negative impact of the discussed relational positioning was not made explicit in the above observations, these quotes are included in this section of results because of the relationship between patients' improvement and the prospect of loss of support associated with it.

Participants shared a view that offering care and safety to patients may lead to them getting used to the comforts of the inpatient unit and staying away from the dangers of everyday life. This was seen as detrimental as it reduced patients' resilience necessary for facing the world. Below a participant shared her views on the risk of harm caused by keeping patients on the unit for long periods of time.

I feel that sometimes we keep patients for a too long a period of time and (...) I feel I am doing a dis-justice to these young people and that's really hard to work with sometimes, cos I'm thinking that we are actually not helping them by keeping them here (49-51, Participant 8)

In summary, the above section illustrates the possible risks related to patients perceiving the frontline team as caring and equipped to manage the risks associated with self-harm and the unit as a retreat from the difficulties of their lives. It was reported that adolescent patients were likely to self-harm when they were under the care of the frontline team. It was also noted that adolescent patients sometimes self-harmed following an improvement in their health. This pattern of behaviour was linked with patients' anticipated decrease in care. Finally, participants shared that they considered allowing patients to get used to the safety and comfort of the inpatient unit to be harmful.

Theme 1.3: Counteracting the negative impact of adolescent patients' positioning

The generated data showed that participants tried to counteract the impact of adolescent patients' relational positioning by taking the following measures.

Forming unhelpful relationships between patients was addressed by encouraging young people to think about the negative consequences of their peer relationships on the unit. However, as illustrated below, the effectiveness of this measure was limited.

There's not a lot we can do. We try to encourage them, we have supportive conversations around their own recovery and their own journey and some of them recognise that the relationship, the peer relationship they have, can be quite unhelpful, and they do sort of take themselves and step away at times but there are times when it can still be quite unhelpful and we don't have any authority to control it (60-64, Participant 9)

Participants reported that frontline professionals tried to reduce self-harm by limiting the impact of the frontline team's attending to individual incidents on the whole group of adolescent patients. This measure was driven with participants' conceptualisation of self-harm as a behaviour driven by feelings of being deprived of care. Below, one participant provided a rationale for not using the alarm, unless it was necessary. The participant explains why she wishes to avoid letting patients peer group that one of them was receiving extra level of support.

The alarm going off in the unit it can cause a lot of distress, even just the alarm is quite a distressing sound. Obviously the young people then know that one of their peers is very distressed and things will escalate with a lot of young people very quickly from there (302-304, Participant 11)

Participants also reported taking measures directed specifically at reducing the negative impact of adolescent patients experiencing the frontline team as 'Social Police'. As evidenced in the quotes below, patients were encouraged to take responsibility for their safety by reducing the level of restrictions put on them and by encouraging them to ask for help.

It's only really glass, and aerosols, crockery and things like that which wouldn't be allowed. They're allowed phone charges even though there's a ligature risk. Unless they've ligatured it'd be removed from the room for a week and then given back to them, and a conversation would be had with the young person about using those items responsibly, and the consequences of not using it responsibly. The fact that if they do tie the phone charger round the neck it will be cut off and ruined (671-677, Participant 11)

We do try to get them to take a bit of responsibility and we also say to them "what can we do to help you, help to support you?". And if it means some of them say, you know, "can you check in with me each hour?" then it's put on the board and the staff are allocated (501-503, Participant 6)

Participants reported that frontline professionals also attempted to instil a sense of responsibility in their patients for their safety by encouraging them to clean their wounds from self-harm.

I always encourage the young people to clean it themselves (...) I think it's very important for them to take their own responsibility and cleaning themselves is one (427-429, Participant 8)

As illustrated in the quotes below, participants shared that they did not wish to promote patients' dependency on the safety provided on the unit and reported that it was important to encourage patients to deal with the frustration of everyday life by reducing their comfort on the unit and encouraging them to take home leave.

Most of young people speak quite highly of this place, and as nice as it is we don't want them to like it that much that they don't want to leave (79-84, Participant 6)

Like (the young person) saying "oh, I'm not going to go on leave". We say "that's O.K." but actually it's not O.K., you're going to be going home, you need to go home and it's not me being cold hearted, it's me saying actually we have to keep you in some form of reality (88-90, Participant 8)

The data also shows that participants worked towards increasing patients' ability to benefit from treatment by engaging them, taking on a collaborative and non-judgmental stance and supporting them to develop an increased capacity to mentalize. Having a good relationship with their patients and having good knowledge of their patients' needs helped them with supporting their patients in accepting support. The data illustrates that these measures were not consciously employed by frontline professionals to counteract the identified harmful relational factors but to promote engagement and reduce self-harm.

Active communication of intent to help, an empathetic stance and the fostering of a collaborative stance were seen as crucial for patients' engagement.

Unless the first thing you respond to is “you seem really upset, I am attending to you, I want to help” unless you give them that, then they are not going to want to come out of what’s going on at that time (429-432, Participant 1)

As humans you just always want to find the answer and solve (...) but actually they just need you to listen and empathise and understand them (129-132, Participant 7)

Not telling someone how they feel, not telling someone what they should do, is not kind of practical. (...) I think (being) more collaborative rather than being a person who comes with what the person should do (853-855, Participant 2)

A few participants reported that patients were more likely to accept support from healthcare professionals who they have a good relationship with.

You really need to know someone quite well in order for them to listen to you or to try to get through things and even then it doesn't always work because if someone is wanting to self-harm that urge is very, very strong and they may do that whatever (238-240, Participant 10)

It was reported that healthcare professionals required good knowledge of their patients and their history of family relationships to be able to effectively engage them.

It's about knowing your patient, sometimes offering some medication at a difficult time is useful to someone but then may not be applicable to someone else cos they may refuse medication. Sometimes it can be just sitting with someone, sometimes it may be doing something constructive (125-128, Patient 10)

You should always have a much better understanding of their whole life, what has impacted on them so negatively that they have needed to come into the inpatient health setting, so you may have a better understanding of the family dynamics or trauma event (356-360, Patient 9)

Once you have a better understanding of their background, it kind of changes your perspective on them as a person and it can mix into richer kind of interaction with them, cos you have a much better understanding of their history and of their personality (444-446, Participant 9)

The reported measures supported frontline professionals to take alternative roles to those mentioned earlier in their relationship with their patients. The need for providing relational rather than concrete safety was recognised alongside the need for communication of attentiveness, supporting patients to think about their difficulties rather than trying to solve them.

Participants spoke about the application of mentalization-enhancing interventions to support patients with poor affect regulation. One participant reported that an increase in mentalizing capacity decreased patients' impulsivity and risk of self-harm.

It's about getting them to mentalize themselves and also other people, and sometimes people who are here are not very good at that (...) the more they mentalize and are aware the less likely they are to be so impulsive, and if they think about other people for a moment and what their feelings are when they self-harm it may stop them, so it reduces the amount of self-harm (476-478, Participant 10)

Another participant reported that enhancing patients' mentalization capacity helped patients manage their feelings without having to seek support from others.

It's quite empowering for the young person cos they have such a range of emotions and feelings that they can't explain and can't understand and for us to sit with them and say to them "you're feeling this way" because, and they recognise it, and they go actually "yeah that's why I'm feeling this way" and that empowers them to then recognise it later on when they're feeling this way. They can make that connection and they can go "O.K., I'm feeling like this" and they can remember "I'm feeling like this because of this" and they can help themselves manage rather than relying on other people to manage (335-341, Participant 9)

Adolescent patients' increased capacity to mentalize was seen as a possible solution to the negative impact of patients' relational positioning on the unit.

Overarching Theme 2: Self-harm Elicits Care and Attention

Study participants reported a concern over the impact of their responses to self-harm on the wellbeing of their patients.

Theme 2.1: The view that self-harm elicits care and attention

In the previous section, the data showed that participants thought that self-harm among adolescents admitted into the inpatient unit was related to adolescent patients' relational positioning on the unit. This section focuses on a view, widely shared by participants, that self-

harm often performed the function of eliciting care and support; and that the inpatient unit reinforced this function.

We recognise that a lot of the young people use self-harm as a way of eliciting care and eliciting emotions from people that they've maybe not necessarily had throughout their life-experiences (80-85, Participant 9)

A lot of it here is young people feeling very rejected and lonely and unwanted for various reasons and harming is a way of them receiving care and getting more staff's attention and if they cut badly enough then they have someone go to A&E and sit with them for few hours and that interaction that they have with someone at A&E might be one of the best interactions that they've had all week, if they don't get along with their peers or have sort of very negative interactions with their family (321-326, Participant 11)

Participants reported a view that responding to self-harm with care may reinforce its function of eliciting care and consequently lead to more incidents.

They would associate that with "if I self-harm then I elicit a strong care response in you" and I think it can lead on to more behaviours, escalated behaviours to elicit a stronger care response (218-220, Participant 9)

You don't want the young person to be getting all the staff's attention and those kind of really deep conversations straight after they've self-harmed because then it becomes a reward for that behaviour (295-298, Participant 11)

Healthcare professionals' views about the function and causes of self-harm were linked to their conceptualisations of the effect of their responses to self-harm in adolescent patients who engage in it.

Theme 2.2: Responses driven by the view that self-harm elicits care and attention

Participants shared their commitment to making sure that their responses to self-harm did not cause harm to their patients. A rich description of how frontline professionals attempted to prevent reinforcing patients' learning that self-harm elicits care from others was found in the data. Taking a clinical and a matter of fact approach to caring for patients immediately after they had self-harmed was one of the measures taken by frontline professionals to achieve this aim.

It's better to deal with it clinically and then some time later have that conversation about what triggered that event (235-236, Participant 7)

I want to deal with it in a very matter of fact way at the time like "oh you cut, you need to clean it up, let's deal with it" kind of thing, it doesn't really need to be anything more than. Get it sorted out and then usually the next day try to have a bit of a more chat about why they've done it, because you don't want to reinforce that (292-295, Participant 11)

When I'm dressing a wound I try and keep it quite clinical because I don't like the fact that people think self-harming will lead to support and one-to-one time (...) I try make dressing the wound quite separate to offering the supportive time. If you do that then people might think "oh well, I'll do something else to get the supportive time", "I'll go and ask for it" (255-258, Participant 12)

However, taking on a pragmatic and clinical approach was associated with a risk of normalising self-harming behaviours. The quote below illustrates this issue.

There's two ways of looking at it, obviously you don't want to be very dramatic about the instance at the time, I don't think that's helpful for the young person, but it is also not a normal thing to do, so you don't want to be too matter of fact. Sometimes I will even say like afterwards, if they have better mood, if the time is right, I would just kind of say "oh it's quite gross", or something like that, also let them know that it really isn't normal and it really is quite a gross and repulsive thing to do to most people (...) you don't want them to then think that this is normal behaviour in this setting (307-311, Participant 11)

Participants justified taking a clinical and a matter of fact approach with the need for maintaining professional boundaries. This point is illustrated below.

You don't want to reward things like that by sort of going into this motherly role and I think sometimes you can see people who want to tend to the needs, and that's their way of like making this person feel better, cos that's what mums tend to do. So it's about keeping it quite clinical I think in order to remember what our relationships and roles are (252-254, Participant 8)

We're professionals at the end of the day. We're not their family members and we're here to care and we're here to do our job on a certain level, (give a) sense of boundary (...) A parent would give a much more emotional response to a situation like that whereas a professional might have been more pragmatic about managing it (225-226, Participant 9)

However, reported data showed that after some reflection participants also thought that maintaining professional boundaries did not necessarily mean that healthcare professionals should not show warmth to their patients, only that they needed to find a balance between

validating patients' distress and not offering too much care. Making a decision about how much care one should give while maintaining professional boundaries was seen as a difficult task which required a lot of experience and good knowledge of patients' needs.

We have a very fine line in giving too much care and support that we then blur the boundaries between "are we professionals or are we parents?" and try to find the balance between not giving too much support but giving enough support to emotionally validate their experience (84-87, Participant 9)

(What one needs is) knowing the young person, knowing the history, knowing the kind of difficulties in relationships that they have, understanding the reasons why they self-harm and also the experience of the staff as well of them. There is a level of experience the staff member has of how they manage it when they deal with the young person (...) how long they've worked in this environment, how often, how much they dealt with this, and a good understanding of their boundaries and the relationships with the young people and maintaining that professional boundary (98-92, Participant 9)

Another way of deterring the function of eliciting care from self-harm was supporting patients to take responsibility for their actions. This was reported to be achieved by encouraging patients to clean their wounds. It was noted that this also supported patients in developing skills they may find helpful after their discharged from the inpatient unit.

A lot of the time we get the young people to facilitate the cleaning of the wounds themselves, stand with them and give them the saline and the cotton wool and ask them to clean it, so that we just keep their level of independence to sort of prevent that reaction, "if I harm then I get care". So it's about "you can get support but we're not completely caring for you" so it's giving them that sense of responsibility back (201-206, Participant 9)

It's something I feel more comfortable with than totally caring for them (...) it's less beneficial to care for them too much than it is to support them to kind of take a bit of responsibility and independence for the situation (213-215, Participant 9).

The above actions were driven by a conceptualisation of self-harm performing the function of eliciting care.

Overarching Theme 3: Responses to Self-harm

The data shows the impact of attending to the task of prevention and management of self-harm on frontline professionals' affective states and processing style. The determinants of the severity of healthcare professionals' responses are reported alongside the identified risks related to the affective and cognitive changes: spreading of uncontained affect and reactive responses. Measures taken to respond to the identified challenges are reported.

Theme 3.1: Affective and cognitive responses

Participants reported experiencing a range of affective states in response to self-harm and to failing to prevent it. Also, participants reported that attending to an incident of self-harm led to a change in their processing style.

Subtheme 3.1.1: Affective responses to witnessing self-harm

Many study participants reported that they had strong affective responses to witnessing self-harm. Below a study participant reported her response to the sight of wounds and scars.

Disgust (...) I do actually have a pretty unpleasant physical reaction to seeing wounds and blood, like I feel very sick and very faint (445-446, Participant 11)

Sad, I mean I would be with anyone, but especially when you're working with really young people, some of whom have actually already significantly damaged their bodies (412-414, Participant 11)

A few participants reported that it was the underlying causes and the states of mind accompanying self-harm rather than the sight of wounds and scars that impacted them.

It just makes me really sad (...) especially when you see young people who have potentially so much but have not got these fundamental skills to manage with life, that they have to hurt themselves. It makes me sad to think that they hate themselves that much and they are so uncomfortable with themselves to do that (345-348, Participant 8)

Talking to someone, and you're talking about a really serious topic, and they're just giving you no outward display of emotion whatsoever, like very flat and there's obviously a massive turmoil going on inside this person for them to behaving this way, or so you'd think, and then they are just talking to you very matter-of-factly about very serious things. It leaves me very confused about where to go next (383-387, Participant, P11)

It was noted that learning about patients' histories of abuse, losses and neglect generated a feeling of disempowerment in frontline professionals.

You know that terrible things happen to people, you know that people get raped and people sometimes are abused by their family members and that they get bullied and you know that members of their family commit suicide, do things like that and it's horrible, and that things like that occur in the world (...) it can make you feel quite ineffective as a staff member (71-76, Participant 11)

Overall, attending to self-harm was reported to lead to affective responses.

Subtheme 3.1.2: Responses to a sense of limited effectiveness

Many participants reported experiencing negative feelings in response to their limited effectiveness in preventing self-harm. Participants reported feelings such as irritation and powerless.

(I feel) irritation and annoyance, not that they've done it but that we're not managing to help them stop doing it, and often it feels very repetitive. It can just be the same thing. It feels like doing the same daily, people who self-harm very regularly and then it's really frustrating (451-453, Participant 11)

You feel a bit hopeless because it happens again and again and again and you are doing all these interventions and you're trying to offer support and you're trying to pre-empt the time when it happens, to get in there before it happens, you're doing everything you can to make sure they don't have a blade, that they can't do anything, and then it happens again and you go "ah! I did everything I thought I could and it happened again" (171-175, Participant 12)

Participants reported that their negative feelings were directed to services they worked in, their patients and themselves. Below, one study participant reported their negative feelings towards the unit they worked in.

We've got a patient here at the moment who I really think does not need to be here, and since they've been here they've started to self-harm, and that is where I get angry that the service fails people (353-355, Participant 8)

One participant noted how a sense of limited effectiveness in preventing self-harm may give rise to negative feelings towards young people who engage in it.

People can start to feel quite negative about some young people, it's a reflection of how it makes us feel, like we are not doing our job, or we're useless (111-113, Participant 7)

Many study participants spoke about a sense of guilt for failing to prevent self-harm.

If you're going in after (self-harm) then we have failed (...) from the staff point of (view), you kind of feel like "I should have picked up on that" (590-593, Participant 2)

In summary, the data showed that the frontline team's negative appraisals of their effectiveness contributed to their negative affective responses.

Theme 3.1.3: Determinants of affective responses

Participants reported a number of factors impacting their responses to self-harm. One reported that the frontline team's position in the wider system of care made it difficult for frontline professionals to evaluate their patients' progress, which could contribute to their feelings of frustration and limited effectiveness.

As frontline staff, the nurses, our perspective is very different on the young person than maybe the MDT's (multi-disciplinary team's), the family therapist, or the psychologist, or the doctors, because we work with them very closely twenty-four hours a day, but often the MDTs have a kind of bigger picture of them, so they see where they've come from much more than we do – the family, home life and their family situation – sometimes we get quite frustrated when things don't change or things don't improve, when actually this young person has got whatever. There's a very difficult family to go back to and there's a lot of things that's got to change in that system before they're going to get better (154-161, Participant 7)

A few participants reported having more intensive responses to self-harm in patients they had a relationship with.

It is worse with these ones you have a close relationship with (474, Participant 11)

A few participants noted that their responses tended to be more intense when they had a busy shift.

It depends on how your shift's been. If you've been running around all over the place and it's been really stressful for you, you're going to be more frustrated (193-195, Participant 12)

Other determinants of the intensity of healthcare professionals' responses to self-harm were experience, familiarity and knowing what to do next.

When you know the patient, when you have worked with them for a long time and you know their risks, then you know you've got a certain level of experience behind you, so your reaction can be very different to somebody who isn't faced with that every day and doesn't know the patient so well (125-128, Participant 9)

I have never felt worried that someone would self-harm because I feel that when people do self-harm, which actually we have to deal with it quite frequently compared to most places elsewhere, probably even more than most inpatient units, I think we always know the course of action in terms of what happens next and how we fix this (329-333, Participant 1)

Another participant reported that the intensity of her responses was affected by the unit's view that the frontline team's task was not to stop self-harm but to address the underlying causes.

What we are treating here is not self-harm. In a way it does not really matter whether they are self-harming or not. It's these people are feeling really awful, they are feeling like they've got no options left, they are feeling that all they want to do is just kill themselves rather than live another day, it's a painful life, and that's what we are trying to fix. It does not matter whether or not they hurt themselves, because we are trying to help them feel better in their lives (344-348, Participant 1)

A realistic view of self-harm prevention held by the unit's management was associated with a decreased level of anxiety experienced by frontline professionals attending to self-harm. The quote below illustrates this point by evidencing the impact of the changes in the unit management's views on the limits of self-harm prevention on one study participant's work.

It made my job feel a bit easier because even though I would obviously never want anybody to self-harm I did have that whole anxiety and worry that if they did I was going to be in trouble, so would get really jumpy because it was getting to the point that a young person was moving a wound. I was like “what are they going to do?” which would obviously have an impact on my relationship with that young person, cos I was so worried about the consequences of them harming themselves (276-280, Participant 5)

Subtheme 3.1.4: Changes in processing information

Participants reported that the focus of their attention changed when they were attending to an incident of self-harm. At the time of dealing with an incident their attention was directed to the task of restoring safety.

I can see the situation is getting to the point (...) and obviously I'm trying to talk to them and see what is going on, but my inside is more of what's going to happen than what's going on in their mind (326-329, Participant 5)

You go into that mode where you think, “this is the situation where I've got to remove that risk, what do I need to do to get rid of that and make it not a risky situation?” (277-278, Participant 7)

If someone is bleeding a lot, what you need to do as a nurse is stop that bleed, so that's the first thing, and then while you're doing that as a mental health nurse you want to calm the patient and make sure it's safe, there's nothing else they can use to harm themselves with. It's quite instinctual at the time. I don't spend a lot of time thinking about it (242-248, Participant 12)

It was reported that at the time of responding to an incident healthcare professionals' awareness of their emotional responses decreased and that the realisation of the emotional impact of attending to an incident came later.

When something like that happens I go to very much “O.K., this is what we need to do” rather than “this is how I feel” and then maybe afterwards think about how I felt at the time (713-715, Participant 2)

Your mind changes into a very sort of pragmatic, focused, we need to deal with the situation, and then it's not until after the situation, when you do de-briefing in your head and think about the feelings and emotions and the situation a bit more (188-191, Participant 9)

Participants described this shift in one's relating to a situation as a change in a mode of thinking. The change in the focus of attention that takes place when one starts to engage in prevention and management of self-harm seemed to make frontline professionals vulnerable to the impact of their unrealised emotional responses. This point is elaborated in the next section.

Theme 3.2: Risks associated with affective responses

Participants reported affective and cognitive responses to self-harm prevention and management associated with uncontained anxiety, reactive responses and the consequent increase in incidents of self-harm on the unit.

Subtheme 3.2.1: Uncontained affect

Many participants reported a range of risks associated with uncontained affect. Below, study participants reported how affect spreads from healthcare professionals to patients.

Any emotion on the inpatient unit spreads like that (participant flicks her fingers), you have to be so aware of maintaining your own emotions because if you don't it will be worse impact (209-211, Participant 8)

If you panic or flap or are distressed it has a massive impact, especially as a nurse, or you know management, if you're a managing a shift, like a nurse coordinator or a nurse in charge you set the tone for how the shift is going to go. If you panic, the staff panic and the patients panic (339-342, Participant 4)

Study participants reported how healthcare professionals' uncontained affect led to incidents.

There have been incidents here when it was very difficult on the ward and people haven't quite been able to do that "O.K. take a breather" or haven't been able to put their hand up and say "I need some sort of rest or be released from something because I am overwhelmed" and then things have gone wrong and then the spread of affect from one staff member to another staff member quickly infected all of the staff, and then the level of affect you see in the young people across the whole ward increases because the staff are stressed (500-507, Participant 1)

We often get into the scenario where everyone gets caught up in an incident and there's thirteen other teenagers that need support and know that something's happening and that just like raises the emotions and the anxiety and leads to more incidents (392-395, Participant 7)

Summarising, as evidenced above uncontained affect was recognised as a significant challenge to providing care to young people who self-harmed.

Subtheme 3.2.2: Reactive responses

Study participants recognised that high affect spread among healthcare professionals and patients, and increased risks on the ward. These difficulties were compounded by an associated risk of healthcare professionals' reactive responses in the state of high affect. One participant reported that high affect was linked with impulsive behaviours.

Any response you'd have in a high-stress situation (...) you are acting very quickly and you're acting quite impulsively to deal with the situation (556-559, Participant 11)

Two study participants spoke about the dangers of reactive responses, here referred to as instinct. In a latter quote, a study participant explained how acting on one's instinct may be detrimental to patients' needs, as it reinforces unhelpful ways of relating.

I think instinct is if someone's sitting in front of you and they're hurting themselves your instinct is to try and stop them, and sometimes that isn't always the right thing to do because people self-harm for a variety of reasons, and sometimes it carries on for years. It's not something they're going to give up. And they don't stop when they leave here, often, but they can't stay in the unit forever (326-329, Participant 10)

Your instinct might be to tell somebody "stop" and then you realise that actually that's the kind of relationship that they had, you know, growing up with parents. That's the unhelpful relationship that's currently being challenged in family therapy or another setting and you're about to prove that that is the sort of response that they were always going get (165-169, Participant 4)

As reported above, reactive responses were seen as potentially reinforcing negative patterns of relating.

Theme 3.3: Responses to the challenges related to the responses to self-harm

Participants spoke about the measures they took to process their responses, to manage high affect on the ward and to prevent reactive responses.

Subtheme 3.3.1: Measures taken to process affective responses

Participants reported how they dealt with affective responses. The majority of participants reported that they had found it helpful to share their feelings with others and to realise that their colleagues shared similar experiences. This point is illustrated in the quote below.

You will come out being really frustrated when someone's just stuck an object in their arm, "how has this happened again?", really angry about it, and then someone else who's not involved in the situation is equally as angry and upset by it, and that helps justify your emotional response. It's helpful being in a team. It'd be very difficult going through that process alone (309-313, Participant 12)

One participant reported that it was helpful when her colleagues challenged her guilt, stirred by a failure to prevent self-harm, by reminding her that patients were responsible for their actions.

A lot of them don't accept any responsibility for their actions, so often you can feel a bit guilty after someone self-harmed, like of "I should have not left them a hair grip in their room, now they putting it up their arm", "why didn't I see that?", "why wasn't I more careful about that?", "why didn't I stay with them?" Then so you can get all of these feelings, and then it's often quite helpful to speak to someone about it and they'll be like "it was their decision to do that" (615-621, Participant 11)

Talking to colleagues and using staff support groups (such as case discussions) helped participants take a step back to reflect on their responses and use those reflections to increase their understanding of their patients' difficulties.

There can be a lot of mind games, a lot of young people have emerging personalities disorders, so I suppose that's where it's really important to take a step back, not get

drawn in by it, and just talk to someone else about it and they can give you another perspective (629-633, Participant 11)

We've got quite a good relationship with therapists on the ward, so we've (talked about) how we feel about some young people and the family therapist will say "that relationship that you have with that young person I feel the same dynamics with the parents", when things like that are happening it kind of validates how you're feeling and how you're acting on the ward (405-409, Participant 12)

Subtheme 3.3.2: Measures taken to manage uncontained affect and reactive responses

Study participants reported that they drew on the concept of mentalization promoted by AMBIT to reflect on their responses to self-harm incidents.

It's more about us, as a team, mentalizing ourselves, being aware of the impact of incidents on our emotions and how those emotions impact on others (405-406, Participant 7)

It was reported that healthcare professionals worked collaboratively in managing their emotions by letting each other know when they appeared stressed and by offering support.

We use AMBIT on each other, so if you think somebody looks distressed or stressed or chewed down (...) you can approach them and say "do you want five minutes?" (327-330, Participant 4)

Staff are very good here, really supportive, and that's where you are supportive as a team as well, not just to that young person because whoever is on the obs (observations), whoever would be on the one to one, that you need to be helping them out. So you'd sort of be keeping sort of a close eye not only on the young person but also the staff as well in case they need a bit of support (310-314, Participant 6)

Staff support groups were seen as helpful for reflecting on the impact of healthcare professionals' responses on their patients. Participants reported how they found attending healthcare assistant groups.

We do a lot of "let's reflect on the situation with this patient". I found this specific thing difficult and I think other people may also be finding this specific thing difficult. How can we help to change our approach so that other people don't experience this psychological anxiety? (474-477, Participant 1)

Finally, participants reported that taking a break when they felt overwhelmed helped in making sure that their state of mind did not affect their practices, as evidenced in the quote below.

Say I am finding it a little bit too much, and they would be able to relieve you from whatever was or you know give you five minutes off the ward, or have a five minutes off, say, chat, to help you release that level of emotion you are experiencing, so you are then able to go back out on the floor and be helpful to others. Because if you're feeling anxious or angry or frustrated or whatever else it is very difficult to prevent that from affecting your clinical practice (488-493, Participant 1)

Participants also reported measures they took to prevent their reactive responses to self-harm. It was noted that it was important to reflect on patients' patterns of behaviour and how healthcare professionals fed into them in their responses. In these accounts, their responses were focused on promoting patients' development.

Not repeating their patterns of behaviour (...) they've already had, so with some patients, all they know is to make noise to get a reaction from parents, like shouting, or you wanting to tell them to stop doing something because sometimes that's a natural instinct to tell them not to, to stop doing something not to and then actually that's what they want, that emotional reaction that they expect (155-158, Participant 4)

Your instinct might be to tell somebody "stop", or "don't", and then you realise that actually that's the kind of relationship that they had, you know, growing up with parents, that's the unhelpful relationship that's currently being challenged in say family therapy or another setting and you're about to prove that that is the sort of response that they were always gonna get if they behaved like this. So sometimes you have to know that that's how their parents would react and you need to take a different approach that might be from another perspective, getting them to question why what they're doing could be things wrong you know (164-170, Participant 4)

Overarching Theme 4: Frontline Team's Use of Adolescent Mentalization-Based

Integrative Treatment (AMBIT)

The data shed light on frontline professionals' use of AMBIT in caring for adolescents who self-harmed. The emergent picture showed that participants were fairly familiar with the concept of mentalization, although their accounts suggested that some of them they did not feel

confident in using mentalization-enhancing techniques. Study participants also evidenced the use of aspects of the mentalization practice promoted by AMBIT to manage affect among healthcare professionals and support healthcare professionals to process feelings evoked in caring for young people who self-harmed. This area of use of AMBIT was evidenced in detail above therefore it is not covered here. Limited reports of the use of other aspects of practice promoted by AMBIT (e.g. key relationships) in working with patients who self-harmed were captured. Most participants reported that they did not draw on the model consciously and many thought that AMBIT described good practice that every mental health professional should engage with following their instinct of care.

Theme 4.1: Mentalization and mentalization-enhancing intervention

All participants spoke about the concept of mentalization and mentalization-enhancing interventions. A few participants considered mentalization-enhancing interventions as effective in improving patients' emotional regulation and reducing self-harm. This point was illustrated earlier.

A few participants shared their concerns about using mentalization-enhancing interventions on an inpatient unit. One commented that these were not the first call intervention in working with self-harming adolescents, as these were not task and action focused.

You can't approach managing self-harm using AMBIT only. I think you can use that AMBIT model but then also you have to use kind of bit of cognitive-behavioural therapy type stuff, motivational interviewing, engaging people in distraction is a big one and then also there's lots of conversations about them planning and managing that risk, like how to manage risk and like making plans to prevent, you know, things from happening. So I think yes we do employ AMBIT, but as frontline staff that's probably not the majority. It is not the first choice (...) you can't always be having mentalizing conversations and there is a lot of being frontline staff which is all more about, more kind of task focused and less get you doing this, get you doing that, we need to plan this, we need to do that you need to get up and moving so a lot of being front line staff is not mentalization-based (453-462, Participant 1)

The same study participant found the concept of mentalization somewhat intangible and therefore difficult to apply.

I think personally my brain works better with like more structured like “do this, do this, do this” type things, whereas mentalization is a bit more kind of “woolly” (...) It’s (the concept of mentalization) not like you physically put something on paper “you do this, this, this and, this” and that’s how you improve and I find that more difficult to work with (69-81, Participant 1)

Another participant shared her difficulties with using mentalization-enhancing techniques. She reported that she found it difficult not to offer solutions and stay with patients’ feelings and that she needed more training to be able to use mentalization-enhancing interventions with more confidence.

Mentalization doesn't really have a solution focused approach, and I feel like it is important to have that. I don't think that mentalization does it, and I find it difficult to know how the individual can move forward if all they doing is focusing on that (...) I feel like I can't leave the conversation with just saying to them "this is how you're feeling". I feel that you should have a bit more of the solution focused or a CBT like, just recognising and making links between thoughts and feelings and behaviour and what you could do to help (...) it makes me feel a little bit uncomfortable, but I can't just focus on feelings, like how they're feeling right now. I have done it and then moved on to a distraction technique, like “let's make a play list for you to listen to before bed or shall I read you a book now (...) I would appreciate more help with mentalization, just different, just help with the technique and also help with just knowing what to say sometimes (208-233, Participant 3).

Overall, the data showed that frontline professionals knew about mentalization-enhancing techniques but their understanding of the theoretical concepts underpinning these techniques was limited.

Theme 4.2: Individual key relationship

Many study participants commented on mentalization-enhancing interventions but only a few referred to the use of individual key relationships. One participant shared the view that

frontline professionals showed more familiarity with the concept of mentalization than of the concepts recommending the use of individual key relationships.

We have the mentalization-based with the actual conversations that we have so probably we need to work more at supporting the staff that do have those key relationships. I think somebody completely different but somebody that has built up a very good relationship, somebody on their care team, that can be kind of the conversations (...) by staff "she is their favourite" or quite negative conversations rather than supportive conversations and I guess that does not really fall in with what AMBIT, saying that somebody spends a lot of time with somebody as one person, saying "she's becoming too attached to her" so I think staff are finding it difficult to adjust their mindset (756-763, Participant 2)

As showed in the first overarching theme, a few participants commented on the benefits of therapeutic relationships in their practice.

That's important that AMBIT model focuses on people who have that relationship and that bit of knowledge (317-318, Participant 4)

Also, as illustrated in the quote below, professionals who did not have relationships with their patients were considered to be less likely to effectively prevent self-harm.

I would never put a non-familiar member of staff in that position because the likelihood is use of medication, out of not knowing the patients, or somebody actually getting hurt or her causing severe harm, to ourselves and then you have to manage the emotions of that staff member (323-326, Participant 4)

In summary, the data shows that study participants reported limited familiarity with AMBIT's principle of forming key relationships, but they showed an appreciation of forming therapeutic relationships.

Theme 4.3: Conscious and unconscious use of AMBIT

Most study participants reported that they did not draw consciously on AMBIT in their work with young people who self-harmed in their everyday clinical practice. In the quote below this point is illustrated.

I don't think I used it consciously at all. I did the training when it first came out but I think in here you just get wrapped up with doing things and you don't actually think, "oh actually I used this, or I used that". You know we go on a lot of training, they are always trying to promote training for all sorts of things, and it's not until you step back or you're sort of doing your appraisal for the year that you think "oh actually that's, we used that, that's what we were using when we dealt with this young person". I don't think, although, you know, say about the AMBIT, you don't consciously think "this is what I'm doing". It's not until I don't know we might have a HCA (healthcare assistant) group and the facilitator will say "oh you know this is what we're doing and this is part of the AMBIT" and actually yeah it wasn't it – because from the training point of view I don't keep thinking of the AMBIT, I just get on with my job (469-478, Participant 6)

Another study participant reported that the model is used widely among frontline team members, although its use may not be conscious.

We use it in so many aspects, so many different aspects of how we work (...) we use it in supervision, we use it in group supervision, we use it in one to one sessions with the young people, we use it in kind of debriefs, we use it when we sit and have a cup of tea in the staff room with our colleagues, you know, thinking, so I think as a model we implement it in lots of different ways even if again we don't consciously think that we're using it (304-309, Participant 9)

Only one study participant reported a conscious use of the model, which she found helpful for reflecting on her clinical practice. Notably, this participant had received education in counselling.

It makes you think about what you do and how you can maybe improve, follow it a little bit more and do it a little bit more (836-837, Participant 2)

It is like CBT where you have a set structure. I feel I kind of use the theory and probably use it a little bit more and it's helped me to identify what I am doing (385-387, Participant 2)

Theme 4.4: Views on AMBIT

Many participants reported that the model prescribed practice every mental healthcare professional should engage in by simply following their instinct to care. Participants in their descriptions of the model portrayed it as an encapsulation of core therapeutic principles. The quotes below illustrate this view.

It's the kind of stuff the people did anyway without having the name for it (493-493, Participant 5)

Everyone on the team instinctively follows these kind of things anyway, which are laid down within it (...) you would hope that people wouldn't be judgemental, that you are going to bear the young person in mind, and the other things that AMBIT proposes (186-189, Participant 10)

We are meant to use like an AMBIT-based approach, but people just don't really talk about it that much; since I've been here, I don't think I've had a conversation with anyone about AMBIT. I'd say that all of us staff members mentalize that young people anyway, cos it's something that you do (...) just thinking about how they might be feeling and reflecting it back at them (572-577, Participant 11)

Recognising that whatever behaviours they're presenting with, however they are behaving, we always try to recognise that there is a reason why they behaving that way, they're trying to communicate something with the way that they behaving or the way they acting or what they saying, and I think it's about naturally having that empathy and having that level of understanding, which I think anyone who does this job naturally I'd like to think naturally has. Cos a lot of the reason, that's why we come into this profession, and why we've done mental health training, because we have that level of understanding. I think it's just developed more in this setting because we use it so frequently (295-301, Participant 9)

We'd just do it naturally, we are all compassionate people, it is just how you'd talk to someone who's struggling that you know well. (...) obviously it takes a while to build the relationship with the young person before you feel comfortable (597-599, Participant 11)

I don't necessarily see it as a valid model, I see it more like cool practice (485, Participant 8)

Summary

The four overarching themes generated in the analysis have been presented in this chapter. The researcher mapped the generated themes and the relationships between them. This led to a generation of a model of processes posing challenges to the frontline team providing care to adolescent patients who self-harmed. This model is presented below in the Figure 3.

The frontline team's responses to the identified challenges, including their application of AMBIT, are also mapped onto the model.

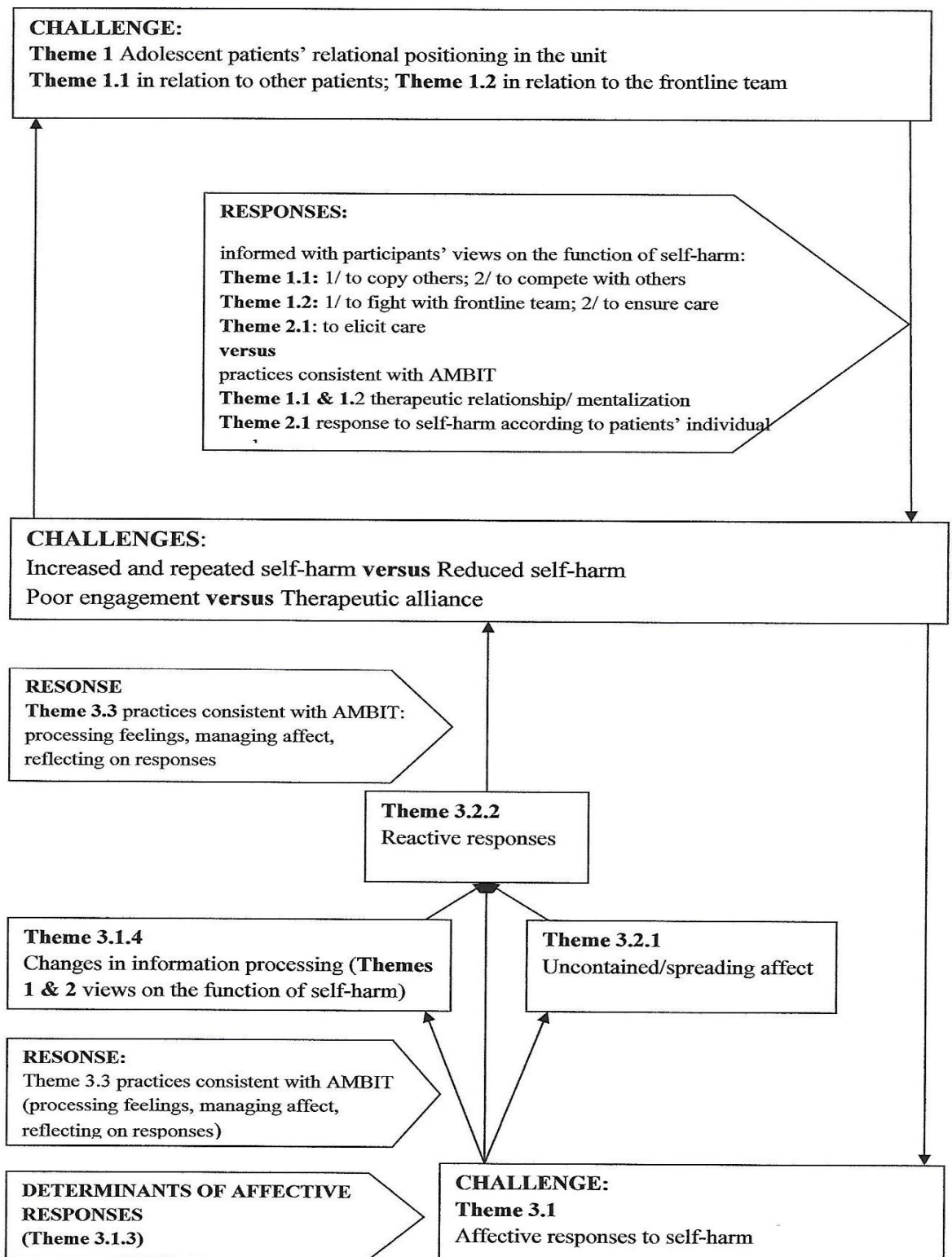


Figure 3. Model of the processes posing challenges the frontline team’s care for adolescents who self-harmed

Chapter 4: Discussion

Chapter Overview

This chapter discusses the findings of the study. The model of processes posing challenges to frontline professionals' care to adolescent patients who self-harmed is discussed and reviewed in the context of relevant research and theory. This is followed by a review of the use of Adolescent Mentalization-Based Integrative Treatment (AMBIT) by frontline professionals in their work with this patient group. The chapter continues with an assessment of the study quality in relation to its methodological strengths and limitations. This is followed by a presentation of the study's clinical and research implications. The chapter concludes with the researcher's personal reflections on the research project.

Research Summary

The current research was conducted on an adolescent inpatient unit which implemented AMBIT. It aimed to investigate the challenges faced by frontline professionals caring for adolescent patients who self-harmed whilst being treated on the inpatient unit, and their responses to these challenges. Special attention was paid to frontline professionals' use of AMBIT.

A qualitative study paradigm was used and a critical realist stance employed. In line with this position, the study aimed to investigate not only the challenges encountered by frontline professionals but also the processes which generated them. The research findings were generated with semi-structured in-depth individual interviews with twelve frontline professionals.

Four main themes were generated with a descriptive inductive thematic analysis. The first three themes described challenges encountered by frontline professionals in their work with

adolescent patients who self-harmed and their responses to these challenges. The fourth theme elucidated the frontline team's use of AMBIT in the explored area of clinical practice. The generated themes and relationships between these were mapped against each other and a model of processes posing challenges to frontline professionals' care for adolescent patients who self-harmed was generated. This model was presented in the final section of the results chapter.

Findings Summary and Review

In this section the research findings are summarised and reviewed. This is followed with a review of the generated model of processes hypothesised to pose challenges to the frontline team's care for adolescent patients who self-harmed introduced in the final section of the research findings chapter. The section continues with a discussion and a review of the model in the context of relevant theoretical perspectives.

The current research employed a critical realist stance and it followed its theoretical perspectives on the advancement of knowledge (Sayer, 1992). In line with these, the research findings are used for increasing the understanding of the processes shaping the investigated practices. This is achieved by evaluating the validity of the theoretical perspectives presented in the introduction chapter by relating them to the research findings.

The research aimed to conduct a formative evaluation of the processes shaping the frontline team's clinical practices (Weiss, 1994). Therefore, frontline professionals' responses to the identified challenges are discussed with special attention being paid to the frontline team's use of AMBIT. The challenges related to the frontline team's application of this approach are identified and discussed.

Summary of the generated findings and their review in the context of relevant research

The generated data suggest that the challenges to the frontline team's care for adolescent patients who self-harmed were linked to two groups of processes: processes shaping adolescent patients' relationships with their peers and the frontline team; and processes shaping frontline professionals' responses to work with this patient group. The generated data suggest that these two groups of processes contributed to adolescent patients' poor engagement with treatment and their repeated self-harm.

Challenges related to adolescent patients' unhelpful relationships and the frontline team's responses to these challenges

Study participants' accounts indicate that the identified challenges to adolescent patients' engagement with treatment were related to adolescent patients' positioning on the inpatient unit encouraging forming unhelpful relationships. Study participants' accounts delineated four processes by which the unhelpful relationships may have been formed, and may have contributed to adolescent patients' poor engagement and their increased self-harm.

A few study participants noted that peer pressure among adolescent patients admitted to the unit led to forming overly close peer relations. It was noted that such close relationships at times got in the way of adolescent patients' recovery and sometimes in such relationships adolescent patients self-harmed to be like others (Theme 1.1). It was noted that not only peer pressure but also peer rivalry shaped relationships among adolescents patients treated on the unit (Theme 1.1). A few study participants hypothesised that adolescent patients sometimes engaged in self-harm in response to having care withheld from them when the frontline team was attending to high risk incidents.

The dynamics occurring in the patient–frontline team relationship were seen to further contribute to the challenges frontline professionals encountered in caring for adolescent patients who self-harmed. A few study participants noted that when adolescent patients perceived the frontline team as controlling their freedoms, not only they were less likely to collaborate with the frontline team but also at times they attempted to fight and undermine the frontline team’s control with self-harm (Theme 1.2.1). Furthermore, it was noted that adolescent patients who self-harmed tended to develop an unhelpful dependency on the safety provided by the frontline team and such dependency was seen as a threat to adolescent patients’ resilience required for managing their difficulties outside the inpatient unit. It was noted that sometimes adolescent patients responded to their improvements with an increase in their self-harm. Also, a few participants noted that that adolescent patients were more likely to self-harm whilst on the unit than on their leave, and they hypothesized that this was caused by adolescent patients’ trust that the frontline team would ensure their safety.

Study participants’ descriptions of the processes posing challenges to the frontline team’s care are largely consistent with the research literature findings reviewed in the introduction chapter. They also offer an elaboration of the processes identified in the reviewed literature.

The generated findings are consistent with the reviewed research literature suggesting that healthcare professionals considered adolescents’ self-harm to be a manifestation of adolescent patients’ poor mental health and adolescent group processes (Anderson, Standen, Nazir, & Noon, 2000; Rissanen, Kylma, & Laukkanen, 2011, 2012), and provide further elaboration of these conceptualisations in the context of an inpatient unit. The generated data showed that a few of study participants thought that adolescent patients were more likely to self-harm when they got in contact with the feelings of ‘being deprived’ and controlled. Furthermore, participants thought that adolescent patients were more likely to get in contact with such feelings

when they formed unhelpful relationships promoted by their positioning on the unit, marked by adolescent group processes of peer pressure, rivalry and opposition.

There are some similarities between participants' conceptualisations of the functions of self-harm and those reported in the reviewed research literature. For example, both the generated findings and three of the reviewed studies indicated that self-harm was seen as helping to manage difficult feelings (Anderson et al., 2000; Rissanen et al., 2011, 2012; Sandy, 2013). Study participants' views provided an elaboration of this conceptualisation in the context of an inpatient unit by capturing a view that self-harm may help to manage intensive emotions stirred by peer pressure, rivalry, opposition and need for safety. Furthermore, the generated findings, similarly to the findings of five reviewed studies (Anderson et al., 2000; Anderson et al., 2005; Dickinson, Wright, & Harrison, 2009; Rissanen et al., 2012; Sandy, 2013; Cleaver, Meerabeau, & Maras, 2014), evidence that frontline professionals also held a view that self-harm performed a function of eliciting care and attention.

Similarly to the reviewed research literature, participants in this study also agreed with a view that adolescents' self-harm may be caused by a range of individual, systemic and institutional factors. As in Rissanen and colleagues' (2011) study, a few participants were in agreement with a view that self-harm in adolescent patients could be caused by difficult states of mind, exposure to self-harm and an admission to inpatient services (Anderson et al., 2000; Anderson et al., 2003, 2005; Rissanen et al., 2011, 2012; Sandy, 2013).

Participants' accounts evidenced that many of the frontline team's attempts to prevent adolescent patients' repeated self-harm and to address their poor engagement were informed with frontline professionals' understanding of the processes shaping adolescent patients' unhelpful relationships (Theme 1.3). When self-harm was viewed to be caused by peer pressure

and to perform a function of forming close peer relationships, frontline professionals made attempts to alert their patients to the negative consequences of such relationships (Theme 1.1 & 1.3). When self-harm was viewed as caused by patients' rivalry and as performing a function of competing for care, frontline professionals made attempts to ensure that adolescent patients did not feel that they were competing for attention and support (Theme 1.1 & 1.3). When self-harm was viewed to be caused by patients' experience of being controlled and deprived by the frontline team, frontline professionals made attempts to increase patients' freedoms and their responsibility for their safety (Theme 1.2.1 & 1.3). When self-harm was seen to perform a function of ensuring proximity to the frontline team, frontline professionals attempted to stop patients from becoming dependent on their care (Theme 1.2.2 & 1.3). Finally, when self-harm was seen to perform a function of eliciting care and attention, frontline professionals attempted not to reinforce this function by not showing care or by responding to self-harm in a clinical way (Theme 2.1 & 2.2). The generated data did not clearly indicate the effectiveness of the above detailed measures (Theme 1.3 & 2.2). These findings, in the researcher's knowledge, have not been replicated elsewhere.

Participants' accounts also evidenced frontline professionals' use of aspects of practices promoted by Adolescent Mentalization-Based Integrative Treatment (AMBIT) in responding to the described challenges. Frontline professionals tried to build therapeutic relationships with their patients and to support them in enhancing their capacity to mentalize (Theme 1.3). The generated data also indicated that at times frontline professionals informed their responses to self-harm with their knowledge of the individual relational patterns of their patients (Theme 2.2). Some evidence was found for the effectiveness of these measures in responding to the described challenges (Theme 1.3); however, these measures were not employed intentionally to counteract

Challenges to frontline professionals in care for adolescents who self-harm

the negative consequences of adolescent patients' unhelpful relationships promoted by their positioning on the inpatient unit.

Challenges related to frontline professionals' responses to caring for adolescent patients who self-harmed and their attempts to manage these challenges

The second group of processes captured in participants' accounts are related to frontline professionals' responses evoked in the care for adolescent patients who self-harmed (Theme 3). Participants' accounts indicated that frontline professionals' responded with increased negative affect to exposure to self-harm, caring for those who engaged in it and repeated failures to prevent it (Theme 3.1.1 & 3.1.2). These findings are consistent with the reviewed qualitative research which explored healthcare professionals' responses to self-harm in adolescents (Anderson, Standen, & Noon, 2003; Medina, Kullgren, & Dahlblom, 2014). The generated data add to the quantitative research literature findings indicating an association between healthcare professionals' negative responses to adolescents' self-harm and their subjective sense of poor effectiveness (Crawford, Geraghty, Street, & et al., 2003; Wheatley & Austin-Payne, 2009; Timson, Priest, & Clark-Carter, 2012) by suggesting that a repeated failure to prevent self-harm led to frontline professionals not only experiencing negative feelings towards their patients but also to themselves and the system of care.

Study participants listed the following determinants of their affective responses. It was noted that the frontline team, due to their positioning in the system of care, were less able to evaluate the effectiveness of their efforts to support their patients and therefore more likely to experience negative feelings about the repeated failures to prevent self-harm. These findings add to the understanding of the reviewed research literature indicating that frontline professionals

reported higher than other professional groups levels of negative responses to adolescent patients who self-harm (Dickinson & Hurley, 2012; Timson, Priest, & Clark-Carter, 2012).

It was evidenced that frontline professionals tended to respond more intensively to self-harm when they had a busy shift and little time for a break; and/or when they failed to prevent self-harm in patients they had a close relationship with. The former finding is consistent with Anderson and colleagues' (2003) and Medina and colleagues' (2014) studies which suggested that the busy nature of healthcare settings negatively impacted healthcare professionals' work with adolescents who self-harm. The latter finding, in the researcher's knowledge, has not been replicated elsewhere.

Study participants stated that affective responses were less intense in frontline professionals who had a lot of clinical experience, familiarity with work with self-harm and with risk management procedures; and who held a view that the care for adolescents who self-harm was not limited to self-harm prevention. These add to understanding of the identified in Dickinson and Hurley's (2012) study negative association between specialist training and negative affective responses to adolescents' self-harm. These findings are also consistent with the reviewed research findings suggesting that inadequate training was a barrier to healthcare professionals providing good quality care to adolescents who self-harm (Anderson et al., 2003, 2005; Crawford, Geraghty, Street, & Simonoff, 2003; Dickinson, Wright, & Harrison, 2009; Medina, Kullgren, & Dahlblom, 2014).

Participants' narratives indicated that frontline professionals' affective responses led to changes in their information processing style (Theme 3.1.4). These changes entailed a reduced awareness of their own responses and a narrowing of the attention focus to information relevant to risk identification, prevention and management. Participants' accounts also suggested that the

unmanaged emotions and the cognitive changes led to a spread of uncontained affect and reactive responses in the team, weakened adolescent patients' engagement and increased their self-harm (Theme 3.1 & 3.2). Finally, participants' narratives indicated that the increase in self-harm led to further affective responses in the frontline team. These findings, in the researcher's knowledge, have not been replicated elsewhere.

Participants' narratives evidenced that the frontline team successfully used AMBIT to manage the negative consequences of their affective responses to self-harm. AMBIT was used by frontline professionals to help each other to recognise and manage their increased affect (Theme 3.3). It was also demonstrated that AMBIT was successfully used to increase the frontline team's ability to reflect on their responses and gather knowledge about their patients' patterns of relating (Theme 3.3). The current study evidences that AMBIT can be successfully used to develop reflective stance among professionals working with adolescents who engage in self-harm, identified as essential for work with this patient group in inpatient services in two reviewed research studies (Rissanen, Kylma, & Laukkanen, 2012; Sandy, 2013).

Below the generated model of challenges to the care for adolescents who self-harmed is presented and reviewed in relation to the relevant theoretical perspectives.

Review of the generated model of challenges to the frontline team's care to adolescents who self-harmed in the context of relevant theoretical perspectives

The outlined above processes, hypothesised to pose challenges to the frontline team's care for adolescents patients who self-harmed, were mapped onto the model presented in the end section of the research findings chapter. In this section, this model is reviewed in context of the theoretical perspectives outlined in the introduction chapter.

This section starts with a review of the processes related to adolescent patients' relational positioning on the unit. This is followed by a discussion of the processes related to the impact of frontline professionals' affective responses on their practices. Finally, the relationship between these two groups of processes is explored.

Processes related to adolescent patients' unhelpful relationships

The model suggests that adolescent patients' positioning on the unit encouraged forming unhelpful relationships between adolescent patients and their peers, and adolescent patients and the frontline team. The descriptions of these processes largely overlap with some of the descriptions of the processes hypothesized to impact adolescent patients who self-harm and professionals caring for this patient group outlined in the introduction chapter.

The generated data indicated that adolescent patients' relational positioning on the unit made them vulnerable to form unhelpful overly close relationships with their peers and to self-harm to copy each other. These descriptions of adolescent patients' behaviours are consistent with psychoanalytic perspectives on the developmental processes taking place during adolescence, and the possible impact of those processes on adolescent patients' relationships in residential settings (Anderson, 1998; Waddell, 2002). These theoretical perspectives posit that the core task of adolescence is a formation of the adult self and a transition into the adulthood (Anderson, 1998), tasks which entail separation from the adolescent's parents and forming close peer relationships. Furthermore, the discussed psychoanalytic perspectives posit that the adolescent relies in the early phase of adolescence on projections of different aspects of the self into the other, and in the later phase of adolescence on introjections of different aspects of the other into the self (Waddell, 2002). In light of these perspectives, peer pressure to imitate may lead to adolescents' use of self-harm as a mean for identity formation and the adolescent's

tendency to copy self-harming behaviours may be thought about as a part of a natural developmental process. Waddell (2002) argued that it was the interaction between the above detailed developmental processes and other factors that determine whether self-harm was or not a manifestation of mental health difficulties. These factors are discussed further in the following section.

The generated data suggested that adolescent patients' relational positioning on the inpatient unit made them vulnerable to experience their peers as rivals and the frontline team as controlling and restricting; and that these experiences led to adolescent patients' use of self-harm to compete for care with peers and/or to oppose the frontline team's control. These descriptions of the causes and functions of self-harm in adolescent patients' relationships on the unit are again largely consistent with psychoanalytic perspectives' descriptions of the unconscious processes leading to self-harm (Maltsberger, 1993, 2004). These perspectives propose that the self-harmer's internal world populated with hostile and controlling objects predisposes him or her to respond to situations in which they experience a reduction in care or freedom with distress. These perspectives further propose that the self-harmer deals with this distress by splitting the 'bad' internal objects from the 'good' ones and by projecting them into his or her body and/or into the other. Once these objects are projected outside the self, they are punished with self-harm. These findings were also fairly consistent with the predictions of the causes and functions of self-harm in adolescent patients made by the mentalization theoretical model (Rossouw, 2012). The model proposes an alternative elaboration of the processes noted in the data and suggests that situations of having one's care and/or freedom reduced lead to an activation of the 'alien self' and high levels of distress. This model proposes further that such distress can be managed by identification with an aggressor (Freud, 1936) in which the adolescent identifies with the depriving and abusive (controlling) other and he or she directs their inner hate and

hostility outside the self, in this context into other patients, frontline professionals and/or their own body.

Lastly, the data suggest that adolescent patients' relational positioning on the unit made them vulnerable to become dependent on the safety provided by the frontline team. A few participants noted that sometimes adolescent patients self-harmed after they experienced a significant improvement in their wellbeing. Participants also expressed a view that adolescent patients tended to self-harm more whilst on the unit because of their belief that the frontline team would protect them from the overt harm caused by self-harm. These findings are also fairly consistent with the predictions made by psychoanalytic perspectives on the processes shaping patient-healthcare professional relationship within residential settings proposed by Tom Main and his followers (Main, 1975; Griffiths & Hinshelwood, 1997; Steiner, 1997; Skogstad, 2001). These perspectives propose that patients' deterioration in the residential care is caused by the unconscious processes of collusive double projections affecting patients and healthcare professionals (Main, 1975). These processes are hypothesised to lead to patients and healthcare professionals taking on the roles of the "ultimate patients" and the "ultimate carers" (respectively, Main, 1975, p. 103), patients moving into a state of mind called psychic retreat (Steiner, 1997; Skogstad, 2001) and consequent deterioration in their wellbeing (Griffiths & Hinshelwood, 1997).

Participants' conceptualisation that the function of self-harm was to ensure proximity and continuity of care as well as eliciting care and attention does not directly converge with the theoretical frameworks outlined in the introduction section. Interestingly, this widely shared conceptualisation is consistent with the Theory of Operant Conditioning (Skinner, 1957). However, in light of the theoretical model of mentalization, this behavioural view on the function of self-harm would be seen as failing to recognise that actions are driven with opaque

mental states and would be thought as coined in non-mentalizing mode of thinking. The processes hypothesised to form this conceptualisation are discussed in more detail in the following section.

Processes related to frontline professionals' affective and cognitive responses

The generated model depicts the processes shaping frontline professionals' responses to adolescent patients who self-harmed found in this research study to pose challenges to the frontline team's care for this patient group. The model suggests that affective responses were stirred in the care for adolescent patients who self-harmed and impacted healthcare professionals' information processing style and, when uncontained, led to a spread of anxiety among frontline professionals. The model suggests further that the changes in frontline professionals' cognitive style and the spread of affect among the frontline team led to frontline professionals' reactive responses undermining their relationships with their patients and increasing their patients' self-harm. The descriptions of these processes largely overlap with some of the descriptions of the processes hypothesized to impact healthcare professionals working with adolescents who self-harm in the context of an inpatient setting outlined in the introduction chapter.

Study participants observed that that exposure to self-harm, working with adolescent patients who self-harmed and repeated failures to prevent self-harm caused frontline professionals negative affective responses towards themselves, their patients and towards the system of care. These findings are consistent with psychoanalytic perspectives on the unconscious processes of projective identification (Klein, 1946), counter-transference (Winnicott, 1949), and the Theory of Social Systems as a Defence against Anxiety (Menzies-Lyth, 1960).

Klein's (1946) and Winnicott's (1949) theoretical developments of projective identification and counter-transference provide theoretical frameworks for understanding healthcare professionals' responses to working with patients who engage in self-harm and are consistent with the observations made by study participants that working with adolescent patients who self-harmed stirred negative responses to this patient group. These theoretical conceptualisations provide further elaboration of the processes by which these responses may have been evoked. In light of Klein's (1946) theoretical conceptualization of projective identification, frontline professionals' negative responses could be understood as an inevitable part of forming a helping relationship with patients who defend from the pain stirred by getting in contact with their inner hostile and punishing objects with the defence mechanisms of splitting and projection. In light of Winnicott's (1949) theoretical conceptualisation of counter-transference, frontline professionals' negative responses could be thought about as a natural part of providing care to patients who experience those who care for them as hostile and punishing, and as a vehicle of understanding the quality of the caring objects populating those patients' inner worlds. It is important to note at this stage, that in line with the above theoretical conceptualisations, the view that the function of self-harm was to elicit care and attention, could be understood as a manifestation of projective identification with adolescents' patients controlling inner objects or as healthcare professionals' experience in their counter-transference of controlling inner caring objects belonging to their patients' inner worlds.

Menzies-Lyth's Theory of Social Systems as a Defence against Anxiety (1960) provide a theoretical framework for understanding healthcare professionals' negative responses towards themselves and the wider system of care evoked in working with patients in institutions with a primary task of providing care, and are consistent with the observations made by study

participants that failures to prevent self-harm in adolescent patients evoked in frontline professionals negative responses to themselves and to the system of care.

Menzies-Lyth's theory (1960) provides further elaboration of the processes by which such responses may have been evoked. In light of this theoretical framework, frontline professionals' negative responses to themselves and to the system of care stirred by repeated failures to prevent self-harm can be understood as a manifestation of paranoid anxieties related to professional accountability and/or depressive anxieties related to professionals' sense of responsibility for not being effective in caring for their patients.

This theory can be also applied to understand some of the frontline team's practices that led to emotional distance between the frontline team and their patients. Such practices, if implemented systemically, can be thought about as indicating of an operation of institutional defences. In this vein, frontline professionals' practices informed with a view that adolescent patients self-harmed to elicit care and attention may be considered as an indication of an operation of institutional defences on the inpatient unit participating in the study.

The research findings indicated that exposure to self-harm, self-harm prevention and management led to changes in frontline professionals' information processing. These changes were characterised by a reduced awareness of one's own mental states, a focus on identifying risk and a propensity to resorting to instinctual actions aimed at identifying and removing risks.

These descriptions are consistent with the predictions made about the impact of anxiety on cognitive functioning delineated by the psychodynamic concept of the paranoid-schizoid position. This theoretical conceptualisation posits that in the paranoid-schizoid position, one's state of mind is shaped by the operation of the defensive mechanisms of splitting and projection (Klein, 1946) which lead to a binary experience of the world (as either 'bad' or 'good'),

persecutory anxiety and a focus on threats to the self. Notably, in line with this conceptualisation, one's cognitive processing in the paranoid-schizoid position oriented towards the internal world is governed by the operation of persecutory anxiety and shows impaired reality testing (Klein, 1940). The cognitive changes reported by study participants could be thought about as characteristic to the paranoid-schizoid position and as putting frontline professionals' at risk of engaging in reactive actions driven with the need to manage their inner anxieties rather than with reality-based needs of their patients. Such responses may lead to frontline professionals' failures to engage their patients in the processes of treatment and to ensure their patients' safety. It is also important to note that in light of the discussed theoretical conceptualisations, the cognitive changes reported by study participants would also put frontline professionals at risk of failing to engage in the complex task of communication with their colleagues and at risk of engaging in actions undermining their joint efforts to contribute to the primary task of care for their patients.

Study participants' descriptions of frontline professionals' information processing style at the time of attending to self-harm incidents are also consistent with the theoretical model of mentalization which proposes that an increase in affect and consequent loss of mentalization capacity results in changes in cognitive processing (Bateman & Fonagy, 2006). In line with this model, frontline professionals whose mentalization capacity is diminished are less able to think of their patients' actions as driven with opaque mental states. As it has been already stated, in light of this model, the uncontested and widely shared among frontline professionals view that adolescents patients engaged in self-harm to elicit care and seek attention can be thought about as coined in the non-mentalizing mode of thinking.

The processes by which frontline professionals' reactive responses may pose challenges to their engagement of adolescent patients and to their collaboration with their work colleagues are discussed below.

Study participants' descriptions of the impact of frontline professionals' emotional responses evoked in the care for adolescent patients who self-harmed on healthcare professionals' processing style, behaviours and the impact of those behaviours on others are also consistent with the predictions made by the theoretical model of mentalization (Rossouw, 2012). The generated findings, consistently with the model, evidence that high affect stirred by attending to the prevention and management of self harm led to a change in thinking mode in frontline professionals that impacted their response to their colleagues and their patients. These findings are consistent with the mentalization model which proposes that an increase in affect puts healthcare professionals at risk of a loss of their mentalization capacity (Bateman & Fonagy, 2006). The model further proposes that a decline in mentalization capacity hinders healthcare professionals' ability to read their own states of mind and states of mind of their patients and colleagues, and that it drives frontline professionals' reactive responses directed at managing their own affective states. It is further posited that frontline professionals' poor attunement to their colleagues and patients' states of mind (Rossouw, 2012) may contribute to a systemic increase in affect on the inpatient unit. The above described sequence of individual and interpersonal events is also consistent with the processes observed by study participants that led to the emergence of uncontained anxiety and a further increase in reactive behaviours among frontline professionals.

Interaction between the two groups of processes

In this section the possible interaction between the two groups of processes outlined above is discussed and related to theoretical perspectives on the unconscious processes governing the patient-healthcare professional relationships in residential settings and with theoretical frameworks on the processes impacting healthcare professionals' work with 'hard to engage' young people proposed by Adolescent Mentalization-based Integrative Treatment (AMBIT).

The research findings did not directly uncover data evidencing the interaction of the two groups of processes observed to pose challenges to frontline professionals' care for adolescents who self-harmed whilst being treated on the inpatient unit. However, the generated data evidence that both groups of processes undermined frontline professionals' efforts to engage adolescent patients with treatment and to prevent adolescent patients' self-harm. Adolescent patients' unhelpful relationships with their peers and the frontline team, promoted by their positioning on the unit, were found to lead to their poor engagement and repeated self-harm. And exposure to self-harm, work with adolescents who self-harmed, and the repeated failures to prevent self-harm were found to lead to the frontline team's affective and cognitive responses, spread of affect and reactive responses further contributing to adolescent patients' repeated self-harm and poor engagement.

In view of the above, the researcher hypothesised that the two groups of processes which resulted in adolescent patients' poor engagement and self-harm, when uninterrupted, further consolidated adolescent patients' unhelpful relational positioning on the unit, and intensified frontline professionals' negative responses shaping their care for adolescent patients and their collaboration with their colleagues.

The hypothesis formulated by the researcher is consistent with psychoanalytic perspectives on the interplay of individual and interpersonal unconscious processes of double projections resulting in difficulties with helping patients treated within residential settings proposed by Tom Main and his followers (Main, 1975; Griffiths & Hinshelwood, 1997; Steiner, 1997; Skogstad, 2001). The research findings indicated that adolescent patients' poor engagement and their increased self-harm were possibly caused by, among other processes, adolescent patients' unhelpful relationships on the unit. The research data indicate that adolescent patients tended to seek safety in the frontline team or experience frontline professionals as withholding care and controlling. In light of the discussed perspectives, adolescent patients' relating to the frontline team as providers of safety is consistent with Main's proposition that patients in residential settings tend to seek 'ultimate carers' in the system of care (Main, 1975). Perhaps disappointment with not being able to find such safety in the frontline team led to adolescent patients experiencing frontline professionals as withholding and controlling. The research findings add to the elaboration of the above conceptualisation of the unconscious processes posing challenges to the care for adolescent patients who self-harmed by suggesting that peer relationships may pose additional challenge to patients' engagement.

The research findings provide alternative to Main and his followers' (Main, 1975; Griffiths & Hinshelwood, 1997; Steiner, 1997; Skogstad, 2001) conceptualisation of the unconscious processes impacting the frontline team that focuses on the impact of high affect on frontline professionals' practices. These conceptualisations were discussed in the previous section.

The hypothesised interaction between these two groups of processes is consistent with AMBIT's view of the challenges to providing care to 'hard to reach' young people which are related to a combination of 'hard to reach' young people's poor affect management and capacity

to mentalize, and their difficulties in forming safe attachments with healthcare professionals; and healthcare professionals' having their mentalization capacity threatened by encountering high level of affect and acting out behaviours in 'hard to reach' young people (Bevington & Fuggle, 2012). The current research findings enrich the understanding of the challenges to frontline professionals' care for adolescents who self-harmed in the context of an inpatient unit by identifying the specific to this setting relational positioning shaping adolescent patients' interaction with their peers and the frontline team.

Frontline team's responses to the challenges to the care of adolescent patients who self-harmed

This section starts with a discussion of the frontline team's responses to the challenges to the care to adolescent patients who self-harmed and these responses are related to the theoretical and practice frameworks promoted for by AMBIT.

Counteracting the negative consequences of adolescent patients' unhelpful relationships

Study participants' accounts evidence that frontline professionals' responses to the challenges linked to adolescent patients' forming unhelpful relationship on the unit were often informed with their understanding of the processes forming those relationships.

Frontline professionals attempted to prevent self-harm caused by peer rivalry by removing the possible causes of rivalrous feelings. Also, frontline professionals attempted to prevent self-harm caused by adolescent patients' feeling out of control and of reduced sense of freedom by increasing increase adolescent patients' sense of freedom and agency.

When self-harm was conceptualised by frontline professionals to perform a function of getting care and attention and to take place in the context of patients' dependency on the safety ensured by the frontline team, frontline professionals engaged in actions directed at not reinforcing such function and such type of a relationship by maintaining professional boundaries, clinical approach and encouraging patients to learn to dress their wounds. However, it is important to mention that study participants did acknowledge that professional boundaries needed to take different form for different patients, and that a decision about how to maintain professional boundaries required a consideration of the individual patient's needs.

Similarly, in order not to promote patients' dependency on the frontline team' care, frontline professionals attempted to ensure that adolescent patients took responsibility for their safety and that they did not avoid exposure to the world outside the unit.

Only the frontline team's measure of increasing adolescent patients' awareness of the dangers associated with forming overly close peer relationships was not informed with frontline professionals' view on self-harm causes and functions.

The evidence suggesting that the responses discussed above were informed with the theoretical and practice frameworks promoted by AMBIT (Bevington & Fuggle, 2012) is limited. It is possible to link frontline professionals' attempts to prevent rivalry among adolescent patients and to prevent adolescent patients feelings out of control with AMBIT's recognition that 'hard to reach' young people may have higher emotional sensitivity to reductions in their care and freedom. Also, few study participants' reflections on maintaining professional boundaries may be linked with AMBIT as it indicates participants' mentalizing of their patients' needs. However, none of the measures described above directly correspond with

the application of the theoretical and practice frameworks promoted by AMBIT and none of them were linked by the study participants with this approach.

Furthermore, frontline professionals' widely shared practices aimed to prevent reinforcing self-harm by not showing care to patients and by encouraging them to dress their wounds in the aftermath of self-harm are not prescribed by AMBIT.

Nonetheless, the generated data show aspects of practices promoted by AMBIT employed by the frontline team in helping their patients to increase their mentalization capacity. This mental function was linked by a few participants with a reduction in self-harm and with an increase in patients' engagement. However, the application of mentalization-enhancing interventions was not directly linked with attempts to counteract the challenges to the frontline team's care caused by adolescent patients forming unhelpful relationships on the unit.

Counteracting the negative consequences of frontline professionals' responses to working with adolescents who self-harmed

The generated data show that the frontline team used a range of measures consistent with the therapeutic stance of a 'well connected-team', and the practices of mentalization and supervisory structures promoted by AMBIT in responding to the challenges to the care for adolescent patients who self-harmed linked to the negative impact of frontline professionals' responses on their practices.

The frontline team's application of the mentalization practice was evidenced by participants' appreciation of the impact of unmanaged affect on their practices and in the measures they reported to take to prevent the negative impact of high affect on their work. The generated data also show that participants drew on the theoretical model of mentalization

(Fonagy & Allison, 2012) when talking about their responses but they did not make an explicit link between their affective responses and the identified changes in their cognitive styles and in their behaviours.

The generated data evidence that frontline professionals' practices were consistent with the therapeutic practices of mentalization and supervisory structures, and the stance of the 'well-connected team' promoted by AMBIT (Bevington & Fuggle, 2012). For example, one of the measures used by the frontline team was a simple system of communication aimed at supporting each other in identifying and managing states of high affect. Another measure reported by participants to be used to manage the states of high affect was professionals' keeping an eye on each other's needs and providing support to each other. One more measure reported by study participants aimed at managing affective responses in work with adolescent patients who self-harmed was the frontline team's use of formal and informal groups for processing their affective responses. Participants reported that the frontline team attempted to manage their affective responses by sharing their experiences with others, having them normalised and being supported in reflecting on these. The latter measure involved frontline professionals being supported in reflecting on their own responses, increasing their understanding of their patients and their awareness of their impact on their patients. Different forums and forms of support for processing frontline professionals' responses were reported. These included formal forms of supervisory support (e.g. staff support groups, healthcare assistant group, case discussion group, individual supervision) and informal forms of support developed by the frontline team (having a cup of tea, the end of shift debrief).

The generated data indicate that participants considered the above reported measures to be effective in managing the negative consequences related to their increased affect. These findings confirm the hypothesis set out in the introduction chapter that AMBIT may be used

successfully in supporting frontline teams in responding to the challenges related to the negative impact of unconscious processes on the care for adolescent patients who self-harm. These also strengthen Seager's (2008) claim that psychoanalytically-informed treatment models are well positioned to cope with the challenges of working with patients who engage in suicidal actions.

The frontline team's use of AMBIT

The generated data presented in the fourth overarching theme evidence frontline professionals' familiarity with AMBIT, some of its underlying theoretical underpinnings and its possible application in the care for adolescent patients. In this section, these findings are discussed.

Participants' accounts showed that many of the frontline team's practices explored in this research study were consistent with the therapeutic stance of the 'well-connected team' and the practices of mentalizing and supervisory structures promoted by AMBIT; however, not all participants linked these practices with AMBIT.

Participants demonstrated some familiarity with the theoretical concept of mentalization and mentalization-enhancing interventions in their accounts capturing their thinking about and responding to the needs of adolescent patients who self-harmed. A few participants considered interventions aimed at increasing mentalization capacity as an effective intervention for reducing adolescent patients' self-harm and increasing adolescent patients' engagement. Also, a few participants reported that they drew on the theoretical concept of mentalization and aspects of mentalization-enhancing interventions in preventing self-harm in adolescent patients. Finally, the generated data showed that the frontline team applied aspects of the practice of mentalization for management of the negative impact of their own affective responses on their practice.

Nonetheless, participants' understanding of the theoretical concept of mentalization and the use

of mentalization-enhancing interventions had some limitations. A few participants reported that they needed more training to be able to use mentalization-enhancing interventions confidently. Furthermore, one participant shared a view that the practice of mentalization had limited value for the task-oriented frontline team as it did not offer prescriptive and tangible guidance.

Implementation of practices informed with the therapeutic stance of the ‘well-connected team’ and the practice of supervisory structure was extensively evidenced in participants’ accounts of managing the frontline’s teams responses to the task of caring for adolescent patients who self-harmed. However, only participants holding higher level of managerial responsibility linked these practices with AMBIT.

Overall the generated data evidenced fairly limited familiarity with AMBIT among frontline professions. This finding can be thought about in context of the frontline team’s limited exposure and formal training in the theoretical framework underpinning AMBIT and in the application of theoretical frameworks in clinical practice. Limited familiarity with these can account for frontline professionals’ difficulties in drawing on AMBIT in their work with adolescent patients who self-harmed and in recognising when their practices were consistent with/informed by this approach. Unsurprisingly, similar difficulties with implementation of the Mentalization-Based Treatment by nursing team professionals in an inpatient unit in Holland were reported by Hutsetbaut and colleagues (2012).

The generated findings show that participants recognised that developing therapeutic relationships with their patients and having knowledge about their patients’ difficulties were crucial for successful engagement of their patients. However, little evidence was found for frontline professionals’ practices consistent with the principle of ‘individual key relationship’ promoted by AMBIT. Furthermore, one participant considered this to be one of the areas of

AMBIT implementation in a need for further development. It may be hypothesised that the limited data evidencing application of practices informed with the principle of 'individual key relationship' was related to the frontline team's limited familiarity with AMBIT or with the difficulties in organising patients' care with a team on a rota.

The data show participants' views on how the theoretical and practice frameworks promoted by AMBIT were used by the frontline team in their work with adolescent patients who self-harmed. There was only one participant who reported that she had drawn consciously on theoretical concepts promoted by AMBIT to reflect and improve her practice. Notably this participant had a higher degree in counselling and perhaps this supported her in making use of the approach. Perhaps those with no previous experience in application of theoretical models in clinical practice stood a lower chance of utilising the approach in their work with adolescent patients.

The data show that most participants considered AMBIT to be an encapsulation of core therapeutic principles that all healthcare professionals should instinctively follow. These findings alarm to the dangers related to the frontline team's superficial understanding of the therapeutic practices advocated by AMBIT. Furthermore, a few study participants equated practices recommended by AMBIT with actions driven by one's own instinct of care. The danger related to frontline professionals holding such views is that they may not recognise that their reactive (instinctive) responses may be harmful to their patients.

Summary

In this section the model of processes posing challenges to frontline professionals' care for adolescent patients who self-harmed was summarised and reviewed in the context of the research literature and relevant theoretical perspectives. This section concluded with a review of

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frontline professionals' use of AMBIT in dealing with the identified challenges. The generated data indicate that due to the complexity of the theoretical and practice frameworks underpinning the approach, its application may require certain modification to meet the needs of frontline teams.

Quality Assessment

This section presents an appraisal of this study in relation to its strengths and limitations.

Strengths of the current study

The current study's strengths are outlined below.

Literature review

The research question in the current study was informed with an outcome of a systematic review of research literature in the area of healthcare professionals' views, attitudes and experiences of working with adolescent patients who self-harm. The body of the research literature identified by the systemic search showed high heterogeneity. Therefore, the Narrative Synthesis Guidance (Popay, Roberts, Sowden, Petticrew, Arai, & et al., 2006) was followed. The trustworthiness of the review was strengthened by a clear and detailed record of the steps taken in the production of its outcomes.

The originality of the research topic

The study makes an original contribution to the research literature in the area of barriers preventing adolescent patients who self-harm to access specialist care. In the researcher's knowledge, this study is a first attempt to investigate the specific challenges experienced by inpatient frontline teams in caring for adolescent patients who self-harm and their responses to

these challenges. Furthermore, this study is a first attempt to investigate frontline professionals' use of Adolescent Mentalization-Based Integrative Treatment (AMBIT).

Choice of methodology

The study had an exploratory focus and qualitative methods were employed to meet its aims of investigating the researched phenomena within its specific context. The exploratory qualitative research approach was judged to be appropriate for investigation of the researched phenomena and their underlying processes. The research approach, data generation (individual semi-structured in-depth interviews, orthographic transcription) and the analysis method (descriptive inductive thematic analysis) employed in the study were appropriate to the aims of this research project and consistent with its theoretical position.

The convenience purposive criterion sampling strategy (Patton, 1990) was employed to recruit frontline professionals who felt confident about sharing their clinical practice in the interviews; and who were interested in making a contribution to advancing knowledge in the researched field. This strategy was employed to increase the chances of identifying participants who could share their views openly without risking harm to their personal and professional lives. The recruitment procedure succeeded in recruiting a relatively heterogeneous sample and allowed for generation of rich data required for exploration of the researched phenomena.

The use of individual semi-structured open-ended interviews allowed the researcher to take a flexible stance in the elaboration of themes in participants' accounts, the existence of which she had not conceptualised prior to conducting the interviews. As the research subject was considered to be sensitive (McCosker, Barnard, & Gerber, 2001); the use of focus group was judged as inappropriate. This was because it was anticipated that this data generation strategy was likely to inhibit participants' openness in sharing their views. The research schedule was

devised to promote rapport and to increase participants' openness in sharing their views about the researched subject.

The inductive pattern-based thematic analysis of semantic data was used for the exploration and description of the researched phenomena. This method of analysis was judged to be appropriate for the data generation required for the investigation of this area of clinical practice, given that it had not been explored prior to this project. It allowed for a generation of themes which increased access to the deeper reality of the researched phenomena (Denermark, Ekstrom, Jakobsen, & Karlsson, 2002).

Validity and reflexivity

The threats to the validity of the study findings were conceptualised and the measures to respond to these threats were generated during the early phases of the research planning. The main threats identified were the researcher's bias, and participants' reactivity and bias.

The potential negative impact of the researcher's unrealised bias on the processes of research design, data generation, analysis and interpretation was managed by the researcher's use of a reflective diary and supervision. The researcher identified her assumptions and expectations about the researched phenomena, the study participants and the processes governing the investigated phenomena. Also, in line with the theoretical position taken in the study, the researcher's previous knowledge and interests were seen as providing a specific focus, as enriching the investigation of the researched area and helping to make an unique contribution to the body knowledge on the processes impacting healthcare professionals' practices.

The impact of participants' bias and reactivity on the outcome of the data generation was minimised by providing study participants with full information about the research aim, by

transparency in respect to the limitations of confidentiality and by promoting a sense of agency in study participants about advancing knowledge.

The use of the semi-structured interview guide with open-ended questions and the researcher's attempts to remain neutral in the processes of recruitment and data generation were other measures used to minimise study participants' reactivity.

Finally, the validity of the study description, analysis and interpretation were strengthened by the following measures: audio recording and transcribing of the full content of the conducted interviews; inclusion of quotes in the report of the research findings, reporting the audit trail of the process of data generation and analysis; paying attention to negative cases; considerations of alternative understandings of the researched phenomena; and generating rich data.

Transferability

The research shows some external generalisability (Maxwell, 2013). Its findings identified aspects of the underlying causal mechanisms of the researched phenomena which are likely to affect clinical practices in other settings. As the same processes may lead to different outcomes in other contexts (Becker, 1991), a clear description of the research setting was provided to support future readers of this thesis to identify the possible environmental factors that may contribute to such differences.

The research study also shows some internal generalisability (Maxwell, 2013). It was achieved by the recruitment of a reasonably heterogeneous research sample. This sample increased the generalisability of the findings to the rest of frontline team members working on the unit.

Finally, this research project also shows a reasonable transferability. It provides a clear and detailed audit trail and it reports on the sample characteristics and recruitment setting. This allows readers of this thesis to make a decision whether the research findings are relevant to other contexts.

Limitations of the current study

The current study's limitations are outlined below.

Limitations of the research literature review

The use of the Narrative Synthesis (Popay, Roberts, Sowden, Petticrew, Arai, & et al., 2006) for the generation of the research questions increased the quality of this study; however it needs to be considered that the limitations of the reviewed research literature weakened the quality of the research synthesis.

Furthermore, the high level of heterogeneity in the reviewed research literature contributed to a difficulty in identifying patterns in the reviewed findings and undermined the validity of the generated synthesis.

Limitations related to the applied methodology

One of the limitations of the current study is its use of the categorising (pattern-based) data analysis only. The inductive analysis of semantic data used in the study, due to its focus on identifying codes and categories in the data, posed a risk of ignoring the actual relationship between the investigated events in their specific context (Maxwell, 2013). A connecting data analysis strategy (process-based), such as some forms of discourse analysis or narrative analysis,

may be better equipped to identify the relationship between the generated data in its context and could be used to complement the analysis strategy used in the study.

Limitations to the validity

In addition to the limitations stemming from double hermeneutics and the use of verbal data for advancement of knowledge about the researched phenomena, the validity of the research findings was limited by the data generation strategy accessing accounts produced retrospectively to the explored events. Within the theoretical position taken, these accounts would have undergone changes and were less accurate in describing the investigated events (Denermark, Ekstrom, Jakobsen, & Karlsson, 2002).

Another limitation of this study is related to the use of self-report data and to the impact of participants' bias on the process of data generation (Maxwell, 2013). Although attempts were made to increase participants' openness, it was impossible to remove some of the factors impacting their level of disclosure. For example, all participants were made aware of the researcher's supervisory relationship with the clinical psychologist working on the unit. Also, participants were made aware of the limits to their confidentiality. To overcome the challenges related to participants' bias, it may have been helpful to complement the employed data generation methods with an organisational observation research strategy (Brewerton & Millward, 2001).

Limitations to generalisability

The internal generalisability (Maxwell, 2013) of the generated findings was weakened by the use of the convenience sampling strategy (Patton, 1990). This strategy resulted in recruiting participants confident about their practice and fairly familiar with AMBIT, who were interested

in advancing the knowledge in the researched area and in helping a fellow researcher. This was evidenced by participants' justifications of why they participated in the study. This strategy also led to recruitment of a sample of female participants only. This led to a generation of data which may have limited generalisability to some of the frontline professionals who did not volunteer to participate in the research project.

Summary

In this section the strengths and weaknesses of the current research were discussed. In the next section the current research's clinical and research implications are introduced.

Clinical Implications

The research findings indicate that the challenges to frontline professionals' care for adolescent patients who self-harmed whilst being admitted to the inpatient unit were related to two processes: adolescent patients forming unhelpful relationships on the unit and the impact of frontline professionals' affective responses on their work with this patient group. The study provides some evidence that AMBIT was successfully used on the unit to respond to these challenges. The data suggest that the implementation of this approach in the participating unit was adapted to the specific needs of the frontline team's care working with this patient group. The data suggest that the main areas of difficulty were increasing patients' engagement, and self-harm prevention and management.

The data indicates aspects of the therapeutic stance and practices promoted by AMBIT which could support frontline professionals in dealing with these challenges. Notably, most of the measures reported below have been successfully implemented on the participating inpatient unit.

Firstly, frontline professionals' ability to engage adolescent patients who self-harm may increase when they are supported to think about their patients' difficulties with forming therapeutic relationships and their propensity to self-harm as related to the unhelpful relationships they form in inpatient care settings. Frontline professionals may benefit from being supported to link their patients' tendency to form such relationships with the interplay of the following processes: the adolescent' need to form identity and his or her difficulties with mentalization, inherent to the adolescent developmental period; and adolescent patients' relational positioning in inpatient services.

Secondly, frontline professionals may benefit from being supported to develop clinical skills in forming therapeutic relationships with their patients. Should the therapeutic practice of the individual key relationships promoted by AMBIT be followed in the context of inpatient services, it may need to be adapted to the specific needs of frontline professionals who are faced with the challenge of taking different roles in working with adolescent patients (key worker/not key worker). For example, frontline professionals may find it helpful to identify forms of engagement appropriate to their roles (key/not key worker) and their responses to occupying such roles.

Furthermore, frontline professionals may benefit from being supported to think about self-harm prevention and management with help of a simplified and adapted to the context of the inpatient unit model of mentalization. Such a model could be used for identifying triggers to a loss of mentalization capacity in adolescent patients (e.g. feeling controlled and/or deprived) and the strategies for restoring it (e.g. actions directed at reducing the level of affect). More specifically, it could also be used to support frontline professionals to formulate adolescent patients' relational patterns and triggers to self-harm specific to their positioning in inpatient services.

It may be of benefit to support frontline professionals to consider that poorly attuned care may trigger distress in patients with a history of neglect and abuse whose positioning in the services may prevent them from managing the distress in other ways than with self-harm. What is more, frontline professionals may find it helpful to think about the possible link between the high level of affect and the loss of mentalization capacity; and to be supported in developing individualised and attuned ways of helping their patients to manage their distress (e.g. by establishing relational safety).

Frontline professionals may also find it helpful to consider the parallel processes impacting their mentalization and their ability to care for adolescent patients. This could be achieved by an introduction of a simple model depicting how high affect stirred in frontline professionals by the exposure to self-harm or repeated failures to prevent it may undermine their mentalization capacity. Such a model could show how the changes in cognitive style limit frontline professionals' ability to stay attuned to the states of mind of others (colleagues and patients) and to be able to accurately process information needed for successful work with adolescent patients. Frontline professionals may find it helpful to note that when this happens their actions may be driven by their impaired cognitive processing; and that when in a state of high affect their impaired cognitive processing is likely to result in reactive actions that may undermine their relationships with their patients and lead to their patients' distress (e.g. seeking distance from their patients). Such responses may also be misattuned to others and lead to what participants in this study described as a spread of affect and increase self-harm in adolescent patients. In particular, frontline professionals may benefit from being supported to reflect on some of their views on the function of self-harm; how these views inform their responses to adolescent patients and the possible consequences of such responses.

What is more, frontline professionals may benefit from being supported in developing practical strategies for managing their affective responses evoked in their work with adolescent patients who self-harm. The measures taken by the frontline team evidenced by the data are good examples. It may be helpful to support frontline professionals to reflect on how their affective, often negative, responses evoked in the care for adolescent patients who engage in self-harm are a natural part of the task of working with this patient group; however, when unrecognised and unmanaged such responses may limit frontline professionals' effectiveness in helping their patients.

It may be also helpful to think about developing organisational measures reducing the level of anxiety experienced by frontline professionals attending to the task of self-harm prevention and management. This can be achieved by ensuring that frontline professionals have sufficient knowledge about their patients' patterns of relating and by helping them to develop skills in risk assessment and management of self-harm incidents. The latter form of support may entail practical training with role plays. Finally, the generated data suggest that frontline teams' affective responses could be managed by supporting frontline professionals to recognise that the prevention and management of self-harm is an important but a small part of the bigger task of caring for this patient group.

The busy nature of frontline teams' work and frontline professionals' limited familiarity with the theoretical and practice framework employed in AMBIT needs to be thought about when adapting AMBIT to the needs of frontline teams working with adolescent patients who self-harm. For example, as it was suggested above, a simplified model of mentalization adapted to the needs of frontline teams may be used in different forms of supervisory structures to support frontline professionals to formulate the difficulties of their patients and their responses to those difficulties. Also, frontline professionals may find it helpful to develop practical strategies

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relevant to their tasks of engaging their patients and reducing their patients' self-harm with help of the representatives of other disciplines (such as clinical psychologist, psychotherapists) trained in AMBIT.

Finally, it is important to support frontline professionals to recognise that although AMBIT does recommend the use of core therapeutic principles, it does not support a view that 'good' healthcare professionals follow such principles instinctively when caring for their patients.

Research Implications

To the researcher's knowledge, the research literature on the processes posing challenges to inpatient frontline professionals' work with adolescents who self-harm is very limited and there is no research literature on inpatient frontline professionals' responses to such challenges. Finally, to the researcher's knowledge, this is the first study exploring frontline professionals' use of AMBIT in general and specifically in working with adolescents who self-harm.

The claims about the processes hypothesised to pose challenges to frontline teams' work with adolescent patients who self-harm, and their responses to such challenges require further exploration. Future qualitative research recruiting from different clinical populations and settings which implement AMBIT or other theoretical approaches would help to evaluate the validity of the research findings.

The use of organisation observation research methods (Brewerton & Millward, 2001) or of combined categorical and connecting data analysis strategies (Maxwell, 2013) could be of benefit in further exploration of the current study research questions in the participating inpatient unit as well as in other research settings and populations.

Reflective Comment

In line with a critical realist stance employed in this study, science was understood here as a form of social practice aimed at advancing knowledge about reality (Denermark, Ekstrom, Jakobsen, & Karlsson, 2002). The reality of social events was considered as never fully accessible and the knowledge about it was considered to be an approximation, co-produced by the researcher's and study participants' subjective conceptualisations of the researched phenomena. For this reason, in order to increase the validity of the research findings the researcher continued to reflect on the impact of their own subjectivity on every step of conducting the current project.

The following section shares some of the main themes the researcher has explored within a reflective journal she kept to think about these issues (excerpts are provided in Appendix J). It is written in the first person as it referred to her personal reflections.

My views and my interest in investigating the barriers preventing adolescents who self-harm from accessing and engaging with treatment shaped this project from its conception. The choice of the research topic was directly motivated with my need to make sense of my past experiences of working on an inpatient unit providing care to adolescent patients who self-harmed and to contribute to an improvement in the frontline team's practices in this area of clinical work. I specifically wished to identify the processes contributing to frontline professionals developing negative views and responses to adolescent patients who self-harmed.

It took me some time to realise that my desire to contribute to improving frontline professionals' care for adolescents who self-harmed was somewhat reactive and perhaps born out of anger and powerlessness I had experienced in my work in adolescent inpatient services. I embarked on the task of designing this project with a somewhat 'black and white', binary

outlook, hoping to ‘repair’ healthcare services and to ‘rescue’ patients who I considered to be ‘victims’ of healthcare professionals’ harmful and unethical practices. As I progressed with the research project I started realising that I had showed little curiosity in the processes shaping healthcare professionals’ practices and that I took on an overly critical and uncompassionate view of frontline professionals’ work with adolescent patients who self-harmed.

The steps I took to generate my research questions helped me to move beyond my initial stance towards healthcare services, their staff and patients. Conducting a review of the existing research literature on healthcare professionals’ views and responses to adolescent self-harm and learning about relevant psychoanalytic perspectives directed my attention to the challenges healthcare professionals experience in providing care to adolescent patients who self-harm, specifically to the challenges affecting frontline professionals working in inpatient services. Having to integrate what felt to be a very disjointed set of research findings generated by heterogeneous research literature increased my understanding of the complexity of the processes shaping frontline professionals’ practices and perhaps to ‘mentalize’ their experiences of working with this patient group.

The research question was shaped by the outcome of the synthesis of research literature and the choice of theoretical perspectives employed for seeking explanations for relationships in the reviewed data. Both, conducting the research review and the choice of the theoretical perspectives, were invariably affected by my subjectivity. Firstly, despite that the process of the narrative synthesis I have conducted followed the recommended guidance (Popay, Roberts, Sowden, Petticrew, Arai, & et al., 2006), all of its steps involved an element of abstraction and interpretation, and were creative in their nature. Secondary, my choice of theory was guided by my subjective preferences in thinking about individual, interpersonal and institutional processes and by the limits of my knowledge.

The outcome of this research project was shaped by my relationship with the recruitment site and the population I gained access to through contacting the clinical psychologist working on the unit who became my practice supervisor. We formed our research collaboration because we shared an interest in investigating frontline professionals' practices, in exploring the challenges frontline professionals experience in caring for adolescent patients who self-harmed and their attempts to deal with those. We also shared an interest in learning about healthcare professionals' use of Adolescent Mentalization-Based Integrative Treatment (AMBIT) in their work with this patient group. This relational positioning between the frontline team, my practice supervisor and I led to a power imbalance that was likely to impact participants' choices about participating in the study, including how open they allowed themselves to be in the interviews. It is possible that those who felt less confident about their practices or did not feel that the study represented their needs did not volunteer.

Another area I have been reflecting on was focused on the processes which influenced my thinking during the interviews. For example, I started this project with a reasonably firm view about the dangers related to the conceptualisation that self-harm performs a function of eliciting care and attention. However, during the interviews with a few study participants I found myself in an agreement with this view and shared study participants' concern that showing care to those who self-harmed reinforced its negative function. I was puzzled by this shift in my views. It took me a considerable amount of time to find a new perspective to think about the reasons why some of the participants held these views and why I found myself agreeing with them when we spoke about this issue in the interviews. I wondered whether holding such views could have been an indication of the defensive strategies employed by the study participants and by myself to deal with highly emotive material.

Finally, the outcome of this project was shaped by how I conducted the process of data analysis. Before embarking on this task I had designed a clear protocol detailing steps for identifying patterns in the data. I was surprised with the level of interpretation and abstraction that the process of analysis entailed and the challenges related to the use of a categorical strategy (Maxwell, 2013) for data analysis. This made me appreciate that qualitative research was subjective and creative in its nature and that in qualitative research an analysis of the same dataset could produce different outcomes depending on the theoretical assumptions and the analysis method employed.

Summary and conclusions

This thesis presented a qualitative study investigating challenges frontline professionals encountered in their care for adolescent patients who self-harmed and frontline professionals' responses to these challenges on an inpatient unit implementing Adolescent Mentalization-Based Integrative Treatment (AMBIT).

The data were generated with semi-structured individual interviews and were subject to an inductive descriptive thematic analysis. The generated findings provided new insights into the processes impacting frontline professionals' practices of providing care to adolescent patients who self-harmed.

Four overarching themes were generated. The first three themes illustrated the challenges associated with adolescent patients' unhelpful relationships promoted by their positioning on the inpatient unit, and with the impact of high affect on frontline professionals' clinical practice. The fourth theme offered insights into healthcare professionals' use of the practices promoted by AMBIT.

The generated findings were mapped against each other and a model of processes posing challenges to the frontline team's care for adolescent patients who self-harmed was generated. The proposed model was reviewed in the context of relevant research and theoretical perspectives.

The clinical and research implications from the current research were discussed. It is hoped that the findings will contribute to the literature on the barriers affecting adolescent patients who self-harm in accessing specialist services and will be used to help to shape the provision of support for inpatient frontline teams working with this patient group.

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Appendix A: Studies Included within the ‘Literature Review’

Quantitative Studies

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Qualitative Studies

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- Sandy, P., T. (2013). Motives for self-harm: views of nurses in a secure unit. *International Nursing Review, 60*, 358–365.
- Medina, C. O., Kullgren, G., & Dahlblom, K. (2014). A qualitative study on primary health care professionals’ perceptions of mental health, suicidal problems and help-seeking among young people in Nicaragua. *BMC Family Practice, 15*, 129–137.

Mixed Methods

- Anderson, M., Standen, P. J., Nazir, S., & Noon, J. P. (2000). Nurses' and doctors' attitudes towards suicidal behaviour in young people. *International Journal of Nursing Studies, 37*, 1–11.

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- Cleaver, K., Meerabeau, L., & Maras, P. (2014). Attitudes towards young people who self-harm: age, an influencing factor. *Journal of Advanced Nursing*, 70(12), 2884–2896.
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- Dickinson, T., & Harley, M. (2012). Exploring the antipathy of nursing staff who work within secure healthcare facilities across the United Kingdom to young people who self-harm. *Journal of Advanced Nursing*, 68(1), 147–158.

Appendix B: Letter of Invitation

Letter of Invitation

Title of Project: Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing a Mentalization –Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

Name of Researcher: Marta Sosnowska (Trainee Clinical Psychologist)

Date: 01.08.2014

Dear Sir or Madam,

I am undertaking a research study as part of my Doctorate Clinical Psychology Training at the University of Essex.

The study aims to investigate frontline healthcare professionals' experience of prevention and management of self-harm among adolescents admitted to inpatient services. The research will hope to gain insight into this area of clinical practice to provide guidance for promoting wellbeing of frontline professionals and the adolescent patients they work with.

I would like to invite all frontline professionals (including agency workers) who

- have attended any form of training (e.g. induction) in a mentalization-based treatment model (e.g. the AMBIT) and who have acquired the following experience after the training;
- have the experience of being involved in prevention and management of adolescent self-harm while doing an observation (e.g. intermittent observation, one to one observation) or providing direct care

to take part in the study.

Anyone who chooses to take part in the study will be asked to give consent, either via signing a consent form or stating verbally over the phone, to participate in an audio-recorded interview which will last for about one hour. Staff members who will agree to participate in an interview will receive a £10.00 gift token to thank them for their time and effort in sharing with experiences with me.

Thank you for taking the time to read this letter. I am enclosing a participant information sheet which provides further details about the project. If you decide that you would like to participate in the research study please contact me on my mobile [**mobile number**] or email address **msosno@essex.ac.uk**.

Yours faithfully,

Signed:
Marta Sosnowska
Trainee Clinical Psychologist

Appendix C: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

Title of Project: Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing a Mentalization –Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

Name of Researcher: Marta Sosnowska (Trainee Clinical Psychologist)

You are invited to participate in a research project

Before you decide whether to take part, it is important you understand the purpose of the research and what will be involved. Please take time to carefully read this information sheet. If you have any questions about the research please contact Marta on mobile [**mobile number**] or email her on msosno@essex.ac.uk. Marta will go through this information sheet with you if you would like to participate, and answer any questions you may have about the project.

Thank you for taking the time to read this information.

PART ONE: Essential information to help you decide if you would like to take part.

1. Why is this research being done?

This project forms part of the requirements for the University of Essex Doctorate in Clinical Psychology course, undertaken by Marta.

The research study aims to explore frontline professionals' experience of prevention and management of self-harm among inpatient adolescents admitted to a unit which implements a Mentalization-Based Treatment model (e.g. the AMBIT model). There has been very little research in frontline professionals' experience in this area of clinical practice and in healthcare professionals' experience of application of mentalization-based models in this area of clinical practice. Understanding frontline healthcare professionals' experiences in these areas may yield insights which may support mental health care services to develop better ways to support frontline teams and their patients.

2. Why have I been invited?

Marta is interested in hearing your experience of prevention and management of self-harm among adolescents admitted to a unit which implements mentalization-based models. She hopes to carry out interviews with between 12-14 people. You have been invited to participate as you are a frontline healthcare professional who is working with adolescent inpatients and may like to share your experiences.

3. Who can participate?

You will be eligible to participate if you:

- Are a frontline healthcare staff professional

Challenges to frontline professionals in care for adolescents who self-harm

- Have attended an introduction to a mentalization-based model (e.g. the AMBIT)
- Have experience of prevention and management of self-harm among adolescents admitted to [unit's name] after a mentalization-based model was implemented.

4. Do I have to participate?

No, you do not have to participate. Deciding to take part in the research project is completely up to you. If you are interested in participating, contact Marta and she will describe the study, go through this information sheet and ask you to sign a consent form before taking part.

5. What will happen if I agree to participate?

If you are happy to participate, please contact Marta, directly on [mobile number] or msosno@essex.ac.uk, who will arrange to talk, either in person or by telephone, about the research study in more detail and answer any questions you have. She will check that you understand what is involved in taking part, that you are happy to participate, and will ask you to sign a consent form. If you agree to take part, you will then participate in an interview with Marta lasting approximately one hour.

In the interview, Marta will ask you to discuss your work experiences. The interview will be conducted at the [unit's name] or over the phone and will be recorded using a digital audio recorder. Marta will make sure at the end of the interview that you are happy to still participate and will ask you how you felt about the information you discussed. If you are unhappy about a discussed topic being included in the research this will be removed. After completing the interview you will not be required to meet with Marta again.

You are free to withdraw from the project at any time, without having to give a reason and with no implications for your professional role.

6. How will the researcher thank participants for their time and effort?

The researcher will thank participants who will take part in the research with a gift token of £10.00.

7. What will I have to do?

You will be asked to participate in one digitally audio-recorded interview with Marta, either in person or by telephone, and talk about your experiences of prevention and management of adolescent self-harm in the inpatient setting at the [unit's name].

8. Are there any risks or disadvantages of taking part?

For some people, talking about experiences can be upsetting. During the interview with Marta you do not have to talk about anything you do not want to talk about, and if you feel uncomfortable when talking about something let Marta know and you will not be asked to talk about it further.

9. Are there any benefits or advantages of taking part?

We cannot promise that the research project will directly help you, however you may find that talking about your experiences is valuable. We hope that the information we get from the project may benefit frontline healthcare professionals working in adolescent inpatient units and adolescent inpatient service users.

10. What will happen after the research finishes?

Challenges to frontline professionals in care for adolescents who self-harm

When the project has finished all participants who took part in it will be given an overall summary of the findings, these findings will also be presented at the [unit's name]. All information which may identify you personally will be removed.

The project will be submitted to the University of Essex Clinical Psychology Doctorate Course. A copy of the thesis will be deposited in the Albert Sloman Library at the University of Essex. A summary of findings may be provided for policy makers, service-providers and academic researchers. Findings may also be written into an academic journal article, and presented at national conferences.

No information which may identify you will be included within the report or presentations. If you agree, quotes taken from your interview will be used within the findings, but these will be made anonymous.

11. Will my taking part in the research be kept confidential?

The experiences you share in your interview will be made anonymous, so other people will not be easily able to identify you. Marta will follow ethical and legal guidelines, and all information about you will be handled confidentiality, except where:

- There are serious concerns for your safety
- There are serious concerns for the safety of other people
- You have said something that might threaten the security of the [unit's name]
- You have disclosed something which is illegal.

In these instances, where Marta believes this poses a potential future risk, she will share this information with her research supervisor and [name of the research supervisor] at the [unit's name] but not the other experiences you have shared within your interview. Marta will let you know before this information is shared.

12. What will happen to the information I provide?

The interview will be digitally audio-recorded and only available to Marta and her supervisors to listen to. The audio-recorded interview will be transcribed (written out). The digital recording of the interview will be securely destroyed after it has been transcribed, and transcripts, will be disguised (made anonymous) and stored securely. Anonymous transcripts may be looked at by Marta and her supervisors.

No identifiable information will be stored on personal (home) computers. No written report will include information that will allow another person to identify you from your responses. The anonymous transcript of your interview may be kept for up to 10 years by the University of Essex School of Health and Human Sciences in order to allow articles to be written and will then be securely destroyed. If you have concerns about the quotes from your interview being used in the research write-up, you can discuss this with Marta.

If the information in Part 1 has interested you and you are considering taking part, please read the additional information in Part 2 before making any decision.

PART TWO: Further information about the research study.**1. What will happen if I don't want to carry on with the research?**

If you decide to withdraw from the research project, either during the interview or afterwards, please contact Marta calling her mobile [mobile number] or sending her an email on msosno@essex.ac.uk. She will ensure that all of your data is destroyed securely, and will not be used within the research write-up.

2. What can I do if I am unhappy with some aspect of the project?

If you have concerns about the research, please contact Marta in the first instance, calling mobile number [mobile number] or sending an email msosno@essex.ac.uk. She will do her best to answer your questions. If you remain unhappy and wish to complain formally, you can do this following the standard [mental health trust's name] complaints procedure. You may also contact Marta's research supervisors or the Lead Sponsor for Marta's research at the University of Essex.

3. What can I do if I am harmed by this research?

In the unlikely event that you are harmed during the research project and this is due to someone's negligence then you may have grounds for a legal action for compensation against University of Essex but you may have to pay your legal costs. The normal National Health Service complaints procedures will still be available to you (if appropriate).

4. How will the confidentiality of my data be managed?

- Your data will be collected from one digitally audio-recorded interview. The digital audio-recording will be made anonymous (you will be given a pseudonym, or fake name) and transcribed using Microsoft Word, and stored by Marta on a University of Essex computer and on her personal computer in password protected and encrypted electronic files
- The digital audio recording will be securely and safely destroyed after the interview recording is transcribed
- The anonymous transcript of your interview will be stored for up to 10 years at the University of Essex
- Only Marta will have access to view identifiable data you have provided
- The data you provide will not be transferred outside of the United Kingdom
- Marta will adhere fully to the Data Protection Act (1998).

5. What will happen to the results of the study?

Anonymous findings will be written up into a research report submitted to the University of Essex Doctorate in Clinical Psychology programme by Marta. This thesis will be deposited in the Albert Sloman Library. Anonymous findings will also be presented:

- To adolescent inpatient mental health service providers
- To mental health policy makers (for example: Department of Health)
- To other academic researchers within the area of clinical mental health
- To an academic journal for publication
- At academic and clinical conferences in the form of a poster presentation
- To healthcare professionals who have participated in the research project.

6. Who is funding and organising the research?

This research is being done as part of the qualification for the Doctorate in Clinical Psychology, by Marta. The research is funded and organised by the University of Essex.

7. Who has reviewed the study?

This research project has been reviewed and given a favourable opinion by the University of Essex Science and Health Faculty Ethics Committee, and a managerial / ethical review within [mental health trust's name]. If you decide to take part, you will be given a signed copy of your consent form and a copy of this information sheet to keep.

FURTHER INFORMATION AND CONTACT DETAILS

<p>Specific information about this research:</p> <p>Please contact Marta who will be happy to answer any questions you have about the project. You can contact Marta calling mobile number [mobile number] or sending her an email to msosno@essex.ac.uk</p>	<p>Advice as to whether you should participate:</p> <p>Please feel free to discuss this research project with friends or family and work colleagues, who may be able to help you decide whether you would like to participate.</p>
<p>Who to approach if you are unhappy with the research study:</p> <p>Please contact Marta in the first instance who will do her best to answer your concerns. You may contact Marta calling mobile number [mobile number] or sending her an email msosno@essex.ac.uk. If you would like to make a formal complaint, please contact: 1/ PALS at the [mental health trust's name and email] 2/ Marta's research supervisor: [name and email of the supervisor]; 3/ Marta's workplace supervisor: [name and email of the supervisor]; 4/ the Lead Sponsor for Marta's research at the University of Essex: [name and email of the sponsor].</p>	

If you think you would like to participate in the research study, please contact Marta calling mobile number [mobile] or sending an email to msosno@essex.ac.uk.

Appendix D: Recruitment Advert

Research Participants Needed

Are you

- a frontline Healthcare Professional?

Have you

- experience in prevention and management of adolescent self-harm at the[unit name]?

Have you

- been introduced to a mentalization-based model (e.g. the AMBIT)?

My name is Marta Sosnowska. I am a Trainee Clinical Psychologist at the University of Essex. I hope to interview frontline healthcare professionals about their personal experiences of prevention and management of adolescent self-harm. The information will be used in a research project as part of my Doctorate in Clinical Psychology.

The study aims to investigate frontline healthcare professionals' experience of prevention and management of self-harm among adolescents admitted to inpatient services. The research will hope to gain insight into this area of clinical practice to contribute to guidance about promoting wellbeing of frontline professionals and the adolescent patients they work with.

I will be attending staff meetings and community meetings on the ward, where I will talk about the project and provide further information. There will also be an opportunity to ask any questions about the study.

If you are interested please contact Marta Sosnowska on the number, or email listed below:

[mobile number]
msosno@essex.ac.uk

Appendix E: Consent Form**Participant Consent Form**

Title of Project: Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing a Mentalization –Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

Name of Researcher: Marta Sosnowska (Trainee Clinical Psychologist)

Please initial

I confirm that I have read and understood the Participant Information Sheet dated [01.08.2014] (Version 1) for the above research project.

I have had a chance to ask questions about the above research project, and these have been answered satisfactorily.

I understand that I am free to withdraw from the research project at any time without needing to provide a reason and with no implications for my professional role; and request for my data to be destroyed.

I understand that I do not have to talk about any experiences I do not want to discuss.

I consent to my interview(s) being digitally audio-recorded, and anonymous transcripts of my interview being stored for up to 10 years by the University of Essex.

I consent to quotes and extracts from my interview(s) being used within academic reports, in conference posters, research articles, and summaries for other researchers, policy makers and service-providers where these have been made anonymous.

I understand that the information I provide in my interview(s) will be treated confidentially except in instances where: I or someone else is at risk; or if I disclose that a crime has been committed; and these areas are believed by Marta to pose potential future risk.

I agree to participate in the above research project.

I want to be informed about the research findings.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

1 copy for participant; 1 copy for researcher file.

Appendix F: Remuneration Form**Remuneration/Gift Token Letter for Participants**

Title of Project: Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing a Mentalization –Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

Name of Researcher: Marta Sosnowska (Trainee Clinical Psychologist)

Dear Participant,

Thank you for your contribution to the research study “Frontline Healthcare Professionals’ experience of prevention and management of adolescent self-harm in inpatient services implementing a Mentalization –Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals’ Experiences”.

Please accept this £10.00 gift token to show my appreciation for your time and effort in sharing with me the experiences you have had while working here, at the [unit’s name].

If you have any further questions about the study, please contact me on mobile number [mobile number] or my email **msosno@essex.ac.uk**.

Yours faithfully,
Marta Sosnowska
Trainee Clinical Psychologist

Appendix G: Interview Schedule

Draft Interview Schedule

<p>Interview Introduction (following consent)</p> <p>a/ Outline purpose of the interview</p> <p>b/ Describe how interview data will be stored and what it will be used for</p> <p>c/ Inform study participant of how anonymity and confidentiality will be protected</p> <p>d/ Check that service-user is still happy to participate. If not, terminate interview; if yes, collect demographic data and proceed to the interview questions.</p>
<p>Frontline healthcare professional introduction</p> <p>a/ Background questions, gather info and ‘warm up’, develop rapport</p> <p>b/ Reasons for participating</p> <p>c/ Length of time of work in the service</p> <p>d/ Journey into the current professional role in the setting</p> <p>e/ General experiences of working in the service- good and bad</p>
<p>Question eliciting a story:</p> <p>Could you please tell me about a situation when you were on observation with a young person who started or, you felt, was about to engage in an act of self-harm? Can you think of a situation after you received an introduction to an MBT model?</p> <p>*if inclusion criteria extended:</p> <p>Could you please tell me about a situation when were involved in direct care of a young person who started or, you felt, was about to engage in an act of self-harm? Can you think of a situation after you received an introduction to an MBT model?</p>
<p>AREA 1: PROFESSIONALS’ EXPERIENCE IN RESPONSE TO ADOLESCENT SELF-HARM</p> <p>AREA 1A: PROFESSIONALS’ EXPERIENCE IN RESPONSE TO ADOLESCENT SELF-HARM</p> <p>Main question: What thoughts went through your mind? /What were you concerned with at the time?</p> <p>AREA 1B: STATES OF MIND ATTRIBUTED TO YOUNG PATIENTS WHO SELF-HARM</p> <p>Main question: What was happening for the young person at the time?/What was the young person concerned with at the time?</p>
<p>AREA 2: APPLICATION OF AMBIT TO UNDERSTAND THE DESCRIBED EXPERIENCES</p> <p>AREA 2A: APPLICATION OF AMBIT TO UNDERSTAND OWN EXPERIENCES</p>

Main question: How did you make sense of your thoughts and feelings at the time?

Additional questions/prompts:

- What ideas from your introduction to AMBIT and/or other form of support (e.g. supervision, reflection groups, MDT meetings, care planning, etc.) were you able to apply to understand your reactions?
- What form of support was of particular benefit to you?
- Was there anything particularly helpful to understand your response to/negative feelings about what was happening?

AREA 2B: APPLICATION OF AMBIT TO UNDERSTAND EXPERIENCES OF YOUNG PATIENTS WHO ENGAGE IN SELF-HARM

Main question: How did you make sense of what was happening for your patient at the time?

Additional questions/prompts:

- What ideas from your introduction to AMBIT and/or other form of support (e.g. supervision, reflection groups, MDT meetings, care planning, etc.) were you able to apply to understand their reactions?
- What form of support was of particular benefit to you?
- Was there anything particularly helpful to understand their reactions?

AREA 3C: APPLICATION OF AMBIT TO MANAGE THE REPORTED EXPERIENCES

AREA 1C: APPLICATION OF AMBIT TO MANAGE OWN EXPERIENCES

Main question: How did you use your understanding of your experiences to manage your feelings?

Additional questions/prompts:

- What ideas from your introduction to AMBIT model and/or other form of support (e.g. supervision, reflection groups, MDT meetings, care planning, etc.) were you able to apply to manage your reactions/ negative feelings?
- What form of support was of particular benefit to you?
- Was there anything particularly helpful to manage your response to/negative feelings about what was happening?

AREA 2C: APPLICATION OF AMBIT TO SUPPORT YOUNG PEOPLE WHO ENGAGE IN SELF-HARM TO MANAGE THEIR EXPERIENCES

Main question: How did you use your understanding of their experiences to manage their feelings and actions?

Additional questions/prompts:

- What ideas from your introduction to AMBIT model and/or other form of support (e.g. supervision, reflection groups, MDT meetings, care planning, etc.) were you able to apply to manage their reactions?
- What form of support was of particular benefit to you?
Was there anything particularly helpful to manage their reactions?

ENDING

- Check if study participant is happy with information provided
- Opportunity to ask questions about the research
- Discuss dissemination plan and feeding back findings

Challenges to frontline professionals in care for adolescents who self-harm

Appendix H: Coding Examples

The screenshot displays the MAXQDA 11 software interface. The top menu bar includes Project, Edit, Documents, Codes, Summaries, Memos, Variables, Analysis, Mixed methods, Visual tools, Windows, MAXDictio, and Toolbars. The Document System on the left shows a tree view of documents, with 'Interview 12' selected. The Code System below it shows a hierarchy of codes, with 'un/helpful forms of support' selected. The Document Browser on the right shows a transcript of an interview with lines of text and corresponding code labels. The transcript includes the following text:

106 A: I'm not sure I have really made sense of the whole situation because like I said I can't really like in myself imagine being in that position where I'd be doing that, so I don't think it's something I can ever make sense of what went on so I guess you just look at situation and what needs to be done like I guess I'm quite focused on task that come out of whatever situation and that's obviously offering support cleaning the wounds, dealing with reporting so I'm quite focused on that which is I guess the way I make sense of it, focus on what comes next, yeah, so I don't really know (laugh).

107 Int: So it sounds like you, is it that it feels at the time that dressing the wound is first priority or-?

108 A: Yeah, definitely, I think physical health like if someone is bleeding a lot, what you need to do as a nurse is stop that bleed so that's the first thing and then while you're doing that as a mental health nurse you want to like calm the patient and make sure it's safe there's nothing else they can use to harm themselves with. So I think they quite instinctive I don't think that's something that at the time I spend a lot of time thinking about. Em, which is why I think it's handy having that I had a warning and I could be like right this is what I need to do this this and this and if something else comes up while you're in the situation you would have to think when you get there and I don't think I feel much about it until afterwards when I can then go back that wasn't really nice, it's not very nice situation to be in it's not something I particularly enjoy and you don't feel great there someone's in the frame of mind that they doing harm to themselves, yeah.

109 Int: When you attend to those wounds do you think about the kind of, about a level of emotional involvement with the young person or is that something, or do you become quite clinical in thinking oh that needs to be dressed in a professional way?

110 A: I'm trying to keep-, when I'm dressing a wound I try and keep it quite clinical because I don't like the fact that people think self-harming will lead to like support and one to one time so I try and make as much as I can, of course it's not always possible when you think someone might just use something else but I try make dressing the wound quite separate to offering the supportive time. Em, just in the-, because I think if you do that than people might think oh well I'll do something else to get the supportive time like I'll go and ask for it, doesn't always work. But I try, that's what I try and do.

111 Int: Is that something that the unit does? Or is it something you think-

112 A: Yeah. I do think that other people on the unit do do that and I think that's what obviously I was told to do. Em, to separate the clinical and the supportive side of things and just to encourage people to seek support in a constructive way like yeah.

113 Int: How did you-, how did you make sense of your own experiences when you think about experiencing frustration, sadness? How does that, when you think about it-

114 A: I think it's quite rational and like every, I'd probably say every member of staff, maybe not every member of staff, but a good chunk of them will come out of the situation on the ward when they're frustrated and they a bit irritable by something that's happened and then I would like try to support them, say it's not your fault like they've made that choice to do that and all we doing is your job and offering support but then when it's you and you've been in that situation like you are frustrated and you are a bit, a bit angry about it sometimes, I guess, if someone snuck a blade on the ward they've betrayed you, haven't they? You've got a level of trust that someone coming on to the ward, they've signed an agreement that they not going bring blades on to the ward and yet they do. Em, but then I think it's an emotional response isn't it? It's not a rational response and I think it's quite difficult to have rational response when that is something that is emotive like someone's bleeding it's quite an emotive thing. And I guess I just try to remind myself that other people have the same reaction. But while I would tell this to other people perhaps is something I do to myself. So you can kind of understand it I guess.

115 Int: So you're thinking, yeah, and would that be something you'd be telling yourself or would you be-, or in a way how do you help yourself?

116 A: I try and tell myself that, but it doesn't mean that, like I can't stop myself often feeling something inside

Challenges to frontline professionals in care for adolescents who self-harm

The screenshot displays the MAXQDA 11 software interface. The main window shows a document browser with a list of interview documents. The 'Code System' pane on the left lists various codes, with '3 medication to manage low mood and urge' selected. The central pane shows a transcript of an interview with line numbers 70-88. The transcript includes the following text:

70 A: Probably really what's happening in front of me. I mean I do know that that person is very risky she did other things that involved me, but then there've been other people who haven't been so risky and things have been managed, so.

71 Int: And when you say she was risky, do you mean that she was self-harming in such a severe way that she was causing threat to her life?

72 A: Yes. Very, very impulsive and very impulsive.

73 Int: I had an image of slashing so it felt as if-

74 A: And another time tis same patient took my swipe card which hasn't been taped in, which she used to do and she'd run off to the railway tracks so that was another time that was you know lots of anxiety cos you had to call the police and everything else.

75 Int: How was it for you considering your responsibility you hold as a nurse being in a situation where you felt you were not able to provide help and protection you-

76 A: It's difficult but now I'm further up the rode I feel, I feel much better and it might just be because I've seen a lot of things already that things don't shock or phase me as much, I also know that there is a team and we are working together. Especially the experienced people that we would all support each other.

77 Int: So I'd imagine when you worked as a bank worker you didn't have it?

78 A: No, no and I was still new to it as well.

79 Int: You said it can be quite shocking to be exposed to the young person who engages in a behaviour like this?

80 A: Umm, but then if you're not shocked a little bit, if you're too blaze, then maybe you shouldn't be doing that kind of job because you know it would-, there's got to be some shock factor however small.

81 Int: Why is this important?

82 A: Because it keeps you on your toes and otherwise you get blaze about risks and things.

83 Int: So that helps you to stay focused-

84 A: Yes, this is an intense ward to work on and you do need to be alert and vigilant even when everything is quite and everyone seem very settled there could still be something further down the evening or further down the corner that you don't know about. So you still need to have that sort of alertness really.

85 Int: So that would be unhelpful to lose this element of shock. It's like a balancing (overlapping speech) not to overwhelm you.

86 A: It is.

87 Int: You remember at the time with this particular person what do you think was happening in her mind how do you think of why she chose to do what she did?

88 A: I think she may have chosen to do that on a one to one because I was bank and she didn't know me so i think she realised that she could get away with it easier because I didn't know her I didn't know what her real risks were or how she was likely to present and had she'd been with someone more familiar on her

The interface also shows a 'Document System' pane on the left with a tree view of documents, and a 'Code System' pane with a tree view of codes. The status bar at the bottom indicates 'Simple query (OR combination) 1 / 1' and the date '14:22 18/09/2015'.

Challenges to frontline professionals in care for adolescents who self-harm

Appendix I: Searching for Themes

Microsoft Excel - all 12_STAFF RESPONSES2 [Compatibility Mode]									
Con Document	Code	respose	to what	cont ext	what help	what does not help	Segment	Author	
awareness of one's own responses									
interview 2.1.2	staff RESPONSEs to upset clients/risky clients2staff RESPONSE to an incident2talking about feelings later2trying to understand what had happened	some awareness of anxiety and shock but full extend of reaction realised later	sh	sh		forms of support which help to understand	P2: I think it that yea more action emm yea I think when something like that happens I think I go to very much ok this is what we need to do rather than this is how I feel and then maybe afterwards think about how I felt at the time does taht make sense ? so not I dont think I am aware of it at the time apart from what I need to and the obvious ones feeling anxiety or feeling a bit of shock but I dont really think about very much and tell deal with the situation so life was safe and then I guess yea afterwards you do and then you talk about it in the staff team or say there is the nurse came back said this is what had happened before you got there and then coming in emm and not knowing what happened beforehand because it is that sudden kind of aright we need to do beds now, you dont have time to say what happened 5 minutes ago when they start so not really having yea i think is it heightens your levels of anxiety I think not knowing but I guess going over it afterwards you get a clearer picture of what happened emm why it happened emm yes but distressing situation to be in general I think	Marta Sosnc	
Interview 4.1.1	CHALLENGEs4 self-harm, causes and function (care)- terrible to witness4 one	getting in contact of ones response after incident	sh	sh	handing over		I think yeah when you speak to other people it does seem more real you know you kind of deal with it in the moment and when you're handing over you think it's actually terrible what's happened but it's quite common as well on here just another incidence if that makes any sense	Marta Sosnc	
Interview 4.1.1	CHALLENGEs4 management of insertion4 after you intervene you are left	causes of self-harm stay with you	sh	sh			A: yeah, at the time it's not, of course I felt like oh my words she came with an open wound on her arm and you think about it like that I think you just like I say you quite focused on reducing any risk so getting that stopped which she did stop but then you've got the questions that she's been asking, they're quite difficult an then taking yourself out of that situation when they do calm down	Marta Sosnc	
Interview 6.1.1	TASK6 when you attend to a young person you focus on their needs6 you think	thinking about ones responses afterwards	sh	sh			A: No, I cos you don't think about it at the time, you're more focused on obviously trying to prevent anything happening and it's not till afterwards that you actually think God, it's this, this and this. Em, yeah, so.	Marta Sosnc	
Interview 8.1.1	staff RESPONSEs to upset clients/risky clients8 when its busy you learn about your RESPONSEs at home	making sense of own experiences after once comes back	sh	sh		too busy	Int: With this person, you know with this instance which has just happened two hours ago, (pause), how did you make sense of how- of the way you felt? A: Yeah, I probably won't until I get home, I don't think you do, I don't think, when you (go at an instant at) work, you can't really process it while you at work, you don't have that freedom to do that because if you do you not sure how it would really impact on you, so it's not-. I mean you could go and do de-brief with staff but i would probably, wouldn't do that unless I was, unless it was quite on a ward and I was able to-, I don't know, you should do de-briefs, it's really important, it's really important, but I guess you get a little bit hardened because you see it regularly but to be honest I probably won't know how I feel about that instance until I go home, yeah.	Marta Sosnc	
Interview 11	staff RESPONSEs to upset clients/risky clients11 RESPONSE to high axniety situation11 when immediate stress reaction goes away still	feeling stressy long after an incident/obs/ difficult to swithc off/dreams	sh	sh			Em, but kind of after the immediate situation has been defused the heart slows down a bit, it will sometimes still when I get home still feel like aroused and have that kind of, I don't know how to describe it. Just that stressy feeling in my chest and I would struggle with sleeping like I can't get to sleep after I've done-, cos I do loads of late shifts mainly, sometime I'm going home at nine o'clock or on a shift at noon I'll be going home quarter to eleven so it's quite late and yeah, still just sometimes having that alertness and kind of weariness I suppose if makes it really difficult to unwind and get to sleep when you get home. I guess that'd be when you more likely to have the like the dreams that you wake up in the middle of the night and think that the, that you've gone to sleep when you're on one to one and stuff like that cos you're still at quite like aroused state when you go to sleep but usually like now I have got better at switching off when I go back home.	Marta Sosnc	
Interview 11	staff RESPONSEs to upset clients/risky clients11 when unsupported to deal with it you take it home	stress take it home	sh	sh	affects more when no time to process		I've got to think back to when it was really like that and I guess I had less experience at the time as well. I definitely think they've tightened up on offering support as well so I suppose there were shift previously where I probably wasn't offered the support I needed any I just kind of-, had to go home and I was living in a shared house with the people I didn't know when I've moved in, so I'm not sure if I could really talk to people about it, obviously you wouldn't divulge information anyway but they weren't really people I could really say oh I've just had to deal with something very unpleasant at work (laugh) today. So I guess I probably sometimes I would just get home and I would like sit and think about it, just sit and think about it for myself and still feel quite stressed, like I mean I still have quite a physiological RESPONSE like just that kind of stressy feeling that you get in your chest and stuff, not be able to unwind from it.	Marta Sosnc	
Interview 11	staff RESPONSEs to upset clients/risky clients11 dreams related to work11 then you go home & when	process it in your dreams	obs at night	r/sh			and then I'll often, when I go home, I'll often wake up and think that Oh god I've lost them, I've lost them, and I'll jump of my bed and be like looking for this patients and I'll be like no, no, no I'm home like, that's really, really ridiculous.	Marta Sosnc	

Challenges to frontline professionals in care for adolescents who self-harm

Microsoft Excel - all 12_STAFF RESPONSES2 [Compatibility Mode]									
Com	Document	Code	respose	to what	context	what help	what does not help	Segment	Autl
negative feelings stirred by difficulty with experiecing oneself as effective in preventing self-harm									
1	Interview 6.1.	staff RESPONSEs to upset clients16 when unwell person who you know well SH again6 you start having negative thoughts6 frustrated about the work you put in6 frustrated in the face of loss of valuable life time	frustrated about loss of life time/low effectiveness	about slow progress in working with long standing problems underline self-harm	repeated SH		relationship with patient	A: Yeah, you can feel frustrated you know, cos you think you ooh you know, you've worked quite hard for two or three days with this young person and then something might just happen and you sort of feel like sometimes you feel like you take two steps forward three steps back and for this young person that how it was for long time, because there was going to be no immediate fix for them and it was gonna-, we all knew it was going to be a long haul but you sort of want to (laugh) aid them the best you can and I think that, em, that what we sort of want for any of them, we certainly don't want the young people here for the long haul you know it's supposed to be sort of a relatively quick turnaround, which, but that's not always going to happen for everybody, because sometimes they are coming in here and other things raise their ugly heads and, you now, there's other issues and you know there are here for a, for longer, and they need to be in here, but yeah you do get frustrated sometimes and you sort of want the emm why it happened emm yes but distressing situation to be in general I thinkake up and I think that I've actually I got that tied I got into patient's bed and have gone to sleep and then I wake up and I think God, what am I doing, I could lose my job for that like that's so creepy get out of bed and then I'll be like, no, you're home like don't be silly. And I thought that was really weird, sounds really creepy, doesn't it when you think you got into patient's bed but actually few of my colleagues had that as well so I guess that's just more being ridiculously tired when you on shift sometimes and still having to be alert and responsible	Mart
3	Interview 7.1.	staff RESPONSEs to upset clients17 its frustrating when you can not fix things	frustration	having your need to fix frustrated	repeated SH			A: Yeah, cos as humans you just always want to find the answer and solve, so we have a lot of conversations with the young people that you're really tempted to try and find them an answer or try and find a solution to their problem, but actually they just need you to listen and like emphasise and kind of understand them so.	Mart
4	Interview 9.1.	staff RESPONSEs to upset clients19 conflicted feelings of frustration and empathy9 frustration that patient dont take offered support	frustration	patients have plenty of support but they dont use it when just about SH	R			here's still that element of frustration sometimes because you know the young people are offered a lot of support you know they have people around you know we have a very high staffing ration here compared to kind of other units adult wards so I think there is an element of frustration sometimes that you know there is staff around so you can come and see- you know seek support when you're feeling like harming yourself so you know there if a feeling of frustration that you haven't found support that's available to you but also you know empathy as well because there is really a point where they feel there is no other option than to harm themselves I can't imagine how horrible that must feel for them to be at the stage where they don't feel there's any other option, so yeah.	Mart
5	Interview 11	staff RESPONSEs to upset clients11 reponses to a SH here11 a sense that we are repeating same things again and	irritation, annoyance, frustration	that we are not managing to help them stop doing it	SH			A: (laugh) I'm really squeamish blood is not too bad, wounds I'm (bits of flesh and all, at all, like it's certainly getting easier). What else do I feel relief if the situation has been managed and their haven't self-harmed, irritation and annoyance not that they've done it but that we're not managing to help them stop doing it and often it feel very repetitive it can just be the same thing, it feels like doing the same daily, people who self-harm very regularly and then it's really frustrating like what are we doing to help them?	Mart
6	Interview 12	staff RESPONSEs to upset clients12 RESPONSE to self-harm by deep out12 frustration-the busier/more stressful shift the higher frust12 if someone says they dont feel frustration they r lying	frustration	about having to attend to repeated self-harm	r/sh	stressful shift		Int: How does that makes you feel, when you know that someone might be using self-harm in that way? A: Em, I don't know, I've feel a lot of pity towards the individual but you do get frustrated don't you? I think anyone who told you they didn't get frustrated when day in and day out the individual was self-harming and they were dressing wounds and doing the same thing, I think they'd be lying. But, I think it depends as well on how your shift's been and I know it's not very good to say but if you've been running around all over the place and it's been really stressful for you, you're going to be more frustrated than if it's been relaxing and you've had all your work done and you've been sitting relaxing with the young people. I think how you react and how you feel about the situation will be very different when that's the case	Mart
7	Interview 12	staff RESPONSEs to upset clients12 Sh sometimes frustating and upsetting as U cant make better	frustrated	that young patient self-harm against care provided	r/sh			Int: And how did you feel when you were with her, when you were trying encourage her to dress her wounds? A: Em, I-, this isn't going to sound very good but I, I-, I can find on occasions self-harm a little bit frustrating cos obviously you're doing everything you can to stop it from happening and you're trying to really work with these people and then they go and do something like that so you do find it upsetting and frustrating but the wounds itself it doesn't upset me things like that I'm quite good at managing and I look at it very clinically. Em	Mart
8	Interview 12	staff RESPONSEs to upset clients12 when someone lied to you and smuggled in blade12 frustated, angry, betrayed	frustration/anger	about lack of progress that young people self-harmed against staff effort to help or about patient breaking their	sh			Int: How did you-, how did you make sense of your own experiences when you think about experiencing frustration, sadness? How does that, when you think about it- A: I think it's quite rational and like every, I'd probably say every member of staff, maybe not every member of staff, but a good chunk of them will come out of the situation on the ward when they're frustrated and they a bit irritable by something that's happened and then I would like try to support them, say it's not your fault like they've made that choice to do that and all we doing is your job and offering support but then when it's you and you've been in that situation like you are frustrated and you are a bit, a bit angry about it sometimes, I guess, if someone snuck a blade on the ward they've betrayed you, haven't they? You've not a level of trust that someone coming on to the ward they've sinned an agreement that they not going bring	Mart

Appendix J: Excerpts from Reflective Journal

2/1/2015, Notes on review of the research literature

I have been reviewing the literature on healthcare professionals' views, responses and attitudes to adolescents who self-harm. I am really surprised with how limited is the research literature in this area, considering the high prevalence of self-harm among adolescents.

I was also really surprised with how heterogeneous the existent research literature is. I noted that many studies showed poor quality, particularly the quantitative ones. The heterogeneity of the research studies and their poor research rigour made it very difficult to extract patterns from the reviewed findings. I found it very hard to bring all those finding together to create a coherent narrative.

The reviewed research used different measures (many of them showed poor psychometric qualities), recruited from very heterogeneous populations and was deeply affected by the selection bias. The synthesis had a mosaic type quality and required a lot of time and reflection.

The difficulties with synthesising the reviewed research literature made me think about psychoanalytic perspectives on linking (Bion, 1959) and I wondered whether it was not only me who had difficulties in thinking about adolescent self-harm but also the authors of the research studies I had been reviewing. In thinking about the possible causes of that I referred to some psychoanalytic perspectives on the function of self-harm which suggested that it defended from psychic pain by not thinking. I wondered whether this quality of self-harm affected thinking of those who attempted to learn more about it.

Anecdotal knowledge in the area of frontline professionals' views and attitudes to adolescents who engage in self-harm indicates that healthcare professionals find it really difficult to work with this patient group, and my past experience of working in inpatient services made me think that most healthcare professionals had really negative views of adolescents who self-harm and had negative responses to working with this patient group. However, there was some indication in the reviewed quantitative research that healthcare professionals had positive views and experiences of working with adolescents who self-harm. I was really surprised by that. However, a critical appraisal of the literature helped me to learn that the validity of these findings was very poor.

The review of the research findings also helped me to evaluate my view that all healthcare professionals struggle with working with this patient group. I was able to identify a range of processes which may contribute to a formation of negative views and responses in healthcare professionals. I hypothesised that frontline professionals were more likely to report high levels of such views and responses. I thought that this was caused by the fact that many of the identified processes were at work on the frontline. As a result of the research review I started thinking about reframing my research question from healthcare professionals' experiences of working with adolescent patients who self-harm to the challenges they experience in caring for this group of patients.

The discussed learning also helped me to prepare for the interviews. I started realising that my initial view on the explored area was 'black and white'. Before conducting the review I was thinking that I was going to access negative views and responses. I realised that this may have been really difficult to uncover such data. I also started thinking that perhaps things are going to be more complex than I had anticipated and that I would need to listen carefully to my participants' accounts to attempt to identify and understand the processes which contribute to their difficulties.

17/01/2015, Reflections on my response to a participant sharing their view that the function of self-harm was to elicit care

Interview eight. I am really surprised with my response to a participant sharing a view that self-harm performs a function of eliciting care and a view that showing care to adolescent patients who self-harm is harmful as it enforces this function.

Today, I found myself being in an agreement with this view and I did not show curiosity about this view and the interventions informed by it. This is really surprising as my view about the function of self-harm are very different to this one and I also consider such view to cause challenges to care for adolescent patients.

I wondered about the possible causes of this happening in the interview situation. I wondered whether my gratitude and an increasing awareness of the difficulties frontline professionals experience in their work with adolescent patients caused that I took on an empathetic stance. I need to be aware of that this may happen again in the interview situation and ensure that in my future interviews I may show more curiosity in my participants' views.

08/02/2015, Reflections on participants' reasons for taking part in the research

This has been my eleventh interview so far. I am really struck with that most of the study participants stated that one of the reasons for their participation in this study project was their awareness of how difficult it is to generate data for research, knowledge they had acquired when they were conducting research projects themselves. I am also noticing that most of the study participants are interested in advancing knowledge and improving practice in the care for adolescent patients who engage in self-harm.

The recruitment strategy succeeded in the recruitment of participants who feel comfortable about their practice. I am aware that this will mean that the profile of the research sample may weaken the internal generalisability of the generated findings.

Appendix K: Thesis Proposal and Ethical Approval Forms

Thesis proposal

Title: Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing an Mentalization-Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

ID 1202466

Doctorate in Clinical Psychology,
University of Essex
Word Count = 5890

Summary

Rates of self-harm among adolescents are higher than in the adult population. Self-harming adolescents with complex needs may require inpatient treatment to ensure their safety and improve their mental health. Research shows that frontline professionals consider the task of management of self-harm as challenging, hold negative attitudes toward adolescent self-harm and experience negative feelings when working with self-harming adolescents. Negative feelings experienced in caring for patients with complex needs have been associated with professional burnout.

Mentalization-Based Treatment (MBT) models are new treatment programmes designed to address the needs of 'hard to reach' young people with severe and complex mental health difficulties. They offer a conceptual framework for managing adolescent self-harm and high levels of anxiety experienced by staff carrying out this task.

This research aims to examine frontline professionals' experience of prevention and management of self-harm among inpatient adolescents and of drawing on an MBT model in carrying out these tasks.

It is hoped that findings from this research project will contribute to a development of better practice in facilitating psychological containment for self-harming adolescents. Also, research findings may yield insights into the relationship between the use of MBT models and the levels of stress experienced by frontline professionals working with self-harming inpatient adolescents. The research findings may contribute to an improvement in the wellbeing of this group of health-care professionals. Consequently, the findings of this proposed research project are likely to bring benefit to quality of care, and patients' and staff's wellbeing.

I aim to conduct a qualitative study; purposively recruiting 10-14 frontline professionals, based upon specified inclusion criteria, from adolescent mental health inpatient services which implement an MBT model. Data will be sampled through in-depth semi-structured interviews lasting approximately 60 minutes. Findings will be discussed in relation to psychological theory and disseminated.

Research Background

Adolescent self-harm

Self-harm has been internationally recognised as a major healthcare problem in young people (Greydanus & Shek, 2009). The understanding of the term “self-harm” varies across different countries. Current literature in the UK follows NICE guideline (2012) and describes self-harm as a behaviour that involves an act of self-poisoning or self-injury carried out irrespective of motivation (Hawton, Harriss, Hall, Simkin, Bale & et al., 2003). Drug-overdose, self-poisoning and self-cutting were found to be the most common forms of self-injury (Greydanus & Shek, 2009).

Self-harm is a common clinical problem in the general population. For example, in 2000-2001, 220,000 people presented to emergency services across England seeking help following self-harm (Hawton, Bergen, Casey, Simkin, Palmer & et al., 2007). Numbers of adolescents seeking help for self-harm seems to be twice as high as those in the adult population (Ferrara, Terrinoni & Willians, 2012). The prevalence of self-injury among young people is difficult to determine as the estimates vary according to sample methodology and geographical location. The highest prevalence rate of 70% was recorded by The Child and Adolescent Self-harm in Europe study (CASE; Madge, Hewitt, Hawton, de Wilde, Corcoran & et al., 2008), a large multi-centre study conducted across seven countries including the UK. The data were obtained in this study with anonymous questionnaires from a large sample of over 30,000 young people (Madge, Hewitt, Hawton & et al., 2008). The results highlighted the pervasiveness of this phenomenon and that rates have risen in the recent decades (McDougall, Armstrong & Trainor, 2010). The high rate of self-harm among young people is often linked with the profound physical, cognitive and social developmental changes taking place in adolescence, particularly in respect to the process of brain remodelling and its impact on impulse control and emotional regulation (McDougall, Armstrong & Trainor, 2010; Rossouw & Fonagy, 2012).

Self-harm is associated with an increased risk of suicide and poor mental health. Research findings indicate that the risk of suicide increases over fifty times after self-harm (Zahl & Hawton, 2004; Hawton, Harriss, Hall & et al., 2003; Owens, Horrocks & House, 2002; Hawton, Zahl & Weatherall, 2003) and that approximately 5% of self-harm patients seen at the emergency services commit suicide within nine years of the self-harm incident (Department of Health, 2007).

Prevention and management of adolescent self-harm is therefore given high priority by mental health services (NICE, 2004; NICE, 2012). National guidance in the UK recommends that all adolescent self-harm patients seeking help from healthcare services should receive a comprehensive psychosocial assessment and should be offered a hospital bed for extended observation and risk management (National Collaborating Centre for Mental Health, 2004). Adolescent patients who show acute suicidality associated with mental health disorder should be admitted to inpatient services (McDougall, Armstrong & Trainor, 2010; NICE 2012).

Unfortunately, only a small proportion of young people who engage in self-harm seek help from healthcare services (Madge, Hewitt, Hawton & et al., 2008). Hawton, Rodham, Evans, & Weatherall (2002) reported that only 12.6 % of adolescents who admitted to self-harm presented to healthcare services. Sadly, some of these who sought help reported that healthcare professionals showed negative attitudes to them (Rissanen, Kylma & Laukkanen, 2009).

Young people who are admitted to inpatient services face further difficulties. Stress experienced by those patients as a result of the transition from their everyday life to an inpatient ward may contribute to an increase in their self-injurious behaviours (McDougall, Armstrong & Trainor, 2010). Brophy's (2006) study showed that the standard procedures for management of risk of self-harm in inpatient wards contributed to an increase in adolescent inpatient patients' sense of lack of control and a desire to self-harm again. In another study by Dorer, Feehan, Vostanis, & Winkley (1999) almost one third of young people rated their experience of an inpatient admission as negative. Perhaps unsurprisingly, research indicate that young people particularly valued healthcare professionals who listened to them (Brophy, 2006), and showed them respect (Crockwell & Burford, 1995; Sinclair & Green, 2005).

Healthcare professionals' attitudes to and experience of working with young people who self-harm

Some light on the causes of the difficulties experienced by young people seeking help from health services can be shed by research literature on healthcare professionals' attitudes to and experience of working with adolescents who self-harm.

Research findings suggest that healthcare professionals perceive acts of self-harm as manipulative in their nature and service users resorting to these behaviours as manipulative, deceiving and "attention seeking" (Smith, 2002; Reece, 2005; Wilstrand, Lindgren, Gilje, & Olofsson, 2007; Cooke, 2009; Kibler, 2009; McHale & Felton, 2010; Saunders, Hawton, Fortune, & Farrell, 2011). In a study conducted by Breeze & Repper (1998) in a sample of psychiatric nurses, service users who self-harmed were seen as the most difficult patient group to work with, posing a threat to nurses' professional competence and control of the ward. Those who self-harm repeatedly and those who are perceived to be in control of their actions tend to attract more negative attitudes (Mackay & Barrowclough, 2005; Saunders, Hawton, Fortune & et al., 2011).

Literature on healthcare professionals' attitudes to self-harm and suicide attempts focussed specifically on the population of adolescents is limited. Adolescent suicide attempts were reported to be understood by healthcare professionals as powerful acts of complex communication used when other ways of communicating fails. Its causes were attributed to the incongruent and challenging family and social systems young people were surrounded with (Anderson, Standen & Noon, 2005). Attempted suicide was also perceived as a sign of poor mental health (Anderson & Standed, 2007). Adolescent self-harm seems to attract negative attitudes (Crawford, Geraghty, Street & et al., 2003) and low levels of sympathy and compassion (Wheatley & Austin-Payne, 2009). Psychiatric nurses participating in a study conducted by Rissanen, Kylmä & Laukkanen (2011) perceived acts of self-harm as un-shameful and contagious. In Dickinson, Wright and Harrison's study (2009), negative attitudes among frontline healthcare professionals working in inpatient services were indicated by healthcare professionals' use of labels such as "personality disordered", "attention seeking", "manipulators" and "difficult patients" to describe young patients who self-harmed. Research showed those frontline professionals working in inpatient units, who showed more negative attitudes to self-harming adolescents, tended to report more worries about working with this group of patients (Wheatley & Austin-Payne, 2009).

Research literature provides strong evidence that caring for people who engage in self-harm elicits strong negative emotion in healthcare professionals. Healthcare professionals

reported that supporting people who engage in self-harm evokes feelings of powerlessness, hopelessness as well as distress, shock, disgust, guilt and anger (Reece 2005; Duperouzel & Fish, 2007; Wilstrand, Lindgren, Gilje & et al., 2007; Thompson, Powis & Carradice; 2008). Working with adolescent self-harm was described as challenging and frustrating (Anderson, Standen & Noon, 2003; O'Donovan, 2007).

Psychiatric nurses caring for self-harming adolescents and adults are repeatedly involved in the challenging and emotionally charged task of preventing and managing the risk of harm. This task involves engaging in emotionally demanding relationship with patients in distress. This has been identified as a cause of burnout, a state of physical and emotional exhaustion, associated with negative self-concept and attitudes to work as well as loss of concern for patients (Pines & Maslach; 1978). The risk of burnout is high in professional groups which experience higher levels of exposure to stressful and emotionally charged situations. Costs of burnout are high and include negative impact on the quality of care delivered and an increase in the absenteeism and sick leave (Maier, Watkins & Flescher, 1994).

Promotion of good practice

Prevention of burnout among healthcare professionals working with people who self-harm as well as modifying negative attitudes and experiences requires investing in education, team work and supervision (Smith, 2002; Duperouzel, 2007; Cooke, 2009). Promotion of good practice in prevention and management of self-harm requires appropriate training and support (NICE, 2004).

Healthcare professionals reported a need for training to learn how to manage negative feelings elicited in working with adolescents who self-harm and attempt suicide, as well as to improve their skills in effective ways of working in this area of clinical practice (Anderson, Standen & Noon, 2003; Crawford, Geraghty, Street & et al., 2003; Dickinson, Wright & Harrison, 2009; Wheatley & Austin-Payne, 2009). Research evidence exists to support the claim that adequate training successfully equips healthcare professions to manage their negative reactions (Dickinson & Hurley, 2012; Timspon, Priest & Clark-Carter, 2012).

Healthcare professionals require training in therapeutic models designed for treatment of self-harming adolescents. There are few evidence-based treatments for this group of patients (NICE, 2012) and their effectiveness is limited (Rossouw & Fonagy, 2012). Mentalization-Based Treatment (MBT) models are some of the most recently developed treatment programmes designed to address the needs of 'hard to reach' young people with severe and complex mental health needs. For example, the Mentalization-Based Therapy for Adolescents (MBT-A) is a psychodynamically oriented treatment programme based on a model of treatment developed by Bateman and Fonagy (2006) for patients with severe Borderline Personality Disorder. Research evidence for effectiveness of the MBT-A is emerging (Rossouw & Fonagy; 2012). Another example is the Adolescent Mentalization-Based Integrative Therapy (AMBIT) which was developed originally as a collaborative strategy for community-based work with 'hard to reach' young people. It is a treatment programme integrating techniques and practices derived from a range of evidence-based modalities of interventions (Asen & Bevington, 2007).

MBT models offer organising frameworks and treatment strategies for treatment of young people with complex mental health needs who engage in self-harm. They work on the basis that improving mentalizing, defined as a capacity to represent human behaviour in terms of

mental states (Bevington, Fuggle, Fonagy, Target & Asen, 2012), leads to an increase in self-control in patients with problems with affect dysregulation and poor impulse control (Fonagy, 1998). The models advocate for development of attachment relationship with patients, staying mentally close, even at times of crisis, and adopting a non-knowing stance to patients' states of mind (Bevington, Fuggle, Fonagy, Target & Asen, 2012; Hutsebaut, Bales, Busschbacj, & Verheul, 2012).

An implementation of MBT models may provide inpatient healthcare professionals with conceptual tools for understanding the needs of self-harming patients and for intervention planning in respect to self-harm prevention and management. MBT models can also be implemented for staff support to aid reflection. For example, the AMBIT is designed to provide containment to professionals who experience high levels of anxiety interfering with their clinical practice (Bevington, Fuggle, Fonagy, Target & Asen, 2013).

However, the process of implementation of MBT programmes may be challenging. For example, Hutsebaut, Bales, Busschbach & Verheul's (2012) case study reported on difficulties encountered in the process of implementation of the MBT-A model which included "high staff turnover, temporary curtailment of the programme, high level of patient and parent dissatisfaction, safety risks to patients and negative publicity" (p:2).

Problem statement

As stated above, research evidence shows that healthcare professionals working with adolescents who self-harm hold negative attitude toward this group of patients and their actions, and experience intensive negative feelings in response to providing treatment to those clients. Furthermore, research literature shows a relationship between experience of negative feelings and high levels of burnout in healthcare professionals (Pines & Maslach, 1978).

Frontline healthcare professionals working in inpatient adolescent units are often exposed to incidents of self-harm. Negative attitudes, negative feelings and burnout in these professional groups pose a threat to producing positive outcomes in ambulatory care of self-harming adolescents. These issues need to be addressed at an organisational level. The NICE guidelines (2012) recognizes this and states that healthcare professionals require supervision and specialised training in this area of clinical practice. Frontline teams, in particular, rely on training, supervision and applications of specialised treatment models for ensuring good practice in working with self-harming adolescents.

MBT models have been developed specifically to address the needs of 'hard to reach' young people and have been increasingly implemented across a number of inpatient units in the UK and Europe (Bevington, Fuggle, Fonagy, Target & Asen, 2012; Hutsebaut, Bales, Busschbacj & Verheul, 2012). However, no research data exists yet to elucidate the experience of frontline healthcare professionals of prevention and management of adolescent self-harm in services which implement an MBT model and in the experience of healthcare professional groups/ teams of using an MBT model in working in this area of clinical practice.

Theoretical links

Psychodynamic theories lend a framework for understanding of the intra- and inter-personal processes related to healthcare professionals' attitudes to and experience of working with adolescents who self-harm (Foster, 2009).

Psychodynamic theories suggest these phenomena may be explained by understanding of the psychic functioning characteristic to adolescence. This developmental stage involves reworking of earlier developmental phases (Anderson & Dartington, 1998; Briggs, 2002) which origin from early developmental successes and/or failures in building capacity to mentalize. Mentalizing is understood here as making sense of physical and psychic experiences and representing them in mental states representations (Bateman & Fonagy, 2006). Capacity to mentalize helps individuals to think and tolerate emotional intensity and discomfort (Ingham, 1998; Reisenberg-Malcolm, 2001).

Attachment theory proposes that mentalization capacity is formed in an early attachment relationship with primary caregiver. Its development depends on the quality of early relationships between an infant and their primary caregiver and its potential for providing a secure base and experience of being thought about. These, in turn, foster an internalisation of working models crucial for future capacity to self-soothe and self-regulate (Allen, Bleiberg & Haslam-Hopwood, 2003). Winnicott (1967) put forward an idea that mentalization capacity emerges out of development of a sense of 'true self' and ego. He proposed that it is fostered in a relationship between an infant and a 'good enough mother' who is in a state of 'maternal preoccupation' and reflects and responds to infant's states of mind. The process of maternal mirroring and handing of the infant gives rise to the personalisation and development of the 'true' self. A mother's tolerable failures to mirror and handle helps the infant to experience separateness and supports development of ego with its capacity to tolerate frustration (1962). Finally, Bion (1962) proposed that the capacity to mentalize emerges out of an internalisation of a process of early containment in which a caregiver makes sense of child's experiences and gives them back in a tolerable form (Bion, 1962).

Kleinian theory provides a useful conceptual framework for the understanding of the deficits in mentalizing occurring in adolescence. It suggests that during adolescence early childhood anxieties of persecution and destructive impulses, characteristic to the schizo-paranoid position, are reactivated (Klein, 1946). The defences a young person may need to employ to manage these anxieties may pose a threat to their capacity to mentalize (Foster, 2009). The paranoid-schizoid position is understood here as a state of mind belonging to the early phases of infant development that determines the way an infant positions himself/herself in relationship to an object (an internal representation of the other). In the schizo-paranoid state of mind, an infant does not have the tools to deal with the complexities of his/her emotional experiences that involve powerful loving and hating impulses (Menziés-Lyth, 1988; Lemma, 2003). The infant finds it difficult to cope with his/her own aggression and the coexistent worries about the damage their aggression causes to their internal world of objects. In order to deal with these, he/she employs a defence mechanisms of projection and/or projective identification through which the aggressive impulses are evacuated onto the other. Another way of coping involves a defence mechanism of splitting off, both of the self and the object, into 'good' and 'bad'. These defence mechanisms give rise to the internal state of anxiety (called 'persecutory') that the split off 'bad object', to whom the aggressive impulses were projected onto, will retaliate back at the infant (Lemma, 2003).

As stated above, with the reactivation of the schizo-paranoid position in adolescence, acute anxieties are re-experienced and the primitive defence mechanisms of splitting, projection and projective identification are employed to defend against them (Klein, 1946; Waddell 1998). During this stage, young people's ability to mentalize and stay in contact with psychical pain is compromised. Therefore, they work to 'expel' their psychic pain by 'not-thinking' and enacting (Waddell, 2005). The above theoretical framework helps to understand self-harm as one of many forms of enactment young people engage in to manage their states of mind. The early experience of containment determines the extent to which a young person functions in the state of mind of primitive anxiety and to what extent he/she relies on the defence mechanism of externalisation (Foster, 2009).

The difficulties in tolerating psychic pain together with an overreliance on the defence mechanism of evacuating psychological discomfort, pose specific challenges to healthcare professionals working with adolescent patients. Menzies-Lyth's Theory of Social Defences (1998) proposes that healthcare professionals caring for patients who rely on primitive defence mechanisms may find it very difficult to remain in more mature states of mind and to offer emotional support and containment to their patients. The externalisation defences employed by adolescent patients may evoke in others states of primitive anxiety. These may account for the well evidenced negative experiences reported by healthcare professionals involved in care of young people who self-harm.

Menzies-Lyth's Theory of Social Defences (1998) proposes that healthcare professionals may defend against the primitive anxiety states of mind by resorting to practices such as: avoiding relationships with their patients; relying on action and 'doing' rather than 'thinking' and trying to understand (mentalizing). These social defences parallel the psychic defences associated with adolescent coping styles (Waddell, 1998). The Theory of Social Defences provides a useful conceptualisation framework for understanding the negative experiences of inpatient care reported by young people who seek help for self-harm. Negative attitudes among healthcare professionals can be understood as functional in that they create an emotional distance from relationships evoking psychological pain. Similarly, an overreliance on care procedures may serve as an institutional defence in that it may stop healthcare professionals from thinking and feeling and consequently from providing relational space for fostering mentalizing in their patients.

Healthcare professionals' ability to support their patients depends on their own capacity to deal with the psychic pain experienced in the relationship of caring (Menzies-Lyth, 1988). Training, supervision and clinical experience can support healthcare professionals in this respect. However, due to the high levels of stress present in secure settings, frontline healthcare professionals often need a specific type of support which involves help to 'digest' and make sense of the states of mind evoked in them in response to caring for their patients. They find themselves, similarly to their patients, in a need for containment by the higher institutional structures (Byron & Duff 2005).

Frontline staff find themselves needing to increase their capacity to mentalize to tolerate the psychic pain evoked by engaging with an adolescent's internal world and defensive enactments (Foster 2009). Training and practicing an MBT model may support healthcare professionals in improving their mentalization which may decrease their need for use of social defences and as a result may support them to provide relational space promoting emotional development of their patients.

Aims and Objectives

I aim to explore inpatient, frontline healthcare professionals' experiences of prevention and management of adolescent self-harm as well as their experience of the application of the MBT models in carrying out these tasks. I specifically aim to investigate:

1. Frontline healthcare professionals' experience of caring for self-harming inpatient adolescents.
2. Frontline healthcare professionals' experience of drawing on an MBT model to understand and manage their response to adolescents' self-harm.
3. Frontline healthcare professionals' experience of drawing on an MBT's model to understand and manage adolescent self-harm.

Research aim

The aim of this research is to investigate frontline healthcare professionals' experience of prevention and management of adolescent self-harm and their experience of use of an MBT models to carry out these tasks.

The results from the proposed research project may yield valuable insights into facilitating psychological containment of adolescents who self-harm, overcoming relationship ruptures, and managing self-injurious behaviours among young people. Furthermore, it may yield insights into the benefits of the MBT models to manage the stress experienced in working with adolescent self-harm. This is likely to benefit: service-user satisfaction; quality of care; staff's and patients' wellbeing; and recovery.

Methods

This study will employ qualitative methods for data generation and analysis for the investigation of the research question. Data will be sampled with in-depth semi-structured interviews conducted with inpatient frontline healthcare professionals. Participants will be recruited with a purposive case sampling procedure. Interviews will be conducted with an interview guide developed for the needs of the study (Appendix A). Data will be coded and analysed with thematic analysis.

Methodology

Event- centred narratives will be elicited from study participants as the data generating strategy. Narrative methods of story-telling will be used to learn about the inner worlds of the recruited participants (Larsson, Lilja & von Braun, 2013).

Setting

In line with methodological guidance for qualitative design studies, I will conduct the study in the natural setting "at the site where participants experience the (...) problem under study" (Creswell, 2012, p45). Individual interviews will be conducted in staff meeting rooms on the units providing care to adolescents in one or more National Health Services trusts. If potential participants find it impossible to attend a face-to-face interview, then an option of participating in an interview conducted over the phone will be offered.

The researcher has already contacted a consultant psychologist from an adolescent unit in [location], The [unit's name] at the [mental health trust's name], who has expressed interest in being involved. The [unit's name] team implements the AMBIT model. The project may require recruitment from more than one unit; therefore other services may need to be contacted.

Sample Size and Sampling Methods

For qualitative data, purposive criterion sampling (Patton 1990) will be employed to recruit 10-14 participants from inpatient frontline teams.

Inclusion criteria for participants' recruitment are defined as follows:

1. Frontline healthcare professionals (registered and un-registered healthcare professionals);
2. Healthcare professionals who had an introduction to an MBT model and acquired the following experience after that introduction;
3. Healthcare professionals who have been involved in prevention and management of adolescent self-harm understood as acts of self-cutting, self-mutilation, self-strangulation, head-banging, with or without intent to die, among inpatient adolescents on extended observations. If recruitment of the above specified sample size, based on the above criteria, does not yield a sufficient sample, then the third criterion (above) will be extended from:

“among inpatient adolescents cared for on extended observation”

to

“among all inpatient adolescents, including those not under extended observation”.

Exclusion criteria are as follows:

1. Non-frontline healthcare professionals employed in clinical and non-clinical role at the unit (e.g.: consultant psychiatrists, clinical psychologists, social workers, etc.);
2. Healthcare professionals with no experience of involvement in prevention and management of self-harm among adolescent inpatients;
3. Healthcare professionals who have not had an introduction to an MBT model;
4. Healthcare professionals who have limited understanding of the English language. The use of the English language will be assessed by the researcher when they meet the potential participant first time. The level of understanding of the English language will be assessed by whether or whether not the participant is able to understand the participant information sheet.

Research Procedure

The research procedure will be refined following ethical review recommendations. Adhering to unit procedures, the researcher will liaise with nursing management at the [unit's name] to arrange attendance at staff meetings to promote the study; to disseminate information, inclusion criteria, and procedure for expressing interest. The researcher will reassure potential study participants of their rights to retrospectively withdraw consent to participate; outline the strategies being taken to protect their anonymity and procedures for managing the risk of professional and psychological harm.

During those meetings, the researcher will distribute a written invitation to participate in the study to frontline healthcare professionals (Appendix B). The invitation letter will summarize

all of the above mentioned information. Detailed information about the proposed project will be included in a document called 'Participant Information Sheet' (Appendix C). Finally, the researcher's contact details will be included both documents for healthcare professionals interested in participating in the study. In order to reach healthcare professionals unable to attend the meetings, an email will be sent by a delegated staff member at the participating service with an invitation to the study and with full information about it. Additionally, a poster will be placed at the staff office (Appendix D).

Following an expression of interest raised by a healthcare professional, the researcher will contact them either via email, over the phone or in person to check with them that inclusion criteria are satisfied and exclusion criteria do not apply. If the health professional decides to take part in the study and meets the inclusion criteria, the researcher will arrange a suitable date and time to conduct the interview at the premises of the participating inpatient unit/s. If the potential participants cannot attend a face-to-face meeting, an option of an interview conducted over the phone will be offered.

Willing participants will be met/called at the agreed time and date, and consent to participate in the study will be sought after restating participants' right to withdraw from the research and procedures employed to ensure participants' anonymity and professional and personal safety (Appendix E). The aims and procedures involved within the research will be reiterated, and if the participant agrees to participate in the study, the interview will start. General questions promoting rapport will be asked before proceeding to questions about healthcare professionals' views, knowledge, attitudes or life experiences related to the 'sensitive' (McCosker, Barnard&Gerber, 2001) object of the study. At the end of the interview, participants will be encouraged to add relevant information and to share their experience of the interview. Interview participants will be offered a £10.00 gift token as a token of researcher's appreciation for the time and effort they put into the study. (Appendix F).

In-depth Interviews

In-depth semi-structured interviews with open-ended questions will be used to investigate the researched area of clinical practice (Creswell, 2012). All participants will be asked the same group of questions to allow for "greater comparability in response, and increased simplicity in coding" (Potter & Wetherell, 2005, p: 163). Interviews are estimated to last approximately 60 minutes. The length of the interviews may vary depending upon participants' level of engagement. If an interview is interrupted or more time is required, a follow-up interview date will be arranged.

In order to protect participants' anonymity, participants will be allocated pseudonyms and only limited demographic information will be collected. This will include their professional role and length of employment in the adolescent inpatient unit. A draft interview guide, with open-ended questions constructed to gather data relevant to the research questions is presented in Appendix A. The guide was developed in consultation with the [unit's name]'s staff, clinical practice and research supervisors.

Transcription, Coding and Data Analysis

Transcriptions will be made from interviews recorded with a good quality recoding system. Thematic analysis (Clarke & Braun, 2013) will be used for qualitative data coding and analysis.

Psychodynamic theory may be used for data analysis and will be used for data interpretation. Other theories, such as attachment and systemic theories also may be employed

Validation

Following Maxwell's guidance (1996), a number of strategies will be employed to eliminate threats to the validity of the research findings. In order to prevent threats to description validity, full content of the interviews will be audio-recorded and fully transcribed. Extracts of data transcriptions will be included in the presentation of the findings. Finally, theoretical validity will be strengthened by paying attention to discrepant data/negative cases, consideration to alternative understanding of the researched phenomena; and rich data form in findings presentation. The researcher will take on a reflexive stance and will seek feedback from research and clinical supervisors to minimise the risk of the impact of researcher bias on the analysis, interpretation and theorising.

Ethical Issues

The proposed research project will concern the NHS staff therefore the NHS R&D approval will be sought. Also, ethical approval will be sought from the University of Essex. Participants' privacy and anonymity will be protected in the following ways. Collected data will be stored securely on the University of Essex computer system and after being anonymised on the private computer of the researcher. Only the researcher and their research academic supervisors will have access to identifiable participant data. The data will not be transferred outside of the United Kingdom. The confidentiality of the obtained data will be ensured, except for cases raising concerns about the safety of the study participants and/or others. If risks to self or to others are identified, the researcher will seek consultation from the link person on the unit and/or research supervisors. If deemed necessary, the whistle-blowing policy will be followed. Participants' anonymity will be maintained in data presentation by the use of pseudonyms.

Potential study participants will be informed about the aims of the study, limits of confidentiality and the right to withdraw from the project in the invitation letter and in person at the beginning of the interview process. Also, potential participants will be able to contact the researcher before they decided to take part in the study to clarify any relevant issues. Informed direct consent will be obtained from frontline healthcare professionals who agree to take part in the study.

Full consideration will be given to the discomfort participants may experience in the interview procedure. It is predicted that some participants may experience negative feelings when describing their experiences. Following McCosker, Barnard & Gerber's guideline (2001), a protocol for conducting interviews in a study focusing on 'sensitive' phenomena will be employed. It details strategies aimed at addressing the psychological impact of the research (Appendix G).

Timetable

The flowchart below presents detailed timetable of the proposed research project.

Stage 1 - Develop research proposal (March 2014 Final Proposal)

↓

Stage 2 – Contact and gain co-operation of acute adolescent service (January-March 2014)

↓

Stage 3 - Apply for Ethical Approval (March-August 2014)

↓

Stage 4 - Gather data / conduct research

Recruit participants, if participants withdraw recruit more participants (August 2014 – October 2014)

Collect data with in-depth interviews (August 2014 – October 2014)

Write the first draft of the introduction and method section (November 2014)

↓

Stage 5 - Data analysis

Transcribe interviews (August 2014 – November 2014)

Data coding and analysis (August 2014 – January 2015)

Re-draft the introduction and method section (January 2015)

↓

Stage 6 - Write up results

Produce first draft of the results and discussion section (February 2015– April 2015)

↓

Stage 7 - Produce thesis

Complete the write up, give final draft to supervisor of research (April – May 2015)

Final corrections, and submit (June –July 2015)

↓

Stage 8 - Submit thesis July 2015

↓

Stage 9 – VIVA (Before August 2015)

↓

Stage 10 - Prepare publication and other forms of research findings dissemination (August 2015)

↓

Stage 11 - Submit for publication and disseminate tailored summary of research findings to targeted audiences (September 2015)

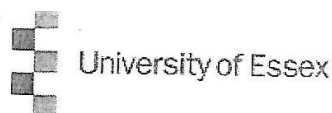
Dissemination

A short final report will be shared with study participants, adolescent inpatient units involved in the study project and Trusts commissioning services for young people. It will be distributed after submission of the thesis for examination.

In order to share the findings with academic communities, an article will be submitted for publication to research journals such as: British Journal of Clinical Psychology, International

Journal of Mental Health Systems, International Journal Of Nursing Studies, Journal of Adolescence, Journal of Clinical Psychology, Journal of Psychiatric and Mental Health Nursing. A shortened version of the research report may be shared with: 1/ policy makers and guideline developing bodies specialising in management of self-harm among adolescents admitted to acute units; 2/ educational institutions providing training to mental health professionals; 3/ managers and clinicians responsible for overseeing the development of treatment practices in adolescent acute services providing care to young people who self-harm.

Finally, the research findings may be disseminated to different audiences tailored to their needs such as: 1/ an informational leaflet for mental health professionals taking up employment in adolescent acute services; 2/ individual and/or group supervision guidelines for supervision for frontline healthcare professionals.



Application for Ethical Approval of Research Involving Human Participants

This application form should be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and fetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research should not commence until written approval has been received (from Departmental Research Director, Faculty Ethics Committee (FEC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project.

Applications should be made on this form, and submitted electronically, to your Departmental Research Director. A signed copy of the form should also be submitted. Applications will be assessed by the Research Director in the first instance, and may then be passed to the FEC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1.

Frontline Healthcare Professionals' experience of prevention and management of adolescent self-harm in inpatient services implementing an Mentalization-Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
Do you object to the title of your project being published? Yes / No
3. This Project is: Staff Research Project x Student Project
4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Marta Sosnowska	Chief Investigator/Principal Investigator, Trainee Clinical Psychologist, Doctorate in Clinical Psychology Programme, School of Health and Human Sciences
Dr Frances Blumenfeld	Academic Research Supervisor, Programme Director Doctorate in Clinical Psychology, Clinical Lead, School of Health and Human Sciences
Dr James Fairbairn	Workplace Research Supervisor and Local Collaborator, Clinical psychologist, Tier 4 CAMHS, Darwin centre for Young people, Block 19 Ida Darwin, Fulbourn, CB215EE

5.

Proposed start date: 01/09/2014



University of Essex

6. Probable duration: 01/10/2015
7. Will this project be externally funded? Yes / No
If Yes,
8. What is the source of the funding?

Challenges to frontline professionals in care for adolescents who self-harm

9. If external approval for this research has been given, then only this cover sheet needs to be submitted
 External ethics approval obtained (attach evidence of approval) Yes x / No

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): *Marta Sosnowska*

Name(s) in block capitals: ...MARTA SOSNOWSKA.....

Date: 29/08/2014

Supervisor's recommendation (Student Projects only):

I have read and approved both the research proposal and this application.

Supervisor's signature: *Sharon Ford*

Outcome:

The Departmental Director of Research (DoR) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the FEC

This application is referred to the FEC because it does not fall under Annex B

This application is referred to the FEC because it requires independent scrutiny

Signature(s): *W. Wilson*

Name(s) in block capitals: *W A / Ms Wilson*

Department: *S.H.H.S*

Date: *15/9/2014*

The application has been approved by the FEC

The application has not been approved by the FEC

The application is referred to the University Ethics Committee

Signature(s):

Name(s) in block capitals:

Faculty:

Date:

Cambridgeshire and Peterborough

NHS Foundation Trust

Understanding children, young people and families
Research and Development Department

29th August 2014

R&D Ref: M00656

Ms. Marta Sosnowska

26 Albany Road

Manor Park

London

E12 5BE

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 Cambridge
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Direct Dial: 01223 596472 ext 6472
 E-mail: stephen.kelleher@cpft.nhs.uk
www.cpft.nhs.uk

Dear Ms. Sosnowska

Frontline Healthcare Professionals' experience of prevention and management of adolescent self harm in inpatient services implementing a Mentalization-Based Treatment model: A Qualitative Study of Inpatient Frontline Professionals' Experiences.

In accordance with the Department of Health's Research Governance Framework for Health and Social Care, all research projects taking place within the Trust must receive a favourable opinion from an ethics committee and approval from the Department of Research and Development (R&D) prior to commencement.

R&D have reviewed the documentation submitted for this project, and has undertaken a **site specific assessment** based on the information provided in the SSI form, and I am pleased to inform you that we have no objection to the research proceeding within CPFT.

Sponsor: University of Essex

Funder: University of Essex

End date: 01/10/2015

Protocol: Protocol Version1, 01/08/2014

Conditions of Trust Approval:

- The project must follow the agreed protocol and be conducted in accordance with all Trust Policies and Procedures especially those relating to research and data management. Any mobile devices used must also comply with Trust policies and procedures for encryption.
- You and your research team must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998 and are aware of your responsibilities in relation to the Human Tissue Act 2004, Good Clinical Practice, the NHS Research Governance Framework for Health and Social Care, Second Edition April 2005 and any further legislation released during the time of this study.
- Members of the research team must have appropriate substantive or honorary contracts with the Trust prior to the study commencing. Any additional researchers who join the study at a later stage must also hold a suitable contract.

Challenges to frontline professionals in care for adolescents who self-harm

- You and your research team must provide to R&D, as soon as available, the date of first patient first visit.

If the project is a clinical trial under the European Union Clinical Trials Directive the following must also be complied with:

- the EU Directive on Clinical Trials (Directive 2001/20/EC) and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Regulations 2004;
- the EU Directive on Principles and Guidelines for Good Clinical Practice (EU Commission Directive 2005/28/EC); and UK's implementation of the Directive: The Medicines for Human Use (Clinical Trials) Amendment Regulations 2006;

Amendments

Please ensure that you submit a copy of any amendments made to this study to the R&D Department.

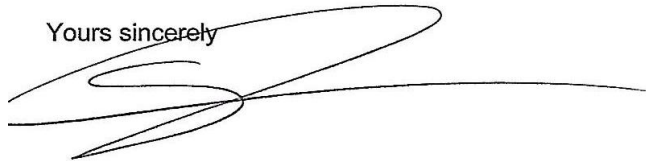
Annual Report

It is obligatory that an annual report is submitted by the Chief Investigator to the research ethics committee, and we ask that a copy is sent to the R&D Department. The yearly period commences from the date of receiving a favourable opinion from the ethics committee.

Please refer to our website www.cpkt.nhs.uk for all information relating to R&D including honorary contract forms, policies and procedures and data protection.

Should you require any further information please do not hesitate to contact us.

Yours sincerely



Stephen Kelleher
Senior R&D Manager

Cc Frances Blumenfeld, University of Essex; James Fairbairn, CPFT.

Appendix L: Protocol for Conducting Interviews

A protocol for conducting interviews focusing on 'sensitive' phenomena areas employed in the study:

1/ Maximum 1.5 hour interview duration is suggested in order to protect the wellbeing of the study participants. However, if study participants express an interest to continue with the interview beyond the suggested time limit, the interview may be extended.

2/ Psychological safety will be considered in designing the interview schedule. General questions promoting rapport will be asked before proceeding to questions about views, knowledge, attitudes or life experiences related to the 'sensitive' object of the study. At the end of the interview, participants will be encouraged to add anything they consider relevant to the subject of the study and to share their experience of the interview.

3/ At the beginning of the interview, the researcher will advise participants about its format. The researcher will acknowledge that the subject of the interviews may be considered as 'sensitive' and that talking about it may generate intense emotional responses. The researcher will also explain how these will be attended to.

4/ If the interviewee shows signs of intense negative emotion, the researcher will take on a 'counselling role', allow time for expression of emotion (e.g. cry) and acknowledge the importance of expressing feelings for the interviewee's wellbeing. The researcher will use their clinical judgment to identify any signs of distress.

5/ The researcher will express acceptance of and will validate the interviewee's emotional responses which they may perceive as "unacceptable".

6/ If appropriate, the researcher will respond to an interviewee's questions to promote trust and transparency.

7/ The researcher will comment of the strengths of the interviewee in relation to extending the body of knowledge in the researched area.

8/ The researcher will allow the interviewee to take a break or to terminate the interview should the interviewee become distressed. Should this happen, the researcher will offer an opportunity for the interviewee to feedback about their experience of participating in the interview and will support the interviewee in identifying strategies to cope with the distress.