

Young persons' experiences of inpatient care when presenting with self-harm

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Abstract

In the UK, self-harm is a major healthcare problem. Self-harm is an especially common behaviour in young people admitted to psychiatric inpatient care and is one of the primary reasons for presenting to hospital. The management and treatment of self-harming behaviours can be challenging, and few treatment guidelines are available for inpatient settings. Poor understanding of self-harm and how to manage it effectively is likely to lead to staff feeling hopeless and helpless, but also to reduced support for the young people under their care. The current study constitutes an attempt to build on what is known by exploring young people's reports on their experiences of inpatient treatment when presenting with self-harm. A grounded theory methodology was used to analyse the data. There were two key study aims which were: to obtain young people's reports on their experiences of inpatient care when presenting with self-harm; and to integrate these views into a grounded theory that would serve as a model for understanding features of young persons' experiences of inpatient care when presenting with self-harm. Semi-structured interviews were conducted at two NHS inpatient units supporting young people with mental health difficulties. Analysis of these interviews was done in accordance with grounded theory. Two core concepts of humanness and restriction emerged from the data which contribute to the construction of meaning and understanding. Service implications and recommendations highlight the need for improved understanding, maintaining relationships and continued connection during admissions. The methodology contributed to developing a rich and detailed understanding of young persons' experiences of inpatient care when presenting with self-harm.

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Chapter 1: Introduction

1.1 Chapter Overview

In the UK, self-harm is a major healthcare problem (Majid *et al.*, 2016). One of the most common reasons for admission to hospital is self-harm and the Royal College of Psychiatrists (RCP) estimates there has been an increase in the incidence of self-harm in the UK over the past 20 years (Holley *et al.*, 2012). It is reasonable to assume that the incidence is underestimated however, as these estimates are based on those individuals receiving medical assistance. Self-harm is an especially common behaviour in young people admitted to psychiatric inpatient care and is one of the primary reasons for presenting to hospital (Ougrin *et al.*, 2012; Hawton & Rodham, 2006). There has been considerable interest in examining the characteristics of self-harming young people, including risk and protective factors, but also evidence-based treatments for this behaviour (Fleischhaker *et al.*, 2011). Lengel and Mullins-Sweatt (2013) report statistics revealing that, not only is self-harm common amongst young people, but it appears that there has also been an increase in the incidence of these behaviours amongst this group. They add that studies of deliberate self-harm in both clinical and nonclinical samples report increasingly high rates of non-suicidal self-harm and suicidality in all age groups, but most prominently in young people and young adults.

The management and treatment of self-harming behaviours can be challenging, and few treatment guidelines are available for inpatient settings (Doyle *et al.*, 2017). The lack of understanding about the motivations behind adolescent self-harm can have a negative impact on how mental health professionals respond to young people who present with these behaviours (ibid). Poor understanding of self-harm and how to manage it

effectively is likely to lead to staff feeling hopeless and helpless, but also to reduced support for the young people under their care (Rouski, Hodge & Tatum, 2017).

In this chapter key terms used throughout the study are defined. A brief overview of self-harm behaviour in young people, services available to them and a discussion on including young people's views in research follows. The rationale for, and aims and objectives of the study is offered, and a preliminary review, in line with constructivist grounded theory (Charmaz, 2006), of literature pertaining to young people's inpatient experiences of care when presenting with self-harm is presented. This is followed by an exploration of the study limitations within the available research.

1.2 Some Relevant Terms

Several terms are used throughout the research and consequently a definition of some of these concepts, as understood by the researcher, was thought to be helpful for the reader. It is acknowledged that there often exists more than one definition in the literature and therefore the choice is subjective.

1.2.1 Young person/people. The term young people refers to adolescents. It refers to the participants who took part in the study, but also those included in the literature used in support of arguments made within this paper. The term includes those young people between 12 and 18 years of age. How this period of development is defined has long posed a difficulty. It is the phase of life that stretches between childhood and adulthood. Jaworska and MacQueen (2015) highlight that it is a period that encompasses both biological growth and major social role transitions. More than ever, and in part due to the unprecedented effects of pressures such as social media

and digital marketing on well-being, this period now occupies a greater portion of the life course. Nonetheless, in the current study, the age range is limited to that already stated.

1.2.2 Inpatient services. In the context of the current study, inpatient services are defined as the units that contain ‘hospital beds’ and provide 24-hour care. Within the units where the study is located it is possible for young people to be detained under the Mental Health Act, with the consultant psychiatrist acting as the responsible clinician. It is noted, however, that only a small number of young people are detained. The young people have access to a range of skills offered by multi-disciplinary teams. In the current study, the two units from which young people were recruited are part of one NHS Mental Health Trust. These units are described later in the paper.

1.2.3 Community services. Community services are those accessed from the young people’s homes or residence, for example the family home. Services are located at sites within the local area provided by agencies which may include NHS provisions. The support that may be on offer could include health, social or independent sector services.

1.2.4 Mental health difficulties. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) defines a mental disorder as a syndrome characterised by clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning; mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities (APA, 2013). Several different terms can be found throughout the literature including mental ill health, psychiatric disorder, mental health difficulties and mental disorder. In this study, the term

‘mental health difficulties’ was chosen and is also used by the service in which the research was conducted. In addition, lay terms such as difficulties or struggles are also used.

1.2.5 Suicidal behaviours. Although the current study focuses on non-suicidal self-harm, in order to distinguish these behaviours from suicidal behaviours, a comment is included here. It is important to note, however, that the two terms share many overlapping characteristics, and it is also the case that many adolescents engage in both suicidal behaviours and non-suicidal self-harm. Suicidal behaviours include completed suicide, suicide attempts, and suicidal ideation (Miller, Rathus & Linehan, 2007).

1.2.6 Non-suicidal self-injury (NSSI) and self-harm behaviours. There are several different terms used throughout the literature pertaining to self-harm, including self-injurious behaviour, parasuicide, non-suicidal self-injury and, of course, self-harm. In this study, the term self-harm is used and includes all these behaviours regardless of suicidal intent. It is often difficult to assess the degree of suicidal intent accompanying intentional self-injury and some consider these behaviours as part of the larger spectrum of young people’s suicidal behaviours even though, by definition, they involve no suicidal intent (Miller, Rathus & Linehan, 2007). The National Institute for Health and Clinical Excellence (NICE) defines self-harm as intentional self-poisoning or injury, irrespective of the apparent purpose of the act (NICE, 2004). For the purposes of this study, however, the Gratz (2003) definition is used, to mean behaviours of deliberate, direct destruction or alteration of body tissue, without conscious suicidal intent but resulting in injury severe enough for tissue damage to occur.

1.2.7 Care, treatment & support. Care, treatment and support are terms used interchangeably throughout this study, but they are intended to reference the range of therapeutic interventions applicable within the settings, whether in the inpatient units or in the community. These include, but are not limited to, nursing and support worker interventions and support, consultant interview and interventions, psychology and other talking therapy input, occupational therapy, social work and school integration services.

1.3 Exploring Self-harm Behaviour In Young People

1.3.1 How common is it? Steeg *et al.* (2018) found that few countries record national data on hospital attendances for self-harm. They state that estimates per 100,000 of the population exist for Ireland (199), the US (150), and Sri Lanka (315), while in the case of England, the figures are 362 for males and 441 for females. These authors highlight that there is a strong relationship between hospital treated self-harm and subsequent suicide, reporting that studies revealed 0.5% of people were found to have died by suicide within a year of a hospital presentation. This rose to 3.9% after five years and to above 5% after nine years. They add that individuals who have self-harmed are also at higher risk of premature death from other external causes and from natural causes. Self-harm is probably the greatest predictor of future suicide (Hawton, Zahl, & Weatherall, 2003) and is clearly recognised as a serious public health problem. However, reliable characteristics or prevalence data on the phenomenon remain sparse (Doyle, Treacy & Sheridan, 2015). In a 2004 study conducted by Muehlenkamp and Gutierrez, young people reported extremely high rates of self-harm ranging between 15.9% and 18% (Muehlenkamp & Gutierrez, 2004). Prevalence data, however, is likely to be underreported as the majority of young people who self-harm do not present to mental health services and these behaviours are therefore not always captured and

recorded accurately (Doyle, Treacy & Sheridan, 2015; Rossow & Wichstrøm, 2010). The international CASE (Child and Adolescent Self-Harm in Europe) study of young people's self-harm conducted in 2008 found a 13.5% self-harm rate for females and a 4.3% self-harm rate for males (Madge *et al.*, 2008). In 2015, Doyle, Treacy and Sheridan (2015) reported a 12.1% lifetime history of self-harm in young people.

It appears that, while there are a number of community studies seeking to determine the prevalence rates of self-harm among young people, results vary considerably. The available reports suggest that this is certainly a high prevalence behaviour and consequently in need of investigation due to its possible fatal consequences. Prevalence rates reported from studies in the United States, for example, reveal that suicide in young people accounts for more deaths in this age group than all natural causes combined and it is ranked as the third leading cause of death, preceded only by accidents and homicide (Miller, Rathus & Linehan, 2007). Given the association between suicide and self-harm, this is indeed significant.

1.3.2 Who is at risk? Research reveals that young people most at risk of non-suicidal self-injury are those with multiple problem behaviours and the risk is positively correlated with the number of these problem behaviours (Miller, Rathus & Linehan, 2007). Doyle, Treacy and Sheridan (2015) identify exposure to self-harm of a friend or family member, physical or sexual abuse and sexual orientation concerns as factors independently associated with self-harm, whilst Mewton *et al.* (2019) describe risky alcohol use, drug use, unprotected sex, sleep duration and smoking as a fair to good predictor of health outcomes associated with the leading fatal (suicide attempt and self-harm) and non-fatal (major depression and severe psychological distress) global burdens of disease amongst young people. Miller, Rathus and Linehan (2007) further

describe distal risk factors, and highlight that young people with prior suicidal behaviours, mental disorders, chronic family disturbance, gender, and those who are LGBT or come from minority ethnic groups are at greater risk. They also define proximal risk factors that include stressful life events, sexual and physical abuse, academic difficulties, functional impairment from physical disease or injury, suicide in the social milieu and access to suicidal means. These researchers note that proximal risk factors combined with one or more distal risk factors is what heightens the risk of self-harm. A limitation of this view, is that proximal and distal factors are deeply related and intersectional and separating them undermines the psychological relationship between them. Miller, Rathus and Linehan (2007) add that past self-harm behaviours are stronger predictors of future self-harm behaviours than stressful life events or other proximal risk factors.

1.4 Services For Young People Who Self-harm

1.4.1 Service provision. The NHS provides mental health care for children and young people experiencing serious problems. Services for adolescents who present with suicidality and/or self-harm have received much attention and in 2010 the World Health Organisation made a key recommendation to improve the monitoring of both suicide and self-harm (Witt & Robinson, 2019). The quality of health and welfare services for younger people has been found wanting in the past (Clarke *et al.*, 2001). More recently, a review by the Care Quality Commission (CQC) showed that the quality of existing services for young people is variable (DoH, 2017). Currently, NICE guidelines advise that psychosocial assessments should be organised following presentation to emergency services (NICE, 2004). The benefits of psychosocial assessment is a well-researched area; multifactorial care is necessary following self-harm (Hawton & Harriss,

2007) and access to care after discharge is important due to the correlation between suicide risk and reduced level of care (Cooper *et al.*, 2013).

In addition to self-harm being a major risk factor associated with suicide, repeating self-harm and requiring emergency care after acts of self-harm also place a significant strain on the health economy and acute hospitals (Majid *et al.*, 2016). It therefore makes sense that services would have as their goal, to change or ameliorate factors in a young person's life that underlie their problems. Whilst young people are less likely than other groups to be referred to psychiatric services, as they are more likely to be offered self-help as their initial service provision, they do attend when referred (Majid *et al.*, 2016). This may indicate opportunities for intervention.

1.4.2 Current evidence-based intervention. Miller, Rathus and Linehan (2007) describe two strategies for treating suicidal and self-harm behaviours. The first involves treating suicidal behaviours indirectly by treating associated disorders. The belief behind this strategy is that, if the associated disorder is treated, suicidal behaviours will reduce in turn as an indirect benefit of therapy. The second strategy comprises focusing directly on the suicidal behaviours, targeting these as the focus of interventions.

- Brief Cognitive Behavioural Therapy (CBT) interventions have been found to be effective in the management of self-harm (Raj, Kumaraiah & Bhide, 2001). Cochrane review showed similar findings that CBT may help those who engage in self-harm (Wise, 2016).
- Dialectical Behaviour Therapy trials have demonstrated effectiveness in reducing suicide attempts and non-suicidal self-harm (Miller, Rathus & Linehan, 2007). Recent studies have demonstrated the effective treatment of impulsive

behaviours associated with suicide and self-harm when DBT is the treatment model (Rathus & Miller, 2015).

1.4.3 The argument for inpatient services. Studies conducted on outcomes for young people admitted to hospital for inpatient care following suicidal or self-harm behaviour, showed no additional benefit of an admission as opposed to outpatient treatment. No benefits have been found for adolescents having access to emergency inpatient admission (Miller, Rathus & Linehan, 2007), although a partial hospital treatment program including DBT has been shown to yield some benefits (Lenz & Del Conte, 2018). There are those who argue for an admission to hospital as it gives the young person and their family time to reflect on what has happened, to have an accurate risk assessment of the circumstances leading up to the self-harm, and for community teams to explore the home environment to which the young person is returning (Ruttle & Chappell, 2006). An admission to an inpatient unit can provide somewhere for the young person to feel safe, to receive treatment and to obtain some respite from the challenges of daily living (Arnold, 1995). Similarly, Hawton and James (2005) advocate assessment in hospital to ensure the young person receives a thorough psychosocial assessment and is given access to appropriate services. This is supported by the current NICE guidance, as mentioned above (NICE, 2004).

1.5 A National Priority

As mentioned previously, self-harm among young people is common, and is a significant public health issue due to the immediate and potential longer-term physical harm it causes, as well as its association with psychological distress (Doyle, Treacy & Sheridan, 2015). In 2014, a “Children and Young People’s Mental Health and Wellbeing Taskforce” was established to consider ways to improve access to support,

and enhance young people's mental well-being. This taskforce noted that mental health problems cause distress to individuals and all those who care for them (*Future in mind, Promoting, protecting and improving our children and young people's mental health and wellbeing*, DoH, 2015). In addition, the economic case for investment in these services is highlighted as 75% of mental health problems in adult life are known to have started by the age of 18. Failure to support children and young people with mental health needs is likely to cost lives, given the risk associated with self-harm and suicide, as well as money, so intervening early could represent an opportunity to help avoid longer term, expensive interventions in adulthood.

Crucially, the taskforce emphasised the importance of involving children and young people in making choices about care and treatment. This is important to ensure that targeted, evidence-based treatments meet their goals and priorities. The Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry underlined serious concerns about UK nursing care as well as shocking deficiencies in basic standards of care; it also highlighted a negative organisational culture fostered by a focus on systems, statistics and reports rather than patient experiences and outcomes (Francis, 2013). As a result, it has since become increasingly important to understand patient experience and tailor treatment plans accordingly. Amongst The Francis Report recommendations, was that service users within clinical health settings and, in particular, the NHS must be placed at the centre of treatment and intervention. The report recommended putting the patient first and prioritising the patient in all of what the NHS does. Staff should be expected to do everything in their power to protect patients from avoidable harm and incorporate patient and public involvement into its structures so as to ensure this focus is always at the forefront of its work (Francis, 2013). The importance of listening to service users' accounts of their illness and treatment has been demonstrated in other areas of clinical

research including dementia and anorexia nervosa, for example (Colton & Pistrang, 2004). The same would undoubtedly be true for self-harm.

In 2017 the government produced a green paper setting out its ambition to invest more, intervene earlier and prevent mental health difficulties among young people (DoH, 2017). This paper builds on the *Future in mind* document mentioned above with an emphasis on improving crisis services for young people and ensuring consistent access to the right help, in the right setting, when they need it.

1.6 The Young Person's Experience Of Inpatient Care

1.6.1 Why there is a need to obtain young persons' views. In order to ensure that service users, including young people, are respected, listened to and can act in cooperation with professionals, their involvement is crucial. It also means that they feel able to influence their own care and treatment (Laitila *et al.*, 2018). Despite the growing interest in service user involvement, in practice, it is not always achieved (Laitila, Nikkonen, & Pietilä, 2011), and involvement sometimes remains at a tokenistic level (Crawford, & Rose, 2014). There seems to be a general consensus on the importance of service user involvement but there is a lack of research reflecting the views and opinions of service users themselves (Omeni *et al.*, 2014). Young person involvement is likely to improve the quality of research by ensuring its relevance, thus resulting in more meaningful research. To this end, it seems appropriate to access the experience of young people in research about them. Both national and local policy agendas have prioritised involving young people in the development of services as well as being more involved their care (Department of Health, 2017). After all, as Schoppmann *et al.* (2007) note, only the individuals engaging in self-harm behaviours are able to inform us about

how it feels to turn to self-harm to, in their example end an agonising mental state, and consequently provide insight into the function thereof.

1.6.2 What makes it difficult to obtain young persons' views? Amongst several contextual factors that may hinder service user involvement, service culture surrounding risk management, and mixed staff perceptions regarding service user contributions and capacity beliefs, remain barriers to service users' voices being heard (Gorfin & McGlaughlin, 2005). This situation is likely to be further exacerbated when young people are involved. It stands to reason that these barriers should be addressed and could be overcome by providing increased support for young people to express their views. It is also true that, in the case of young people, authoritative dynamics are likely to come into play. Service users are more inclined to provide input that they see as pleasing to staff when staff are present at interviews and, consequently, the potential for bias is introduced (Young & Chesson, 2006). Young people may believe they lack choice, and their feelings of powerlessness could render them silent when asked for their views, thus hampering the inclusion of their perspectives (Gorfin & McGlaughlin, 2005).

1.6.3 How to include the young person. As mentioned previously, with the appropriate support, service users are willing and able to take part in research. Guidance has already been developed on enabling young people to make informed decisions about their participation in healthcare research (Young & Chesson, 2006). Overcoming barriers involves, for example, providing accessible information about what the research entails and giving clear and succinct explanations tailored to individual needs (Chaplin *et al.*, 2009).

1.7 Rationale, Aims And Objectives Of The Current Study

1.7.1 Rationale. There is a striking lack of published research exploring young persons' experiences of inpatient treatment when presenting with self-harm. This is further commented on in the preliminary literature review that follows later in the chapter. It is the researcher's view, and in line with Government policy, that the views of young people receiving care and treatment need to be heard. This research attempts to not only contribute to what is known on the subject of young people's experiences of inpatient care when presenting with self-harm, but also to remain positioned in accordance with government priorities regarding mental health service provision for children and young people with mental health difficulties. More specifically, this study focussed on obtaining young people's views on the inpatient experience in order to develop a grounded theory that emerged from their reports. This methodology is further outlined in Chapter 2.

The current study took place within an NHS Trust. A broader description is provided in Chapter 2. However, a comment on the influence of the Trust's parallel objectives is warranted here. A service-wide audit of a newly developed self-harm care-plan implementation process was being conducted within the Trust. The application documentation for the audit is included in appendix 1. The current research, however, was designed to capture the young people's experiences of inpatient care alongside this implementation, but also treatment as usual. The Trust regularly seeks service user feedback as part of service development and quality improvement. A note on ethical approval in Chapter 2 elaborates further on this. The Trust required an application to the local ethics committee in order to complete the research.

1.7.2 Aims and Objectives. This study attempts to make a contribution to knowledge by exploring the young persons' reports on their experiences of inpatient treatment when presenting with self-harm. A grounded theory methodology was used to analyse the data. The views of the young people were integrated into a grounded theory by which their experiences could be understood. There were two key study aims:

- I. To obtain young people's reports on their experiences of inpatient care when presenting with self-harm.
- II. To integrate these views into a grounded theory model of the factors contributing to young persons' experiences of inpatient care when presenting with self-harm.

The theory will provide knowledge that could be used to inform clinical practice. As already mentioned, self-harm behaviours are common amongst young people and are associated with a range of adverse mental health outcomes. Improved understanding of the young people's experience of inpatient treatment will support the development of effective treatment guidelines, policy development and service planning for young people presenting to inpatient settings.

1.8 Literature Search

Since the inception of grounded theory in the 1960s, there has been ongoing debate about the timing of a literature review when working within this methodology. Recommendations to delay the literature review in order to minimise preconceptions and bias have been questioned (Giles, King & de Lacey, 2013). The researcher agrees with these scholars and holds the view that a preliminary review of the literature does not undermine the rigor of the grounded theory but rather serves to identify gaps in the research field, provide justification for the research, help gain critical

knowledge of key concepts, direct theoretical sampling and enhance theoretical sensitivity. It is also acknowledged, however, that this preliminary search, coupled with prior professional knowledge, influenced the researcher's perspective on what emerged from the data. Charmaz (2006) suggests that, once completed, the literature review should be set aside until the data analysis is undertaken. Consequently, the review that follows remains preliminary. A later inclusion of more focussed literature helps to situate the study among and within related research in order to demonstrate how it builds on and adds to previous knowledge.

1.8.1 The search strategy. EBSCOhost was used to search a number of databases (CINAHL®Complete, eBook Collection, E-Journals, MEDLINE with Full Text, PsycARTICLES® and PsycINFO®) for all years up to and including March 2019.

In order to obtain an overview of the research literature, a number of search terms were combined with Boolean operators (experience* OR perception* OR attitude* OR view* OR feeling* AND self-harm OR self-injury OR deliberate self-harm OR self-mutilation OR self-injurious behaviour AND inpatient* OR hospital* OR hospitalised AND young people OR youth OR adolescents OR young adults). Titles and abstracts (N=351) were scrutinised and exact duplicates (N=58) were removed. Titles were scanned for relevance and non-relevant papers removed (N=30). The abstracts from the remaining papers were reviewed and non-relevant papers again removed (N=109). 27 papers were reviewed against the inclusion and exclusion criteria described below. Subsequent papers were scrutinised for relevance with regards to service user experience of inpatient treatment. Papers that did not focus on participants' experience were also removed (N=20). Appendix 2 is a diagrammatic summary of the literature search procedure.

1.8.2 How studies were inclusion or excluded. Studies examining young people's subjective views and experiences of inpatient care when presenting with self-harm were included in the preliminary scoping of the literature. In the initial searches, a limited amount of research was found. The search criteria were therefore extended to include a broader range. Any studies that examined experiences of hospital care of service users presenting with self-harm behaviours were included.

Importantly, for the purposes of the current study, there was no research specifically reporting on the young person's experience of inpatient care when presenting with self-harm. This provided further motivation for the current research. At the same time, however, at this stage, it was felt appropriate to extend the search criteria to include the experiences of people across the full age range. This was done to ensure that not too much was missed in terms of relevant available knowledge. Four non-English papers were removed from the initial search after linked English abstracts showed little relevance to the current study.

1.8.3 Identifying relevant research. Seven published articles exploring service users' views and experiences of hospital care, treatment or interventions when presenting with self-harm were identified. As mentioned, there was particular paucity in available research with regards to specific experiences of inpatient treatment among adolescents or young people presenting with self-harm. Six of the seven studies had a qualitative design and thus met the criteria more closely as well as aligning with the methodology used for the current research, which is discussed further in the next chapter. An additional systematic review paper by Taylor *et al.* (2009) on attitudes towards clinical services among people who self-harm was also included. Although the study by Hume and Platt (2007) has the prevention and management of self-harm as its

focus, the experiences of interventions are reported on and it was thus deemed appropriate to be included in the literature review. Similarly, Smith-Dowling, Knowles and Hodges' (2018) exploration into the understanding of experiences of the self-harm of others taps into experiences within mental health settings and was therefore also included. The researcher acknowledges that these papers fit the inclusion criteria more loosely, but it was deemed helpful to include them in order to widen the exploration.

1.8.4 Summary of the key studies. Six qualitative papers were included in the review. The additional systematic review by Taylor *et al.* (2009) reviewed 31 studies, 16 of which were based on service users' experiences in the UK, and the rest from other countries. These authors sought to identify all relevant qualitative and quantitative studies that included participants of either gender or any age who had engaged in self-harm and had contact with hospital services. Relevant international literature was also sought as well as reference lists of relevant studies. Experts in the field working in non-English speaking countries were consulted in an attempt to eliminate the need for language restrictions. They were able to report on any known published or unpublished literature concerning attitudes to services among those who self-harm. Quantitative studies were used to provide evidence about the general experiences of the larger population of people who self-harm, whereas qualitative studies were used to extend understanding through the recounting of specific examples and incidents. There were no limitations on study quality; however, more weight was given to those with a stronger design when reporting on the results. The relevance of the studies to the review objectives was also considered.

The earliest qualitative research paper on the experience of care following admission among service users who self-harm was that of Lindgren *et al.* (2004). They described

the participants' experiences of the care they received at hospital as well as how these compared to their desired care. The participants were nine Swedish women between the ages of 19 and 35, with a mean age of 25, who had been treated in inpatient or outpatient settings and they narrated their experiences of care following self-harm. The methodology used was a qualitative content analysis from which themes were formulated. All the participants received care at a psychiatric clinic in northern Sweden and five of the nine had received inpatient psychiatric care within the previous year.

In a study conducted by Horrocks *et al.* (2005) the authors aimed to elicit people's stories of their experiences of attending hospital following self-harm. In-depth qualitative interviews were carried out and the researchers aimed to interview a broad spectrum of people in an attempt to learn about the range of experiences described. A free association narrative interview method was used so as to allow the participants to report openly and in their own words. There were 45 participants ranging between the ages of 18 and 56.

Schoppmann *et al.* (2007) aimed to enhance understanding of patients who present with self-harm by gaining insight into their lived experiences. The authors adopted a hermeneutic phenomenological research perspective. They used methods of participant observation and qualitative interviewing to generate their data. The sample was gathered from two psychiatric institutions in the north-western part of Germany which specialise in the treatment of people presenting with self-harm. The authors included data on patient observations that took place at these units. One of the wards was an all-female ward whereas the other accepted male patients as well. Interviews were conducted with four female patients presenting with self-harm and with a member of the nursing team in one of the units.

Also, in 2007, Hume and Platt investigated service users' views on interventions for the prevention and management of self-harm. These authors undertook 14 semi-structured interviews with service users admitted to hospital for a repeat act of self-harm. The data was analysed thematically, drawing broadly on some of the principles and techniques of grounded theory. These authors recruited participants who had been admitted to hospital following self-harm between the ages of 16 and 50. The participants were selected using quota sampling based on two age groups, the first ranging from 16 to 29 years; and the second from 30 to 50 years, as well as on the basis of gender. Seventeen patients were approached and 14 participated in a face-to-face qualitative interview using a semi-structured interview guide. Although the study noted themes around accounts of personal circumstances, for the purposes of the current study more weight was given to these patients' experiences of interventions for self-harm.

In 2011, researchers in Sweden, again led by Lindgren (Lindgren *et al.*, 2011) conducted a study to illuminate interpretive repertoires that jointly construct the interaction between women who self-harm and professional caregivers within psychiatric inpatient care. Participant observations and informal interviews were conducted with six women who self-harmed, as well as their professional caregivers. These were analysed using the concept of interpretive repertoires from the discipline of discursive psychology. The researchers chose a focused ethnography as they were investigating a distinct problem within a specific context for the study. The participants had a median age of 23 ½.

Finally, in 2018, Smith-Gowling, Knowles and Hodge conducted a qualitative study aimed at exploring young people's experience of the self-harm of others and interviewed a total of eight young people between the ages of 13 and 18 who were resident at one of

two adolescent mental health inpatient units in the North of England. These interviews were analysed using interpretive phenomenological analysis to identify themes.

The study designs, including a description of participant demographics and research methodologies, are described in appendix 3.

1.8.5 Sensitised concepts. Hutchinson (1993) advises that, in grounded theory methodology, when the literature review precedes data collection and analysis, not only does it allow for gaps in current knowledge to be identified, but it also sensitises concepts and improves conceptual clarity. This enhanced theoretical sensitivity, a major tenet in grounded theory, relates to the ability to gain insight, to understand and give meaning to the data, and to separate the relevant from the irrelevant (Strauss & Corbin, 1998). Some concepts that emerged from the literature are therefore highlighted.

a) *Individuality and uniqueness.* Lindgren *et al.* (2004) discussed the importance of patients being “seen” beyond the surface, a phenomenological perspective of being acknowledged at a deep level coupled with having one’s emotional distress that lies behind the symptoms observed. Being seen by staff in this way also helped the participants to begin to see their ‘self’. Horrocks *et al.* (2005) observed that feelings of isolation and worthlessness were exacerbated when there was purely medical contact without acknowledging of the patient’s unique emotional states. The theme highlights a desire among participants to feel valued, not stigmatised. Lindgren *et al.* (2004) described participants feeling valued when staff took their problems seriously and this led to the patients taking their behaviours seriously too. Experiences were reported as unsatisfying by participants when staff and patients disrespected one another and adopted a non-listening approach. Furthermore, Horrocks *et al.* (2005)

commented on the service users' internal states and their impact on the individual's experience. The authors noted that some of the participants in their study commented on their anxiety about being seen as mad and feeling overwhelmed by the complexity of their life problems. When participants were treated with respect and warmth and understanding, feelings of self-worth were regained.

b) *Autonomy, control and collaboration.* Service users valued choice about available treatment alongside a desire to be involved in care and decision making (Lindgren *et al.*, 2011; Horrocks *et al.*, 2005). A perceived lack of involvement in management decisions was associated with negative experiences of management by participants (Schoppmann *et al.*, 2007). Feelings of being disempowered were prevalent throughout the literature alongside positive experiences of care that were associated with greater participation in care and care decisions. Lindgren *et al.* (2004) reported that, through staff valuing patient autonomy, participants gained the ability to participate in and make decisions about their care. Horrocks *et al.* (2005) noted the contrast between positive and negative experiences of communication between staff and participants and how this affected people who had self-harmed. They highlighted the importance of interpersonal aspects of care and working together. Schoppmann *et al.* (2007) found that nurses could detect early signs of an impending loss of control and that subsequent collaboration with patients in terms of treatment was a key influencer on the experience of care.

c) *Understanding.* The literature reviewed pointed to a need for a shared understanding of self-harm amongst patients and staff. For example, Lindgren *et al.* (2004) elicited accounts where patients viewed self-harm as a coping and survival strategy and a way of dealing with difficult psychiatric pain. They made statements

explaining that, by physically inflicting harm, emotional pain became more manageable, and that, far from wanting to die, they perceived self-harm as an act that could make them feel better. The patients expected that this knowledge would help staff to support them. Similarly, Schoppmann *et al.* (2007), reported on patient accounts that claimed self-injurious behaviour was an effective strategy intended to end a painful experience of alienation. The findings indicated that self-harm could be appropriately understood as a form of self-care and serves to end harmful emotional states. Additionally, Hume and Platt (2007) found that only a few patients spoke of terminating their self-harm as their main concern but emphasised the importance of staff understanding. From these reports, it seems that a shared view and understanding of the reasons for engaging in self-harm resulted in changes in the experience of the care received in this context. Being understood by staff also facilitated self-understanding among the participants (Schoppmann *et al.* (2007). Clearly, being able to communicate with staff was found to be imperative. Taylor *et al.* (2009) reported that clarity of communication was found to be very important and patients perceived staff as operating according to misconceptions when they felt that staff did not have sufficient understanding of self-harm. However, as Taylor *et al.* (2009) further noted, some participants spoke about not always understanding their own reasons for self-harm and therefore wanting more information from staff.

d) Trust. Leading on from the discussion on understanding, Taylor *et al.* (2009) found that service users valued staff sharing all the information at their disposal and that improved outcomes resulted from the provision of information. Patients appreciated experiences where staff explained everything that they were doing. The authors noted that several service users found it difficult to open up and discuss their problems as they were fearful that this would intensify their distress by reactivating repressed memories.

The patients were concerned about inappropriate staff behaviour and lack of staff knowledge which was associated with barriers to building trust. Schoppmann *et al.* (2007) reflected that patients struggled with trust and protected themselves during threatening situations by deliberately becoming alienated from others, despite the agony this caused them. Hume and Platt (2007) added that patients had a preference for contact with trusted professionals who had specialist knowledge and experience of people who self-harm and had the potential to build long-term relationships with their clients. Lindgren *et al.* (2004) described the importance of being believed by staff. Being believed was accompanied by a sense of feeling worthwhile, and this involved trusting that staff would help them through their struggle. Taylor *et al.* (2009) found that some service users had negative perceptions of interactions with staff, due to feeling that they were not empathic or trustworthy, thus highlighting perceived threats and humiliation as common reasons for negative experiences. Horrocks *et al.* (2005) noted, however, that building trust and a relationship with others, including staff, requires connection.

e) *Environment and interventions.* Smith-Gowling, Knowles and Hodge (2018) commented on young people's experience of how the intense ward environment manifested as a social struggle with self-harm. They explored the conscious and unconscious processes that may be at work during the 'transmission' of self-harm behaviours of others and suggested that exposure to this self-harm appeared to normalise the behaviour. Horrocks *et al.* (2005) noted the clash between the frameworks used when treating people who had self-harmed: medical staff tended to frame difficulties in clinical terms whereas psychiatric services relied on psychosocial understandings of difficulties. Horrocks *et al.* (2005) also noted the difficulties participants reported on leaving the hospital environment to return to previous circumstances, even if after-care was provided, or to circumstances worsened by the

attempted self-harm. Hume and Platt (2007) stated that interventions should acknowledge diverse populations with diverse service needs. They observed a strikingly diverse experience of these numerous interventions for self-harm. These authors reported that patients who were engaged in, and were committed to, a particular intervention tended to recount feeling satisfied with the service. The reasons for this were that it enabled them to escape from their usual normal lives and to be cared for. Hume and Platt (2007) found that experiences of a large number of different interventions were associated with less commitment to or perseverance with any particular intervention.

f) After-care. During Hume and Platt's (2007) study, participants were encouraged to think of ideal interventions for their self-harm and it was noted that they were able to make decisions about their care as well as after-care. Participants who received after-care often faced long waiting lists for therapy and felt frustrated by the delay between discharge and their first appointments with community services. Smith-Gowling, Knowles and Hodge (2018) reported that young people were mostly positive about after-care and welcomed the opportunity to talk. They spoke of the need for more mental health professionals working in hospitals and local facilities in order to decrease waiting times, and argued that it was essential for services to be as accessible as possible in the community. Hume and Platt (2007) found that patients without significant support from family and friends, in particular, feared that they would re-engage in self-harm while waiting for an appointment. Overall the participants in their study reflected diverse experiences and attitudes relating to interventions following admission but, despite this diversity, there was a shared preference for specialist community-based interventions focusing on providing immediate after-care. In their systematic review, Taylor *et al.* (2009) identified staff knowledge, communication and better after-care

arrangements as particular features of care that might increase service user satisfaction. The authors added that many participants suggested psychosocial assessments and access to after-care needed to be improved.

1.8.6 Scoping literature limitations. Several limitations of the studies included in this preliminary literature were reported. Lindgren *et al.* (2004) noted that their findings were based on a small sample of women from a very limited population and that the directed and targeted questions included in their data collection could have been leading. Schoppmann *et al.* (2007) also observed that all the participants in their study were women and highlighted the subjectivity of understanding from the authors' perspective. In Smith-Gowling, Knowles and Hodges' (2018) study, inclusion was limited to those participants proficient in English and hence the findings of the study may not apply to young people who self-harm but who have not yet come to the attention of services. Recruitment across the two inpatient sites used in the study was also unbalanced, which meant the interview conducted at the second site may not have been representative of other young people's experiences of that ward. Limitations in Horrocks *et al.*'s (2005) study were noted, including the fact that only one in ten patients contacted agreed to be interviewed. Many interviews and appointments were cancelled or not attended. The results therefore may not have provided the extensive range of experiences that the researchers had aimed for. In addition, the method of recruitment may have led to participants being skewed towards those who were disgruntled with their treatment. Hume and Platt (2007) reported on a relatively small scale study and admitted that the provisional nature of their findings would benefit from further confirmation or dis-confirmation via a larger scale study. Limitations within Taylor *et al.*'s (2009) systematic review centred on the variety of methodologies used in the studies which made it somewhat difficult to draw accurate comparisons between them.

1.8.7 Concluding comments on the preliminary literature review. The preliminary review was conducted in order to 'scope' the field relating to young people's experience of inpatient care when presenting with self-harm. The research reviewed highlighted a number of concepts; however, there was very little published investigation specifically targeted at the young person's experience. There may of course be unpublished research in this area. Participants in the studies included in the review generally reflected on the transactional nature of an admission, mostly in terms of interactions with staff, but also in relation to their sense of agency, autonomy and value. The milieu was also regarded as an important part of the experience. The literature review yielded studies reporting on a variety of subjects: adult women's experiences of inpatient care when presenting with self-harm; accounts by those attending hospital following an episode of self-harm; views on interventions offered for those who self-harm; repertoires of interactions between patients and staff; and the young person's experience of being exposed to others' self-harm in these settings. In addition, a systematic review of attitudes towards clinical services among people who self-harm was also included. Limitations of the studies were also noted. Until now, no known published study has focussed specifically on exploring young people's experiences of inpatient care when presenting with self-harm. Consequently, obtaining information about this area of research is important. It is likely to have a significant impact on the provision of care and services for these young people. A concluding comment, however, in relation to the current study and grounded theory methodology, is that it was necessary for the researcher to be careful to ensure that the aforementioned themes and categories from the literature actually existed in the study data in order to avoid imposing pre-existing ideas and theories onto it (Giles, King & de Lacey, 2013).

1.9 SUMMARY OF THE CHAPTER

This chapter provided an introduction to the study. Some key terminology was defined and a brief overview of self-harm in young people, including prevalence rates and risk factors as well as current service provision, was presented. A short reflection on the government agenda and the need for obtaining young people's views followed. Finally, a preliminary 'scoping' literature review, which included seven research papers, highlighted several concepts including individuality and uniqueness; autonomy, control and collaboration; understanding; trust; environment and interventions; and after-care. The limitations of these studies were also reported. A suitable grounded theory methodology for the research paper was identified and the following chapter describes this in more detail.

Chapter 2: Methodology

2.1 Chapter Overview

This study aims to explore young persons' experiences of inpatient care when presenting with self-harm. The goal is to integrate the factors that contribute to their experiences into a theoretical model and, in so doing, improve current understanding. The model also intends to provide a theory of how these factors interact with each other. The theory is derived directly from the young people's responses. A constructivist grounded theory approach (Charmaz, 2006) is used as the means of achieving the study aims. A description of the grounded theory philosophy, why it was chosen, and how it is conducted is presented in this chapter. Elliott *et al.* (1999) provides guidance on ensuring the quality of qualitative research, which is outlined in the chapter. A brief comment on the researcher's position is also included and an overview of some of the potential ethical issues is provided alongside a description of the interview process.

2.2 Philosophy Of The Approach

A necessary starting point of enquiry is establishing whether the philosophical assumptions that underlie the research method fit with the researcher's own view (Koch, 1995). This view is set out below. Saunders, Lewis and Thornhill (2009) submit that research philosophy relates to the nature of knowledge and how it is developed. The researcher's philosophical perspective and assumptions affect beliefs about how knowledge and social behaviour is "uncovered". The research is guided by paradigm, the basic belief system or world view of the researcher, which is the overarching framework that organises the researcher's world (Heron & Reason, 1997). The formulation of a research question and the selection of methods in order to answer this question is influenced directly by the research philosophy adopted, and thus, it forms the basis of the research process (Bryman and Bell, 2011). The adopted philosophy guides the choice of the research method used and offers a particular standard against which to evaluate the quality of the research (Rubin and Rubin, 2012).

Two key concepts in research philosophy are ontology and epistemology. Guba and Lincoln (1994) state that one's ontological position relates to a view of whether reality is objective and external to human beings or if it is instead created by one's own consciousness. Thus, it references the form and nature of reality, and what one can know about reality. Epistemology, in turn, is concerned with how knowledge can be acquired and what it can be understood to represent. It is contingent upon whether one takes the view that knowledge is a hard body of objective reality or whether it is a subjective experience connected with the nature of the relationship between the "knower" and the "known" (Guba & Lincoln 1994). These definitions likely simplify the terms into binary positions, but it is likely more complex and most research could be placed on a continuum between the poles (Bakker, 2019). It stands to reason that the

research methods are embedded in commitments to a particular view or version of the world and ways of knowing that world (Usher 1996). The methodology stems from how the researcher believes knowledge can be gained. For instance, two main terms that have historically been used to describe differing perspectives on the nature of reality or the world are “positivist” and “interpretivist” approaches (Broom & Willis, 2007).

Auguste Comte coined the term positivism and the positivist stance believes that social behaviour is governed by universal laws and that knowledge should be treated as objective (von Wright, 1971). New epistemologies have been pursued as challenges to positivist approaches have increased, and there has been greater interest in examining methodologies which originate from interpretive enquiry, and which attempt to substitute scientific ideas of prediction, explanation and control with the notions of meaning and understanding (Carr & Kemmis, 1986). Interpretivists are more sceptical of generalisations, and place importance on social interaction where consequences may be more difficult to predict. From an interpretivist stance, the focus is on interdependence rather than independence and knowledge is understood as part of the coordinated activities of the social actors involved (Gergen & Gergen, 1991).

Constructivism and interpretivism are terms that appear in the vocabulary of social science methodologies and form a loosely connected family of methodological and philosophical persuasions (Schwandt, 1998). The goal here, and in line with the current study, is to understand the complex world of lived experience from the point of view of those who live it. Schwandt (Ibid) states that constructivists or interpretivists believe that to understand this world of meaning one must interpret it and thus share a general framework for human inquiry. These terms therefore share a common intellectual heritage. Constructivists argue that what is viewed as objective and ‘the truth’ is in fact

the result of perspective (Ibid). Importantly for the current research, this means that knowledge and truth are created, not discovered, and that there is a pluralistic character to reality. In essence, constructivism means that human beings do not discover knowledge so much as construct or make it.

As the current study is embedded within the constructivist philosophy, caution is exercised with regards to one-sided interpretations. Instead, emphasis is placed on the construction of theory. The research, in as much as it is qualitative, steered towards trustworthiness and credibility (Cope 2014). Curtin and Fossey (2007) and Cope (2014) suggest that, from the aforementioned qualitative perspectives, the researcher needs to ensure that findings are a true reflection of a lived or personal experience of the phenomenon being investigated and thus, they too emphasise trustworthiness.

In addition, and in particular alignment with the current researcher's stance, the researcher is engaged in the process and is required to enter the world of the research participants (Silverman, 2000). The researcher is immersed in the research and it is therefore vital to reflect on the ways in which personal values, experiences and beliefs shape the understanding of the experiences of research participants, and to maintain a critical and open-minded approach (Miles & Huberman, 1994). The researcher's position is further guided by a reflexive approach which allows for reflection on his personal, individual point of view. As previously mentioned, it has been argued that a researcher's involvement in research inevitably and fundamentally influences the process and the findings (Willig, 2001). In the current study, it is the researcher's view that he is unable to remain a completely unbiased observer in the process of theory development and it is for this reason that a comment on his position is offered later in the chapter.

2.3 Why Use A Qualitative Approach?

Pope and Mays (2006) highlight that the contribution qualitative approaches to research make to knowledge is increasingly accepted. The study aims are reached through the use of a qualitative methodology and complex details in young persons' experiences are explored in depth and, in so doing, gaps in the existing literature are addressed. When seen against the aforementioned epistemological and ontological backdrop, it is the researcher's view that it would be difficult to capture the essence of these experiences and understand them using traditional quantitative or even traditional qualitative methodologies. The study intends to develop a theory by constructing a model of the factors that underlie to young persons' experiences from their perspective, and so a constructivist methodology was deemed appropriate; or, to be more specific, constructivist grounded theory (Charmaz, 2006). This is expanded on in the following section.

2.4 Grounded Theory

2.4.1 Introduction to grounded theory. Grounded theory methodology is a qualitative approach that seeks to develop a theory grounded in systematically collected and analysed data (Ramalho *et al.*, 2015). As mentioned, the approach adopted in the current study is that of Charmaz' constructivist grounded theory methodology (2006). However, it is important to note that the history of grounded theory involves two previous permutations: traditional or classical grounded theory methodology; and evolved grounded theory methodology (Ibid.). In 1967, the sociologists Glaser and Strauss developed grounded theory in response to failings of the predominant positivist paradigm in describing experiences in the social sciences (Glaser & Strauss, 1967). These scholars argued that the prevailing methods of enquiry, aimed at testing

hypotheses driven by existing theories, did not accommodate newer ways of understanding phenomena and nor did they provide rich descriptions of relationships or concepts within the social world. Glaser and Strauss (1967) introduced the idea whilst studying interactions with terminally ill patients in a hospital setting. It was during this study that they created a method aimed at constructing a theory rather than testing hypotheses (Ramalho, 2015). They developed a method of simultaneous data collection and analysis that allowed for the development of a theory grounded in the data (Glaser & Strauss, 1967).

Common to all three variations of grounded theory methodology is the emphasis on the theory emerging from the data. Differences relate, however, to how the authors view the influence of the researcher within the process. Following its inception, Glaser further developed the classical or traditional grounded theory approach whereby he continued to emphasise the objectivity of the researcher in the sense that they should approach the subject under study without preconceived notions which could contaminate the analysis of the results (Glaser, 1992). He argued against categories being constrained or inhibited by prior knowledge or reading. Strauss diverged from Glaser and, along with Corbin, suggested that theoretical sensitivity or researcher bias is unavoidable to some degree and that it could in deed helpfully acclimatise the researcher to key ideas and concepts within data (Corbin and Strauss, 2008).

The degree to which researchers can be removed from the research and indeed the extent to which they should engage with literature on the subject prior to data collection, is questioned by Charmaz (2000). She disputed whether grounded theory could be conducted with no prior assumptions or biases. Despite their divergences regarding the methodological approach, these theorists remained connected by the shared core notion

that, in order to produce a grounded theory, it is vital to allow such theory to emerge or to be discovered, and to avoid "contamination" of the research product by the researcher (Ramalho, 2015). Glaser and Strauss take the stance that there is an objective theory which exists independently from discovery or perception and that the researcher can purge preconceived ideas and assumptions (ibid.) This idea of objectivity is, in a sense, epistemologically more aligned with positivism or post-positivism (Lincoln, Lynham & Guba, 2011). These authors argue that knowledge is constructed in nature and inextricably linked to researchers and their interactions with others and the environment (ibid.). Charmaz (2003) explicitly bases constructivist grounded theory on the research paradigm in which knowledge is constructed in the process of social exchange. In the case of constructivist grounded theory, it is suggested that eliminating the researcher's influence from the research process is impossible (Ramalho, 2015).

To summarise, constructivist grounded theory, like classical and evolved grounded theory, is an inductive approach. Participants' reports on their experience, as well as their social worlds, are explored through questions targeted at identifying concepts and understanding the relationships between these concepts within the reports. There is no attempt to confirm or disconfirm any hypotheses but instead, by following a set of guidelines, grounded theory constitutes a process during which the researcher aims to identify themes in a set of unstructured data through systematic analysis (Charmaz, 2006). Sense is made of participant experience by organising themes into a theoretical explanatory system which is 'grounded' in the data. An important tenet for Charmaz, though, is that the researcher cannot be removed from data collection and analysis, and thus the resulting theory depends on the researcher's view and its groundedness results from the researcher's commitment to analysing what they actually observe in their data (Charmaz, 1990).

2.4.2 How grounded theory is used in this study. As discussed in Chapter 1, a preliminary ‘sensitising’ literature review was conducted early on in the study. The goal was twofold. Firstly, it sensitised the researcher to important areas that could inform data collection and, secondly, to improve the researcher’s cognisance of relevant themes when analysing this data. In addition, as Charmaz (2006) highlights, the theory is “constructed” within the context of the researcher’s experiences, perspectives and relationships to the data. Consequently, it is important to carefully document the research process at every stage in order to reflexively consider the researcher’s relationship with the data (Ramalho, 2015). This is done to increase transparency with regards to the researcher’s influence on the construction of grounded theory (Pidgeon & Henwood, 1996).

2.4.3 The motivation to use grounded theory? Corbin & Strauss (2008) propose that grounded theory is suited to enquiries where little is known about the phenomenon under investigation. The paucity of published research on young persons’ experiences of inpatient treatment when admitted for self-harm is striking. The current research draws upon the young persons’ multiple perspectives and subsequently integrates them into a single theoretical understanding of this experience. The stance taken by the researcher was to explore these views and experiences without holding preconceptions about what these may be, but to acknowledge that he has previous knowledge due to his position and occupation. By drawing on a variety of young persons’ perspectives, it is argued that one is able to gain a rich understanding of the experience and the complexity held within. The grounded theory approach was adopted so that the perspectives raised by the young people could be explored in depth with a view to enhancing understanding and developing the theory (Strauss & Corbin, 1997).

2.5 The Implementation Of Grounded Theory

2.5.1 Data Collection. Grounded theory is compatible with a range of data collection techniques (Willig, 2001). Semi-structured interviewing, participant observation, focus groups, diaries and almost any other form of qualitative material can generate data for grounded theory (Pidgeon, 1996). Recorded interviews are common means of collecting data. These are then transcribed verbatim in order to retain detail and minimise any data reduction prior to analysis (Willig, 2008). Individuals can be guided to give a focussed and detailed account of their experiences through the use of semi-structured interviews. The nature of these interviews allows for a flexible approach that contributes to free and open disclosure of information and therefore facilitates broad and deep data, less constrained by pre-determined themes (Willig, 2008).

2.5.2 Open coding and categorisation. As suggested in the section above, data is analysed in segments, which are categorised in order to both summarise and account for each piece of data and to show how the researcher has selected, separated and sorted data to begin an analytical accounting of them (Charmaz, 2006). The process of open coding occurs in the early stages of analysis and is the pivotal link between collecting data and developing an emerging theory to explain these data (Ibid.). The researcher is able to capture the detail, variation and complexity of the data and it involves reading the data repeatedly and asking questions of it (Strauss & Corbin, 1998). Words, phrases, sentences or longer segments are arranged in meaningful units and then labelled as categories (Willig, 2008). Initial coding should stick closely to the data rather than applying pre-existing categories to them (Charmaz, 2006). Charmaz describes fit and relevance as advantages of initial coding, whereby the study fits the empirical world when codes are constructed, and is relevant when an inclusive analytical

framework is offered. She also highlights that the researcher is forced to think about the material in new and innovative ways (Ibid.).

2.5.3 Constant comparison. Constant comparisons are made during data coding and categorisation in order to explore similarities and differences with existing categories (Glaser & Strauss, 1967). This process ensures the coding practice maintains its momentum, moving back and forth between these similarities and differences (Charmaz, 2006). New categories or subcategories will be identified, and categories are not only built up, but can also be broken down again into smaller units of meaning (ibid). Charmaz highlights considering multiple interpretations of the data throughout the process so that the full complexity and diversity of the data can be recognised. The ultimate objective of constant comparative analysis is to link and integrate categories in such a way that all instances of variation are captured by the emerging theory (Charmaz, 2006).

2.5.4 Theoretical sampling. Theoretical sampling involves collecting further data in the light of categories that have emerged from earlier stages of data analysis. Charmaz (2006) describes theoretical sampling as seeking out pertinent data to develop an emerging theory. Data collection is guided by simultaneous analysis as key themes guide the process. As this analysis progresses, theoretical sampling contributes to the development of the properties of the categories until no new properties emerge (Ibid.). Theoretical sampling is concerned with the refinement and, ultimately, saturation of existing, and increasingly analytic, categories and therefore directs the researcher where to go (Ibid.). In essence, the researcher analyses initial data and, based on this analysis, continues to collect data which confirm or disconfirm what is found.

2.5.5 Focussed coding and theoretical saturation. Moving towards more directed and selective and conceptual codes is known as focussed coding (Glaser, 1978). It occurs when the initial codes emerging from the open coding process are synthesised in order to explain larger pieces of the data. Charmaz (2006) describes using the most significant and/or frequent earlier codes to sift through larger amounts of data, which requires more decision making about which of the initial codes are most appropriate to categorise the data incisively and completely. Strauss and Corbin (1998) explain that focussed coding brings data back together in a coherent whole following the fragmentation that has occurred through the process of the initial coding. Theoretical sampling and focussed coding continue until theoretical saturation where no new categories are identified and any additional data only serves to confirm what has already been found (Strauss & Corbin, 1998).

2.5.6 Memo writing. Memo writing is an important part of the grounded theory method and is a pivotal intermediate step between data collection and writing papers (Charmaz, 2006). Throughout the process of data collection and analysis, the researcher maintains a written record, or memo, of theory development. Charmaz describes this as catching one's thoughts, capturing comparisons and connections and crystallising questions and directions the researcher can pursue (Ibid.). Writing memos means writing definitions of categories and justifying labels chosen for them, tracing their emergent relationships with one another, and keeping a record of the progressive integration of categories and their subcategories. In essence, writing memos provides an opportunity to become actively involved and engaged in the data and to develop and fine-tune subsequent data gathering. Pidgeon and Henwood (1996) describe memos as essential in terms of guiding the researcher's understanding as well as keeping to the analytic process. It is a process that allows the researcher to explore ideas about the

emerging categories and forms the core of the grounded theory. Indeed, Glaser later viewed the writing of theoretical memos as the 'core stage' in the process of generating theory, with memos defined as the theorising write-up of ideas about codes and their relationships as they strike the analyst while coding (Williams & Keady, 2012).

a) *Diagramming.* Charmaz (2006) reflects on the notion of adding concrete images of one's ideas in memos. Strauss and Corbin (1998) treat this part of developing a grounded theory as an intrinsic part of the methods. A variety of diagramming methods such as maps, charts and figures are used in order to explore relationships whilst constructing their analysis and to demonstrate these relationships in completed work. They enable one to see the relative power, scope and direction of the categories in the analysis as well as the connections between them. Diagrams can illustrate the structure and purpose of a theory and are able to clarify the theoretical structure (Morse, 2006). Diagrams were used during the analysis of the current study data with the intent to make sense of any categories and interpretations that emerged (draft diagrams are also included in appendix 4).

2.6 The Focus On Research Quality/Publishability

Qualitative research is commonly criticised as subjective, anecdotal, subject to researcher bias and lacking generalisability or transferability but, from a qualitative perspective, credibility and trustworthiness take precedence over concepts such as rigor or validity (Cope, 2014). The underpinning philosophy of qualitative research addresses complex problems such as perception and experience; it therefore seems prudent that qualitative researchers avoid using quantitative terminology. In qualitative research, strategies are incorporated to improve trustworthiness, including triangulation and reflexivity (Johnson & Waterfield, 2004). Qualitative research is, by its very nature,

interpretive and this leads to criticism that it may lack credibility or be unsystematic (Pope & Mays, 2006). Elliott, Fischer and Rennie (1999) propose a set of guidelines for ensuring the legitimacy, validity, credibility and quality of qualitative research in order to obtain publishability. Their aim is to reassure traditional quantitative researchers that qualitative research is methodologically rigorous. These guidelines are briefly summarised below along with how they were applied in the current study. They further guide reflections on the quality of the study in chapter 5.

2.6.1 Owning one's perspective. In order to help readers interpret the researcher's data and understanding of them and consider alternatives, researchers specify their theoretical orientation and anticipations (Elliott, Fischer & Rennie, 1999). As Willig (2008) emphasises, it is important to remain aware of the researcher's contribution to the construction of meaning throughout the research process and to acknowledge the impossibility of remaining outside of the research matter while conducting it. To this end, the researcher provides a narrative of his position below. In addition, a reflective diary tracking the researcher's assumptions, thoughts and feelings during the research process aided reflexivity (see appendix 5 for an excerpt of the research diary).

a) Researcher's position. In line with these guidelines, it is imperative to consider the ways in which one's position may influence the data analysis and interpretations thereof. How the research is positioned epistemologically and ontologically has already been reflected on in Chapter 2. In order to facilitate further transparency, the researcher position is further laid out here. He is a 41-year-old white male from a middle class South African background who immigrated to the UK in 2006. He is working as a registered clinical psychologist and has been practicing for 14 years with a special interest in young people presenting with self-harm. Most of his experience

as a clinical psychologist has been in inpatient settings. Prior to commencing his current role as principal CAMHS clinical psychologist, he worked in an adult female acute inpatient unit specialising in personality disorders and those presenting with self-harm. It was here that he developed his interest in self-harming behaviours and the factors that could contribute to improved outcomes for these service users. His experience of a relative paucity of research into how young people experience their care and admission led to an interest in developing this field. This interest was further inspired during talks with the researcher's clinical supervisor and an on-going service-wide focus on developing care-planning and treatment for young people presenting with self-harm.

The researcher was reminded of Charmaz' (2006) comments that differences between the interviewer and research respondents in terms of race, class, gender, age and ideologies may affect what happens during the interview. The researcher shares this constructivist stance and views knowledge as emerging within the social interaction. It is striking that there is a higher prevalence of young females admitted to hospital who self-harm and, as a male researcher, it was important to consider whether gender would have an impact on the knowledge discovered. It is acknowledged that the Trust interest in care-planning may have impacted on initial questions, however, the grounded theory methodology allowed for data to emerge independent from this focus.

In addition, the researcher acknowledges his struggle with the researcher/practitioner dilemma described in more detail in section 2.7.2. Approaching young people from the researcher perspective is an underestimated departure from the role of psychologist. The researcher, through the use of a reflexive diary already spoken about above, noted an internal struggle in terms of this departure. The complex role of holding in mind duty

of care and own expectations against research objectives when hearing about the struggles of the young people is indeed a challenge.

In summary, there were three main areas that arose, meriting further reflection:

- The researcher's own position: As discussed in the philosophy of the approach in section 2.2, owning one's perspective in section 2.6.1 (a) and the researcher practitioner dilemma below in section 2.7.2.
- Data collection: This is seen alongside the philosophy of approach in section 2.2, the consideration of expectations discussed below in section 2.7.2 and in terms of how the influence of being a clinical psychologist may have had on how the interviews are conducted. This is considered as it would of course be very difficult to suspend any interviewing skill gained through years of clinical experience during the collection of data. This may have influenced how young people responded to the questions. This was held in mind through the use of the reflexive diary and also through conversations held between the researcher and clinical and academic tutors.
- Analysis: As mentioned, from a constructivist perspective, the influence of the researcher's experience on how the data is analysed and interpreted is not denied or necessarily undesirable. It is entirely possible that the same data could be analysed differently. It is, however, felt that, through the use of reflexivity and deliberate awareness of this influence, that the data remains a true reflection of the voice of the young people being interviewed.

2.6.2 Situating the sample. Describing the research participants serves to help the reader judge the range of persons and situations to which the findings might be

relevant (Elliott *et al.*, 1999). A ‘pen-portrait’ of the young people who were included in the current study is presented in the Findings chapter.

2.6.3 Grounding in examples. Examples of data collected in the current study are provided in order to illustrate how they contribute to the analytical procedures used in the grounded theory. This intends to show the understanding and interpretation developed in light of them. Grounded theory is grounded in the data, and the examples allow readers to conceptualise possible alternatives, meanings and understandings. Chapter 3, in which the findings of the current study are reported, includes direct quotes from the young people recorded verbatim in order to help illustrate how the categories and concepts were generated and to demonstrate the analytic process (see appendix 6 for an extract of an interview transcript).

2.6.4 Providing credibility checks. Researchers can make use of several methods to check the credibility of the categories (Elliott *et al.*, 1999). In the current study researcher-supervisor discussions about the emerging categories and concepts contributed to credibility. A sample of the participant transcripts was also analysed separately by the clinical supervisor and the categories and themes compared with those found by the researcher. Different perspectives were sought not only achieve validation, but also to widen the researcher’s own understanding (Olsen, 2004).

2.6.5 Coherence. The presentation of data, analysis, findings and understanding generated within the study should be integrated and presented in a way that forms a data-based story, framework or underlying structure (Elliott *et al.*, 1999). The data should therefore not only be presented logically, but should also retain its nuances (*ibid.*). Written representations alongside diagrammatic illustrations of the data are provided in

the findings chapter. Regular review with the academic tutor and clinical supervisor facilitated the construction of the grounded theory.

2.6.6 Accomplishing general vs. specific research tasks. Elliott *et al.* (1999) suggest that researchers need to be clear about whether they are commenting on a general understanding of a phenomenon or a specific instance. In both cases the limitations of the applicability of the findings beyond the original context need to be made explicit. Pidgeon and Henwood (1996) highlight that an appropriate range of participants is necessary where the aim of research is to generate a general understanding. However, systematic and comprehensive descriptions are required where a specific understanding is sought. The aims of the current study have already been presented and a summary of the participants is provided in the Findings chapter. The outcomes of the analysis are clearly shown in the presentation of the findings and the limitations to the generalisability thereof is highlighted in Chapter 5.

2.6.7 Resonating with the reader. Elliott *et al.* (1999) state that the findings of the research need to be presented in a way that stimulates resonance in readers and reviewers who should be able to judge it to have represented the subject matter accurately or to have clarified or expanded their appreciation and understanding of it. Draft versions of each chapter were read by the researcher's clinical and academic supervisors and the study was then read by an academic tutor in an attempt to make sure resonance was attained.

2.7 Ethics

2.7.1 Approval. As discussed previously, there is current interest in improving the standard of care provided to young people presenting with self-harm and admitted to hospital. Within the Trust in which the researcher is situated, a self-harm specific care plan and nurse training is being implemented alongside an audit of the intervention. The current research ran alongside this, but aims to build an understanding of young persons' experiences in hospital when presenting with self-harm through the construction of a grounded theory emerging from the data, as opposed to auditing the intervention itself. Although it is common and usual practice to engage with young people in terms of obtaining feedback on services and input with regards to their experiences, ethical approval was sought for the current study from the Local NHS Clinical Audit and Ethics Committee and was granted in May 2018 (see appendix 1). Approval was also sought from the University of Essex Ethics Committee which was granted in July 2018 (see appendix 7). The Trust in which the study was conducted regularly and routinely runs research, audit and service development initiatives. The current study falls within the already well-established protocols and procedures used in support of these endeavours.

2.7.2 Researcher/practitioner dilemma. Further consideration of a potential ethical dilemma associated with being both a researcher and practitioner within the inpatient units incorporated in this study warrants attention. Qualitative research, and constructivist grounded theory especially, by its nature involves close engagement with participants, therefore providing the context for boundary issues to arise (Thompson & Russo, 2012). All efforts were made to remain objective, but it is understood and accepted that total objectivity is not possible. This acceptance is in line with

constructivist grounded theory. It is important to reflect on the differences in purpose of a therapeutic encounter and the research encounter within the context of the inpatient site. The research encounter has as its goal the collection of information which in itself may not be directly focused on the needs of the young people. It is of course entirely possible, that the young people retained expectations that the researcher could bring about change as opposed to solely collecting information on their inpatient experience. It was therefore important to describe the role clearly to the young people in order to combat any possible therapeutic expectations.

For the researcher, being reflexive is an aide used in order to facilitate efforts to put aside personal feelings and preconceptions, and helps keep in mind the effects that his own experiences has on the research process. No individual therapeutic work was offered as a practitioner by the researcher to those young people who agreed to be included in the study. Any individual therapeutic work was offered and conducted by other qualified, appropriate and suitable professionals on the unit.

2.7.3 Young person safety and maintaining confidentiality. The researcher tried to anticipate any adverse effects on any of the young people who participate in the study. A protocol was developed following discussions with managers on the units where the study takes place in order to mitigate any potential problems. It is acknowledged that some of the content of what was being discussed could be of a sensitive nature and could have led to some distress. Before conducting any interviews, the young people were asked to confirm again that they were happy and willing to take part. They were also offered the option to be accompanied by another member of staff to the interview if they so desired. Although breaks were offered routinely, the researcher also remained watchful for any mood changes or need to stop the interview. There were

no incidents of challenging behaviour or emotional distress. Young people were encouraged to ask that the interview be stopped or delayed if they became upset or did not want to carry on with the interview. Support put in place for the young people included the researcher directing the young person to the unit manager or other suitable professional, should the need arise. The young people were provided with a participant information leaflet (see appendix 8) prior to commencing the study and were assured of their anonymity and that all identifying information would be removed from the transcripts. Although the findings from the study would need to answer the research objective, they would also need to be relevant and practical to those young people who took part.

Conducting studies involving service users who are experiencing high levels of distress can present ethical dilemmas. The safety and care of the young people occupied the highest priority at all times. Information governance procedures were in place and, as mentioned, data was anonymised. Confidentiality of all the young people was ensured during the research process. The researcher adhered to the Data Protection Act (1998), the British Psychological Society Code of Ethics and Conduct (BPS, 2009), and the British Psychological Society Code of Human Research Ethics (BPS, 2011). In addition, he adhered to the UK policy framework for health and social care research (DoH, 2017), as well as ethical guidelines for research set out in the University of Essex code of practice for postgraduate research (University of Essex, 2017).

Confidentiality was assured, however, the young people were informed of the researcher's duty of care should any information be disclosed that jeopardised their welfare or the welfare of others. They were informed that transcripts would be analysed

by the researcher and excerpts from selected anonymised transcripts would be analysed by the clinical supervisor for the purposes of credibility checking.

It was important to consider the location and environment where the interviews were conducted as the young people may have felt obliged to answer in certain ways given the context of their admission. It was also important to recognise the natural power imbalance between adult (researcher) and young person (participant), and the effect that this may have had on the data collected. Assurances were given that research findings would be fed back to participants if requested and it was recognised that it may be appropriate to disseminate anonymised findings to a wider audience to improve the value of the study.

2.7.4 Agreeing to take part. The British Psychological Society (BPS, 2011) has set out guidance for obtaining informed consent, which the researcher adhered to. The young people were initially assessed for capacity to provide their consent. In line with the Mental Capacity Act [MCA] (1983), young people are assumed to have capacity and to make decisions for themselves unless it is proved otherwise. Capacity was assessed using the MCA (1983) 2-Stage test. Firstly, this included assessing whether the young person had an impairment of their mind or brain, whether as a result of an illness, or external factors such as alcohol or drug use; and secondly whether this impairment meant that the young person was unable to make a specific decision when they needed to. The young people were allowed time to make a decision about whether they wanted to take part in the study and every effort was made to ensure that they understood the information relevant to the study, were able to retain that information, and use or weigh it up as part of the process of making the decision.

Information was presented to the young person, explaining what would happen, what was being asked of them and, depending on whether they then agreed or declined to take part, what that would involve. Assurances were given that there were no adverse consequences in terms of their care should they decline to participate and that they could withdraw from the study at any time. An information leaflet about the study was provided to the participants (see appendix 9 for consent form and appendix 8 for the participant information sheet). Written consent was required and obtained together with parental consent for those young people under the age of 16 (see appendix 10 for parental consent form). Interviews commenced with another discussion of the information that was provided in the patient information sheet and opportunities were given to ask questions prior to the interview.

The consent form ensured that the participants consented:

- That they had read and understood the relevant study information sheet
- That could ask anything that they were unsure about relating to the research
- That they were able to withdraw at any time as their participation was voluntary
- That they understood how confidentiality would be maintained or shared if necessary
- That they had agreed data from their taped interview could be included in the final report
- To take part in the research

Before commencing with the interview, the young people were again guided through the consent form and asked to confirm their consent verbally.

2.8 Design

As already discussed, a qualitative design was adopted in this study, or more specifically, constructivist grounded theory. Data was collected through individual semi-structured interviews with ten young people admitted across two acute psychiatric hospital sites. All young people were invited to an individual interview, led by the researcher. The interview was based on eight main question areas generated from the literature by the researcher and his clinical and academic supervisors (see appendix 11 for semi-structured interview schedule). Through the maintenance of a reflexive approach during the research process and constant comparison, each subsequent interview was directed towards more relevant areas of study. This process is in line with theoretical sampling mentioned previously and the inductive nature of the grounded theory approach (Charmaz, 2006). The individual interviews were audio recorded with consent and then transcribed. The transcripts were systematically analysed for themes emerging from the data which culminated in the development of a grounded theory.

2.8.1 Research Context. The research took place at two CAMHS acute inpatient units. These units, one a 16-bed unit and the other with 9-beds, are located within an NHS Trust in the South of England. The units are geographically separate. They are managed and staffed by their own teams. The organisation and structure of the units are consistent across the Trust, with operational managers and lead managers meeting regularly to ensure parity of provision across services. They have similar and closely aligned treatment protocols and procedures, which mitigate any experiences being influenced too heavily by differences in treatment approaches between the units. Staff members include consultant psychiatrists, a medical team, psychologists, occupational therapists, social workers, a family therapist, nursing staff, support workers, administrative, kitchen, cleaning, estates and service management staff. The researcher

was working in one of the units as the lead principal inpatient clinical psychologist. Service documentation describes the aims of the two open units as providing effective in-patient mental health care of high quality for young people aged 12 to 18 through the use of a patient-centred, needs-led approach, with the Care Programme Approach (CPA) guiding discharge planning and aftercare. Both units provide a range of evidence-based therapeutic interventions specific to and dependent on presentation. Psychiatric diagnoses include a range of psychotic and mood disorders, eating disorders, somatic disorders and emerging personality disorders. The research was conducted on two units for two reasons. The first was to increase the transferability of the findings and the second was to obtain increased numbers of young people's views.

2.8.2 Participants. Participants of this study were a convenience sample of young people, aged between 12 and 18 years. Ten interviews were conducted and the predefined definition of self-harm, as described in Chapter 1, was used to direct the sampling. Ethical approval was obtained and subsequent conversations conducted with the senior members of the management teams of the units in order to explain the nature of the study, as well as to share the study protocol and provide an opportunity to ask questions. Based on the exclusion and inclusion criteria, young people were approached on an individual basis. Generic outcome measures, a welcome pack and unit information is routinely provided for all young people admitted to the unit. This is done by a support worker and mitigates the power relationship possible if approached by the researcher. As part of this process, managers proposed that the support worker ask the young person whether they would like to participate, making it clear that the young person was free to agree or to decline without any consequences for subsequent treatment. As the young person was "gate-kept" through this process prior to commencing any treatment or research, the likelihood of coercion was obviated. If agreement was given to the

support worker, young people were only approached for interview at least one week following their admission, which was intended to serve two purposes. The first was to allow time for the young person to be able to comment more effectively on the treatment they had received, and the second was to allow for a “cooling-off” period between agreeing to take part in the research and actual participation, giving them more opportunity to withdraw if they wished to do so. In addition, young people have regular contact with support workers and nursing staff on the unit. For those young people already admitted prior to the research commencing, and meeting inclusion criteria, support workers provided the study information leaflet during usual meetings and offered an opportunity to take part. Again, these young people were approached a week later by the support worker to confirm whether they would like to take part and the same process was then followed as for those new to the unit.

In summary, the following inclusion criteria were applied:

- Young people aged 12 -18 years
- Currently a voluntary or compulsory admission to psychiatric hospital
- Presenting with self-harm as defined in Chapter 1
- At least one week present on the unit
- A level of cognitive ability and verbal communication to be able to give informed consent and understand what was being asked of them so as to participate in the research process voluntarily

The following were exclusion criteria:

- Significant cognitive impairment
- Florid and acute psychosis
- Inability to consent to participating in the research

2.9 Procedure

2.9.1 Interviews. The rationale for using semi-structured interviews has been described above. Intensive qualitative interviewing fits grounded theory methods particularly well as both grounded theory methods and interviewing are open-ended yet directed, shaped yet emergent, and paced yet unrestricted (Charmaz, 2006). The intent was to explore, in depth, experiences of young people in the hospital presenting with self-harm. The interviews were held away from the usual ward area in interview rooms. They comprised broad-stem open-ended questions which had been developed in collaboration with the clinical and academic supervisor. The stem questions were designed to be used flexibly, as the collection of interview data is considered to be an evolving process (Ibid.). Interpretations from early interviews impacted on later data collection, and initial themes or emerging categories required further following up. More direct and focused questions aimed to encourage elaboration and expansion of the responses. This meant that emphasis on particular areas was guided and adapted as a result of data from each previous interview and there was constant refinement of early ideas. The interview schedule included prompts for the researcher to assist the young people in elaborating on their comments.

The semi-structured interview covered several broad areas including:

- Overall experience
- Views on care plans and treatment
- Helpful and unhelpful aspects of care
- Barriers to engagement & involvement in care
- Environment

2.9.2 Interview procedure. Following review of the patient information sheet and upon receipt of consent forms, young people were interviewed in an allocated room located on the assessment and treatment unit, but away from the general ward area as described previously. Interviews were planned to last for an hour. A period of time was offered following the interviews for the young people to have any concerns or questions that may have come up for them answered or discussed. All the interviews were audiotaped and transcribed within two weeks following the interview. Consent for recording was included on the consent form (see appendix 6 for sample interview extract). The time frame for transcribing had been decided in order to ensure that the data remained fresh and the researcher was best placed to analyse the responses as closely to how they were expressed as possible. Demographic was documented separately from the transcripts. Many theory-guided decisions are made throughout the transcription process and this in itself is considered a form of analysis (Riessman, 1993). In order to help the researcher to become immersed in the data, the transcriptions were read several times before initial line-by-line open coding commenced, as described above. The process of transcription was an extremely labour-intensive process, but it is the researcher's view that this was a useful step in remaining close to the data and facilitated constant comparison, as described by Charmaz.

2.10 Summary Of The Chapter

This chapter provided an overview of the research methodology adopted in the current study. It offered a summary of the philosophical approach and stance of the researcher as well as a rationale for the use of a qualitative research methodology and, more specifically, the use of grounded theory. A summary of the grounded theory process was presented as well as an explanation of how it constitutes a suitable method for meeting the aims of the research. There was discussion of some guidelines intended

to ensure the quality of the research, as well as some of the necessary ethical considerations. The design of the research was further elaborated, including a description of the research procedure. The interview process was described. The following chapter provides a detailed analysis of the data that was collected through this process.

Chapter 3: Findings

3.1 Chapter Overview

This chapter aims to present the grounded theory analysis. An initial pen-portrait of participants is provided. The themes generated from the participants' responses about their experiences of inpatient admission when presenting with self-harm are arranged around two major or 'core' concepts. The core concepts, in turn, consist of categories and subcategories. The first core concept is 'Humanness', which captures categories including connectedness, interpersonal factors and intrapersonal factors. The second core concept is 'Restriction', which was generated from comments about hospitalisation, clinical interventions and the experience of dilemmas relating to being in hospital for self-harm.

3.2 Description Of The Young People

This section provides a description of participants in order to aid the reader in assessing the range of young people who took part, and to whom the findings will be relevant (Elliott, Fischer & Rennie, 1999). In order to protect confidentiality and anonymity, participants are referred to by a pseudonym and identifying information was removed. Ten young people consented to take part and agreed to be interviewed. A brief description of each one is provided below:

Participant 1: Amy. Amy is a 15-year-old white British female admitted to hospital for assessment and treatment. She is a voluntary patient presenting with emotional dysregulation, suicidality, and self-harm by cutting and scratching. She has not been diagnosed with a mental disorder; however, working differential diagnoses of emerging emotionally unstable personality disorder, anxiety and depression have been suggested. In addition, questions have been raised regarding a possible autistic spectrum disorder. Amy is from a higher socioeconomic status and lives with her mother and father and is an only child. She has refused to attend school and had not attended over a period of 3 months prior to admission. Following a series of overdoses and non-accidental self-harm she was referred for admission. This referral was made by the medical team from a general hospital where she had presented at A&E. She had not been known to mental health services prior to this. Amy was interviewed two weeks after her date of admission.

Participant 2: Cindy. Cindy is a 16-year-old white British female admitted for assessment and treatment. She was under the care of the Assertive Liaison Outreach Team, but has been unable to maintain her safety, presenting with severe self-harm and suicidality. She cut her arms and legs severely, with the resultant injuries needing suturing and on-going medical treatment and monitoring. She had been detained under Section 2 of the Mental Health Act (MHA) at the time of admission, and subsequently appealed against this. This was Cindy's first admission and she was unhappy about being brought into hospital against her will. Cindy has a working diagnosis of emerging emotionally unstable personality disorder. Cindy lives with her parents and is the second of three siblings. Her parents are affluent, well-educated and both work in high-responsibility roles. Cindy was interviewed one week after her date of admission.

Participant 3: Susan. Susan is a 17-year-old mixed-race British female admitted to hospital for treatment. She is currently a detained patient under section 3 of the MHA. On admission, she presented with self-harm behaviours that included cutting, burning her skin, scratching and picking at the scars. She was also intermittently suicidal. This is Susan's third admission to a mental health unit. She had been briefly discharged to community services for a two-week period but struggled to cope and was readmitted after engaging in further self-harm. Susan is a 'looked after' child, living with foster parents who also house three other young people with mental health difficulties. Susan was interviewed two months after the date of her admission.

Participant 4: Lisa. Lisa is a 17-year-old white British female who was admitted to hospital following an episode of depression and several episodes of self-harm. She has previously been detained under the MHA for a short period. During this admission, however, the section was rescinded. Lisa is one of two siblings. Her parents are separated. They are from a middle-class socioeconomic status and both work but, for a variety of reasons not appropriate to share for the purposes of this study, Lisa is unable to live with either. Her discharge from the unit has been delayed whilst social services investigate an appropriate placement prior to discharge. Lisa presented with several disinhibited behaviours at the time of her admission, of which self-harm by scratching and cutting was one facet. During her admission, her diagnosis was reviewed and changed to one of emerging emotionally unstable personality disorder. Lisa was interviewed five months after her date of admission.

Participant 5: Karen. Karen is a 17-year-old white British female presenting with long standing episodes of self-harm and suicidality. She has had multiple admissions to different mental health units in the past. Karen will soon be turning 18 and approaching

discharge from the unit and has been accepted by an adult community mental health team. Karen has a working diagnosis of emerging emotionally unstable personality disorder. She is an only child and had been living with both parents before her admission. Her father works and her mother is a stay-at-home parent. They report being financially stable. Karen is well known to CAMHS but is ambivalent about transition to adult services. Karen was interviewed four weeks after her date of admission.

Participant 6: Gail. Gail is a 17-year-old white British female admitted to the unit following two failed suicide attempts and several episodes of self-harm. She is well known to CAMHS and has had two previous admissions, one of four weeks duration, and a second admission for a fortnight. Gail is a 'looked after' child. Her current placement has broken down and her discharge from hospital has been delayed due to no suitable alternative placement being available. She has struggled to remain in mainstream education and receives personal independent payments. Her mental health has deteriorated since being in hospital and she continues to present with self-harm behaviours whilst on the ward. She had a preliminary diagnosis of severe anxiety and depression, but this has now been revised to emerging emotionally unstable personality disorder. Gail was interviewed four weeks after her date of admission.

Participant 7: Maddy. Maddy is a 15-year-old white British female initially presenting to the unit with an eating disorder diagnosis coupled with reports of self-harm behaviours. During her four-month admission, it was revealed that she has engaged in several episodes of self-harm, both on the unit and in the community. She has also been suicidal and absconded from the unit on two occasions. Her diagnosis has been reviewed and she is now diagnosed with an emerging emotionally unstable personality disorder. Maddy is not originally from the UK and moved with her family to England

approximately five years ago. Her mother had suffered an illness and is deceased. She is an only child and lives with her father who is from an affluent upbringing and is the managing director of a large company in the UK. Maddy was interviewed three months after the date of her admission.

Participant 8: Zoe. Zoe is a 16-year-old white British female admitted to the unit following several episodes of self-harm. She was detained under section 2 of the MHA; however, this has since been rescinded and she is consequently a voluntary patient. She has had several admissions to mental health hospitals in the past, both to the current unit and other hospitals. She is well known to community CAMHS and had received community treatment prior to coming into hospital. She lives with her three siblings and both her parents in a middle-class suburban area of London. She has a diagnosis of body dysmorphia. Zoe was interviewed three weeks after the date of her admission.

Participant 9: Paula. Paula is a 17-year-old white British female presenting with a bipolar mood disorder. She has also engaged in multiple episodes of self-harm and her diagnosis is under review as there is evidence of an emerging emotionally unstable personality disorder. She is known to community CAMHS but has not received any psychological treatment through those services despite having been on a waiting list for some months. She has previously received treatment from a private health care provider but did not find this helpful. Paula is an only child and lives with her parents, both of whom have also suffered mental health difficulties and have been admitted to hospital for treatment in the past. They receive disability benefits. Paula was interviewed four weeks after her date of admission.

Participant 10: Jo. Jo is a 17-year-old white British gender fluid young person presenting with self-harm behaviours, including cutting and scratching. Jo has a working diagnosis of emerging emotionally unstable personality disorder. They is a voluntary patient, but was reluctant to stay on the ward and had returned home against medical advice twice since being admitted. Jo presented as highly anxious but was pleasant on approach. They lives with both parents and has a particularly close relationship with their mother. The family live in an affluent suburban area on the outskirts of London. Jo is well known to CAMHS, having received outpatient treatment for anxiety approximately six months prior to being admitted to the unit. Jo was interviewed three weeks after admission.

3.3 Analysis Of Data

A summary of the core concepts, categories and subcategories emerging from the analysis is provided in figure 1. This chapter provides a detailed description of these concepts and categories along with the associated subcategories and includes diagrammatic representations of each throughout. A model of the resulting grounded theory is presented at the end of the chapter showing the links between the different components. Explanations of the concepts and categories are supported using illustrative excerpts obtained from the young person interviews.

As described in the previous chapter, the analysis of the data began with line by line, open coding of the interview transcripts. The resulting categories were then developed through repeatedly comparing individual codes to see if these could be subsumed by a higher order definition that moved beyond description to interpretation.

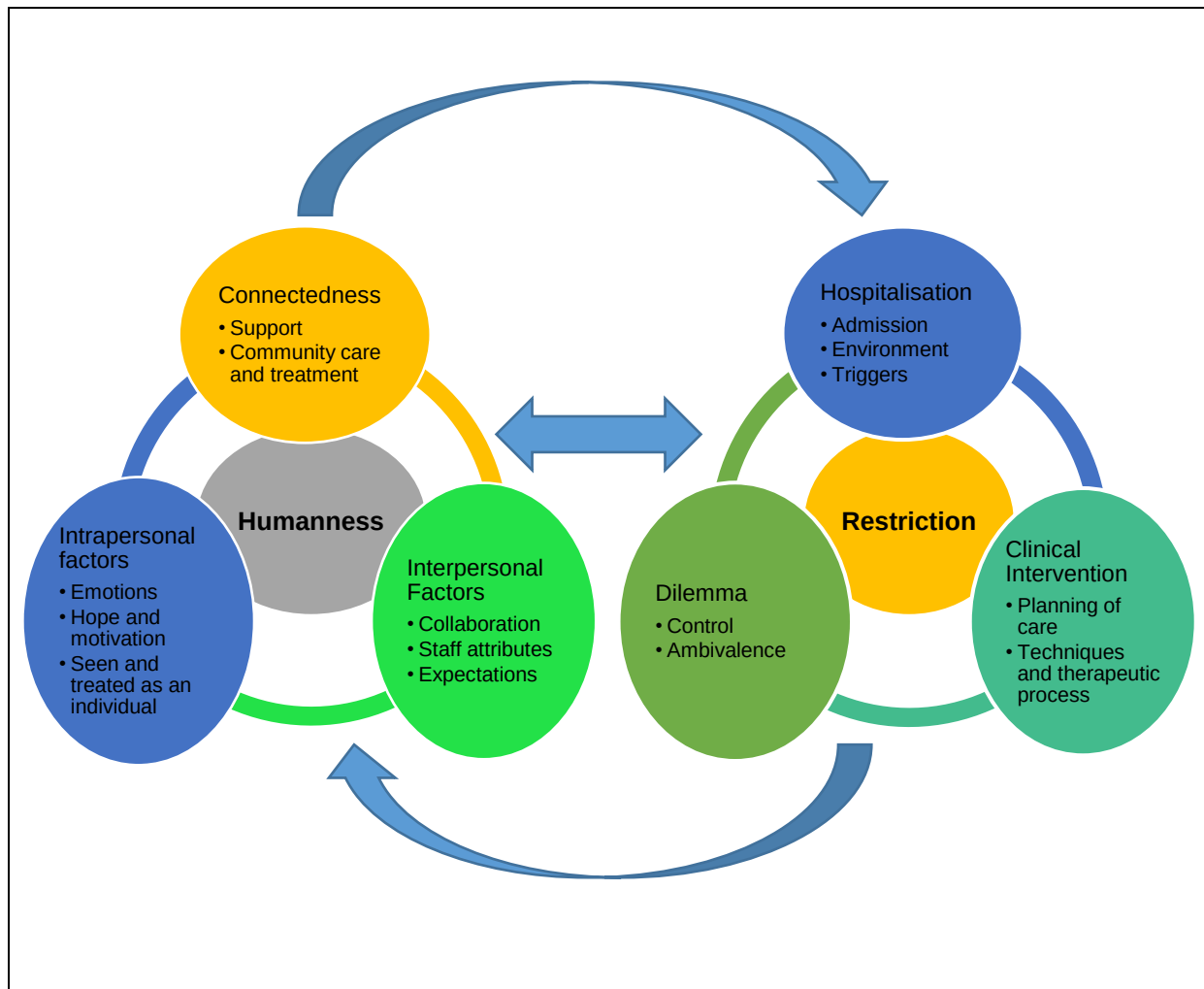


Figure 1: Core concepts of Humanness and Restriction with related categories and subcategories.

At the outset of the analysis, however, a brief comment as researcher: It has been a privilege to hear from the young people who agreed to participate and attempt to understand and make sense of their experiences during their hospital stay. Whilst writing this chapter, it was felt important to keep in mind a comment made by one of the young people during the very first interview conducted for the project:

“We are stuck, sometimes against our own will. And in that moment, I’m just thinking, could you just keep quiet, you just don’t get it. I feel staff think they understand what’s going on inside other people’s lives. But they don’t even know

what it's like to be shoved in a place like this, against your own will sometimes and you can't actually physically leave" (Cindy, line 95).

Of course, it is not possible to understand the experience described completely. It is also true that, from the researcher's perspective, the current study is an attempt to bring together the voices of the young people in order to improve this understanding. Grounded theory allows the researcher to remain close to the actual data and the initial challenge was to suspend preconceptions, and avoid forcing ideas into categories that were more representative of the researcher's assumptions and interpretations than the young people's experiences. After all, as Charmaz (2006) highlights, grounded theorists new to the model often struggle to suspend their judgments. The researcher acknowledges the power dynamic within the relationship and that consequently he is likely to be seen as a 'professional' who is part of the service, and that it is through this lens that attempts to understand the data are made. The researcher was struck by how detailed, open and frank the young people were when sharing their experiences and it is hoped that the analysis does the data justice.

3.3.1 The core concepts. The analysis of the data revealed the emergence of two core concepts which are held in dynamic tension. The concepts and the relationship between them will be explained further below. They represent the conflict and tension between what was wanted by the young people and what was in place or indeed what was needed, but also captures the young people's experiences or perceptions of treatment. This is in terms of their view on humanness and their associated assumptions about what this entails, but also in finding themselves, others, their relationships, the treatment, and support offered as viewed through a particular restrictive lens inherent within the inpatient setting. Figure 2 highlights this contradiction and tension where the young person presents with risk behaviours requiring care and treatment. This is within

what is experienced as a restrictive environment in which management strategies are utilised, against the backdrop of a desire for liberty, control and volition. The experience is underpinned by being 'seen' as human and retaining what constitutes being human in order to allow the young person to engage with and contribute to their treatment and management of self-harm.

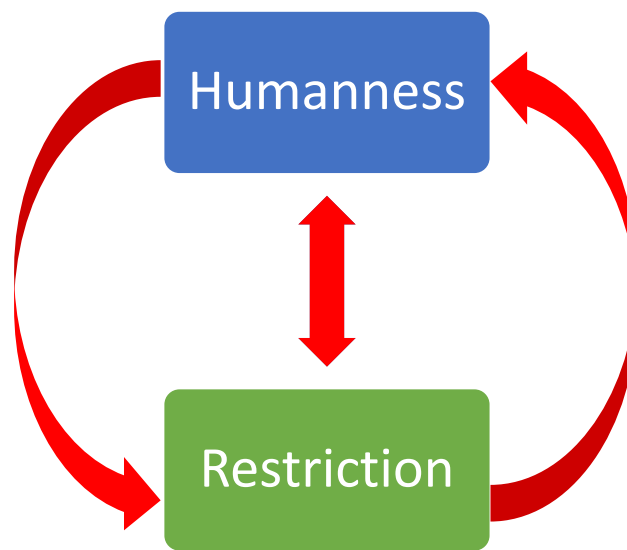


Figure 2: Core concepts, relationship and tension

The concepts and diagram attempt to highlight both the reciprocity and the tension between them. These concepts, and their related categories will be further defined and described in the rest of the chapter. Although initially an attempt is made to define the concepts and categories as discrete, the model presented intends to capture the dynamic nature of the connections between them. What emerged throughout, as will be demonstrated, was a complex and dynamic model, where the components remained in constant interactive relationships.

3.4 Humanness

“Being in hospital, well, sometimes I don’t even feel like a human being any more. I feel like an animal” (Amy, line 303).

The concept of ‘Humanness’, or the young people’s views on human qualities, encapsulates their experiences of connectedness, interpersonal factors and intrapersonal factors whilst in hospital. It contains what could be described as a reciprocal process between the three categories which is further explained in the resulting grounded theory section later in the chapter. Feeling connected to support structures outside of hospital, including community services and family, as well as feeling part of a community, was highlighted and there was overlap between in-hospital relationships with staff and other young people both directly and indirectly. Both were influenced by, and also influenced, internal, intrapsychic aspects. Naming the concept ‘Humanness’ aims to emphasise that the young persons’ stories consistently contained references to “being seen”, respected, valued as human beings, and seen as individuals, as well as highlighting how working within a relational context was important. Young people sometimes described how relationships could impact on their internal states and how having a sense of value and respect remained a key moderator of experience. This section explores the components of this concept in more detail, and is followed by an account of how it links to the second concept of ‘Restriction’.

3.4.1 Connectedness. This category covers how young people felt in relation to their connection with others, the outside world, and their lives outside of the hospital. They viewed this as a factor linked closely to the emergent concept of being human. Connection describes a sense of belonging to a community, or a group, and the belief that they were not separate from the world.

The category also includes young people's perceptions of contact and involvement with resources in the community, of which the following are examples:

"I think you need to still have that connection and contact with people outside, like family and people who care. You don't want to forget about them, because then I feel you would feel much more isolated" (Zoe, line 155).

"...once you've been in here for a while, it doesn't even have to take that long, it's really difficult to get back into the community again. It's like you feel disconnected, you think, oh wow there's still a world outside" (Cindy, line 152).

The connectedness category contained two subcategories, namely 'support' and 'community care and treatment' (Figure 3). The researcher noted that the subcategories were not only part of the connectedness category, but there was an interaction between them and, although defined discretely below, either could be emphasised as impacting on the experience of the young person. 'Support' and 'community care' can in some conversations be seen as synonymous or a continuum of support.

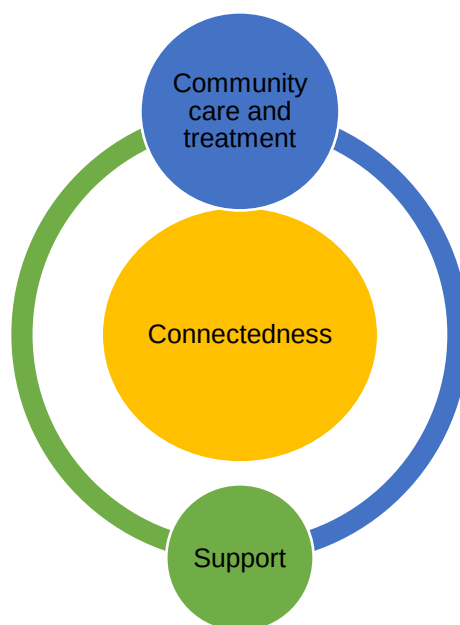


Figure 3: Connectedness and subcategories of support and community care and treatment

a) Support. Young people spoke about the sorts of things that they would perceive as sources of support and how this impacted their experience of connection. They felt that family, peers and engagement had an impact on how they experienced their admission too. In addition, the young people reflected on the support they received from members of staff:

“So, if I’ve had a whole day of finding things really difficult, some staff members will then try and come up and support me. They will ask me if I’m okay because I think it’s kind of noticeable when I’m not in a good mood, very noticeable...it is nice that it is noticed and that it is supportive...staff could then give me support when I feel urges to self-harm. And I think that this is useful” (Maddy, line 152).

“Having support or somebody around makes things easier, but it isn’t always around and that makes it more difficult, and I feel a bit disconnected” (Susan, line 24).

The young people spoke about their peers, i.e. other young people on the unit, and the impact this had on their experience. Some young people felt a sense of connection with their peers, due to the fact that they had similar experiences:

“That’s like a little bit different talking to the young people...its better talking to young people than to staff because the young people actually understand where I am coming from and they haven’t learned to say things from a book...and they can understand and we’re sort of connected in a way” (Cindy, line 85).

“Talking to patients really helps, ‘cause you’ve all gone through similar stuff, and you all like understand each other, and that really helps and they are really supportive...it’s also like more normal to be talking with people your age” (Gail, line 33).

“I find it helpful to be around other patients...because, well...yeah...um, because they understand more than the staff would. I could talk to somebody that isn’t a staff member. And then I could get help from somebody that isn’t a staff member and sort of get support from somebody who knows where I’m coming from, it’s also like we have a stronger connection than others you know?” (Maddy, line 51).

Family or carer involvement and engagement also impacted on the young person’s experience. Keeping contact with them was seen as an important way of maintaining a connection with the outside world as well as part of a human experience. The young people reported that they wanted to return home and this highlighted how important family relationships were emphasised connectedness:

“when you are at home you can sort of, you have your family to go to and other people that you can go to, whereas when you are in here, you’ve got visiting times and you can’t really see the people that are usually supportive to you...” (Amy, line 240).

“It’s quite bad when you can’t use your phone because then you feel more isolated and you feel as though no one cares and nobody is thinking about you outside because you’re not able to have that communication with the outside world which I think is really important. I think it is really important to keep in touch with the people you know in the community” (Zoe, line 152)

There were some personal and idiosyncratic stories about wanting to stay connected as one service user described in the following excerpt:

“I do have pets at home, and I’ve been in hospital for a long time and I do think that they miss me so it’s really difficult to be away from them” (Susan, line 185).

In effect, this subcategory highlighted the young people’s perceptions of various areas of support, contributing to their sense of connection, a human component, and impacting the overall inpatient experience.

b) Community care and treatment. The young people made reference to remaining connected with community services during their inpatient stays. They spoke about after-care and some of the challenges they faced regarding the community support available. Some of the young people noted that it can be helpful if CAMHS remain involved throughout the admission and in terms of after-care:

“Well, I’ve been really lucky in that I’ve already been told that there’ll be like a real strict plan in place and I will be seen in the community. It’s been really nice to stay in touch with my care-coordinator, I think this is an important thing” (Amy, line 367).

“So, I still have somebody from that team coming to see me and I still have that little bit of attachment and still a connection and that’s why I’m in this hospital because it’s close to my community team. And like when I’m in ward round then my main care person can be there too...The only good thing about being in this hospital is I still have that little bit of attachment and still a connection” (Cindy, line 248).

“I think the main thing is that when you are getting discharged from hospital you need to be reassured that there is going to be some sort of plan in place for when you are going to the community. So, when you are leaving hospital, if someone is just discharged and there is no care, that would be really unhelpful” (Zoe, line 236).

The desire emerged somewhat as an expectation, a subcategory discussed later in the description of the interpersonal category, but also contributed to connection and as such, a human concept. Some young people spoke about frustration impacting on their experience because of perceived failings in community service provision. They felt let down as, in their view, an admission could have been avoided if they had been able to

engage with community services sooner. This experience itself had a detrimental impact on engagement:

“That sort of thing is not on offer in the community. So, if I had got help earlier, I wouldn’t have been in here...I think I could’ve been helped sooner and now I’m frustrated...people just thought I would get better by now putting me in hospital rather than actually helping in the community and that would have prevented me from having to come into hospital...It didn’t have to get this bad in the first place to be here” (Amy, line 205)

“I think with the whole CAMHS thing, they said I wasn’t bad enough, so they didn’t accept my referral... like as my parents say, if I had got the referral accepted and things would have happened quicker in the community, maybe I wouldn’t be in hospital, it’s tough when you realise, things didn’t have to be this way” (Paula, line 187).

Although moving out into the community often seemed to be presented by staff as a positive move, the young people spoke of having mixed feelings about it:

“Yeah, I think I engage in the treatment, but I am very aware, to my knowledge when I leave here, this support will drop quickly” (Paula, line 197).

The apprehension about integrating back into the community was echoed by other service users as well, who noted the loss of connection following admission and the shortcomings of what was on offer in the community:

“I know I am really looking forward to going home, but really what sort of community support is there, it’s all pretty gloomy if you think about it, CAMHS can’t offer much compared to hospital, we’re going to have to fend for ourselves, I’ve not even heard anything from the team since being admitted” (Gail, line 221).

“Like some of us have been in here for a really long time so then it becomes really daunting to have to go back out into the community...when you do eventually go outside it’s like really scary and intimidating...you don’t feel it’s right or you feel it’s scary, you feel like an outsider to the rest of the world and then you just know that there will be no support from CAMHS when you leave either, you’re thrown out” (Amy, line 352).

These young people’s responses again show a desire to remain connected with community services but to be valued and thought of as worthy of the care, another perception of a human expectation demonstrating the links with other areas in the experience such as the interpersonal factors category discussed below..

3.4.2 Interpersonal factors. This category covers the young people’s reports on relational factors or between-person interactions, something perceived as a human experience. Interpersonal factors describe how the young people’s experience was impacted on as a result of collaboration with staff, staff attributes and expectations. The reports indicate the significance of relationships on the overall experience of young people but also how these relationships influence the experience:

“You don’t get the feeling that people don’t care. You would never say, oh you don’t care. You know that they do care so that gives you more motivation. I think it is good to know that ‘cause I really think relationships are important and it’s all about caring” (Zoe, line 10).

“There is so much that happens here, but the main thing is how we get along with each other, I mean, like with the staff. It really makes a difference on how my day goes, being treated like a human being” (Gail, line 4)

The interpersonal factors category, with its three subcategories, ‘Collaboration’, ‘Staff Attributes’ and ‘Expectations’, are shown diagrammatically in Figure 4. All the subcategories include an interpersonal component and contribute to the overall

experience, but equally are interactive and influence each other. For example, what young people expected on the unit and how staff approached young people would have an impact on collaboration. The subcategories are explored in more detail below.

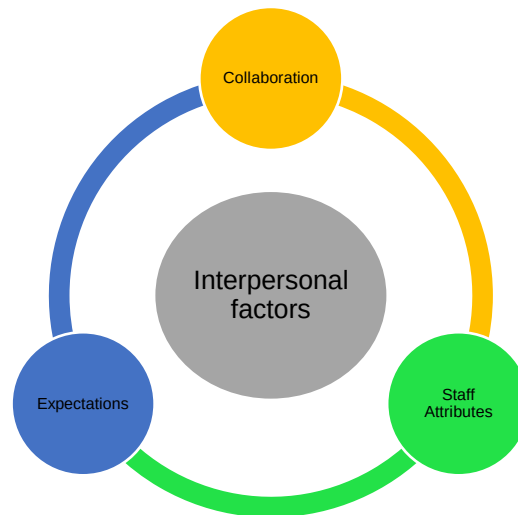


Figure 4: Interpersonal Factors with the subcategories of Collaboration, Staff Attributes and Expectations

a) Collaboration. Young people spoke about working together with staff when designing and implementing treatment and planning their care. They also discussed jointly working towards outcomes. It appears that the experience of their care was impacted on by their sense of being involved in decisions but also being able to “talk” to staff. The young people talked about working alongside staff members on the units when trying to manage their behaviours and how this had an impact on their overall experience of treatment, but also their level of engagement while on the unit:

“I do feel involved when we make the care plans together, but this doesn’t happen a lot. The consultant does listen to both perspectives and then I feel involved and we can agree together on the plan for being in hospital. Being able to make decisions makes me feel happy because then it’s more like we are

equal, like they are not the boss and we are more equal. That makes me feel much happier, it's like we can work together towards my goals" (Susan, line 197).

"...they sit with you and they want to comfort you and talk to you. It can make you feel like you're like, yes somebody actually cares. So, having the sense that somebody cares really has a big impact on my experience. It makes me feel as though I can work with these people, to work to get better" (Jo, line 32).

The young people reported their experiences of feeling as though others cared when they were included in decisions and that this improved their ability to work with staff, but again this impacted the sense of being treated as 'human':

"Sometimes I've had a chat with people, and I've come out of that conversation really feeling much more positive, I won't even think about the self-harm any more. Like last night I was talking with a support worker about slippers, it was only slippers, but the urge to self-harm was gone. I feel like this is when things go well between me and staff and we are like on the same page, when they include me and treat me like a person" (Gail, line 293).

"when you're asking those things about your care, that's a really good thing. It makes us feel listened to like they are not just taking charge of my care, I am also part of that and making decisions. It feels as though I'm working with staff then, yeah, like I'm also able to think and make a choice" (Zoe, line 199).

"Like, if I ask for leave and they've said that things are good at the moment and I've done what they asked for, I can feel quite involved when I'm asked those questions. And then I feel part of the process, and valued" (Maddy, line 180).

Young people commented on the barriers to engaging in treatment when they were unable to work collaboratively, and did not perceive others as valuing their contributions:

“Like if you weren’t comfortable with the staff, like not comfortable talking to them, and talking could be helpful...because if you’re not that kind of person who is easily able to talk about everything, or explain yourself well, then it can be difficult for staff to understand and to work together with them...but isn’t this like any normal relationship, it’s like we all are...then your overall experience would be much better, and staff would have a better understanding so you can plan together” (Jo, line 174).

b) Staff Attributes. Young people made several references to staff attributes. This sub-category captures the qualities of staff and how they interacted with the young people, which, in turn affected the young people’s experience during their inpatient stays. Staff attributes are those qualities of the staff that had an impact on the young persons’ experience but also what was communicated during interactions between staff and young people. It also emerged that these attributes indeed impacted collaboration and expectation:

“When staff stay positive and show they are interested, then I think to myself that these people believe in me so I’m going to believe in myself, that makes me want to work with them too” (Zoe, line 12).

“It just depends on who I find it easier to talk to. If the staff members are kind of not so stuck up. Just calmer. Sometimes it can feel as though some staff members are just really into their job but don’t really pay attention to us...and I would just not feel comfortable talking to them because of how they are and I don’t feel comfortable just blabbing out the things that are bothering me” (Maddy, line 111).

There were certain qualities that staff were able to convey that the young people felt facilitated engagement, such as acceptance and adopting a non-judgmental stance:

“Um, I think like, I don’t know, just talking, I’ve found it really helpful and you know, when its non-judgmental, do you know what I mean? Like staff are really sympathetic and like really, like nice” (Karen, line 59).

“I mean some people are more approachable than other people and some of the staff are also more approachable, it’s kinda the things that make us all different, I think that’s normal though and how all people are” (Cindy, line 337).

“It really depends on what staff are on and who is better at facilitating whatever has been planned for...some staff can be in tune with how I feel, listen to what I’m saying and give their time to listen to me and that makes a really a big difference, I feel treated like a person then” (Zoe, line 109).

In addition, young people spoke about wanting to be understood. They described how this conveyed caring and helped them in recovery. When staff were able to convey a sense of understanding the young person’s difficulties, this seemed to have a positive impact on the experience:

“And I want to feel understood and that the staff are engaged in what I’m saying and not just like listening and going through the motions, or reading from a script” (Maddy, line 142).

“...because they really understand and are trying to help whereas other people don’t really want to help. When I feel understood and I feel that somebody’s listening to me, then I can feel I can talk and then I feel like I can be honest. It’s just like then they understand how you feel so there’s like that hope” (Gail, line 407).

In some instances, the young people did not feel that they were well understood and spoke about the effect this could have on their experience:

“It makes it frustrating because it’s difficult enough being in a crisis and when you’re trying to explain something to somebody else and you can’t explain it in a way that’s understandable it can make things worse. And then it just escalates further” (Jo, line 181).

“I just think that sometimes the staff’s understanding is that if you’re not doing it then you’re doing well...the behaviour hasn’t really been understood” (Paula, line 277).

In addition to understanding, the young people spoke about the effect of experiencing staff interactions and communications as genuine and sincere. They explained that if staff were truly interested in what they had to say and were focussed on the young person’s well-being, this was beneficial, and the opposite was also true, as illustrated in these excerpts:

“Your overall experience is either negatively impacted upon or positively by that...I guess when the staff are nice that’s also helpful, when they’re friendly and they want to talk and you get the sense that they are interested in what you have to say and how you’re feeling rather than just saying that because that’s what they are meant to do” (Jo, line 13).

“So, you can find some of the things that the staff say is invalidating...it just feels like people are just doing a job and don’t really care about the young people...so it doesn’t feel very genuine. What people understand and what I understand are two very different things about what I’m experiencing...sometimes people just sound so robotic” (Cindy, line 119).

“So, when staff are more friendly and understanding and genuine in their responses that makes it much easier to build a relationship” (Amy, line 325).

When the young people found staff to be genuine in their interactions and concerned about their care, they explained how this would have a beneficial impact on their experience.

“You don’t just come here and get help, you get specialist help, it’s like an experience that you will remember, you will remember these people because they don’t just give you help, they sort of genuinely care” (Zoe, line 7).

Lastly, when commenting on staff attributes, the young people highlighted the importance of trust and being able to build trusting relationships, and how this would affect their experience whilst on the unit:

“This was the worst experience ever. It was just difficult to be with strange people. In the beginning I trusted nobody, but that has changed since being here...I feel like I can trust staff” (Susan, line 178).

“...it can be really hard to adjust to talking to somebody you don’t know from somebody that you do know. So, if you’re feeling really down you can go and talk to them. But sometimes it’s really hard to build trust with people you don’t know, and it can take time to build trust...so, when you’re not familiar with staff it makes it more difficult to talk with staff and talk about the things that you’re finding difficult” (Amy, line 246).

“When there is nobody around who I can trust it makes it really difficult at times when like I am really distressed or upset and there’s nobody I feel I can talk with...I feel a bit stuck” (Zoe, line 65).

In the main, the subcategory revealed the experiences of how staff approached the young people. They noted the natural nature of relationships however and this was related to their perceptions of human qualities. The comments not only related to attributes and collaboration, but also expectations as discussed next.

c) Expectations. The third sub-category within the interpersonal category is that of expectations. This sub-category captures the comments made about the young persons' experience both of what they would expect on the unit in terms of interventions and staff interactions. Although a link emerge with staff attributes and working together with staff as mentioned, it also includes what the young people thought was expected of themselves on the unit. The young people talked about their experiences of expectations and mentioned the need for matched and realistic expectations as well as for clarity about what these expectations were:

"Um, well it's my first time (in hospital), so when I first came here, I didn't really know what to expect, I felt lost and didn't know what to do. This felt like really hard at the time" (Amy, line 3).

"I don't really like people looking at me. It's very stressful when you're expected to do something, and you don't feel able to do that, and I didn't really know what I had to do or how to talk to the staff" (Susan, line 69).

All the young people spoke about what they expected from the treatment or from staff whilst on the unit:

"Like they (the staff) should probably give you distraction techniques or talk to you, they should really have things we can use or something. We surely wouldn't be here if we could do this on our own" (Lisa, line 27).

"It feels like I'm stuck between what I want and what some staff suggest, some of what they tell me to do doesn't work, but I think they should have tools to help" (Maddie, line 163).

“I knew things would be harsh or different and stern. But on the preadmission, I would have liked to have more truth...I feel like it probably would have helped me have more real expectations” (Amy, line 180).

Some young people spoke about what they expected in terms of knowledge of their individual needs and what information was shared between staff in order to provide care:

“So, say if like, I think the handover of my care plans isn’t fantastic like between staff, then the plans are in place but nobody communicated to anybody else and so it’s not actually been put in place. Staff wouldn’t really know what would help and that they can be regularly reviewed” (Zoe, line 92).

There were also comments about discrepancies between what the young people expected and what staff on the unit expected. It tapped into those experiences held within interpersonal relationships and being able to work collaboratively, but also how that impacted on overall experience.

“It felt like, what do people expect of me. It was like my first night, did they expect me to be dancing around and skipping around. I was really upset. When you are admitted to hospital it is so difficult to use things. And then they expect you to do things as you come into hospital and try and cope but actually you are still trying to adjust” (Cindy, line 210).

“It makes me quite angry when staff want me to take all the control of things because I’m just like, this is your job, this is your profession, this is what I’d expect you to do, you should know about these sorts of things...I thought that it would be really hard in here to self-harm but it’s much easier than I thought it would be and I think it requires some improvement” (Gail, line 126).

It emerged that the subcategories show clear overlap, and not only do they impact each other but there is complexity in the relationship. They form part of the higher order

interpersonal category but are influenced by each other alongside their influence on each other. Being able to interact collaboratively is impacted on by staff attributes and at the same time expectations can be influenced by these interactions.

3.4.3 Intrapersonal factors. This category covers how young people referenced more intrapsychic processes. It captures the internal experiences of the young people and describes aspects that affect the experience on the unit as moderated by these factors. It incorporates different aspects of the young persons' beliefs about themselves and their individuality and also their emotions, being valued and respected, and their experience of hope and motivation. The category highlights strong links with being seen as human, however, they do not occur independently from one another nor indeed from the other humanness categories and, as with the other categories emergent in the model, they operate in a constant interchange.

"I just wish that...I guess different things work for different people and it takes a certain thing to help me and I don't know what that certain thing is, but I'm an individual, my own person, yeah it feels complicated" (Maddy, line 8).

"So, some of us have like a more psychotic side and some of us are more just emotional, I feel different to others and I feel like there are different things going on inside of me, that is just my own" (Amy, line 47).

"Even talking about it is a really big thing, like for me, talking to somebody and being open to somebody that I want to self-harm, that's a huge thing. I never used to do that, I think there is so much that happens inside me that is making it difficult to talk about it. I don't know whether that is the same for the others, but I guess we're all different" (Gail, line 30).

A diagrammatic representation of the intrapersonal category is shown in Figure 5 along with its sub-categories, 'emotions', 'hope and motivation' and 'seen and treated as an

individual'. It attempts to show the connection between them as mentioned above, but also the dynamic nature of the relationships.

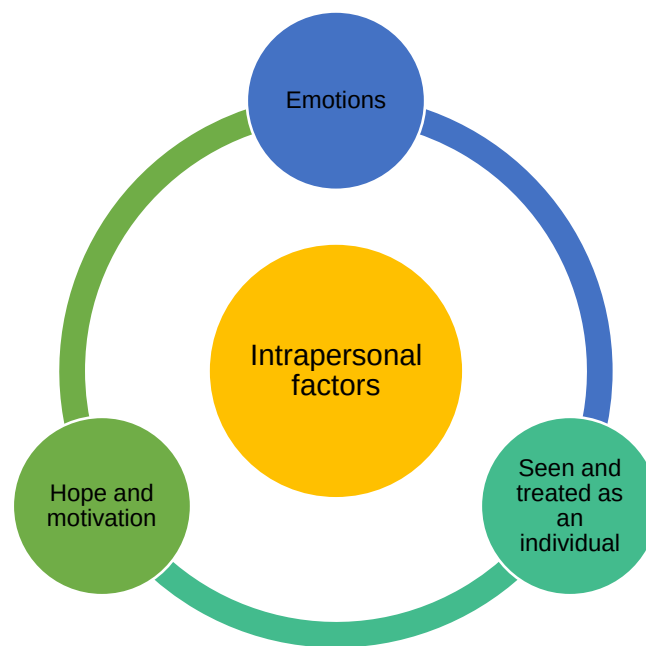


Figure 5: Intrapersonal factors and subcategories of Emotions and Value and Respect

a) Emotions. The young people made reference to their emotions in terms of how they would impact on their experience. Often statements were 'emotionally laden' and young people felt emotionally driven at times. The emotional states of the young people had an impact on hope and how they perceived being treated as individuals.

"I just don't really know what works for me. It makes it stressful not knowing and anxious, it's very stressful because I don't really know what direction to go in, what will work or what will help me in general...I just feel overwhelmed, and my emotions are all over the place" (Maddy, line 33)

Maddy also mentioned how her mood would impact on her urges to self-harm whilst in hospital:

"I don't really know how to explain it, it doesn't make me feel good and at that moment my mood goes down and it makes me want to do things like self-harm... if I'm in a low mood and I just want to do things like self-harm and my mind just goes all over the place...and I feel really stuck in that moment...and then I would just be in that mindset all day and I would be in a bad mood all day" (Maddy, line 105).

Other young people spoke about the impact of having their emotions either acknowledged or not, and how this would influence their experience:

"They don't ask me how I feel, they don't find out how I feel. And I feel really sad...well I don't really blame staff because sometimes it's difficult to guess how people are feeling...but at the same time, they could ask me more often how I'm feeling" (Susan, line 81).

"They will talk about emotions and how it affects you...if they don't get the emotion they will make things up or take guesses and get it wrong...it makes you feel just a bit frustrated, because you heard this like a million and one times...that affects how I'm feeling too" (Cindy, line 120).

"Well, like I know like we shouldn't shout and stuff, but when I get angry, I do shout at staff. And when I get angry, they like just leave me and I'm like just left in an annoyed state and don't even notice and it makes me more annoyed that no one is coming over and trying to help me. It doesn't feel good" (Karen, line 164).

In addition, young people talked about wanting to manage their internal states and emotions whilst on the unit:

"I want to learn how to cope with those feelings and like, you know, cope with like being sad and angry without turning to hurting myself" (Gail, line 221).

“I find it really difficult to deal with my feelings. I wish I had some skills to do it, but I guess that is one of the reasons I’ve ended up here in hospital” (Lisa, line 29).

It was evident once again that emotions were in an interplay with other aspects of the model, which attempts to show the continuous and complex relationship between the components.

b) Hope and motivation. Hope was mentioned by several of the young people, and they explained how their experiences had an impact on their sense of looking towards the future or feeling as though interventions could indeed help. This, in turn, had an impact on motivation and engagement. It was a reflection of an internal experience but impacting on behaviour. Again, there was an interaction with the other subcategories held within the intrapersonal category and indeed across the model. For example, feeling hopeful also was impacted on by connection and collaboration, often impacted further by dialogue and therefore also linked with the interpersonal category.

“So sometimes I’m not sure, staff just think that nothing is right with me and that makes me also feel that nothing is right with me and I feel hopeless, like there is nothing that can help, so what’s the point?” (Susan, line 156).

“...when you look out the windows you can see life happening outside and it can be quite hopeful, so you don’t feel like you stuck in an institution, that can have a positive effect on how I am during the day” (Lisa, line 34).

“So, you feel really gloomy and disconnected from the world. Like you feel no hope if you like, everybody else is getting on with their lives, so that can make me feel hopeless sometimes and I find that difficult” (Cindy, line 154).

Other young people, by contrast, linked their experience of being in hospital with an increase in hope (also through relationships and connection):

“Sometimes I’ve had a chat with people, and I’ve come out of that conversation really feeling much more positive, a bit more like a better outlook on things and that things are going to get better for me, I come out of that conversation...I will want to go to university and want to have a life, It gives you hope that things are not going to be bad forever. You’re not always going to be sad. So, what I’m saying is that part of my time here on the ward has really given me hope” (Gail, line 413).

Young people referenced motivation and how this could change and what factors have an impact on it. There was a relationship between hope and ultimate experiences of motivation. The young people reported better engagement and energy towards treatment when hopeful it was worthwhile as stated above:

“You know that staff care and that they are trying to give you support. I guess if someone else cares that much, then it can really have an effect on how motivated I am, I feel more motivated” (Zoe, line 10).

“Like most people will then like stop self-harming. Either it is like to get out of here or like just better themselves. The motivation can be different for different people and motivation for me is what is causing the self-harm” (Karen, 203).

Some young people also spoke about how their motivation was affected by the responses of staff when trying to engage with them, as this poignant reflection shows:

“I didn’t want to ask anybody for help anymore and it made me want to go quiet again because I have been self-harming for nearly 6 years, and it is the only way that I’ve ever known how to cope. And being in here has made me realise that I want to get the help, I was motivated. Then I got turned away and it made me, well, that belief was reinforced that I don’t want to ask for help because, when I did, staff pushed back and it made me feel like I just don’t want to talk about it anymore” (Gail, line 22).

c) Seen and treated as an individual. The third sub-category refers to aspects pertaining to the young people's thoughts about and references to their individuality, their beliefs about themselves and how they should be treated. Most of the young people spoke about the impact on their experience of care of being valued and shown respect, or indeed as being seen as human. Although influenced by an interpersonal component, the experience was reported as an internal, intrapersonal experience:

"I feel as though I'm not even a person and this makes me even more upset and isolated" (Maddy, line 31).

"There could be a little bit more specific things that are specific to each of us like individualised things, like for some of us it would really help, a specific thing. So, if the plans were more targeted that would be great and that would help a lot more. Other people would also maybe have things that could help them that are different" (Amy, line 261).

"Yeah, well if staff get to know me well and know my behaviours, and then they could actually know what to do and what I want, I would not need to explain what I mean which is something that's really difficult anyway when I'm feeling upset and distressed. Then the staff can comfort me and make me feel safe, to understand me and to get to know me and then my story" (Lisa, line 97).

Although, as noted previously in the support subcategory, young people found solace and support amongst peers, they also highlighted their unique needs and qualities. They regularly referenced the desire to be treated as unique and individual, perceiving their own identity as distinct from other service users on the unit:

"Everyone is different, some people may like to write things down. And some people may want to talk about it. Or sometimes people would like to be given options, sometimes it just feels that people say the same things and we're offered

the same things and that's not necessarily relevant to everybody. Everyone rightly has their own form and understanding, but it needs to be personal" (Cindy, line 232).

"More individualised care would be good, for example groups and education is like for everyone but maybe it would be better if there was a bit more thought about what you need personally and if there's a group of people that may need something different. We are all here for different reasons, and whilst some may be similar it might be useful kind of to adapt the treatment to a more individualised care" (Jo, line 98).

This was echoed by Lisa:

"I think it would make me feel better if things were more specific, it would mean that I'm not being grouped with everyone else because that makes me feel like I'm just a number. And I feel uncomfortable with that and that has a negative impact on my experience like I'm just another person, not my own person. It's like the treatment is not for my specific needs" (Lisa, line 136).

In reporting on being seen and treated as an individual, the young people made some striking comments about being valued and respected and the beliefs the young people had about themselves:

"Being in hospital, well, sometimes I don't even feel like a person any more. I feel like an animal and I don't think even animals should be treated badly. I feel like I'm in the zoo and everybody is watching me" (Susan, line 169).

"It's like a bit like being a dog, an animal, it just really feels like it's inhumane, and sometimes some people are just left with no help and I understand why people are left sometimes because they may hurt someone, but it just feels a little bit inhumane" (Amy, line 66).

Another feature of feeling valued and respected, contributing to being seen as an individual and human, incorporated young people's sense of agency or control. Whether or not they were included or involved in their care and treatment moderated this experience. Although involvement was also mentioned in the interpersonal category to a degree, here young people emphasised how this involvement added to their sense of value:

"I think I don't have a full idea of the choices I'm making, and I think they don't have a good understanding of you, like I think that the patients should be having more discussions with the consultants. This would help them feel like they are respected and I think this will make me feel valued" (Paula, line 246).

"When certain members of staff have been involved, then I do feel involved and understood and then I want to talk but it's difficult to talk to everybody. When I think that staff think I'm okay and normal and ask me what I think then this definitely helps me feel better". (Lisa, line 182).

"Everybody here really listens to you a lot when you're asking those things about your care so that's a really good thing. It makes us feel listened to like they are not just taking charge of my care, I am also part of that and making decisions. It makes me feel important and like a somebody" (Zoe, line 200).

To summarise, the concept of 'Humanness' captured the young persons' experiences of connectedness, interpersonal and intrapersonal factors whilst in hospital. It included the young people's desire to be valued and seen as unique individuals, and their internal experiences, but the concept also highlighted how young people viewed connections with others and how the experience was influenced by interpersonal interactions. In addition, young people highlighted how feeling connected to the world outside of hospital was important, particularly with regards to keeping in contact with family or other

services in the community. Marked interactions between the categories and subcategories were present which emphasised the dynamic links within the overall model.

The counterbalance to the ‘humanness’ concept, then, is the concept of ‘restriction’. This concept and its categories are described in more detail below. It is intended to represent the concepts in terms of constant and evolving tension rather than polarised features of the emerging model.

3.5 Restriction

“It’s like being able to have a meal every day in your life and then somebody saying all of a sudden that you’re not allowed to have that meal. It feels like your way of life has changed and been ripped away from you” (Cindy, line 191).

The concept of ‘Restriction’ organises the young persons’ experiences of being admitted to hospital, the clinical interventions on the unit and the ambivalence associated with being admitted, sometimes against the young person’s will, against the backdrop of an acknowledgment of needing help. As with the ‘humanness’ concept, the three categories are part of a reciprocal and interrelated process. Young people are admitted to hospital when there is a concern regarding their safety and ability to manage safely within the community due to episodes of self-harming behaviours. Treatment is offered in the form of various clinical interventions. However, young people can sometimes find themselves caught between wanting help, being held under a section of the Mental Health Act, or fears of being placed under section, and feeling ambivalent about the help that is being offered. Young people can feel stuck, confined or constrained and hence reported on the restrictiveness that they experience as an inpatient when presenting with self-harm. The

concept continues to be linked to that of the humanness concept, however, a relationship that the emerging model attempts to capture, and as such, the restrictive experience continues to be influenced and moderated by it and its accompanying categories and subcategories.

This section explores the components of this concept in more detail, following which, a brief summary is provided.

3.5.1 Hospitalisation. This category refers to the factors relating to being admitted to hospital for self-harm. It reflects the comments made by young people, not only about being in hospital, but the process of being admitted and what the experience of hospitalisation is like. It consists of the sub-categories of admission, the actual environment and the triggers that the young people reported as affecting their experience whilst on the unit. The confinement they felt, whether as a voluntary patient or one admitted under the Mental Health Act on section, was viewed as restrictive and thus is an appropriate fit within the core concept:

“I feel like it can be useful (to be in hospital) because obviously, if you’re not well mentally and you’re on your own out of hospital you wouldn’t really be able to recover, you would just be doing the same thing” (Maddy, line 203).

Figure 6 is a diagrammatic representation of the hospitalisation category and its sub-categories, ‘admission’, ‘environment’ and ‘triggers’. The links between the sub-categories highlight their interplay and explain a continued connection between them.

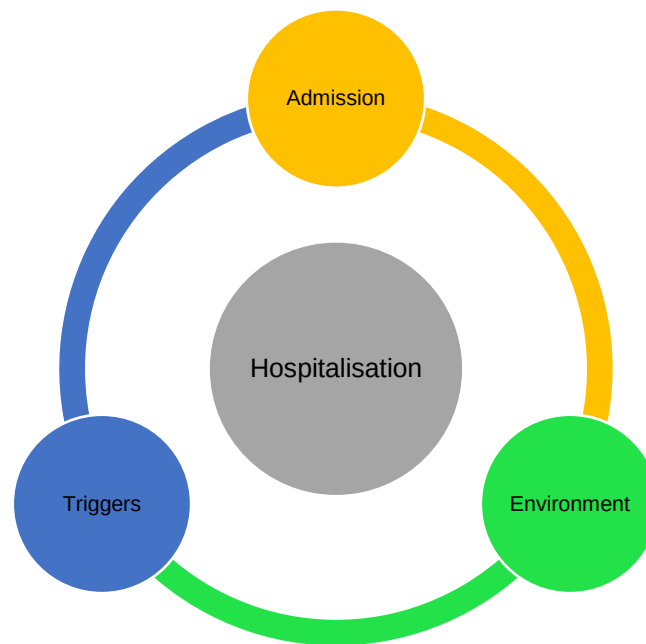


Figure 6: Hospitalisation and subcategories of Admission, Environment and Triggers

a) Admission. This sub-category contains factors related to the process of being admitted to hospital for self-harm. It includes aspects of preadmission, what is helpful or unhelpful about being admitted when presenting with self-harm, and the effects on the overall experience of the young person of being in hospital. The young people commented on how it felt to be in hospital, away from their usual environments:

“I think it’s helpful, a little bit being away from the things that usually cause you difficulties...hospital breaks that cycle and helps you try different ways to deal with those things (the things that have led to the admission) and understand yourself” (Maddy, line 208).

“There is something about being away from your usual life that can change things or make it feel different, so maybe it is a good thing to be in a different environment” (Karen, line 204).

“I’m happy that I am here because I’m safe, I know I am safe” (Gail, line 227).

It is noted that again this links more broadly with connection and aspects of expectations in other areas of the model. Some young people were unhappy about having to come to hospital and in particular about the process of admission and the information shared with them prior to hospitalisation:

“I felt like, I’d been shoved into a place like this, and that I wasn’t really well understood. I had no say and it felt like nobody cared...it can also be something that’s really not helpful because you’re not around your familiar environment at home or your family, so it can make you, sort of worse than what you were before” (Cindy, line 42).

“I knew things would be harsh or different and stern. But on the preadmission, I would have liked to have more truth, I feel like it probably would have helped me have a more real expectation and better set up when I came in here and I could have felt like more prepared” (Amy, line 183).

Similar links as noted above are acknowledged in terms of interpersonal factors here and how things are communicated. Young people feared the Mental Health Act would be used in order to promote compliance. This had an impact on their motivation and engagement. Some of the young people seemed to feel they had very little option but to comply with the admission which, in itself, contributed to their overall sense that the admission was restrictive:

“Even if you are voluntary and you ask for discharge or if your parents ask for discharge they will just put you on a section if they really want you here, which is fine if you need to be here but obviously some people get put in here and it makes them worse than what they were before they came in and they were out in the community” (Amy: line 58).

“I came in on section, but now I’m informal. But they tell me if I do anything that is risky or I have any more arguments or fights, staff tell me that they can put me on section” (Susan, line 101).

“I mean I couldn’t have an option, I think nine times out of ten, that’s why people come in voluntarily, because they’re scared of being sectioned. I would have probably discharged myself if I was informal, so I needed to be on section, but it makes the process a lot longer” (Cindy, line 259).

Young people spoke about coming into hospital and becoming worse, perhaps not needing to be in hospital in the first place, and consequently then being faced with a longer admission. They also mentioned that the restrictive nature of the hospital setting could make things worse:

“And some people have come into hospital not necessarily needing to be in hospital for that intense environment. So that would be less helpful for them. And then they may not need to be in the environment and know that and then make it actually worse for themselves and get stuck in the hospital” (Zoe, line 228).

b) Environment. This sub-category captures elements of the physical environment of the hospital, where the young people spent their time, and how this was arranged. It includes the young people’s sense of the impact it had on their experience. They spoke about some of the things that were helpful in the hospital environment including the space, layout and having access to people to talk with (notable link with interpersonal relationships and connection):

“Well, I guess you can’t self-harm because you don’t have anything that you can use. Everything is locked away or you don’t really have access to things you would normally use. It’s also good that it doesn’t feel really like a hospital” (Paula, line 72).

“Um, well it doesn’t really feel like a hospital, it feels like just a...well there are like hospital aspects, but it doesn’t feel like hospital, more like a house. Well it’s not like there are people in like nurses’ uniforms. It’s more like people are more casual, and more calm...it’s more calm and a better environment than being in a more busier place...there is some shared space which is quite good because obviously there aren’t loads of people so it’s nice if you just sat down and you can talk to other people...and it’s helpful to have your own bedroom. It’s nice that there are spaces outside to go and meet with family” (Maddy, line 78).

“It’s nice to have your own room and some of the rooms that you can use to calm down like the comfort room, and there are always people around that you can get support from” (Amy, line 391).

The young people described some of the things in the environment that had a negative impact on their experience:

“The seclusion room is not soundproof so if somebody is banging in there you can hear throughout the whole ward and that’s really distressing, and that’s not always good, because there’s been like nights where that has been really noisy and it’s not great” (Zoe, line 174).

“Sometimes the environment can be difficult because some of the other people on the ward are not very well. But I understand this as this is what it must have been like when I wasn’t well, in the beginning when I came. The alarms keep going off all the time and this makes things really stressful. It’s very loud and it’s very stressful and it makes me not want to be here. It makes me think I shouldn’t be here. And then I feel sad again” (Susan, line 60).

Again, although included in the environment subcategory and subsumed within restriction, there is a link here with dignity and value and highlights how the subcategory fits within the model and maintains connections across the components.

Some young people mentioned that they liked the open nature of the unit, while others found it challenging, which had an impact on their overall experience:

“Um, I think it’s sometimes difficult being surrounded by lots of other patients who are struggling with self-harm, sometimes I think when a lot of people do it, its spoken about more openly and that is not always a particularly good thing, you kind of see it as a normal thing to do, so it’s not seen as something you should stop as much” (Paula, 79).

“The ward, it’s very badly set out. It’s so open, there’s so many places you can hide things and hide yourself. It’s just very open. Don’t really know how else to describe it. I don’t know. Having an open nursing station isn’t good because they keep like pens, pencils, sharpeners at the nursing station, um, cords you can tie ligatures with which is a form of self-harm. I just don’t think that that’s useful” (Lisa, line 49).

c) Triggers. This subcategory links closely with the environment subcategory but captures the young people’s references to triggers in the hospital environment. Triggers are seen as things, interactions, or experiences that young people observe in the immediate environment that they struggle to manage, process or deal with effectively and which often result in dysregulation of their emotions and behaviours. Some of the young people spoke about how staff interacted with them, a notable link with the interpersonal and staff attributes components, and, in some cases, how the effects of these encounters could be triggering:

“Sometimes they say things that are unhelpful to us and it can be triggering. And the trigger can be a thought about self-harm. I don’t really know how to explain, but it doesn’t make me feel good and at that moment my mood goes down and it makes me want to do things like self-harm” (Maddy, line 94).

“Staff can sometimes think that they are saying the right thing, but sometimes they can be really wrong about things. I had an experience of staff telling me I am being naughty, and that just made me mad and want to self-harm” (Lisa, line 149).

Young people also highlighted being exposed to the distress of others whilst on the ward as a potential trigger (especially as seen against the backdrop of humanness expectations):

“But if you’re watching people like being pinned down or restrained to the floor that’s a really shocking thing to see. I think it can be quite triggering, like when you’re trying to focus on yourself or trying to get out of hospital it’s really hard to see others struggle. It makes me upset and I can’t manage that feeling and then become more stressed myself. It’s quite daunting when you hear people shouting” (Amy, line 189).

“It’s such a bad thing to see, other kids being stressed out, especially since you’re stressed out yourself. Hearing other people makes it hard and it is really quite triggering for me” (Lisa, line 53).

The young people described seeing others’ self-harming behaviours on the unit as a distressing and triggering experience. They stated that they found it difficult to deal with and thought more should be done manage these behaviours:

“People talking about self-harming in great detail sets me off as well and it makes it hard being in here, I feel like people who have self-harmed on the unit, it’s not just me that gets triggered by the cuts, so many people do and it’s just like they should be keeping up monitoring with that” (Gail, line 113).

“If you want to stop yourself self-harming then there should be no triggers, especially seeing other people self-harming on a unit like this. Staff should be

preventing those triggers by saying to people who have got cuts on their arms, please can you cover your arms, and can you cover your injuries” (Paula, line 92).

“Um, I feel like there have been patients here that are extremely triggering. And staff say that they do stuff about it, but they don’t. Like we have had patients that have self-harmed on the sofa and have bled all over the chairs and it was very triggering” (Lisa, line 262).

3.5.2 Clinical Intervention. This category refers to the management strategies used on the unit, the therapies available, and other interventions that are offered to the young people during their hospital admission. The strategies are designed to support the young people or attempt to manage behaviours and/or risk events. The category does not capture the effects of these interventions, but rather, and in line with the research objectives, covers the young people’s views on the effects they have on their experience in a broader sense. Young people spoke about their personal views on what was offered on the ward and how they felt this related to them:

“I just wish that, well, I guess different things work for different people and it takes a certain thing to help me and I don’t know what that certain thing is, it’s a bit strange. I think there are things here I want to do, but sometimes there is just not a good thing that fits, you know?” (Maddy, line 8).

The category comes under the core concept of ‘restriction’ for a number of reasons. The reports of the young people referenced the constraints they experienced as a result of where the interventions take place; there were also limits to what was offered, and they felt that they were given little choice in the matter, a reference to the individuality subcategory. The category consists of the sub-categories ‘planning of care’ and

‘techniques and therapeutic processes’. A diagrammatic representation of the category and its sub-categories is shown in Figure 7.

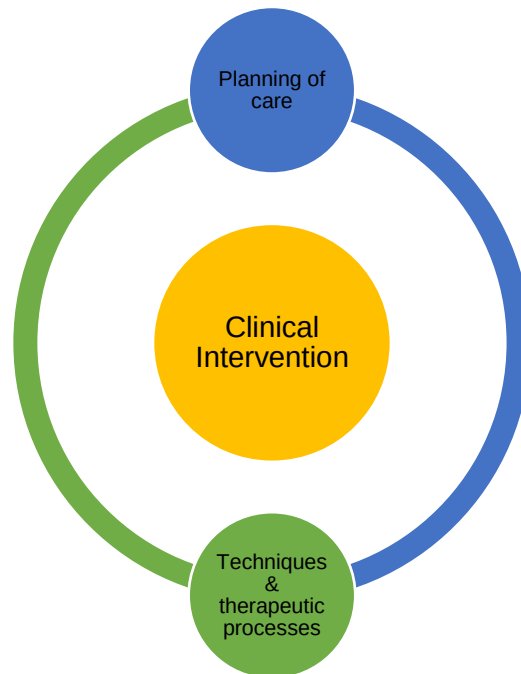


Figure 7: Intervention and subcategories of planning of care and techniques & therapeutic processes

a) Planning of care. This category captures the young people’s comments about how their packages of care have been put together. It included descriptions of services and support being provided in the hospital, and were co-constructed with staff during the process of care-planning. Of course there was a strong interaction with collaboration and connection. As mentioned in Chapter 2, the current study is situated alongside a larger Trust-wide attempt to improve care-planning and treatment for young people who are admitted to hospital when presenting with self-harm.

The young people commented on how the process of jointly planning care affected their experience and the process provides parameters within which the interventions are

described. The young people spoke about the content of these plans and the fact that this would be what was available to them to use:

“Early on when I came to the ward, I had a self-harm care plan, things to do instead of self-harming. Selecting something that I like to do or distraction techniques, or like sensory objects, smelling things or listening to music or just doing something else instead of self-harming” (Zoe, line 81).

“Well, how I understand how it should be is to sit down and write a care plan with somebody, just like going through things, like the beginning of the care plan is about the reasons of my admission and what I want out of my admission, but also getting things on there that would help me if I am struggling” (Gail, line 177).

From these comments, it is apparent that this experience, or subcategory thereof, indeed is impacted on by interpersonal factors. Some young people spoke about how they thought that having care plans, for example, would add value to their stay and be beneficial in terms of improving how to elicit help:

“I haven’t really done one, but I feel that if I had a care-plan specifically about self-harm, I may feel better or that people will know me better, I feel that would help me deal with my thoughts” (Maddy, line 46).

“I think what would be more helpful is that if there was a plan and everybody knows how to help, that would add value to my admission, at least then we will be on the same page I think” (Zoe, line 96).

“Having a very stable care plan around self-harm would be better because, even if a staff member doesn’t like quite know what to do to help, I can be like, can you just look at my care plan, I can have a copy of my care plan and I can go through all the distraction techniques that are written down” (Lisa, line 23).

The young people were all aware of these care-plans; however, some were of the view that these had not been completed and that this in turn had a restrictive impact on their experience:

“Someone mentioned it to me, but they have forgotten to give it to me. I’ve had staff ask me whether I’ve had like the self-harm one but then never getting around to giving it to me. There needs to be more consistency and follow up on these plans and you actually being able to access the things that have been talked about otherwise I feel like I can’t get help” (Paula, line 30).

Even when the care-plans were completed, the young people spoke about the perceived lack of follow-up and review and how this undermined their effectiveness, which they found restrictive and frustrating:

“The care plans are made but then they are not really sustained or followed through on, and definitely I think the handover of my care plans isn’t fantastic, nobody communicated to anybody else and so it’s not actually been put in place, they should be regularly reviewed, it should really be done more regularly, because I haven’t done it since it was made and I feel there should be more attention paid to it. I feel really stuck because there has been no follow-up” (Zoe, line 93).

“They said that they would give me certain things to help distract me. I haven’t been given them, so it’s like you’re asking me to use my care plan but you’ve not given me the things that we put down on the care plan for the distraction techniques, it makes me upset” (Gail, line 202).

“Well, I can’t really remember it that well. But I do have a care plan about self-harm. It is helpful. But I’ve only seen the care plan once and I can’t remember what is in it and what do I do without it?” (Susan, line 118).

As mentioned previously, the young people could see the value of completing the care-plans collaboratively. Some spoke about how this would improve their experience by increasing a shared understanding of their difficulties and thus enhancing their overall level of engagement:

“Well, when we do like, the care-plans, they do try and like, take stuff on board, so it’s about finding a middle ground to manage, I do feel that the process allows me to feel understood” (Karen, line 136).

“The most helpful thing is a care-plan, but being able to discuss these things when I need to, not having a stable care plan or an opportunity to talk things through enough gets in the way of things” (Lisa, line 68).

Although they acknowledged that the care-plans may be useful in hospital, some young people were concerned about the transferability of interventions once they were discharged. They felt that the long-term usefulness of these interventions was restricted to particular environments:

“I think a lot of the time it’s all focussed around, like, distraction techniques. I think, whilst you’re in the hospital environment and you can do it, um, it doesn’t work too well until you’re at home, you kind of have to wait until you can test it out at home kind of thing” (Paula, line 10).

“It’s not that great because these things can still carry on even if they take away the things that I usually use. They will eventually carry on in the community. When I go home it will just happen again. Hospital stops you using these things for a little while, and the care-plan maybe works in hospital, but doesn’t really when I go home. It’s only temporary” (Susan, line 164).

b) Techniques and therapeutic processes. This sub-category refers to the actual techniques and therapies/interventions on the unit that the young people are able, and sometimes required to engage in. Some of the young people highlighted that it could feel overwhelming being asked to take part in the therapeutic programme or engage in therapies and interventions:

“But everything that has been thrown at me, I’m feeling small and I feel like things should be taken one step at a time. More slowly and at a steady pace that one isn’t so overwhelmed with so many different things. I feel like things are moving too quickly” (Maddy, line 90).

Almost all the young people spoke about the talking element of the interventions or the psychological therapies in a positive way but, at the same time, felt that the time allocated to it was not enough and therefore found it limiting in terms of accessing treatment, linked too to interpersonal collaboration and connection:

“That hour I get I really treasure but it’s the only therapy I get, and I feel like I need more than that, more than just an hour because I have so many underlying issues that need to be addressed, I feel like I need more therapy, that even if we, I don’t know, like we did managing emotions group this morning and that was quite good, so it would be really nice to have more things like that” (Gail, line 217).

“I mean like some things you think like when you’re in here, you are talking to staff and you think you know what you’ve been going through, but when you speak to staff and they repeat it back to you, you think oh, okay so maybe I wasn’t right about things. I can hear why that doesn’t sound like a really good option, we just don’t get enough therapy time” (Amy, line 128).

"My psychologist is helping me, she is very encouraging, she always has a lot of enthusiasm, even when I don't feel like doing anything, she still suggests things, and this makes me a little bit more happy. But when she leaves the sessions, I find that quite difficult because we've been working together and when she leaves, I then have those things on my mind and feel like I have to deal with them on my own. Having support or somebody around makes things easier, but it isn't always around and that makes it more difficult" (Susan, line 20).

The young people spoke about some of the techniques they found useful to improve their experience on the unit:

"And I enjoy distractions, and tangles as well. Because I'm doing something productive with my hands because otherwise my hands would be doing something different, self-harming, and things like the lava lamp and fairy lights and candles I find those really relaxing. I feel like it's really just bringing down the emotion, and that's the thing about being here that I found really useful" (Gail, line 277).

Some of the young people were disappointed with what was offered and found these limitations frustrating:

"I've not really had a lot of chance to work on my self-harm overall. And I feel that that's the main reason for me being in hospital. I haven't really had much work done around my self-harm or any skills or techniques. How must I get better?" (Lisa, line 109).

"Um, I think there should be more focus on kind of getting to the stage where you want to stop, instead of just being kind of, given lots of techniques to stop when you don't feel ready. If you focus on why you don't feel ready. I don't think what is here is right for me, so, I don't know really" (Paula, line 108).

Some young people agreed that they were uncertain of the effectiveness or specificity of what was offered, but that they were restricted to what was accessible on the ward:

“I just feel like, oh okay, here’s therapy, here’s medication, here’s um like a meal plan, here’s all this, and it’s just lots of things being thrown at me, but sometimes it feels like that doesn’t feel like it fits with me” (Maddy, line 25).

“And they say, have you tried reading a book or done some colouring in? And when I’m in that distressed state, I don’t really want to do colouring in or reading a book, and then you just sort of say, no it’s not going to work and what they offer here isn’t for me” (Lisa, line 251).

In addition to these frustrations, young people mentioned feeling unsure of the effectiveness of increased observations as an intervention in terms of how it impacted their experience.

“What also makes it so not great is if you just do anything or say something that staff don’t like it feels like they will just increase observations and having someone watch your every move. This is so intrusive, and I don’t even think that it helps” (Karen, line 77).

Some reported how they felt that increasing restriction was indeed less helpful and frustrating, impacting on their experience.

“So, like when I’ve self-harmed because I’m stressed out, suddenly there is like some random person watching me, watching my every move, I’m like, seriously, this is making things worse, surely someone can rather just talk to me and try and understand what happened?” (Paula, line 59).

There was some ambivalence towards these types of intervention, with some young people reporting mixed views.

“So, like with someone keeping an eye-on your every move, I don’t like that, but I guess in that moment when things have gone wrong, it can keep you safe, but it helps if they also talk to you” (Gail, line 70).

There were further concerns relating to the use of restraint as an intervention.

“I find it really horrific when someone is being restrained, I’m like, is this even allowed? I then have to go away and it makes me very stressed out” (Jo, Line 54).

“And the worst thing to see is when someone is being restrained, it just feels so inhumane. It makes things really hard, especially when you got to know someone, and you see this. I’m not sure it’s even a good thing to do to keep you safe” (Gail, 342).

Some young people were administered prescribed medication as part of the clinical interventions they were receiving, however, there seemed to be some uncertainty as to how much this was helpful and how much influence they had on decisions relating to medication. There were some descriptions of medication being seen as something of an agent of control, but also that it sometimes was not enough.

“So sometimes I get upset and all I’m offered is medication, I don’t think that is going to solve the problem” (Lisa, line 29).

6*“When I’ve spoken with the consultant and say I need something to help me with my sleep, I don’t think that is taken seriously, and it really bums me out as I want to sleep”* (Susan, Line 74).

“I’ve asked for medication since coming to hospital, but they keep telling me it’s not what I need, well, it’s how many weeks later and nothing has changed, so I think it is” (Cindy, 206).

3.5.3 Dilemma. This category captures those references that the young people made to experiencing, and struggling with, internal conflicts as a result of being in hospital and the restrictiveness associated with their admission. It captures the comments in which the nature of the admission and the environment as well as the interventions are acknowledged, yet set against the backdrop of conflicting internal, indeed intrapersonal, states:

“So, I know I’m in hospital, and I know I need to be here, but I really don’t want to be here, and I don’t think that there is something that can help me, I feel safe though” (Jo, line 20).

The category includes the sub-categories of control as well as ambivalence. Figure 8 is a diagrammatical representation of the Dilemma category with its sub-categories of ‘control’ and ‘ambivalence’. The tension in the model is particularly notable here where young people struggle to hold onto, and strive to maintain control and how this is brought up against an ambivalence of being in the environment that is both restrictive and providing intervention, treatment, and care.

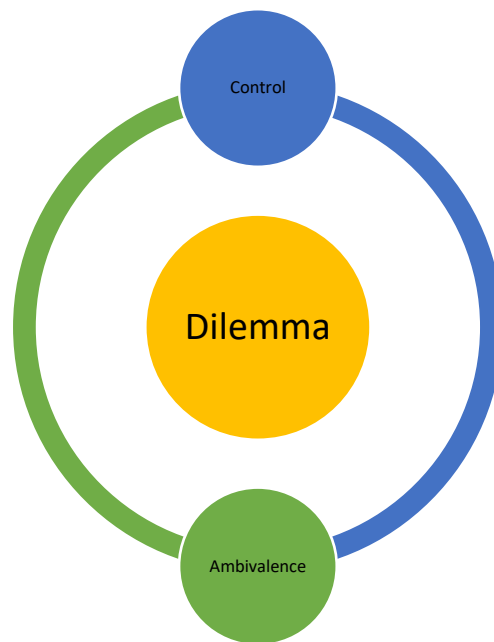


Figure 8: Dilemma and subcategories of Control and Ambivalence

a) Control. Young people often described having less control over their daily lives in hospital, from having to adhere to strict routines, to not being allowed to make decisions about meals or trips out. They spoke about the lack of control they could exert over which interventions they are able to access, as well as the sense of obligation to engage, in order to obtain permissions and privileges. Several young people mentioned the rules and the ward structure. Being in a hospital environment could be physically restrictive for them, as mentioned in both the hospitalisation and clinical interventions categories above, but here they describe further ways in which they felt restricted and “controlled”.

“Not going up to your room or some of the small things like that, I just think those are the rules that are not really worth having. It feels like they’re a bit trivial. The rules and the boundaries make it more difficult, well, it can feel a little bit more restrictive and then you can feel frustrated” (Jo, line 51).

“It feels like punishment. Because you are not allowed your phone, you’re not allowed in the art room, you’re not allowed to go on community access. And it’s just, I don’t know how any of that would make you feel better about yourself” (Lisa, line 212).

“It’s the same thing with having privileges, staff use that as a threat if you don’t do things, you’re only doing it because you are being told you going to have privileges taken away” (Cindy, line 298).

Young people spoke about feeling as though they were not trusted and, as captured in the emergent model, likened the restrictive nature of an admission to an infringement on their humanness:

“I don’t think it’s really humane...it’s like not things that you usually do like going out for escorted walks because you’re not trusted” (Amy, line 45).

Further comments were made about their perceptions of the coercive and sometimes controlling nature of interventions:

“When you’re limited to only an hour a day on your phone, and that is also dependent on whether you go to groups and education and things like that like, it feels like you’re being forced to do something, under control” (Jo, line 77).

“It’s almost as though treatment is done to you or pushed on you and you’re not part of it. So, I get really annoyed because it feels like I’m just being dragged through this thing without any thought, but I have to get leave or something” (Cindy, line 239).

On the second unit where there was less restriction on things like mobile phone use, the young people reported that this had a positive impact on their experience, helping them to feel as though they remain connected, referenced previously, to others:

“I also like the fact that, here, we’re able to use our phones because I think it’s quite bad when you can’t use your phone because then you feel more isolated and you feel as though no one cares and nobody is thinking about you outside because you are not able to have that communication with the outside world which I think is really important” (Zoe, line 157).

b) Ambivalence. This sub-category captures the young people’s struggle between not wanting to be hospitalised or engage in treatment but at the same time recognising the need for an admission or intervention and wanting to improve their lives. Although presented as a subcategory in the dilemma category under the concept of restriction, as already mentioned, the tension and ambivalence is evident throughout the model. Here the intent is to capture it as a component part of the concept as it has a restrictive effect on the experience in terms of the model. The young person struggle is clearly evident in the following example:

“I think it can be useful on the one hand and on another level not so helpful. It sometimes depends on who you are and your situation with your self-harming. For me, I hadn’t previously let people help me so when I came here, and I was on section, I wasn’t actually able to refuse the help, so it was good in the sense that I could then come to terms with needing help and getting it in this sort of environment. I think you’re not really able to hide how you are feeling because you’re in a place where obviously there is something up, you’re in hospital so eventually I was able to show how I felt and get help” (Zoe, line 212).

The statement shows the many contradictory thoughts and concerns that are experienced by this young person. Similar conflicts were reported by other young people interviewed:

“So, it’s not nice but it does make you safer. I don’t enjoy it, but it does stop me self-harming, I’m not sure it has really been helpful towards me, I don’t really feel

like it's helping, I don't know whether it impacts loads on my treatment, I don't even know" (Maddy, line 220).

"So, I have lots of difficulties. So, it can be good to be in hospital as well as bad, it's only temporary. Being in hospital does help you learn skills and cope, even though I don't really want to be here" (Susan, line 163).

"I guess if you are getting to the stage where you need to be admitted, then you probably shouldn't be around the things that you can use to self-harm with, and I guess being in hospital can help, I just don't like it" (Paula, line 305).

Some of the young people gave an insight into their internal dialogue about the dilemma and mixed feelings that they were wrestling with:

"Like I feel, I'm really angry at myself, I got myself into this situation, but don't want to self-harm, but it is my way of coping, so I don't really know what I will do" (Karen, line 4).

"I think that I can do better off the ward, I don't think I really need to be here, I know it hasn't gone well before, I feel there is nothing to help me here though" (Paula, line 5).

To summarise the concept of 'Restriction' captured the young persons' experiences of hospitalisation, clinical interventions and dilemma. It encompasses the experience as influenced by the environment and what is offered in terms of treatment, but also the experience of control (or lack thereof) and the struggle that young people reported when faced with an admission, in particular when this was against their wishes, against the backdrop of recognising the need for help and support. None of the categories were discrete as overlaps between the various categories and subcategories were noted.

3.6 Bringing It All Together

The intent of this study and the analysis of the young persons' responses was to produce a 'model of young persons' experiences of inpatient care when presenting with self-harm'. It emerged from the young persons' responses and suggests factors that influence how young people presenting with self-harm experience inpatient care. A grounded theory methodology was used to analyse the data and led to the emergence of the core concepts and their categories. The model is produced in figure 9 and is a representation of how the different components interact with each other.

The model emphasises the concepts of 'Humanness' and 'Restriction' as key to the inpatient experience of young people presenting with self-harm. Importantly, the model depicts the critical tension that exists between these concepts. The tension is significant to highlighting the "life and flow" of the model. The concepts represent contradiction in terms of what could be perceived as the brutality that exists in the system, but at the same time they are connected through pull in terms of how they are connected. There is therefore interdependence, where they exist not only, or indeed always, as opposing forces, but inextricably linked, simultaneously taking centre stage and playing a supporting role.

The components within the core concepts are represented as dynamic and simultaneously being both influenced by and influencing each other. The model represents each component as discrete, however, throughout the findings attempts were made to highlight the links between them and how the influence travels across the categories in multiple, complex and dynamic ways. The categories are indeed the concepts and thus there is interplay at every point, where there is a simultaneous

emphasis on, and link between, each component forming an overall collective, which in turn is the experience.

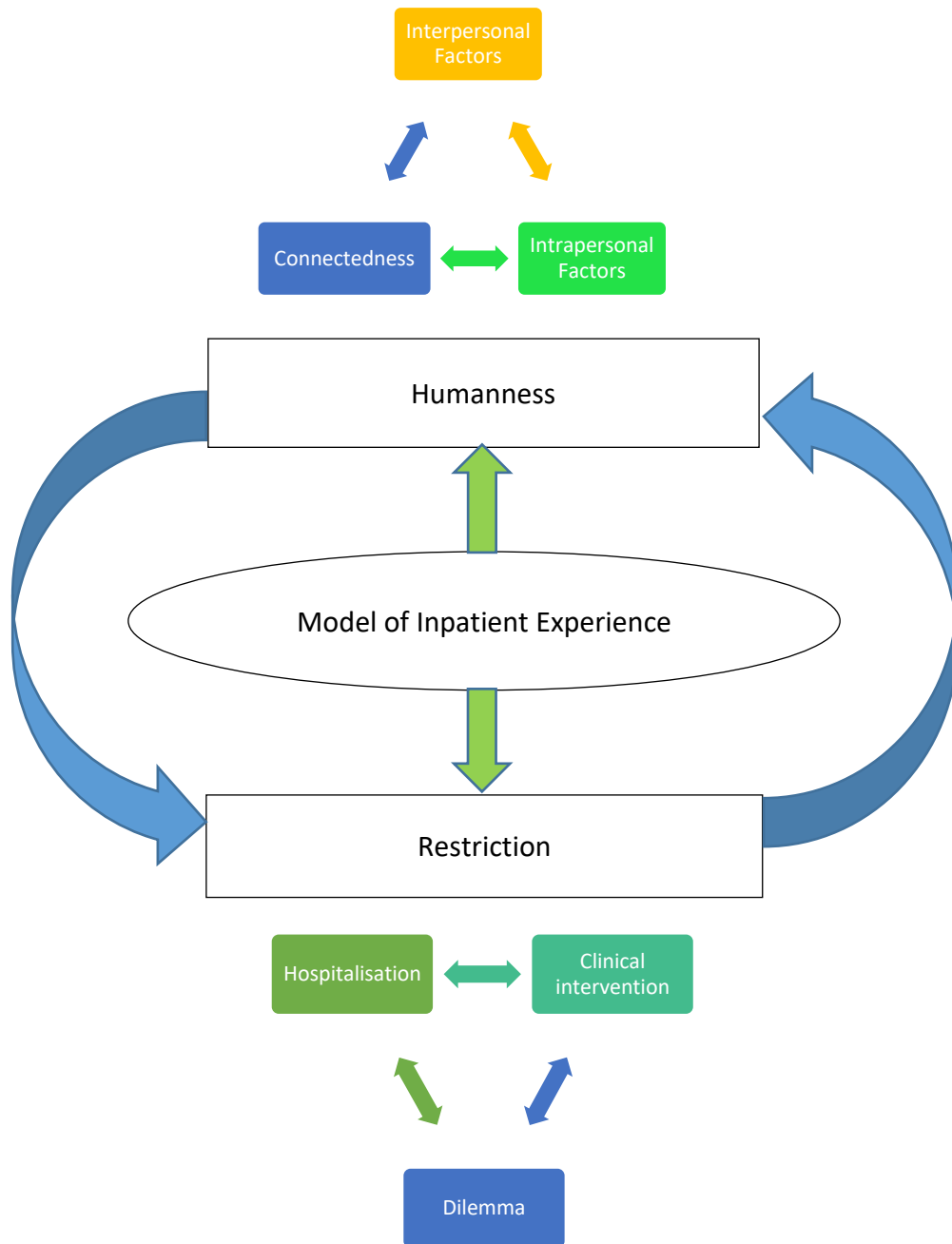


Figure 9: The model of young persons' experiences of inpatient care when presenting with self-harm.

For example, relational interactions are considered as drivers for the young person's internal experiences of value and meaning or being treated as an individual. This is then reciprocal in allowing for a sense of connection to others. This driving force is tempered by an experience of confinement whereby freedom and liberty is pined for, alongside a desire to live, cope and manage in the world. At the same time interpersonal factors, such as the young persons' experiences of relational exchanges as genuine serve as simultaneous drivers in helping young people feel understood and more able to engage in the clinical interventions available on the wards. This is against a backdrop of a desire to be seen as unique and in control straining against governance structures inherently restricting this volition.

Furthermore, the model is a representation of how the experience of inpatient care is constructed and shared by the young people and suggests that the components impacting on this experience are not limited to 'being an inpatient' but are held within social, psychological and experiential elements.

3.7 Chapter Summary

The chapter provided an analysis of the data. It commenced with a brief pen-portrait of the young people who agreed to take part in the study. Two core concepts emerged from the data and consisted of interrelated and interactive categories and subcategories. Both the core concepts of humanness and restriction continued to be linked and interact with one another, seemingly feeding into each other and being mutually influenced by their components. Strong connections remained between the categories and the hope is for a model to be produced that itself captures the elements of the inpatient experience and does the young people who participated in the study justice. This chapter concludes with an attempt to make sense of the young people's

experience by presenting the emergent model of the young person's experience of inpatient care when presenting with self-harm. A discussion of these findings follows in the next chapter.

Chapter 4: Discussion

4.1 Chapter Overview

The current study explores the young persons' inpatient experiences when presenting with self-harm. In order to achieve the study aims, the perspectives of 10 young people admitted for inpatient care were sought. The qualitative nature of this research enabled these young people to describe their individual experiences of the care and contribute to the emergence of a grounded theory: *A model of young persons' experiences of inpatient care when presenting with self-harm*. Given the dearth of published research in this area, it is the researcher's view that this study has yielded a new, rich and interesting model of themes and factors relevant to the young persons' experiences and also the complex and dynamic nature of the relationships between the different parts of this experience. This chapter provides a further discussion of the key findings, which is also reviewed in relation to existing literature, both from the preliminary literature search and more focussed literature. Sensitised concepts were identified and noted in Chapter 1. The researcher attempted to let these 'lie fallow', as Charmaz (2006) suggests, and additional concepts emerged from the data.

4.2 Summary: Relating The Findings To The Literature

In the findings chapter, two core concepts emerged: humanness and restriction. These concepts emerged revealing both a dynamic relationship between them and a tension. This is illustrated in Figure 10 below. The reciprocity and movement is evident

throughout the model, where categories overlap and influence each other and exist both interdependently and simultaneously. The tension emerged within the paradoxical forces relating to the provision of, and desire for care alongside the withdrawal and loss of control and autonomy within the restrictive experience. The core concepts, categories and subcategories are discussed below. Although the discussion highlights the categories discretely, they are reality all in dynamic interaction as previously discussed.

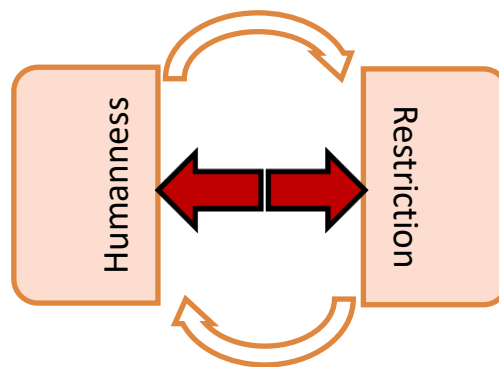


Figure 10: The core concepts of Humanness and Restriction, including relationship

4.2.1 Humanness. This concept emphasised the young people’s reports of wanting to retain a sense of what they believed were qualities related to being “human”. Although this concept is likely to incorporate a broad range of descriptions, here it is conceptualised from the views of the participants and includes ideas around being valued and respected and seen and treated as individuals, but also those relating to relationships and connectedness with others. This concept adds to Lindgren and colleagues’ description of patients’ expectations and experience of being viewed as a human-being and, as noted in the literature review, how their experience of care is impacted on when their humanness and uniqueness is appreciated (Lindgren *et al.*, 2011).

Adams *et al.* (2017) summarise dehumanisation as referring to the denial of a person’s humanness, and hence their unique attributes, when they are viewed as child-like or

animalistic. They add that humanness is lost when people are viewed as an object or machine, denying attributes such as emotional responsiveness, agency, and interpersonal warmth. The young people's comments in the current study often likened their experience to that of animals, and these were indeed some of the most striking reflections. Haslam (2006) has also described the denial of human-nature characteristics as playing a potentially important role within the patient-medical professional context. On the one hand, it may allow for a freeing up of cognitive abilities in order to problem solve a "mal-functioning machine" (Haslam, 2006) but, in contrast, the literature is clear that, from the patient perspective, denying humanness is overwhelmingly negative and is associated with dissatisfaction, fear, and less compliance (Adams et al., 2017). In the current study, three main factors are important within the humanness core concept, namely connectedness, interpersonal factors and intrapersonal factors. The dynamic relationship between these categories has been highlighted and it was clear from the findings that any emphasis on one category was mediated and/or influenced by another. In Figure 11, the Humanness core concept with its corresponding categories is reproduced.

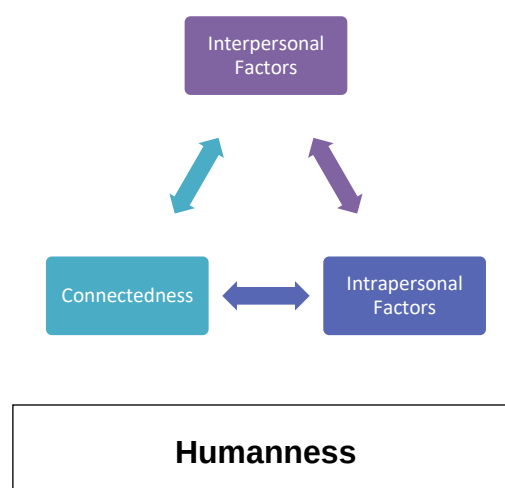


Figure 11: Humanness core concept with related categories

a) *Connectedness*. In terms of connectedness, emerging as a sense of belonging to a community or group alongside the belief that one is not ‘separate’ from the world, this category described young people’s perceptions of their ‘human’ contact and connection with others. The category was further sub-divided to reflect reports of ‘support’ and ‘community care and treatment’. Smith-Gowling, Knowles and Hodge (2018) identified a profoundly social dimension to both the initiation and maintenance of self-harm in adolescents. Keeping connected to the community revealed mixed feelings on the part of the young people as it was noticeable that the role of family and friends as a source of support was not always consistent with the desire for out-of-hospital services. Some participants described a friend or family member as the single greatest source of support in connection with self-harm whilst others felt uneasy about getting support from family members and friends. Feelings of being a burden made participants reluctant to engage with social support. Poor social connectedness is a well-established risk factor for suicide and suicidal acts and the association between poor social support and self-harm and suicide risk has been demonstrated across cultures and among populations with various clinical characteristics (Kleiman & Liu, 2013; Pfeiffer *et al.*, 2018).

Connectedness played a significant role in how young people managed on the ward and supports previous findings. The young people felt distressed and lonely when separated from their families. This is similar to the description by Schoppmann *et al.* (2007) of the central importance assigned to the anxiety caused by being alone. Keeping and possibly even increasing contact were found to be a driver for some of the young people as well as their parents/carers, particularly where significant family/friend events such as birthdays and parties were taking place. The young people wanted to return home or keep in close contact when discharge, which further suggests the significance of

maintaining family relationships whilst in hospital. After all, as Sams, Garrison and Bartlett (2016) claim, family involvement may be the most important predictor of successful psychiatric hospitalisation of adolescents.

In addition, connectedness extended beyond that of family and carer support to relationships with staff on the units. This is consistent with Lindgren *et al.*'s (2004) description of connections with staff being an important aspect of care. These authors mention that, through this connection, the patients develop awareness and an improved connection with their 'self'. Although not explicitly mentioned in those terms, the young people certainly valued relationships with staff when trying to work through their own problems. This is also consistent with research by Salamone, Chur and Winefield (2015), where young people similarly identified their interactions with staff as an aspect of care that contributed to their overall satisfaction with the experience.

The young people reflected on connectedness towards their peers and the impact this had on their inpatient experience. Reports here were mixed as, not only did it impact on whether the experience was viewed as positive or negative, but also whether they indeed 'belonged' on the unit. The young people noted differences in their presentations and behaviours in comparison with their peers and how this had an effect on their sense of where they did, or did not, fit in. Salamone, Chur and Winefield (2015) reported that the way in which young people relate to their peers influences their perception of the appropriateness of their admission, but also the overall level of satisfaction with the inpatient experience. Therefore, the current study extends these findings. However, the young people's views on this were influenced by whether they had come into hospital voluntarily or under section. When admitted against their will, they reported feeling frightened of other patients who they considered more unwell than themselves, and this

led to a sense of not belonging. When young people experienced some form of connection with peers, however, they seemed more likely to report that it was this relationship that was responsible for making the experience a positive one. Peer support seeking behaviour amongst adolescents who self-harm has been found in other studies, as Tillbern, Prazac and Obern (2018) noted; adolescents who engaged in self-harm were four times more likely to seek help from a friend than from an adult.

Alongside the findings relating to 'support', connectedness extended to the young people's perception and/or experience of care and treatment in the community. Remaining in contact with services was reported to be important. Not only was having continued input from community services important for some, but having community treatment planned for post-discharge, even at the early stages of the admission, influenced connectedness and ipso facto the overall experience. The young people raised concerns about the perceived 'cliff-edge' in terms of supportive input when being referred for ongoing treatment in the community following their inpatient stays. There was a clear distinction between the level of support that was received during an admission and what would be received in the community. Many of the young people spoke from previous experience of feeling let down by services in the community, noting that an admission would most likely have been avoided had there been community engagement at an earlier stage.

An assumed narrative from staff surrounding community treatment was positive, but this does not always seem to match the young people's views on this subject. This finding echoes what Taylor *et al.* (2009) found in their systematic review, that discharge could be viewed negatively as service users felt insufficiently prepared to leave the hospital and uncertain about the nature of follow-up support. Their research highlighted that

those being discharged into the community were unsure of what to expect and felt uncomfortable about having to initiate their own care as referrals were often not made. The young people in the current study highlighted a perceived reduced level of intervention, along with an expectation of long waiting lists for therapy. These findings are further supported by those reported by Hume and Platt (2007) who noted an area in need of improvement was immediate after-care following discharge from hospital. Those participants similarly reported dissatisfaction at having to wait long periods for an appointment. Salamone, Chur and Winefield (2017) found dissatisfaction with community-based mental health services, the perceived infrequency of appointments and inconsistency in treatment offered. Some of the young people also reported previously having poor rapport with community therapists or their allocated care-coordinators. What was evident from the reports of the young people in the current study was the appetite they showed for follow-up talking treatments.

b) *Interpersonal factors.* Nearly all of the young people spoke about between-person, relational factors and how these impacted on their experience. They spoke about the qualities or attributes of staff members, the desire to work in collaboration with staff members and how expectations, both of staff and of what they thought was expected of them, played a role in their overall experience. In their investigation of the milieu experience of those admitted to inpatient units, Thibeault *et al.* (2010) reported that one of the most prominent features was that patients did not limit their experience of the unit to that which is tangibly external, but rather told ‘vivid stories’ about their relationships with nurses and other clinicians. Undoubtedly, one of the most salient features was interactions with others, including nursing and support staff and peers. Previous studies have shown that how others respond to young people when they first disclose self-harm, for example, has a bearing on whether they go on to engage with

services (Anderson & Standen, 2007). Coupled with this perilous situation, these authors reported that young people often feel they are treated differently from other patients in these settings and this too can affect engagement and treatment effectiveness. Similar to the current findings, these scholars therefore suggest that the skills that professionals use when interacting with young people who present with self-harm have the potential to affect the young person's experience and engagement with care and likely outcomes. Thomas and Haslam (2017) also found that the therapeutic relationship was a key factor in the success of interventions for self-harm. The current study's findings add to these reports, and give some insight into how interpersonal relationships, staff availability to engage with the young people, and the overall therapeutic relationship impact on whether, and if so how, a young person would seek support.

The findings are also in line with those of Lindgren *et al.* (2004), in describing being treated as human as experienced through staff member kindness, politeness, openness, and the giving of time; and occurring when staff have the courage to see, acknowledge, talk about and explore self-harm behaviours. The young people in the current study spoke about staff member qualities and especially how they contributed to engagement. They emphasised a desire to be understood and how a caring attitude accorded with this and helped facilitate recovery. Some of the young people did not feel well understood and this too impacted on their overall experience of the admission. It seems, in line with the previous literature, that understanding is an important factor impacting on experience. This sentiment is echoed by Taylor *et al.* (2009) who highlighted the need for improved understanding between patients and staff. Lindgren *et al.* (2004) share this view and described experiences of 'expecting' to be understood, explaining that this occurs when staff explore the reasons for self-harm actions and ask how the patients feel, as well as talking openly about them and why they self-harmed. The young people

in the current study showed similarities in this respect, with most describing a perceived lack in terms of feeling understood by staff and others. However, they admit that this was vastly improved when staff took the time to talk to them. There was universal agreement that, when they felt understood, this had a positive impact on their admission experience. Again there are studies which support this finding, describing how mutual support and shared understanding are associated with the expectation that staff are sympathetic and supportive, which can in turn lead to healing and the desire to improve (Hume and Platt, 2007; Samuelsson *et al.*, 2000).

Furthermore, the young people noted when staff appeared or came across as genuine. Taylor *et al.* (2009) found that patient satisfaction was connected to perceptions of staff behaviour towards them and that the perception of genuine concern improved their experience. Relationships and experience were clearly impacted upon in terms of whether young people felt they could foster trusting relationships. Schoppmann *et al.* (2007) noted the importance of trust as a condition for seeking and accepting help. These findings are supported by the current study's findings as the young people described not being able to ask unknown or unfamiliar people for help or support and feeling that they could only get help in the presence of a trusting relationship. They went on to report how their experience was impacted on directly if they felt unable to approach certain members of staff who they were unsure could be trusted to help. The young people spoke about being able to build trusting relationships over time and, as noted above, staff attributes contributed to this process. Trust was hampered by cold, matter-of-fact interactions which accords with Taylor *et al.*'s (2009) description of unhelpful interactions being clinical and impersonal.

Both trust and understanding link with what the young people expect from staff in terms of their relationships and the support offered. Many of the young people described situations with staff who showed inadequate mutuality, causing them to feel misunderstood and not listened to, and they expressed the need for safe relationships regardless of access to support activities. This appears to be in line with previous research which has shown the importance of an adequate treatment alliance in order to achieve satisfactory treatment outcomes in psychiatric care (Brännström, Strand & Sand, 2018). The influence of expectations on the young person's experience extended beyond their expectations of others, to also include what they thought was expected of themselves. They acknowledged feeling some uncertainty about these expectations, and discrepancies between what they expected and how this seemed to create difficulties regarding engagement. In the current study, expectations were shaped by information given prior to admission, but also, for some, by previous experiences. Young people spoke in these general terms about what they thought should be offered on the unit. They discussed feeling disappointed and angered when these expectations were not met. In a study by Salamone, Chur and Winefield (2017), the findings suggested that when desires and expectations are not met, then dissatisfaction is likely to occur. The young people had expectations that they would receive help through talking with staff but also felt they were expected to ask staff for help. Some of the young people felt unable to do this, or at the very least required increased support to enable them to approach staff, which led them to turn to other young people for mutual support, as they did not feel they were able to access or get the help they needed from staff.

In addition, there was an overwhelming appetite by the young people to work collaboratively with staff when designing and thinking about treatment. Not only this, but the young people also highlighted the importance of joint working with staff, being

involved in decisions and being able to talk to staff. The young people seemed frustrated when they encountered barriers to working collaboratively. This seemed pertinent and, as Olasoji *et al.* (2017) report, a collaborative approach to care delivery is seen as an essential element of recovery-focussed practice. The young people thought that a strong working, collaborative alliance was important in order to achieve their goals. This is similar to findings by Schmit *et al.* (2018) who observed that the therapeutic relationship has a high correlation with outcomes in youth clients. These authors found a statistically significant relationship between clinicians' rating of working alliance and therapeutic goal attainment, noting that, as working alliance increases, so does achievement of goals. Shirk *et al.* (2011) also found that the alliance formed was a strong predictor of child and adolescent treatment effects. It was clearly evident that the young people believed that they were able and willing to take some responsibility for the design and development of their care, but struggled to initiate these conversations, which ultimately had a detrimental effect on their overall experience (and possibly their recovery).

c) Intrapersonal factors. The final category under the 'Humanness' concept refers to 'intra-psychic' processes, i.e. the internal emotional and belief experiences of the young people. The current literature on intrapersonal factors in the context of inpatient care is skewed towards suicidal behaviours. Intra-psychic processes has, however, appeared as a significant category in the analysis of the young people's responses in the current study on those who present with self-harm. Freudenstein *et al.* (2012), highlighted the intrapersonal factors that contribute to the overall demands that young people place on themselves and how this can affect self-critical, emotional and behavioural experiences. In the current study, the findings show that, alongside the interpersonal factors already mentioned above, there is a dynamic with internal

processes which mediates how care in the unit is experienced. It appears that intrapersonal factors not only act as a filter to engagement, but also have an effect on expectations and the sense of connection discussed above. The young people reported on the internal experience of their emotions, which is often a driver of self-harm behaviour, but also on their subjective experiences of being seen and treated as an individual.

Self-harm is used by many adolescents as a way to cope with negative thoughts and feelings and they perceive these behaviours as effective. However, at the same time, they report feelings of guilt and shame as a consequence of this self-harm (Tillman, Prazak & Obert, 2018). The young people reported that their behaviours were often very emotionally driven, both in terms of urges to self-harm on the unit and with regards to their overall experience. They revealed a desire to improve their own skills around managing emotions and stated that this was a key goal of admission in their view. Overall, the findings regarding the impact of emotions on experience here are consistent with previous research indicating that emotions and their regulation play an important part in self-harming behaviours. Gratz and Chapman (2007) argued that struggling to manage and regulate emotions is the most significant factor for those who self-harm. In addition, in the current study, the young people went on to describe how their motivation and engagement levels are impacted upon by their mood and, consequently, this too had an effect on their overall experience. For them, emotion and motivation were also reported as drivers of their behaviour on the unit. They described how their emotions and motivation could increase or decrease the extent to which they engaged. Pessoa (2009) describes emotions as strictly personal experiences that provide energy or an internal force that directs the body towards a certain behaviour.

This idea seems to align well with the notion of engagement and how the young people described the impact of their emotions on motivation as well as behaviour.

The young people identified the importance of having their emotions acknowledged. They experienced significant dissatisfaction when this was not the case. As mentioned, the young people's ability to regulate their emotions is accepted as one of their main difficulties. This, coupled with a desire to be able to learn emotional regulation when they encounter mis-recognition or non-acknowledgement of an emotion, had a detrimental impact on the young persons' experience. Of course, their interactions with staff are replete with emotional exchanges and it stands to reason that much information is exchanged through this process. Frustration, sadness and disappointment were noted when expectations around identifying, working with, supporting and acknowledging emotional states were not met. Hareli and Hess (2012) explained that emotions serve as social signals and illustrated how both person perception and situational understanding can be derived from emotional displays. It therefore is apparent that there may indeed be much that is lost or inferred incorrectly through these displays which in turn is likely to have an impact on overall experience. Again, it is not hard to see how this is closely linked to and co-mediated dynamically with the interpersonal and connectedness categories previously noted.

And lastly, in terms of emotions, young people highlighted experiences of hope. Following on from the aforementioned discussion about acknowledging emotions, the negating or dismissal of emotions tended to result in experiences of hopelessness. Connectedness and being able to see the admission in context, and being able to link the experience to future goals and the outside world, were more likely to make the young people feel hopeful. On a positive note, some young people thought of the

admission as being instrumental in improving their emotional distress and felt hopeful about the experience and oriented their thoughts towards goals and a future in which their lives had improved. Having needs met and emotions recognised fostered hopefulness in terms of moving forward. Lindgren et al. (2004) reported on similar patient expectations of acknowledgment, using the term 'confirmed', and describing how this either fosters or stifles hope. In a later study, Lindgren et al. (2011) found that offering time to meet, talk, listen to and take the individual seriously also fostered hope. These factors link intrapersonal factors to connection and interpersonal factors, as mentioned above.

Being valued and respected in terms of being seen and treated as an individual was additionally highlighted by several of the young people. Lindgren et al. (2011) noted suggestions that mental health care could be much improved by confronting prejudice, understanding self-harm, and safeguarding opportunities for dialogue, as well as by considering healthy ways of emotional expression. The young people similarly expressed their views on how they wanted to be treated, referencing their individuality and being shown respect as particularly important. In accordance with the work by Lindgren et al. (2004), in which participants sought to be confirmed, the young people emphasised the importance of being seen as individuals, with unique problems and personalities. Although there was acknowledgment that they were part of a group, there was also a marked desire to be seen as separate and distinct.

Striking comments were made in terms of being valued as human, with references to feeling like caged animals and perceptions of being treated in an inhumane way through a lack of respect and value as human beings. Similar observations were made by Horrocks et al. (2015) who highlighted the significant effects of how care is provided on

patients' feelings of low self-worth. In fact, treating patients as individuals and with respect is a common theme in the literature (Taylor et al., 2009; Lindgren et al., 2004; Horrocks et al., 2015; Hume & Platt, 2007; Schoppmann et al., 2007; Lindgren et al., 2011). Lindgren et al. (2004) discussed the importance of patients being "seen" beyond the surface, a phenomenological perspective which involves being acknowledged at a deep level coupled with having one's emotional distress that underlies the symptoms observed. The young people's experience was similarly shaped and impacted on by perceptions of being valued and treated as unique. A broader incorporation of characteristics more aligned with the young person's personal beliefs was also sought. The young people did not see themselves only as self-harmers or as people with difficulties, but as young people with goals and aspirations and some positive traits and characteristics. Lindgren et al. (2004) made similar observations, describing patients' expectations of being viewed as a human being with assets, desires, longings and needs, and highlighting their frustration when they were seen only as a human being with difficulties. They further commented on the experience of being valued as a determinant of engagement and connection. Again, it seems prudent to keep in mind the links with interpersonal factors noted previously; in particular the young person's desire to be understood and how this impacted on internal factors.

Young people reported that, when staff saw them as human beings, their expectations were more readily met, which in turn fostered their own sense of value and helped to promote their experiences of human dignity. Lindgren *et al.* (2004) found that not being viewed as unique and human, with assets as well as vulnerabilities, was described as "really awful" and created a barrier to initiating any kind of communication with staff. As already mentioned, this connection and ability to interact with staff remains key to the overall experience of the admission. Horrocks *et al.* (2015) commented on the need for

respect but noted participants' assumptions that they would not be respected and would be treated as worthless because they had self-harmed. Hume and Platt (2007) reported on participants' concerns about being judged by staff and other patients due to their self-harming behaviour. It indeed seemed to be the case that the young people felt an increased sense of self-worth when they felt they were being treated with respect, warmth and understanding.

The desire of the young people to feel unique is echoed in Smith-Gowling, Knowles and Hodge's (2018) comments which highlighted the young people's desire to be viewed as separate from the attention seekers, and how social comparison processes divide young people's perceptions of their peers' self-harm. They noted a socially desirable genuine group, as distinct from a less favourable attention-seeking group, which appeared to be intensified and amplified in inpatient settings. They reported on the struggle experienced by young people to be perceived by others as authentic, and not to be classed as an attention seeker, while at the same time eliciting care from others in times of distress.

The young people's sense of agency or control was highlighted as important. They mentioned the importance of having choice about treatment options and being able to make decisions about the treatment they received. When there was a perceived lack of involvement in decisions, this had a detrimental impact on the experience. Young people generally noted feelings of disempowerment regarding decisions related to their treatment but, unsurprisingly, when they did feel involved, their sense of agency was much improved. Taylor *et al.* (2009) reported similar findings whereby the majority of participants called for personal responsibility in terms of deciding on their care and treatment, emphasising the importance of allowing patients to participate in treatment

decisions and keeping them informed of their status. Being involved was seen as one of the young people's most important expectations of their admission and they felt more positive about their experience when given more opportunity to participate in their care and care decisions. The young people felt distanced from their care if they were not given an opportunity to participate, leading to increased withdrawal and a poorer experience. They interpreted lower levels of involvement as associated with staff not valuing their wishes. Schoppmann *et al.* (2007) noted that staff using approaches which acknowledge the expertise of the person they are helping is a necessary component of building trust and confidence. They also noted that participants perceived questioning of their expertise as a rejection. Some young people were reluctant to engage with unknown staff members. Schoppmann *et al.* (2007) described this type of refusal of help as the last possibility of self-protection and self-control.

The overarching theme within the humanness concept in relation to this model is that of the young people's constructs of what makes them human and the categories within are dynamically linked. There are strong references to the social aspects of being human, and relating to others, but also how this is impacted on by internal processes. It was striking to note the strong feelings expressed by the young people of wanting to be valued and seen as unique individuals, but how this was dependent on relational factors which in turn re-influenced being valued and seen as unique and connectedness.

4.2.2 Restriction. The counterpoint in the model of the young person's inpatient experience when presenting with self-harm is the core concept of restriction. A critical tension is highlighted when the young person presents with risk behaviours requiring care and treatment. Treatment is offered within what is experienced as a restrictive environment consisting, not only of the physical hospital environment, but also of

behavioural management strategies and interventions. These take place against a backdrop of the young person's struggle and desire for liberty, control and volition.

The term restriction is likely to conjure up several conceptualisations and possibly some confusion. However, for the purposes of the current study, it refers to the young people's experience of the inpatient environment, rules and boundaries, whether physical or otherwise, and the presence or removal of control. As Spencer *et al.* (2019) state, an adolescent ward is a restrictive and complex environment where restrictions include policies, procedures, routines and 'rules' enforced by staff. This perhaps captures something important about how behaviour is managed within these sorts of settings.

At the outset, it is useful to note the units' position on restrictive practices. The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions (Mental Capacity Act, 2007). In addition, The Royal College of Psychiatrists has issued new guidance suggesting that all informal patients should be assessed. If deprived of their liberty, a Deprivation of Liberty Safeguard (DoLS) authorisation or Mental Health Act assessment must be sought (Penny & Exworthy, 2015). A DoLS ensures that people who cannot consent to their care arrangements are protected if those arrangements deprive them of their liberty (Griffiths, 2017). Arrangements are assessed to check that they are necessary and in the person's best interests (*Ibid.*). However, there remains a dilemma for clinicians as they try to balance the enduring imperatives to promote autonomy and to help those who are unwell. Within the Restriction concept there is a further complex dynamic between hospitalisation, the clinical interventions offered within this environment, and a somewhat more intangible idea regarding the ambivalence experienced within this restrictive environment. The latter is referred to as a dilemma here, and is viewed alongside a desire for freedom from these self-and-other imposed

boundaries. In Figure 12, the Restriction core concept with its corresponding categories is illustrated.

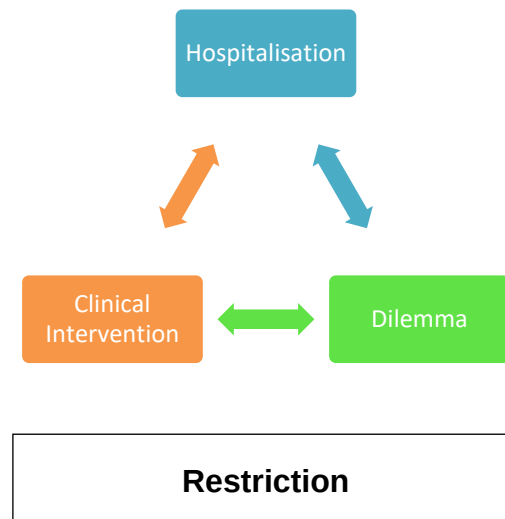


Figure 12: Restriction core concept with related categories

a) Hospitalisation. The rationale for the current study was to gain a better understanding of the experiences of young people who have been admitted to hospital. It seems entirely appropriate and to be expected that the young people reported on this process, not only in terms of the physical environment, but also the experience of the admission itself and some of the problems they encountered regarding exposure to emotionally triggering stimuli whilst in hospital. Gaining understanding of this phenomenon seems particularly timely as it is indeed noteworthy that the overwhelming majority of mental health admissions in adolescents are due to suicidal and self-harming behaviour (Borschmann *et al.*, 2018). Rodham, Hawton and Evans (2004) similarly stated that children and young people have more hospital presentations for self-harm than any other age group and that hospital admissions are at all-time highs.

Reports by the young people on being admitted to hospital for self-harm were mixed. They mostly took the view that it could be helpful to be removed from their usual

environments where they were more likely to have access to means that they could use to self-harm with. This is in line with guidance on inpatient admissions for self-harm, which emphasise that one of the main purposes is to restrict access to potentially lethal means. In addition, they spoke of being able to get away from their normal lives and to be cared for. Donner, Mutter and Scior (2010) reported that some young people view the hospital as a place of safety, respite or transition. The young people in this study, however, described a preference for community-based services, favouring the familiarity of their homes, and expressed some doubt about the effectiveness of being in hospital as a means of stopping self-harm urges. Hume and Platt (2007) reported that young people mostly showed a preference for community services as opposed to hospital-based interventions. The young people in the current study acknowledged that they expected specialist support and some participants occasionally expressed a desire to be admitted to hospital. Some of the young people spoke about feeling less engaged when they had to return to the hospital following discharge for a risk event and came into contact with the same staff. Hume and Platt (2007) reported that young people felt uncomfortable about having to return to the same hospital and encountering the same staff. In line with Chinn *et al.* (2011), some young people saw an admission as a punishment and that the hospital was like a prison. Some young people went as far as to describe the admission as being traumatic, describing anxiety and fear. This is in line with findings from Parkes *et al.* (2007).

Some of the young people spoke about how they viewed being admitted to hospital as actually being detrimental to their own and others' mental health. In certain cases, they thought that either themselves, or some of the other young people who had been admitted, had not met the threshold for an admission and were thus at risk of deteriorating unnecessarily. This idea is supported by conclusions from previous

research, highlighting the risk that service users may experience unnecessary, extended admissions (Slevin *et al.*, 2008 and Hall *et al.*, 2006). This could be the result of poor community services, social care issues or even some young people becoming reluctant to leave and return to their everyday lives which may be unpleasant in terms of social and other issues. The young people, interestingly, reported that long periods of hospitalisation were detrimental and unhelpful. Bryson *et al.* (2017) reported that coercive interventions such as seclusion and restraint, and exposure to aggression, violence, and self-harming behaviours of other adolescents can increase the likelihood of trauma during an acute admission.

The physical environment was also commented on by the young people, including their perceptions of how this impacted on their experience and indeed their mental health. Of course, it is not difficult to make links with how these perceptions relate to the humanness themes commented on in the previous section. Interestingly, in their systematic review of people's attitudes towards clinical services following self-harm, Taylor *et al.* (2009) commented on the remarkably similar experiences of participants despite variations in healthcare systems and setting. Lindgren *et al.* (2004) commented on participants suggesting that the physical milieu of their care is important and noted that participants described the environment as 'not hospital like' but rather, like a house with your own room. The young people in the current study similarly commented on the ward not appearing 'like a hospital' but feeling more 'like a home'. The young people valued having a bedroom that provided them with their own space, but also having opportunities to spend quiet time in relaxation or comfort areas. They explained how this contributed to engagement and connection, a category discussed within the concept of humanness, and how it led to feelings of safety, security and opportunities for growth. Negative aspects that were raised in relation to the environment were a lack of

accessibility to an outdoor area and feeling confined. They mentioned the somewhat contradictory nature of the unit being an 'open' one, yet the doors being kept locked. Some young people, however, acknowledged that this was probably helpful in some cases.

There were several references by young people to struggling to cope with others' distress in terms of self-harming on the unit. They mentioned that this could be 'triggering', meaning that it increased the urge to engage in self-destructive behaviours. In the study by Smith-Gowling, Knowles and Hodge (2018), participants' reported on the effects of exposure to self-harm on a ward, highlighting that it made their experiences much more intense and condensed. They noted that young people often found being surrounded by the distress of others very difficult and that this had an impact on their own self-harm behaviour. The young people described a ripple effect when another young person self-harmed and commented on the unpleasant environment this created, adding that the ward had a direct detrimental effect on their well-being. They stated that sometimes they felt traumatised by being constantly surrounded by people who self-harm. They reflected that being exposed to self-harm in this way was effectively socialising and normalising self-harm as a means of coping with distress, thus increasing their own risk of self-harm. Smith-Gowling, Knowles and Hodge (2018) stated that, in addition to the emotional intensity experienced on a ward, the social dimension of self-harm is also intensified by the physical proximity and undiluted contact with others who have similar difficulties. The young people shared their experiences of how the intense ward environment produced a social struggle with self-harm, and how being exposed to the self-harm of others not only normalised self-harm but also appeared to contribute towards its 'transmission', i.e. the ripple effect mentioned above. The young people reported that, at times, they felt helpless when they witnessed others' self-harm, but also

that they noticed staff were less available to them. Smith-Gowling, Knowles and Hodge (2018) noted young people describing the negative effects they experienced as a result of not being able to help prevent others' self-harm in a ward environment, and feeling helpless which added to a sense of loss of control. The young people claimed that they felt responsible for the safety of their peers at times and that they were being expected to take on a role that they were not equipped for which could threaten their own well-being.

b) Clinical intervention. One of the key intentions of admission to hospital is to keep young people who are engaging in self-harming or suicidal behaviour safe. Of course, the clinical management of self-harm behaviour in the inpatient settings is challenging. The young people reported on the behaviour management, therapeutic and care-planning interventions received on the units. They also spoke about expectations not being met. Awenat *et al.* (2018) reported on inpatients' perceptions of untherapeutic regimes which failed to meet their psychological needs. It is the researcher's view that this category posed an interesting conundrum about where to locate clinical interventions in the model of the young person's inpatient experience when presenting with self-harm. A tension arose in the analysis of how the young people viewed the interventions, their volition, choice or desire to participate in these interventions and the limitations posed by the interventions. Ultimately, the clinical interventions, as described in section 3.3.2, arose as agents of behavioural control and this, at a fundamental level, was conceptualised as a restrictive force. The notion of control, which also falls within the concept of restriction, is discussed later in the Dilemma section of this chapter.

The young people spoke about the planning of their care and therapeutic techniques and processes offered on the unit. They discussed the planning strategies that were

implemented, which had as their goal the safe management of self-harm behaviours. They also spoke more specifically about management strategies such as levels of observation and further behavioural management techniques. It may be useful to note here that the units' policy is that self-harm must be understood in context and that it serves a particular individual function. However, young people are supported to find alternative ways to manage and often this is done through the use of care-plans.

The planning of care, for the purposes of this study, refers to plans around individualised interventions which form part of an attempt to understand the functions of self-harm for the young people admitted to hospital. Common functions of self-harm include gaining a sense of control, communicating one's distress physically, to feel pain or reality in a state of dissociation, self-punishment, avoidance or distraction and to control social boundaries (Thomas & Haslam, 2017). The Trust where the study is located is keen to implement function-specific, individualised care-plans, and this study serves as a complement to this aim by gathering young people's views of care. Despite interest in the field of self-harm, it remains widely misunderstood, and for the young people in the current study, this was thought to lead to unhelpful responses from staff, leaving them feeling frustrated, sad, isolated and angry. In other studies, this misunderstanding has been found to lead to further self-harm and a possible reluctance to seek help in the future (Thomas & Haslam, 2017). Indeed, the young people spoke about the content of their care-plans and the value of these.

In line with the above discussion, the young people found that, when care-plans were in place, they tended to improve understanding, which ultimately affected relationships with staff, engagement in treatment and improved help-seeking behaviour in the future. They spoke about the content of the care plans, although it was not always clear whether the

techniques were well-aligned to the functions of self-harm. Some young people revealed that, at times, a 'one-size-fits-all' approach to the planning of their care was deployed with little thought about what would be the most effective technique at that moment. The findings suggest that staff should aim to understand the function of self-harm, and use this understanding to develop an individualised plan with the aim of managing distress and identifying barriers to the effectiveness of the interventions so they can be worked around. Alongside reports of the value of care-plans, some of the young people stated that their care-plans had not been completed and explained how this could lead to frustration and uncertainty. This was often coupled with concerns that, when plans were in place, they were not followed through, reviewed or updated. In this respect, the young people reported feeling sceptical about what techniques could work, and the transferability of skills learnt to the home environment. There was a desire expressed by the young people to engage more in the planning process, which links in with previous discussions about working collaboratively with staff and being more involved in care. It was the researcher's experience that the young people were motivated to seek a better understanding of their behaviours and wanted support in implementing their plans.

Closely connected with the desire to be involved in the planning of care, were the reports on therapeutic interventions and processes offered to the young people whilst on the ward. In general, acute mental health inpatient services have been criticised for being non-therapeutic and lacking therapeutic activities (Paterson *et al.*, 2018). This was echoed by some young people in the current study who voiced their disappointment about what was offered on the unit. They also spoke of a lack of therapeutic conversations and, in particular, the limited access to talking therapy, despite this being the most highly valued. Dominating the findings in this regard was the young people's need for 'therapeutic talk'. At the same time some felt overwhelmed by what was on offer

and thought they might find it useful to think more idiosyncratically about the development of treatment plans. Some were worried about the potential exacerbation of self-harm urges if they were to begin conversations that they did not feel ready for. In addition, the young people took the view that, if there was limited therapy on offer, they struggled to see the value of the admission. This impacted on their motivation and engagement, as discussed previously in the section on intrapersonal factors. There was some awareness about the techniques on offer but, whilst some young people found this helpful, others were less convinced of their effectiveness.

Their mixed views on behavioural management in terms of the step-wise increase in restrictive practices following risk events were noteworthy. The young people spoke about the limited effectiveness of increased or enhanced observations, in particular with unfamiliar staff, but their most pressing concern centred around the use of restraint. Barnicot *et al.* (2018) define observation as an intervention used to maintain safety in inpatient psychiatric settings by allocating a staff member to maintain continuous visual observation or to remain within arm's length of a patient at risk of harming themselves or others. They reported patient experiences of observation being therapeutic when they perceived staff as emotionally supportive and acknowledging their humanity, but that it can also be nontherapeutic or even iatrogenic when patients perceive staff as ignoring them or lacking empathy, or when the restrictive and controlling nature of observation exacerbates their distress. This clearly matches the reports from the young people in the current study where findings suggested that constant observation negatively impacted on the young people's sense of well-being. Most young people struggled with the lack of privacy but valued feeling safe during continuous observation. Taylor *et al.* (2009) similarly found that participants placed under observation whilst on the ward had positive experiences when staff kept

them occupied and engaged; however, the lack of privacy was a key concern and limited the perceived effectiveness of this form of management.

There were also mixed views on medication. Some young people felt their medication was not optimised and questioned its effectiveness. Interestingly, the degree of acceptance they felt about being on the unit, seemed to impact on the young person's perception of the usefulness of the type of therapy or intervention offered. Additional comments were made regarding individual therapy, group therapy, and family meetings.

c) *Dilemma.* The young people in the current study shared mixed feelings about being in hospital. In the researcher's view, this is understandable. As discussed above, the admission experience is dynamic and highly complex. The young people acknowledged needing and wanting help, but at the same time feeling disconnected from others and lacking influence over their care. They spoke about their uncertainty regarding the effectiveness of an admission for self-harm and reported difficult experiences within the inpatient milieu. They also mentioned their disappointment and frustration with the support offered in community settings. After all, as noted by Brännström, Strand and Sand (2018), many patients do not feel comfortable in the inpatient care setting, which in the worst case can be seen as a repository for those whom the open care system cannot take care of. The word 'dilemma' is defined in the Oxford English Dictionary as a situation in which a difficult choice has to be made between two or more alternatives, especially ones that are equally undesirable. It is the researcher's view that this term captures the young people's struggle between the options they had before them.

The young people identified a sense of having very little control over their daily lives in hospital. They are informed of the units' outlook on self-harm behaviour, as mentioned previously, during the admission process. In addition, their belongings are searched for access to any means of self-harm, upon admission and after returning from periods of leave away from the ward. Any objects with potential for use as a means of self-harm (e.g. razor blades) can only be used under the direct supervision of staff, if needed. Furthermore, there is a routine that the young people are expected to adhere to. This in itself, creates a tension, particularly in light of the young people's stage of development. Rathus, Miller and Linehan (2017) refer to a common tension between pathologising what is normal and normalising the pathology. This seems relevant here when considering the young people's efforts to exert some sense of control over their lives. It is certainly the case that many, non-hospitalised young people struggle with imposed rules and boundaries. Feelings of being disempowered are prevalent throughout the literature. According to Taylor *et al.* (2009), the majority of participants called for more personal responsibility in deciding on their care and treatment, placing particular emphasis on allowing patients to participate in treatment decisions and keeping them informed of their status.

Lindgren *et al.* (2004) reported that, through staff valuing their autonomy, participants acquired the ability to participate in and make decisions about their care. As already stated, Schoppmann *et al.* (2007) noted that the recognition of expertise was a necessary component of building trust and confidence, and questioning expertise was interpreted as a rejection leading annoyed withdrawal. The young people referred to feeling out of control when distressed and, in particular during these times, refused to accept help from unfamiliar people, which may be seen as a last possibility of protecting themselves or exercising control. Lindgren *et al.* (2011) noted patient experiences of

rules in acute psychiatric wards leading to feelings of being victimised, dehumanised, powerless, humiliated, isolated and rejected. Patients described feeling disempowered by threats of punishment and rigid rules, as well as frustration, believing that staff viewed compliance as synonymous with recovery. In Horrocks *et al.*'s (2015) study, members of staff were often seen as judgemental and punitive, though they may not have been actively behaving with that intent. Lindgren *et al.* (2011) found that patients did not seem to be kept fully informed about the rules connected with the admission process, leading to uncertainty, frustration and a sense of neglect of the participants' psychological needs. The young people in the current study reported that inflexible ward rules led to an unsatisfying experience and highlighted the importance of being shown respect as individuals and acknowledging their ability to define their own needs.

For some young people the admission to hospital was a frightening experience, especially when they already harboured heightened feelings of being out of control. Hume and Platt (2007) found that participants expressed a preference for interventions which would enable them to feel in control of their behaviour, which is understandable, but some of the young people viewed an admission as a punishment. They mentioned staff confiscating any object that could be used for self-harm which increased their feelings of lack of control and contributed to the desire to self-harm again. The young people suggested that staff should give them more responsibility for preventing their own self-harm. This seems to highlight the willingness of patients to work in collaboration with staff, as noted above. Taylor *et al.* (2009) stated that individuals admitted to psychiatric hospital report feeling a lack of control and that several felt they were merely being watched and did not receive any sort of therapy for their self-harm. The young people described the rules and boundaries on the unit as something integral to 'the

system' rather than something that they could influence and thus felt they had less control over the experience.

Furthermore, some young people revealed mixed views on medication as a means of controlling behaviour. Thomas and Haslam (2017) found similar views on the use of medication, other drugs and sleep to manage behaviour and suggested that short-term benefits were outweighed by the longer-term costs of such approaches with regards to achieving patient outcomes.

Young people spoke about their experience of autonomy and freedom and compared their lives on the unit with their lives in the community. They held especially negative views towards experiencing a loss of control and independence when restriction was increased. The experience of feeling powerless has been linked to being sectioned (McNally et al., 2007). Restrictions were also described in terms of other unit boundaries and rules, most of which the young people viewed negatively.

Further highlighting the dilemma, young people seemed to have perpetually mixed feelings and ideas with regard to admission, the care that they received, and the contradiction between wanting help and wanting to maintain the status quo and engagement with or refusal of treatment. They also expressed a desire for alternative treatments to inpatient care. They felt frustrated, as already highlighted in connection to the above, about missed opportunities, lack of access to services and ultimately a 'last chance saloon' type experience in terms of being admitted. Similar contradictions were experienced regarding being caught between the usual practices of regulating their emotions and the familiarity of self-harm as a function of coping and the acceptance that this was not an effective way to cope with feelings and distress. Research by

Brännström, Strand and Sand (2018) revealed that difficulties in affect regulation was a central area of need, combined with a risk of inadequate support producing a deteriorating mental state and inpatient care. This sheds light on the struggle that these young people experience, walking the tight rope between care and fear.

Several young people described an inclination to deny their difficulties and resist seeking help. A similar report by Koekkoek *et al.* (2010), whilst studying patients with low treatment efficacy, described how service users frequently experience ambivalence between wanting to be an independent person and feeling like a helpless patient. The young people struggled to use the techniques they had learned independently, in particular when they went home, but they also found it difficult to seek help.

4.3 The Model Of Young Persons' Experiences Of Inpatient Care When Presenting With Self-harm

The findings resulted in a model for the young persons' inpatient experience as discussed in chapter 3.6 and it was found that, although presented separately, there was constantly evolving dynamic between the various components. The relationship was highlighted and expanded on but the tension between the core concepts and dynamic nature of the relationship is noteworthy. The model shows a relationship of reciprocity and interdependence. The emerging categories had influence over others and could at any one time be both emphasised and understated. The relationships between the categories and related subcategories thus remain complex and dynamic. The model is an attempt to represent this movement and complexity.

Overall, the young persons' reports of what was needed, what was on offer, and what was desired arose together, but did not always align and it is here where the overarching contradiction and tension became most apparent.

4.4 Summary Of Chapter

A comprehensive discussion of the findings relating to current literature was presented in this chapter. When the core concepts of humanness and restriction are viewed together, the respective categories seemed to feed off and into each other in a complex and dynamic interaction. As the researcher, it is acknowledged that these categories were grouped subjectively, but it is proposed that they emerged from the data. Although some of the categories have similar qualities to those described in previous literature, the researcher remains confident that they in fact arose in a novel way within this study rather than being influenced unduly by preconceived ideas. Parts of the model were presented throughout the chapter and the model that emerged from the findings produced in chapter 3 was summarised. It is the researcher's view that, ultimately, the *model of young persons' inpatient experiences when presenting with self-harm* is as close a reflection of the voice of the young people as it is possible to achieve. The following chapter considers the implications of the findings, the limitations of the study, and recommendations for further research and conclusions.

Chapter 5: Limitations of study, implications of the findings, recommendations for further research, summary and conclusion

5.1 Chapter Overview

In the previous chapters, the foundations were laid for the development of a grounded theory: *A model of young persons' inpatient experiences when presenting with self-harm*. This theory has emerged from the data collected from interviews conducted with young people admitted to inpatient care following episodes of self-harm. A grounded theory methodology was chosen as very little research has been conducted in this subject area. Many concepts relating to the inpatient experience of young people

who present with self-harm are, of course, yet to be identified and the grounded theory sets the stage for further research in this area. This chapter is a reflection on the strengths and limitations of the study, the implications of the findings, recommendations for further research and a summary and conclusion.

5.2 Strengths And Limitations Of The Study

The aim of this study was to obtain a rich understanding of young persons' inpatient experiences when presenting with self-harm, drawing on multiple perspectives. Some of the strengths and limitations of the study are described below.

5.2.1 Strengths.

- The challenges of including service users in research have been reflected on in Chapter 1 and have been well documented in other research. A particular strength of the current study was in the method used for recruiting young people. The researcher went to all reasonable lengths to ensure this vulnerable group did not feel coerced in any way, nor that their refusal to participate would in any way hamper their access to treatment as usual on the ward. These methods are outlined in Chapter 2. It is the researcher's view that it is for these reasons that the young people were able to talk so freely and frankly about their experiences, and that what is believed to be a relevant and honest theory has emerged from the accounts.
- The qualitative nature and resulting semi-structured interview method is also viewed as a strength of the study. A wide range of aspects particular to the young persons' experience was achieved. The approach, however, also allowed for flexibility and opportunity to explore reports in depth. The focus and direction of

the interviews was thus shared between the researcher and the young people and guided by a genuine interest in what was being said and where the conversations would lead.

- Genuine interest in what would emerge from the data was further enhanced by limiting the initial literature exploration and letting initial ideas 'lie fallow' (Charmaz, 2006). This allowed for reduced bias in developing the prompts used in the interview. Of course, the researcher has extensive experience in the field and could not completely suspend all knowledge, but this was constantly reflected on, both during data collection, and in supervision.
- The researcher noticed a similarity in the accounts from the young people. There was a coherence to the reports, and it was deemed that all the interviews added to the overall theory. There were some consistent themes running through the young people's narratives and these added to the theoretical model. Being able to incorporate all the perspectives was felt to be a strength of the research.
- In addition, a strength was located in the attempts to improve the reliability of the data analysis. This was achieved by the supervisor analysing interviews separately and deriving themes and categories independently of the researcher. The researcher kept a reflective research diary and memos throughout the process, to attempt to improve the quality of the findings (see appendix 12 for an example of a memo extract. See appendix 5 for an excerpt from the reflective research diary).

5.2.2 Limitations.

- As mentioned in chapter 2, convenience sampling was used in order to identify and recruit participants to the research study. As this represents a non-probability sampling method, there are limits to the transferability of the findings. Non-probability sampling has been criticised for its lack of representativeness (Setia, 2016) and, as the sample was selected from the young people admitted to the units where the study took place, sampling bias may limit the degree to which it reflects the characteristics of all young people admitted to inpatient care when presenting with self-harm.
- A further note on a sampling limitation is warranted in relation to the number of participants recruited. There is continued debate over theoretical sampling. This, along with theoretical saturation, is discussed in Chapter 2. Strauss and Corbin (1998) consider a sample of eight to ten participants sufficient for conducting a grounded theory analysis. Although ten interviews with young people, conducted in two psychiatric units, are included here, there are likely to be limits to the transferability of the findings due to the small number of participants. Although it is believed that theoretical saturation had been reached in terms of the ten interviews, it could be argued that more interviews may have yielded new concepts eventually. It is the researcher's view that the process was not ended too soon, but it is thought to be worth considering as a possible limitation.
- Recruitment of young people across the two sites was also unbalanced; thus the interviews conducted at the second service may not have been representative of other young people's experiences of that ward. As mentioned previously, it was felt that the wards were similar in terms of philosophy and approach; however, it

is conceivable that there would be differences that may have had an impact on the experience of the young people that would differ between the units. It is noted, however, that the concepts that emerged from the data at both sites were indeed similar.

- Although every young person admitted to the unit after presenting with self-harm had an equal chance of being included, the time period over which the study took place may have reduced the opportunity for greater demographical variability. Participation in this study was limited to those proficient in English and the findings of this study may not apply to young people who self-harm but who have not yet come to the attention of services. The sample also comprised an all-female (one transgender), white demographic and was unbalanced in favour of higher socioeconomic status. Although prevalence studies would support this group as being the most likely to present with self-harm (Gillies *et al.*, 2018), it is possible that greater demographic variety could have influenced the categories that emerged.
- It was striking to note how articulate the young people interviewed were. Their use of professional terms and language seemed different from the usual adolescent argot. Some of the young people had indeed become 'experienced' inpatients, which possibly explains why they adopted terms and language associated with the setting. To an extent, this may have limited access to the genuine young person experience in relation to the purity of their responses.
- In terms of improving the validity of the findings, perhaps other forms of data collection would be of value in order to triangulate the findings. A focus group

could have been conducted on the questions in the semi-structured interview in order to guide or refine the research further, or additional staff perspectives could have been included, as in previous research conducted in this area.

- As already reflected upon, the researcher cannot stand separate from the participants and the analysis of the data. Similarly, it is the belief of the researcher that objectivity is neither possible, nor necessarily desired. The data was analysed from the researcher's perspective and, of course, this may lead to bias, considering his background and experience of the subject matter. This was discussed in the section on the researcher's position and the researcher/practitioner dilemma.

5.3 Assessing The Quality Of The Research Study

As discussed in Chapter 2, attempts were made to ensure the quality of the research. This was facilitated by employing the criteria by which the quality of qualitative research is evaluated, recommended by Elliot *et al.* (1999). These scholars set out the criteria under the headings of reflexivity, situating the sample, grounding in examples, providing credibility checks, coherence, accomplishing both general versus specific research tasks and resonating with readers.

5.3.1 Reflexivity/Owning one's perspective. The researcher introduced reflexive comments within the research, but also explained his position in terms of paradigm as well as researcher and practitioner. This was done in an attempt to be transparent about his interest in and experience of working with young people who self-harm, but particularly those who have been admitted to inpatient settings. The aim was to enable the reader to consider how this may have influenced not only the choice of

research subject, but also how the *model of inpatient inexperience of young people presenting with self-harm* was constructed. The intent is that the reader can gain some insight into how the data was analysed as spoken about in section 2.6.1 (a).

5.3.2 Situating the sample. Descriptions of the participants were included in the Methodology chapter. ‘Pencil-portraits’, as they were termed, provided details relevant to the research so that the reader could learn something about who the young people that participated in the study were. Hence, the reader is able to acquire a better understanding of the context surrounding the young people in this study and can thus further assess the relevance and applicability of the current findings. Further reflections on the participants are mentioned in the Strengths and limitations section of the study.

5.3.3 Grounding in examples. There are several examples included in the Findings chapter that were obtained from the young people’s transcripts. The reader is able to observe and assess the connection between the data and how this has been interpreted by the researcher. Examples are presented verbatim and coupled with a description of how they fit into their respective categories. An extract from a transcript alongside examples of how some of the text has been coded is included in appendix 6.

5.3.4 Providing credibility checks. Throughout the process, from data collection to data analysis, the researcher consulted with his clinical supervisor and academic tutor regarding possible data interpretation. As mentioned previously, the clinical supervisor independently coded a transcript in order to improve reliability. Initial coding, as well as some of the researcher’s research journal entries were viewed by the academic tutor for comment and advice. The initial coding was presented to both supervisors for comment. In addition, the researcher attended a coding workshop where

initial categories were explored and refined in early attempts to discover how the young people's accounts described a theory. The examples within the text are of sufficient length to allow the reader to make an independent judgment about the meaning of the statements.

5.3.5 Coherence. The researcher has attempted to clearly set out the intentions of the research. A policy of transparency has been adopted in reporting on the steps taken throughout. The intent was to provide a grounded theory analysis that is 'data-based' but at the same time stays as close to the participants' responses as possible. Information was provided about how the data fitted the categories alongside descriptions of how the categories functioned as a whole within the grounded theory. Diagrammatic representations of the concepts, categories and sub-categories were included to further bolster the theory-scaffolding process.

5.3.6 Accomplishing general vs. specific research tasks. Given the nature of the sample and where the research was situated, which is discussed more fully in the limitations section, more research would be necessary in order to assess how transferable the findings are. The hope is, for those reading the current paper, that it will provide some initial thoughts and ideas relating to the young people's experience of inpatient care when they present with self-harm. It may serve as a first step to developing ideas and understanding beyond the scope of this paper, which indeed seems worthwhile given the nature of distress experienced by this group.

5.3.7 Resonating with the reader. It is anticipated that those interested in the field of the experiences of young people who self-harm and present to hospital will not only find the current paper useful, credible and relevant to their practice, but also an

exciting piece of research. At the same time, for those new to the field, perhaps the theory can provide some initial guidance about the experiences of these young people. It is the researcher's view that this study has provided an initial framework for thinking about these experiences and, as discussed below, highlights several implications for clinical practice. Drafts of the paper were sent to supervisors to read and comment on in further attempts to improve resonance. Feedback guided the researcher to adapt and rewrite sections of the study in order to clarify what was being proposed.

5.4 Implications Of The Current Study

This study has identified concepts, categories and a number of factors that play a role in the young people's experience of inpatient care. These findings point to a number of possible clinical, service development and broader community implications. Recommendations in terms of service provision for these young people, for those who organise services, the staff who provide support to these young people and the community in which the services are located, are discussed below. Previous literature provides some context.

5.4.1 Improving understanding. It is clear that self-harm fulfils a variety of often complex functions in young people's lives (Shortland, 2013). This idea is accepted and advocated by the young people interviewed in the study. The current findings highlight how these reasons are different for each young person. The findings have also shown the importance the young people attach to having their unique reasons understood and, in particular, how interventions and plans need to be focussed on this understanding. This is further highlighted in the section below on the implications for care-plans. The important inference here is that, if there is a perceived lack of understanding, the young people have tended to struggle to engage in treatment and they feel less well supported.

Understanding of the functions of self-harm may be improved if narratives are elicited about the events leading to the self-harm, the meaning of these events, the urges associated with the event, the self-harm behaviour itself, what the young person expected would happen or contingencies (Miller, Rathus & Linehan, 2017), and what function the young person felt it fulfilled. Wyatt and Gask (2009) have produced a similar guide to exploring self-harm which includes finding out about the events preceding self-harm, what these events meant to the individual, the amount of planning that went into the behaviour, the expected outcome, how the person felt after the self-harm and what function it fulfilled. Interventions strategies are therefore able to be guided by this understanding. A functional analysis of the purpose and meaning of self-harm behaviour gives young people and their families a sense of hope that things can change and that someone understands their situation and is willing to help them make the changes they have identified. A functional analysis is a well-established methodology for assessing the function(s) of problem behaviour (Petursson & Eldevik, 2019).

5.4.2 Improving and maintaining relationships. Thomas and Haslam (2017) described the importance of factors such as the therapeutic relationship and readiness for change when evaluating the effectiveness of an intervention. The current study highlighted the fact that, gaining the improved understanding described above, required relationships to be improved. Indeed, what the young people valued almost above all else, was their relationships. These encompassed family and carer relationships; and those with staff as well as those with their peers. The study findings point to the importance placed on relationships, and also the role that staff can play in the overall experience of the young people's inpatient stay. The quality of the relationship and interpersonal interactions have been noted in other studies, as discussed previously. Key to the current findings, however, is that the young people have suggested how this

can be improved and maintained. The young people mentioned a number of attributes that would facilitate improved relationships. A commitment from staff to engage with and develop an understanding of the young people's circumstances of admission and functions of self-harm was emphasised. Young people were sensitive to interactions that appeared forced, routine or part of a 'box-ticking' exercise. They were highly attuned to whether staff came across as genuine and noted the impact of insincere responses. The young people noted that it was the relationship that inspired engagement as well as a sense of feeling well-supported. They spoke of having opportunities to build relationships, in particular trusting ones, which were perceived as most difficult when staff were unknown. Providing opportunities to talk was deemed important alongside the availability of staff. Skills training will allow staff to remain sensitive to interpersonal nuances and how this may affect the young people's ability and willingness to engage. It seems just as important to make sure that one-to-one time remains protected.

5.4.3 Connection. Within this study, relational factors have extended beyond mere social interactions, and have incorporated a sense of feeling connected to others. Of course, if trusting and genuine relationships are cultivated between the young people and staff, feelings of connection would be enhanced. However, the young people also highlighted the importance of maintaining bonds and relationships with families and carers, feeling part of a group, and maintaining relationships with community services. The study revealed that some of the young people experienced a disruption in their support network and it therefore seems imperative that opportunities to enhance and nurture family contacts be established in order to maintain these connections. Providing secure and stable communication processes between families and services and supporting efforts to assist attendance at family events, for example, are likely to be welcomed. The study has also pointed to the impact of peer connection and the role this

plays in the overall experience of an inpatient admission. It seems that peer relationships could be a valuable resource to both the service and the young person. Development in this area could ensure that these interactions are as helpful and supportive as possible. Peer support could serve as a useful ancillary resource alongside therapeutic staff relationships. Hasking *et al.* (2013) have shown that social support can offer protection against self-harm; however, the fear of social transmission around this behaviour has led to avoidance of open discussion on the topic. A forum for stories and experiences to be shared would perhaps help to change this and allow information to be better utilised, framed and monitored by clinical staff.

5.4.4 Collaborative development of individualised planning of care. Building on some aspects that have already been discussed, the findings indicate that the young people desire a more inclusive and collaborative way of developing their care. Increasing their involvement in care-planning would be useful in a variety of ways. It is likely that understanding, communication, engagement, motivation and the appropriate support will be increased. The collaborative development of care-plans would serve as a means of increasing the young people's choice and control over their treatment and reduce feelings of dehumanisation that they reported as a consequence of their admission. The findings emphasised the promotion of individualised care-plans, focused on the young people's unique understanding of their self-harm behaviour. Care-plans should take into account the idiosyncrasies associated with each young person, emphasising what is different in terms of the function, as described above, of self-harming behaviours. Including the young people in developing their packages of care, would improve engagement as they would be able to take greater ownership of their care. However, it is clear that the young people did not want to attempt to manage

interventions in isolation, so it would be important to implement a system of regular shared review and follow up of these plans.

5.4.5 Ensuring access to talking therapies. The study highlighted the value the young people attached to being able to talk to a therapist or psychologist. This was reported against a backdrop of placing high importance on relationships and connection, and how these factors contribute to therapeutic conversations and the overall experience. Significantly, however, the young people wanted more than mere conversation. They identified talking therapies and access to competent and skilled professionals as being one of the most important aspects of care. They valued this when it did occur, but also highlighted the difficulties they faced when they wanted more but this was not available. There has been much research into effective inpatient psychological treatments, some of which have been offered on the units, according to the young people's responses. Given that, in the case of children and young people services in particular, NICE guidance dictates psychological assessment and treatment as a primary intervention, it seems prudent to consider means of maintaining good access to these sorts of interventions. Attempts have already been made within community services to increase access to psychological therapies, for example through the initiative known as Increasing Access to Psychological Therapies (IAPT) services. At present, for these young people, their experience on the units has led them to conclude that they would like regular and consistent access to these opportunities. In terms of specific provision, the units in the current study provide a whole time equivalent psychologist for every ten to twelve young people. This is above the Quality Network for Inpatient CAMHS (QNIC) standards. It may, however, be useful to find ways to broaden this provision through novel means, such as upskilling other professionals in psychological models. Psychologists, for example, may be able to support non-

psychology colleagues in implementing psychological treatments should those members of staff have appropriate training in evidence-based interventions. A structured training programme for these psychological therapies for staff would therefore be of value.

5.4.6 The inpatient environment. The ward environment itself seemed to constitute part of what the young people found to be therapeutic. The study suggests that young people would benefit from an improved pre-admission conversation, informing them more fully about what to expect and of the details of the interventions and the environment itself. There were some differences in expectations that seem to have contributed to the young people's experience. Furthermore, access to safe areas, both in a physical sense and in terms of feeling emotionally 'safe' seemed paramount. Improved accessibility to relaxation or soothing environments seems an entirely appropriate implication. However, exposure to triggers and stressors through, for example, the self-harm of others, can in itself be traumatic for young people and the ability or option to be distanced and protected from these events therefore seems important. Additionally, it could be useful to provide support for young people should they be exposed to these sorts of triggers. This could be in the form of a support-group or individual debriefing sessions. The most important idea is that staff recognise the potential for increased risk to the mental health of young people as a result of this traumatic exposure. In addition, managing staffing levels during times of ward stress is important. Competition for attention or the sense that there is a lack of parity of care may indeed fuel dissatisfaction and possibly escalate self-harming or impulsive behaviours. Staff should ensure that the young people have access to support at all times, even if this needs to occur alongside other competing demands on the unit.

5.4.7 Developing community services. The findings have also pointed to the development and improvement of community services. They showed a preference for the maintenance of community service involvement and relationships throughout the admission. The findings indicated difficulties accessing effective, timely and local mental health services, both prior to the admission, which may have prevented hospitalisation in the first place, and following discharge, in order to facilitate continued recovery. There appears to be a view that an admission to hospital could serve as respite for community services or families as opposed to a short, targeted intervention aimed at supporting young people to overcome the immediate risks to self with regards to their self-harming behaviours. Remaining in contact with a care-coordinator or key worker from community teams seems crucial and necessary in order to smooth the process of admission and discharge and allow for the young people to feel supported both during the admission and afterwards. Providing increased opportunities for these services to remain involved in the young people's care is therefore advocated. This is likely to be useful throughout the duration of the admission, from planning the admission to discharge. Enhancing community resources through improved understanding, both in terms of self-harm behaviours and skills development, to support the young people would achieve better outcomes. Improved competency development in terms of evidence-based therapies and interventions and empowerment of community services may contribute to better support.

5.5 Recommendations

This study offers a preliminary investigation into the young people's inpatient experience when presenting with self-harm. Following on from the aforementioned strengths and weaknesses of the research and the implications, a number of recommendations have been identified.

5.5.1 Recommendations for further research.

- It is recommended that research into the inpatient experience of young people presenting with self-harm is conducted with a larger and more diverse sample.
- It is recommended that specific areas within the model be further explored and researched.
- It is recommended that research be conducted into the emergence of the model concepts and categories in different settings. For example, research should be conducted into the experiences of young people making use of community services to establish whether similar experiences of humanness and restriction are present.
- It is recommended that research be conducted into staff experiences of restrictive practices.

5.5.2 Practice recommendations.

- It is recommended that the experience of restrictive practices be explored further, in particular relating to the young people's perceptions and concerns about the use of the Mental Health Act and detention as a means of encouraging compliance. Although it is standard practice on the units to explain patient rights and status at admission, and the young people have access to patient advocacy on the unit, it seems they continue to fear detention or further restriction if they do not comply. Further education and opportunities to clarify rights is therefore necessary.

- It is recommended that further audit be conducted into specific issues that were raised during this study. For example, it would be important to audit self-harm care-plan standards.
- It is recommended that inpatient interventions continue to focus on maintaining and improving relationships within the community for those admitted to hospital.
- It is recommended that training and development of the staff supporting young people admitted to hospital when presenting self-harm be continued, including in psychological models and interventions.

5.6 Summary And Conclusion

This chapter provided a summary of the strengths and limitations of the study. It then highlighted a means of ensuring the quality/publishability using established criteria. Several clinical implications were noted that resulted from the findings and subsequent recommendations were made for further research.

To conclude, whilst the study was subject to some methodological limitations, as outlined previously, qualitative exploration and in particular the use of a grounded theory methodology has provided further understanding into the area of inpatient experience and self-harm. The study offers unique insights into young persons' experience and explicates a grounded theory emerging from these data.

Self-harm amongst young people is a growing concern. There is a relative abundance of quantitative evidence investigating this behaviour in young people; however, there is a notable paucity in published research concerning young persons' experiences of

inpatient care when presenting with self-harm. The current study is an initial investigation into this area and provides information emphasising the relevance and importance of factors contributing to these experiences. It is an investigation that featured two core concepts: humanness and restriction, and has shown the dynamic nature of the complex relationship between them and their respective categories. The study thus provided a rich and detailed exploration of young persons' experiences which will have implications moving forward. Given the findings from the Francis (2013) report and the current emphasis on patient experience and input, this research is timely and relevant.

Overall, the researcher was struck by the frankness and candidness of the young persons' responses and desire to be heard. And, to reflect on the young person comment quoted at the start of the findings chapter, it is hoped that this research contributes to others "getting it" and that the model reflects the experience closely and honestly. After all, the aim is that these findings can contribute to improved care and services for young people going through what is undoubtedly an extremely challenging time.

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Appendix

List of appendices

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2. Summary of literature search procedure
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Appendix 1: Service-wide audit application approval by ethics committee

Clinical Audit ☒ (i.e. measures a standard)	Service Evaluation ☐ (e.g. patient survey)	Other Quality Improvement Project ☐ (please specify) _____
2 (a) Overall project aim or purpose of the audit: The purpose of this project is to evaluate the feasibility and effectiveness of brief ward-based staff training and the introduction of a new self-harm care plan on two SLaM adolescent wards. Self-harm is common among adolescents, and more young people who present with self-harming behaviours are being admitted to inpatient wards (Ougrin, 2012). However, management and treatment of self-harming behaviours can be challenging, and few treatment guidelines are available for inpatient settings. Consequently, it is useful to think about effective ways of managing self-harm on adolescent wards and improving ward staff confidence around managing self-harm behaviours. The National Institute of Health and Care Excellence (NICE) guidelines state that health care professionals who work with people who self-harm (including adolescents) should be trained in the assessment, treatment, and management of self-harm. Cognitive Behaviour Therapy (CBT) and Dialectical Behaviour Therapy (DBT) have an evidence base for the treatment of suicidal and self-harm urges in adolescents (Rathus & Miller, 2002; Fleischhaker et al., 2011; Mehlum et al., 2014). One pilot RCT found the DBT protocol to be feasible and effective in reducing symptoms of self-harm in adolescent inpatient settings compared to treatment-as-usual (Katz et al., 2004). A focus group was recently held with young people on SAU asking for their views regarding how self-harm management on the ward can be improved. In response to the discussions, Snowfields Adolescent Unit (SAU) and Bethlem Adolescent Unit (BAU) are currently offering brief training for staff on CBT- and DBT-informed self-harm management strategies as part of existing in-house training. Staff are also encouraged to offer a new care plan to young people entering the ward where self-harm is recognised as a difficulty. The present audit aims to evaluate the effectiveness of these strategies in managing self-harm on SAU, BAU and KMAU wards. In addition, young people admitted to KMAU who present with self-harm will be interviewed in order to explore in more detail young people's views of how self-harm is currently managed on the unit.		
2(b) Specific objectives. What are the audit standards or criteria? The definition of a clinical audit is that it compares practice to agreed standards such as those defined in NICE guidelines and clinical policies, protocols and procedures. Please also state the source of your standards or criteria (for non-audit projects, clarify measures). Primary outcome: self-reported levels of staff knowledge and confidence around self-harm management, assessed via questionnaires before and after staff training. Secondary outcome: number of incidents of self-harm on the wards (SAU and BAU) in the three months before vs. three months after the implementation of the new care plan. In addition, as per NICE guidance and following from the Francis report recommendations, young people themselves will be asked for feedback regarding the helpfulness of the new care plan. A qualitative analysis of how young people experience inpatient treatment for self-harm will be conducted in support of this aim and to explore in more detail their views.		

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2 (c) In which ways do you think the project will improve patient care / outcomes?

If the newly-introduced approach to managing self-harm management is effective, we would expect to see some or all of the following: (1) an improvement in staff knowledge and confidence around managing self-harm on the ward, (2) a decrease in self-harm incidents, (3) an increase in young people's satisfaction with self-harm care plans (4) improved young people engagement in developing care plans.

From a longer-term perspective, self-harming behaviours are associated with a range of adverse mental health outcomes, yet the evidence base for self-harm management in inpatient settings is lacking. Better understanding of the extent to which staff training and care plans focused on self-harm management can be implemented in adolescent inpatient settings will support the development of effective treatment guidelines for self-harm in this population.

3(a) Who will be on the audit steering group?

The audit is led by the Snowfields psychology team and the psychology team working at KMAU, working closely with ward staff and the psychology team at the BAU.

The self-harm care plan was developed with feedback from the National and Specialist DBT team at the Michael Rutter Centre and Amanda Broughton, CAMHS Head of Nursing.

3(b) What consideration has been given to the involvement of patients, carers or the public?

☒ Full user involvement at all stages of the audit

☐ Partial user involvement (please state which stages) _____

☐ No user involvement (please state why not) _____

3(c) Are you planning to collect data on any of the following equalities protected characteristics? (please tick all that apply)

Age ☐ Disability ☐ Ethnicity ☐ Gender re-assignment ☐

Pregnancy and maternity ☐ Religion or Belief ☐ Sex ☐ Sexual orientation ☐

3(d) Will you analyse your results or service outcomes to see if there is variation between equalities protected characteristics?

Yes ☐ No ☒

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4. Information Governance Requirements: When planning an audit, each project should be evaluated with regard to whether Personal Identifiable Information (PII) needs to be used. Unless there is genuine justification, all PII should be taken out to effectively anonymise the data for audit and research purposes. If you are unsure or need guidance and advice, please contact: dataprotectionoffice@slam.nhs.uk Personal identifiable information (PII) is any piece of information which can potentially be used to uniquely identify, contact, or locate an individual including name, address, full post code, date of birth, gender, ethnicity, NHS number, photographs, videos, audio-tapes etc.		
4(a) Will the data be fully anonymised?	☒ Yes	☐ No (patient identifiers) ☐ No (staff identifiers)
	If yes, how: This audit is using fully anonymous data. Staff questionnaires are completed anonymously. No patient identifiable data is used in this audit (we only use descriptive data about the number of patients on the wards and their primary diagnoses). Recordings of interviews and transcripts with young people will be anonymous.	If no, why not: _____ If no, which personal identifiers will be used: _____ If no, have you made arrangements to gain consent from data subjects? ☐ Yes ☐ No
4(b) Where will the data be recorded?	☒ Manual forms ☐ Electronic spreadsheet	☒ Electronic forms ☒ Electronic database ☒ Other (please specify) Interviews will be recorded to digital files on a secure drive
4(c) Security arrangements	☒ Locked cabinet ☒ Locked office ☐ Other (please specify) _____	☒ On shared folder on SLaM network ☐ On secure network outside SLaM ☒ Files Password protected ☒ Login required
4(d) Will the data be transferred outside SLaM	☐ Yes, in an anonymised format ☐ Yes, outside the EU ☐ Yes, with identifiers ☒ No You must contact dataprotectionoffice@slam.nhs.uk to register any transfer of personal identifiable information in advance.	
	If yes, how? ☐ Physically in person ☐ Physically using a	☐ Electronically using NHS.net e-mail (NHSmial) ☐ Electronically using file encryption and other email

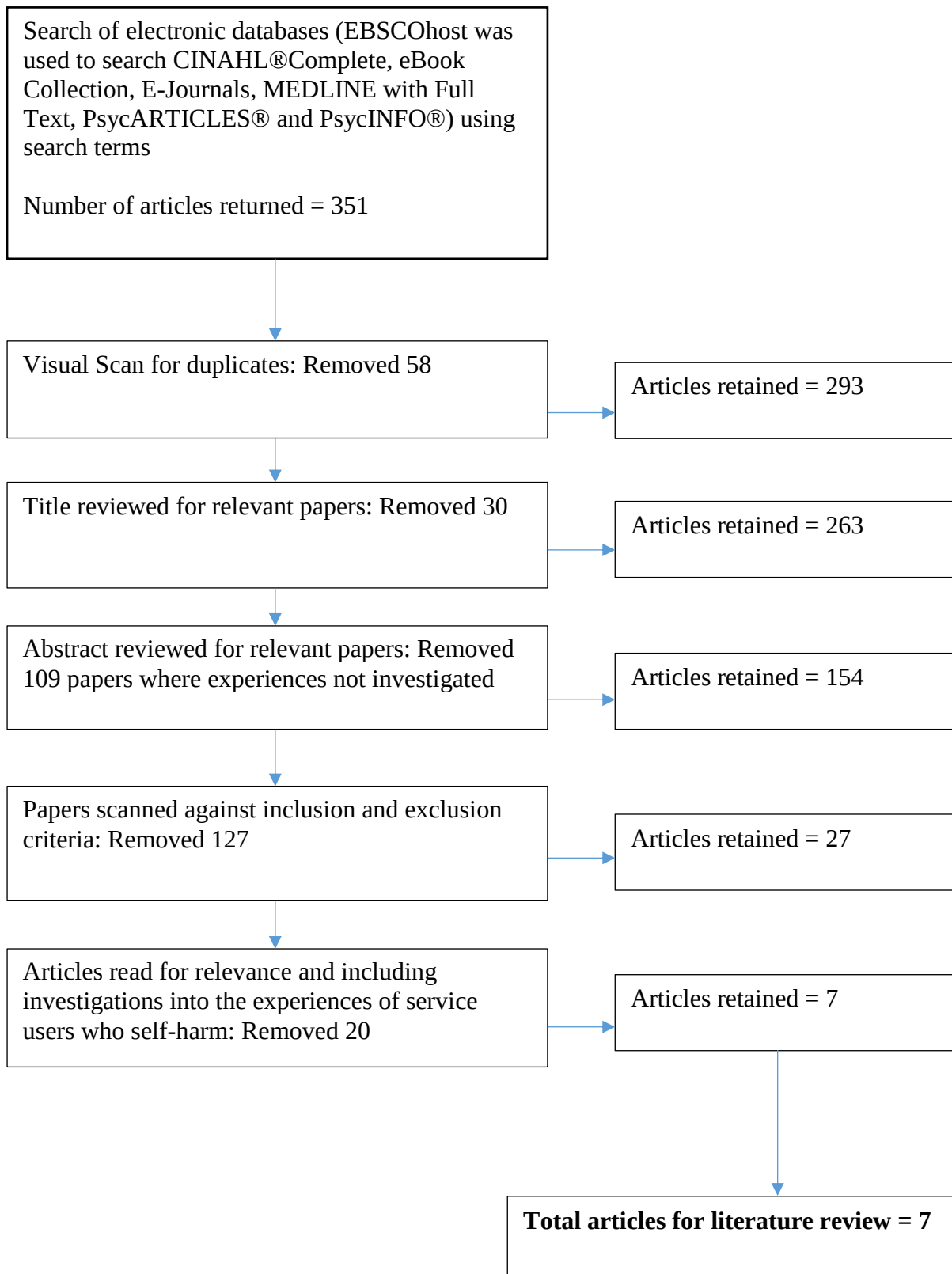
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	secure courier ☐ Physically using registered mail services	☐ Electronically using encrypted portable media ☐ Other (please specify)
4(e) Information Asset Owner: (Individual responsible for the data)	Name: Rachel McMahon & Francois Potgieter (within the Trust)	CAG: CAMHS
	Name: (outside the Trust)	CAG:
	Job title: As above for R McMahon and Francois Potgieter	Organisation: SLaM
5) Data Collection (please answer ALL of the following questions)		
5(a) Where from? e.g. clinical records/ePJS, INSIGHT/CRIS, other service records, direct from patients or clinicians, observations of practice, DATIX.	Number of incidents of self-harm pre/post use of new care plan will be collected from existing DATIX and risk event records on ePJS. Questionnaire measures will be collected directly from patients and staff. Interviews will be conducted directly with young people.	
5(b) How? The data source will obviously influence the method used to collect data. e.g. survey, interview, focus groups, data collection proforma. Please include any other significant aspects of your methodology.	Questionnaires, collection of data from ePJS and audio recordings of interviews will be the sole source of audit information.	
5(c) How much? As a rough guide, a sample should include 20-50 cases.	50 staff questionnaires to be collected. 6-8 Young people will be interviewed in order to obtain feedback on the care plan as part of routine care where self-harm is identified as a problem.	
5(d) Pilot Audit? <u>Y/N</u> (recommended)	SAU, KMAU and BAU have been conducting brief staff training and have used self-harm care plans routinely so we do not think a pilot will, on this occasion, be necessary.	

Appendix 1: Service-wide audit application approval by ethics committee

6(a) With whom and where will the final report be shared? e.g. which committees or service meetings The final report will be written up by Nina Mikita as a service evaluation project for the Doctorate in Clinical Psychology. The young person feedback on their experience of treatment will be written up by Francois Potgieter as a project for the Doctorate in Applied Psychology. As such it will be held in the University library in printed form and published electronically on King's College London's electronic thesis repository as per University regulations as well as the university of Essex electronic thesis repository. Audit results will also be shared with SAU, KMAU and BAU teams, and at the following SLaM service meetings: National and Specialist Psychology meeting and the SLaM Inpatient Psychology meeting.	
6(b) Who will take responsibility for disseminating the results of the project and following through recommendations and actions? And how and when will the recommendations and actions be evaluated, monitored and reviewed? The results will be written up as a report by Nina Mikita under supervision of Rachel McMahon and Sophie Browning (Consultant Clinical Psychologist at SAU). N Mikita will disseminate the results within SAU. Drs McMahon, Browning, and Mikita and Francois Potgieter will disseminate the results at wider service meetings and to the audit committee.	
All completed projects must be followed up with a completed action plan form, available on the SLaM Clinical Audit & Effectiveness Intranet site http://sites.intranet.slam.nhs.uk/cg/default.aspx (Audit Report Template Appendix B)	
7) Project Approval	
7(a) Information Governance Approval: IG Audit approval given by: _____ Date Audit IG approved: _____	7(b) Project Ethical approval given by: Clinical Audit Ethical approval given by: _____ Date of Committee Approval: 10/05/18 <i>Amendments to previously approved audit approved on 10/05/18 by CAG Clinical Governance/Audit Committee</i>

Appendix 2: Summary of literature search procedure



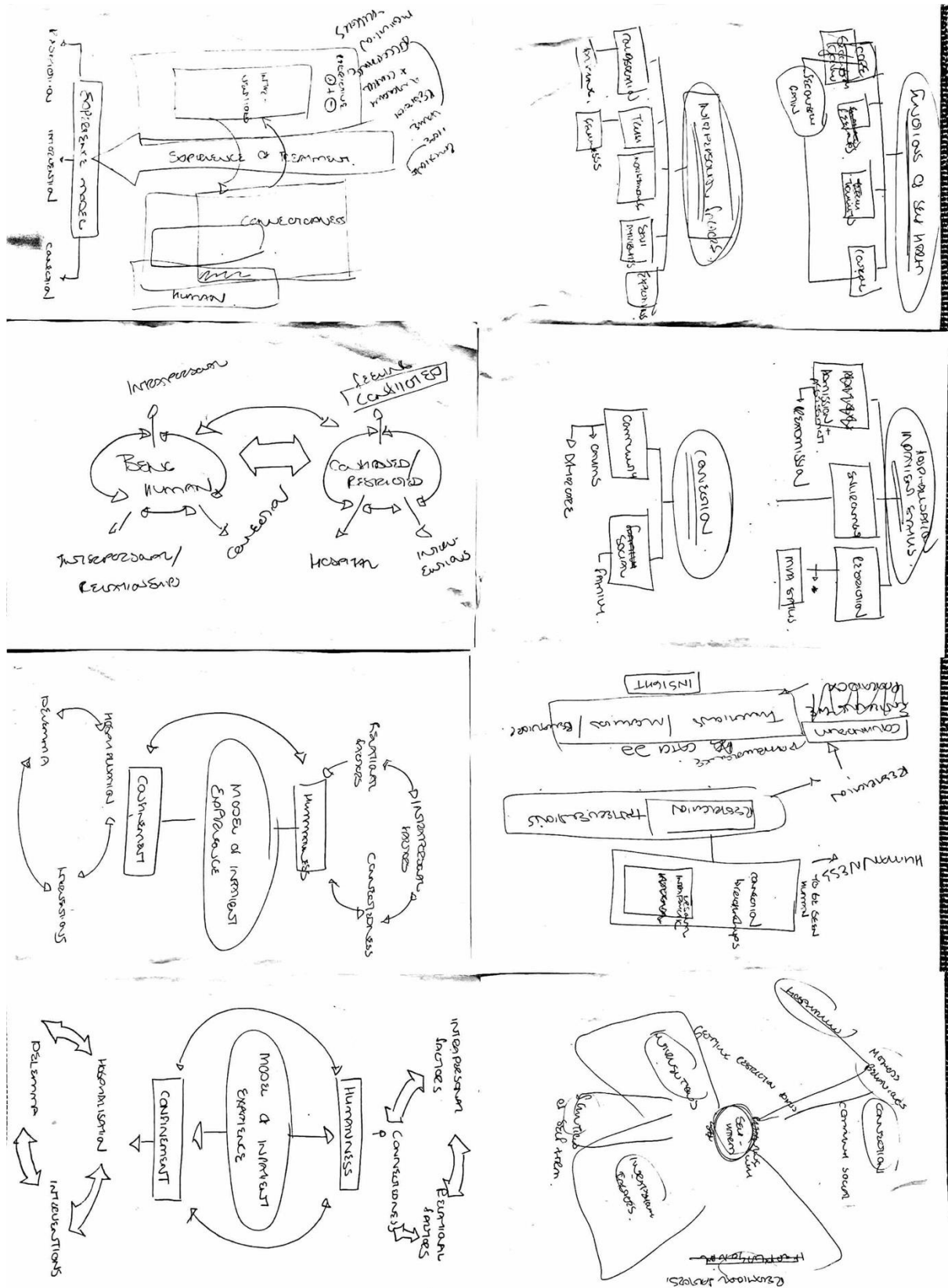
Appendix 3: Summary table of literature

Summary table of studies							
Paper nr.	Authors, Publication Date	Title	Type of study	Aims	Sample	Data collection method	Findings
1.	Lindgren, B-M., Wilstrand, C., Gilje, F., & Olofsson, B. (2004).	Struggling for hopefulness: A qualitative study of Swedish women who self-harm.	Qualitative	To describe how people who self-harm experience received care and their desired care.	Nine Swedish woman, mean age 25 involved in care following self-harm at a psychiatric clinic in Northern Sweden.	Qualitative content analysis of personal narratives identifying characteristic themes of meaning and messages.	Two themes emerged: Expecting to be confirmed while being confirmed fosters hopefulness and expecting to be confirmed while not being confirmed stifles hopefulness.
2.	Horrocks, J., Hughes, J., Martin, C., House, A., & Owens, D. (2005).	Patient experiences of hospital care following self-harm: A qualitative study.	Qualitative –	Elicit people's stories of their experiences of attending hospital after self-harm. To identify aspects that are helpful/unhelpful and suggestions for improvement.	All people attending A&E at two hospitals after self-harm sent letters and asked to consent. N=25; >18 years of age.	Two in-depth interviews were conducted with each participant. Interviews used a non-directive approach based on a free association narrative interview method.	Mixed experiences. Problems in communication between patients and staff. Largely negative emotional experience. Inter and intra personal aspects impact on overall experiences.
3.	Schoppmann, S., Schröck, R., Schnepf, W., & Büscher, A. (2007).	'Then I just showed her my arms...' Bodily sensations in moments of alienation related to self-injurious behaviour.* A hermeneutic phenomenological study.	Hermeneutic phenomenology	To gain insight into patients' lived experience and to contribute to the understanding of this vulnerable group.	99 Observational sequences, five interviews and a set of email texts. 16 – 28 year old female participants.	Participant observation and qualitative interviewing and thematic analysis.	Self-injury should be seen as a self-caring act which serves to end a harmful state. The study found the value and meaning of understanding.
4.	Hume, M. & Platt, S. (2007).	Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users' views.	Qualitative – Grounded Theory	To investigate perceptions of interventions for self-harm among people who have first-hand experience as a result of their own behaviour.	14 patients admitted to hospital following a repeat act of self-harm.	Semi-structured interviews with thematic analysis, drawing broadly on some of the principles and techniques of Grounded Theory.	Recognised the importance of life-difficulties in the self-harm population. Themes related to the nature of patients' self-harm and their experiences of the attitudes towards, and interventions for, self-harm.
5.	Taylor, T. L., Hawton, K., Fortune, S., & Kapur, N. (2009).	Attitudes towards clinical services among people who self-harm: systematic review.	Systematic Review: Mixed methodologies.	To systematically review people's attitudes towards clinical services following self-harm in order to inform service design and improvement.	31 Studies with quantitative, qualitative and mixed methodologies.	Electronic database search and data extraction.	Participants' experiences similar across settings. Poor communication, lack of staff knowledge common themes. The need for after-care to be improved.
6.	Lindgren, B-M., Öster, S. A., & Graneheim, U. H. (2011).	'They don't understand.' Interpretive repertoires jointly constructing interactions between adult women who self-harm and	Interpretive repertoires from discursive psychology.	To illuminate interpretive repertoires that jointly construct the interaction between adult women who self-harm and professional	6 female participants presenting with self-harm and their professional caregivers in two psychiatric	Participant observations and informal interviews.	Caregivers used a fostering repertoire and supportive repertoire and the participants used a victim repertoire and an expert

Appendix 3: Summary table of literature

		professional caregivers.		caregivers in psychiatric inpatient care.	inpatient wards.		repertoire. Essential that patients be treated with respect. Collaboration, and recognising each individual's possibilities for agency also crucial.
7.	Smith-Gowling, C., Knowles, S. F., & Hodge, S. (2018).	Understanding experiences of the self-harm of others: A qualitative exploration of the views of young people with complex mental health needs.	Qualitative	To explore young people's experiences of self-harm of others.	8 young people between the ages of 13 and 18 resident in one of two adolescent mental health inpatient units in the North of England.	Interviews analysed using interpretive phenomenology.	Five themes identified: 1)Pre-admission exposure, 2)Exposure on the inside, 3)An unpleasant environment, 4)Helper vs helped, and 5)Separation from attention seekers , competing for authenticity.

Appendix 4: Selection of draft diagrams used during the development of the model



Appendix 5: Excerpts from reflective diary

15/07

The intention remains to investigate an aspect of the care of young people who self-harm on the unit. I'm really interested in this experience and certainly, when thinking about grounded theory, what is going to show up. As it stands, this is a novel way of doing research for me, in particular suspending a thorough literature review at the start. I have a lot of conflicting thoughts around the researcher/practitioner position. I'll need to note this in the paper and speak with my supervisors. It remains difficult to suspend my judgement and 'dumb out' of the practitioner role. My initial thoughts are this is going to have to be constantly reflected on...

19/07

The first interview is complete!! I'm not sure what I expected, but I'm buzzing though! I'm struck by how articulate and open the interviewee has been. I had a bit of a struggle again with regards to the researcher/practitioner role. I'm reflecting back what I'm hearing and really careful not to assume but to clarify. The interviewee seemed really keen to describe the experience, but even that seems like an interpretation. I'm already thinking about some of what was said and how this relates to the broader Trust initiative. I've got to put that to one side, but I'd like to think more on this in supervision.

01/08

I have conducted my second interview and note how the interview is already shaping up slightly different than the first. I am allowing much more by way of stepping back and clarifying responses as opposed to reflecting and summarising. It's early days, but the data certainly is taking on a path I'd not really thought about. I am aware of trying to focus on my semi-structured interview questions, but it seems the young people so far direct and lead the conversation in new ways and interesting directions. There is far more input, in a far easier manner than I had predicted. Allowing the interviewees 'space' to talk seems to be useful so far.

01/09

I have a lot of ideas 'floating around, and already sense some emerging themes! It's challenging to think of ways to structure these. My inclination is to write these down but I'm aware of creating preconceptions! I'm going to try suspending this urge. I'm reminded of the "lie fallow" suggestion by Charmaz. Feels very exciting nonetheless!

02/09

Following supervision, Peter has suggested a really useful link, as I'm continuing to be faced by challenges with regards to my role of researcher vs. practitioner. "Ahern's Ten Tips for Reflexive bracketing (<http://journals.sagepub.com/doi/abs/10.1177/104973239900900309>).

I found the following key:

'Myerhoff and Ruby (1992) define reflexivity as "the capacity of any system of signification to turn back upon itself, to make itself its own object by referring to itself" (p. 307). Reflexivity involves the realization that researchers are part of the social world that they study (Frank, 1997). This realization is the result of an honest examination of the values and interests that may impinge upon research work (Porter, 1993). The ability to reflect on one's behaviour and motives requires time to reflect and an environment of support and reflective skill (Paterson & Groening, 1996; Rovegno, 1992).

And

The advantage of this process is that the researcher's energies are spent more productively in trying to understand the effects of one's experiences rather than engaging in futile attempts to eliminate them. I really like this idea that I'm not trying to suggest that I am ignoring preconceptions, but purposefully reflecting on them, this makes sense. I need to bear in mind any impact these may have and try and understand it!!! Onwards to the other interviews!

Appendix 5: Excerpts from reflective diary

25/11

I think I am starting find NVivo somewhat obstructive to the process. I'm changing tack and using it to organise the data as opposed to analysis. I feel closer to what is being said if I re-read and explore codes myself. I do feel pretty much immersed in the data. I'm going to attend an NVivo course offered by the university just to get some support.

05/12

Today has been an eye-opener. The expression of not being able to see the wood for the trees comes to mind. There are almost 2500 open codes at this stage which I've tried to put them into larger containers, however, I continue to worry whether I have done this in a helpful or useful way. My struggle remains my own perspective and making choices confidently. Developing the theory is going to take some leaps of faith and confidence which I will need to justify. I'm hoping I'll be able to put this together in a very useable way that achieves its goal of adding to the limited knowledge in this field. I think that this course has been a revelation however and already I think I've made a significant leap forward just by thematic coding framework. I'm scribbling and diagramming away furiously and have about 50 iterations of an emerging model...Oh dear/oh yay!

15/12

I'm continuing the analysis process!!! Even though I've been coding simultaneously as is the process in grounded theory, it all remains an extremely time-consuming process working through the codes and moving towards categories and trying to put these together in a way that makes sense but is still a reflection of the data/grounded in the data. I've thought to go back and refine the codes by comparing similar codes and checking that the code names reflected what was said and not what I was interpreting, again this is tricky! One is tempted to interpret and code too abstractly, so the line-by-line keeps one close to what is actually being said. Comparing what is emerging, I've also gone back to the previous interviews and checking on the categories and themes that have emerged.

10/01

I've had a discussion in supervision about what has emerged. My findings so far show the young peoples' emphasis on relationships. They also reflected on the connectedness maintained with community. The experience was influenced by the interventions themselves and mediated it seemed by intrapsychic factors. The environments and setting played a role and interestingly there is less emphasis on the actual methods and functions of self-harm regarding their experiences of the admission. There is an importance of the interpersonal connectedness during an admission. The level of genuineness and understanding has a major impact. Perhaps it is assumed that there is a need to understand the functions of the behaviours and that the methods of self-harm are significant, but from this theory, it is the relationship that is important.

24/02

I'm writing up and still amending my findings?? Every time I look at what the young people have said, I notice something I've missed before! It's so useful to get feedback from my supervisor! I love how this feels like it is still owned by the young people however, and the emerging model really feels like it makes sense and is a closer reflection!!!

Appendix 6: Transcript extract

Appendix 6: Transcript extract

Genuine Responses	Feeling understood	I: “And how does that (<i>staff not knowing what it's like</i>) influence your experience?” YP: “I feel really is that nobody understands. Sometimes people just sound so robotic and it feels like they're talking down to you. They will talk about emotions and how it affects you, if they don't get the emotion, they will make things up or take guesses and get it wrong, it makes you feel just a bit frustrated, because you heard this like a million and one times, that affects how I'm feeling too. So, I had intense treatment in the community, so I know the language that is used, and it makes it very difficult. Staff saying things that it will get better, and then you're like, I haven't heard that for the millionth time. But when you are genuinely in this situation and they have said it on an everyday basis, you just like, can you just stop talking to me please because you actually it doesn't make a difference to my experience at the moment the things that you're saying, because that's where I am right now.” I: “And is this saying something about how you feel about being in hospital for self-harm?”	<i>Talking about emotions</i> <i>Feeling frustrated</i> <i>Hearing the same thing repeatedly</i> <i>Unique/different</i> <i>Not making a difference</i>	Engagement
	Staff qualities	YP: “I have not found anything good about being in hospital. I think also because I haven't been to school since January and I haven't talked to people my own age and I don't like talking to people in my own age, it's made it necessary for people to talk to people in my own age. But at least they understand, because they're in the same situation as me. It makes you feel a little bit more sane a little bit more normal, and not the only person going through all of this. And it makes you a little bit like, if somebody did say something to you for instance like about feelings, generally you can go there and the young people will be like oh well yes that person is like this or that person is like that and you get a little bit of gossip you like and they can understand. Like the first thing I asked when I came into the ward, I asked one of the young people, like okay so give me advice on which staff are good and which staff are not good and who should I avoid and who should I not avoid, and everybody gets along when we have those talks, and that's a shared experience between all of us. And we don't speak to other people outside so, and this is probably the most of talk to anybody since like I have the whole year. At least that stops the days from going so slowly. Like in the first instance I talked to nobody, and that makes the day go really slowly because you just sitting there and you're not speaking to anybody. When you're talking and doing things the time goes faster.	<i>Admission/Nothing good</i> <i>Talking to others</i> <i>Feeling understood/normal</i> <i>Staff communication</i> <i>Trust?</i> <i>Peer support</i> <i>Testing environment</i> <i>Talking more</i> <i>Benefits of talking</i> <i>Talking helps with boredom</i>	Connection (Peers) Talking

Appendix 7: University of Essex research ethics approval



University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form must 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 must not commence until written approval has been received (from departmental Director of Research/Ethics Officer, Faculty Ethics Sub-Committee (ESC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project. Ethical approval cannot be granted retrospectively and failure to obtain ethical approval prior to data collection will mean that these data cannot be used.

Applications must be made on this form, and submitted electronically, to your departmental Director of Research/Ethics Officer. A signed copy of the form should also be submitted. Applications will be assessed by the Director of Research/Ethics Officer in the first instance, and may then passed to the ESC, 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. Title of project: **The young person's experience of inpatient care when presenting with self-harm**

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 ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Francois Potgieter	Health and Social Care Student
Prof Peter Martin	Education, Health and Social Care, Essex
Dr Sophie Browning	CAMHS, SL&M NHS Foundation trust

5. Proposed start date: ~~October 2017~~ 3rd July 2018

6. Probable duration: 12 Months

7. Will this project be externally funded? Yes ☐ / No ☒
If Yes,

8. What is the source of the funding?

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 ☐ / No ☐

Appendix 7: University of Essex research ethics approval

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):

Name(s) in block capitals: Francois Potgieter

Date: 01/07/2018

Supervisor's recommendation (Student Projects only):

I have read and approved the quality of both the research proposal and this application.

Supervisor's signature:

Outcome:

The departmental Director of Research (DoR) / Ethics Officer (EO) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR / EO 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 ESC ☐

This application is referred to the ESC because it does not fall under Annex B ☐

This application is referred to the ESC because it requires independent scrutiny ☐

Signature(s):

Name(s) in block capitals:

Department:

Date:

The application has been approved by the ESC ☐

The application has not been approved by the ESC ☐

The application is referred to the University Ethics Committee ☐

Signature(s):

Name(s) in block capitals:

Faculty:

Date:

Appendix 7: University of Essex research ethics approval

Details of the Project

1. **Brief outline of project** (This should include the purpose or objectives of the research, brief justification, and a summary of methods but should not include theoretical details. It needs to be understandable to a lay person, i.e. in everyday language that is free from jargon, and the reviewer must be able to understand what participants will be asked to do.)

Self-harm is common amongst young people. The management and treatment of these types of behaviours can be challenging, and few treatment guidelines are available for inpatient settings. The lack of understanding about the motivations behind adolescent self-harm can have a negative impact on how mental health professionals respond to young people who self-harm. There is minimal research exploring the young person's experience of treatment when they present with self-harm and obtaining this information would be important in the effort to increase appropriate support and improve treatment outcomes. The information could also help improve efforts to better understand which interventions are more likely to be effective. The present project aims to address a gap in the literature by providing a detailed description of how adolescents admitted to an inpatient unit presenting with self-harm experience their treatment. It will be conducted against a backdrop of the introduction of a new individualised care-plan for self-harm behaviour within a child and adolescent mental health service in an NHS Trust. Grounded theory involving concurrent data collection, comparison and analysis seems most suited to this aim. Feedback is routinely collected through focus groups and semi-structured interviews on the unit. The project will be an analysis of the data obtained from the semi-structured interviews. Asking questions and obtaining feedback from service users is usual practice within the NHS Trust. The outcome will be evaluated using set criteria.

Participant Details

2. Will the research involve human participants? (Indicate as appropriate)

Yes ☒ No ☐

3. Who are they and how will they be recruited? (If any recruiting materials are to be used, e.g. advertisement or letter of invitation, please provide copies).

The main participants in the study will be young people aged between 12 and 18 years admitted to an inpatient CAMHS unit and who present with self-harm behaviours. Interviews will be conducted with 10 to 15 young people and a predefined definition of self-harm will be used to direct the sampling. Participants will be approached on an individual basis. Generic outcome measures, a welcome pack and unit information is provided for all young people being admitted to the unit. This is done by a support worker and mitigates the power relationship. As part of this process, the support worker will ask the young person whether they would like to participate in the research and make clear the young person is free to participate or to absent from participation. A participant information sheet which attempts to address any concerns will be offered which can be read in the young person's own time. Information provided will make it clear that the young person is free to withdraw participation at any time without their care being affected and that they may choose not to be involved. The support worker would be able to act as a gatekeeper in order to block young people being approached directly. Young people will still have access to treatment as usual following admission from qualified professionals on the unit. This treatment will not be provided by the researcher. As the young person is "gate-kept" prior to commencing any treatment or research, the likelihood of coercion is obviated. Attempts will be made to ensure that discussion

Appendix 7: University of Essex research ethics approval

takes place in a nonthreatening, comfortable manner in a relaxed and open atmosphere where all participants will be encouraged to share any concerns and it will be made clear to potential participants that there is no pressure to participate and they can opt out at any time. There will also be a week's "cooling off" period before potential participants will be approached for interview. The participants will be able to indicate their withdrawal by approaching any of the staff on the ward without having to give a reason. This can then be handed over to the researcher.

Will participants be paid or reimbursed?

No

4. Could participants be considered:

(a) to be vulnerable (e.g. children, mentally-ill)?

Yes ☒ No ☐

(b) to feel obliged to take part in the research?

Yes ☐ No ☒

If the answer to either of these is yes, please explain how the participants could be considered vulnerable and why vulnerable participants are necessary for the research.

The young people on the unit are admitted due to mental health difficulties and are likely to be experiencing distress. It is usual practice to create care plans collaboratively with the young people during their admission. It is necessary to include their views as ultimately, this affects the applicability and relevance of the plans and any interventions offered. The benefits of incorporating the young person's views include gaining insight into, and obtaining a shared understanding of, current treatment and their experience thereof.

Informed Consent

5. Will the participant's consent be obtained for involvement in the research orally or in writing?¹
(If in writing, please attach an example of written consent for approval):

Yes ☒

No ☐

If in writing, please tick to confirm that you have attached an example of written consent

☒

¹ If the participant is not capable of giving informed consent on their own behalf or is below the age of consent, then consent must be obtained from a carer, parent or guardian. However, in the case of incompetent adults, the law in the United Kingdom does not recognize proxy consent by a relative. In addition, the University Ethics Committee is not able to provide ethical approval for such research. It needs to be approved by a Health Research Authority National Research Ethics Service Research Ethics Committee.

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Consent should be obtained before data is collected. How will consent be obtained and recorded? Who will be giving consent? Please indicate at what stage in the data collection process consent will be obtained. If consent is not possible, explain why.

The main participants in the study will be young people aged between 12 and 18 years admitted to an inpatient CAMHS unit and who present with self-harm behaviours. Participants will need to be assessed as having capacity to provide consent. Information will be presented to the young person explaining what will happen, what is being asked of the young person and that the young person can agree or disagree to take part without adverse consequences and that they may withdraw at any time.

Young people aged 16-18 with sufficient understanding will be deemed as able to give their full consent to participate in the research independently of their parents and guardians. Children under 16 will be deemed able to give their consent providing they have been counseled and they have sufficient maturity to understand the nature, purpose and likely outcome of the proposed research, however, parental consent will also be sought for this age group. Parents are similarly routinely asked to fill out outcome measures at the young person's admission and they will be informed of the project and given an information sheet in order to give informed consent. In addition, parental consent will be required where it is viewed that a child is not capable of understanding the implications of taking part in a study or where the child is regarded as incompetent to consent.

When young people are approached to complete the standard outcome measures and asked if they would like to participate in the study, they will be offered the participant information sheet and, if agreeing to take part, and given the aforementioned information on consent, asked to complete and sign a consent form. This will be collected prior to any interview taking place. Following the week's "cooling off period" as mentioned above, and 48 hours prior to the interviews taking place, consent will be discussed again and participants given the option to withdraw should they wish. The forms will be locked in an appropriate document cabinet in a locked office. They will be scanned and entered onto a password protected file where a login will be required to access the information. If under the age of consent, consent will be obtained from parents/carers.

Please attach a participant information sheet where appropriate.

Confidentiality / Anonymity

6. If the research generates personal data, describe the arrangements for maintaining anonymity and confidentiality or the reasons for not doing so.

The categories and themes derived from the interviews will be fully anonymised. Although the information will be collected from young people, the information will not be linked to any participant. All information will be kept in strictest confidence and no personally identifiable information linked to any of the responses. The information will be kept on an electronic database and all paper notes will be kept in a locked cabinet in a locked office. All online files will be password protected.

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Data Access, Storage and Security

7. Describe the arrangements for storing and maintaining the security of any personal data collected as part of the project. Please provide details of those who will have access to the data.

All information obtained throughout the study will be kept in a secure filing cabinet in a locked office. They will be scanned and uploaded to a password protected data file and will only be accessible to the lead researcher of the project and supervisor.

Data Sharing

8. Do you intend to share or archive data generated from this project?

Yes ☐

No ☒ (If no, please skip to question 10)

If Yes,

Please describe briefly and continue to question 9. (Relevant considerations include funder, publisher, or other requirements for shared data. If you have completed a data management plan, the section on sharing/archiving may be copied here.):

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9. Please indicate the means by which you intend to share/archive your data:

Openly available from a data repository (e.g. <i>UK Data Archive, University of Essex Research Data Repository, other repository</i>)	☐
Available via a data repository but with controlled access (<i>Examples of access controls include registration with the repository, requesting permission from the depositor, and data access committees.</i>)	☐
Other (<i>Please provide details</i>)	☐

10. If you answered 'no' to question 8 above, please provide specific reasons why the data will not be made available (e.g. *participants have not consented, sensitivity of the data, intellectual property restrictions, etc.*)

The information will be used solely for this project. Young people and staff will have only consented to its use for these purposes. The findings of the analysis will ultimately be accessible via the usual portals.

It is a requirement of the Data Protection Act 1998 to ensure individuals are aware of how information about them will be managed. Please tick the box to confirm that participants will be informed of the data access, storage and security arrangements described above. If relevant, it is appropriate for this to be done via the participant information sheet ☒

Further guidance about the collection of personal data for research purposes and compliance with the Data Protection Act can be accessed at the following weblink. Please tick the box to confirm that you have read this guidance (http://www.essex.ac.uk/records_management/policies/data_protection_and_research.aspx) ☒

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Risk and Risk Management²

11. Are there any potential risks (e.g. physical, psychological, social, legal or economic) to participants or subjects associated with the proposed research?

Yes ☐ No ☒

If Yes,

Please provide full details of the potential risks and explain what risk management procedures will be put in place to minimise the risks:

12. Are there any potential risks to researchers as a consequence of undertaking this proposal that are greater than those encountered in normal day-to-day life?

Yes ☐ No ☒

If Yes,

Please provide full details and explain what risk management procedures will be put in place to minimise the risks:

13. Will the research involve individuals below the age of 18 or individuals of 18 years and over with a limited capacity to give informed consent?

Yes ☒ No ☐

If Yes, a Disclosure and Barring Service disclosure (DBS check) may be required.³

² Advice on risk assessment is available from the University's Health and Safety Advisers (email safety@essex.ac.uk; tel 2944) and on the University's website at www.essex.ac.uk/health-safety/risk/default.aspx.

Appendix 7: University of Essex research ethics approval

14. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of the Faculty Ethics Sub-Committee and/or University Ethics Committee.

Not at this time. The Trust regularly and routinely runs research, audit, service evaluation and service development initiatives. The project falls within the already well-established protocols and procedures. Evidence of this practice includes approval email and audit form attached (Appendix 2). The Trust is aware of the project confirmed in the attached audit approval form (Heading 7(b) "Project ethical approval given by: Clinical Governance/Audit Committee) and as such fits within the Trust's standard data collection processes.

³ Advice on the Disclosure and Barring Service and requirement for checks is available: (1) for staff from Employment Compliance Manager in Human Resources (email lauren@essex.ac.uk; tel 3506) and on the University's website at <http://www.essex.ac.uk/hr/policies/docs/CRBdocumentpolicy.pdf>; (2) for students from the University's Academic Section.

Appendix 8: Participant information sheet

Participation Information Sheet.

Information sheet for Young People undertaking research into their experiences of inpatient care when presenting with self-harm.

The management and treatment of self-harming behaviours can be challenging. A lack of understanding about the motivations behind this behaviour can make supporting young people difficult during these times. One of the main reasons for an admission to hospital is to keep young people safe and to support them in finding other ways to cope. We recognise that self-harming can be a way of coping with difficult feeling, but we are aware that this is not a long-term solution and we do not support young people harming themselves. We feel it would be helpful to understand the young person's experience of hospital care when they present with self-harm. It is felt that if we understand the experience of treatments during these very distressing times, support can be

better informed, individualised and tailored.

Why have I been chosen?

As a young person admitted to a mental health unit and having told us that you are currently engaging in self harming behaviours, it would be helpful to get your views and try to understand how you experience the treatment and support you receive. You have been approached as you are best placed to provide this information. As mentioned, this can help us tailor treatment and support in the most person centred and individual way possible.

Do I have to participate?

Taking part in this research is completely voluntary and up to you. You may choose whether to take part or not. If you decide to take part, you will be asked to sign a consent form. If you decide to take part and wish to withdraw from the study at any time, you are free to do so. If you decide to withdraw at any time or not participate, this will in no way negatively impact on

the current treatment you receive on the unit.

What is the purpose?

The purpose of this research is to gain an understanding of your experience of care when presenting at hospital with self-harming behaviours. The overall project hopes to gain this information so that we can better plan for future practice and care.

What will happen? What type of study is it? And how will I benefit?

You will be invited to attend a 30-45 minute one-to-one interview held away from the main area of the unit. You will be asked to discuss a set of questions about the care and support you receive. The interviews will be tape-recorded and analysed by seeking out themes in the responses. These themes will then tell us what it is like to receive care. The results will be available to you if you so wish and they will be used to inform the broader question of experience of young

Appendix 8: Participant information sheet

people presenting with self-harm within inpatient settings.

Who will have access to this information?

All the information will be tape-recorded by the interviewer and be held securely in a password protected file. Only the main researcher will have access to this file. The tape recordings will be transcribed and completely anonymised so that all personal and identifying information is eliminated. The audiotapes will then be deleted and destroyed.

What if something goes wrong?

If at any time you feel in need of support during the interview process, the manager of the unit is available to help you manage any issues. There will be psychological support available from a registered clinical psychologist on the unit should you feel concern or distress in any way as a result of taking part in the interview. If you wish to complain or have any concerns

about any aspect of the study then the normal National Health Services Complaints mechanisms whistle blowing policy framework or trust grievance procedures will be available to you. If you disclose anything that we feel is a risk to yourself or somebody else, advice and guidance will be offered, and it will be discussed with the unit manager as to how to provide support and ensure safety at all times. The interview will be terminated immediately, and advice will be given on the next steps.

What will happen to the results of the study?

The results and recommendations will be published. A copy of the report will be available to you upon request from the main researcher contactable at KMAU.

Appendix 9: Young person consent form

Informed Consent for “The young person’s experience of inpatient care when presenting with self-harm”

Please tick the appropriate boxes

Yes No

1. Taking part in the study

I have read and understood the study information dated, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.

☐ ☐

I consent voluntarily to be a participant in this study and understand that I can refuse to answer questions and I can withdraw from the study at any time, without having to give a reason.

☐ ☐

I understand that taking part in the study involves a 45-60 minute audio-recorded interview held away from the main area of the unit and that I will be asked to discuss a set of questions about the care and support I receive. The interview recordings will be transcribed and destroyed.

☐ ☐

2. Use of the information in the study

I understand that information I provide will be used for a research dissertation and possible publication.

☐ ☐

I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared or known beyond the researcher.

☐ ☐

I agree that my information can be quoted in research outputs.

☐ ☐

3. Future use and reuse of the information by others

I understand that the transcribed interview data that I provide to be destroyed following the research.

☐ ☐

4. Signatures

Name of participant [IN CAPITALS]

Signature

Date

I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are freely consenting.

Name of researcher [IN CAPITALS]

Signature

Date

5. Study contact details for further information

Any Further enquires please contact Francois Potgieter 0203 228 3200

Appendix 10: Parent/Legal Guardian consent form

Informed Consent for “The young person’s experience of inpatient care when presenting with self-harm”

Parent/Legal Guardian Consent for Young People aged 16 and under

Please tick the appropriate boxes

Yes No

1. Taking part in the study

I have read and understood the study information dated, or it has been read to me. I have been able to ask questions about the study and my questions have been answered to my satisfaction.

☐ ☐

I consent voluntarily to _____ being a participant in this study and understand that I can refuse or withdraw my consent at any time, without having to give a reason.

☐ ☐

2. Use of the information in the study

I understand that information _____ provides will be used for a research dissertation and possible publication.

☐ ☐

I understand that personal information collected about _____ that can identify him/her, such as his/her name or where he/she lives, will not be shared or known beyond the researcher.

☐ ☐

I agree that _____ information can be quoted in research outputs.

☐ ☐

3. Future use and reuse of the information by others

I understand that the transcribed interview data that _____ provides will be destroyed following the research.

☐ ☐

4. Signatures

_____ Name of parent/ Legal Guardian [IN CAPITALS]	_____ Signature	_____ Date
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I have accurately read out the information sheet to the potential participant’s parent/legal guardian and, to the best of my ability, ensured that information is understood and that they are freely consenting.

_____ Name of researcher [IN CAPITALS]	_____ Signature	_____ Date
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5. Study contact details for further information

Any Further enquires please contact Francois Potgieter 0203 228 3200

Semi-Structured Qualitative Questionnaire

Introduction:

Thank you for meeting with me today. I would like to read through the information sheet again to remind you what the project is about and to check you are still happy to take part. I'll also go over the consent form again (read information sheet and sign consent form again)

I would like to talk to you about how you are finding your time in hospital. Are you happy for me to ask you some questions about that? Remember, you can say no if you want at any time and we will stop. Is there anything you would like to ask me before we start?

1. Can you say a little about how you are finding your treatment/support here in hospital?
 - Prompt: what do think about the help you are getting?
2. Are there aspects of your care you find helpful?
 - Prompt: Are there things that make it better?
 - Prompt: Are there things that make it easier?
3. Are there aspects of your care you find don't help as much/ or are unhelpful?
 - Prompt: Are there things you would change about the support you receive?
4. Can you say something about any care-plans you have?
 - Are you aware of any specific care-plans related to your self-harm behaviours for example?
5. What are your thoughts on the self-harm care plans (if aware of them) that have been discussed with you?
 - Prompt: How do you think they help/don't help?
 - Prompt: Is there anything that you would add to the care plans/interventions that could be helpful for you or other young people?
6. Do you think there are things that are getting in the way of you being able to use of the support you receive?
 - Prompt: What do you think should be in place to support young people in order to help them getting better?
7. Do you feel as though you have a say in your care?
 - Prompt: Ask something about being involved or able to make decisions?
 - Prompt: Do you feel able to contribute to your care?
8. What are your thoughts about being admitted to hospital for self-harm?
 - Prompt: Do you have any thoughts about being away from your usual life whilst you receive care?

Cool down:

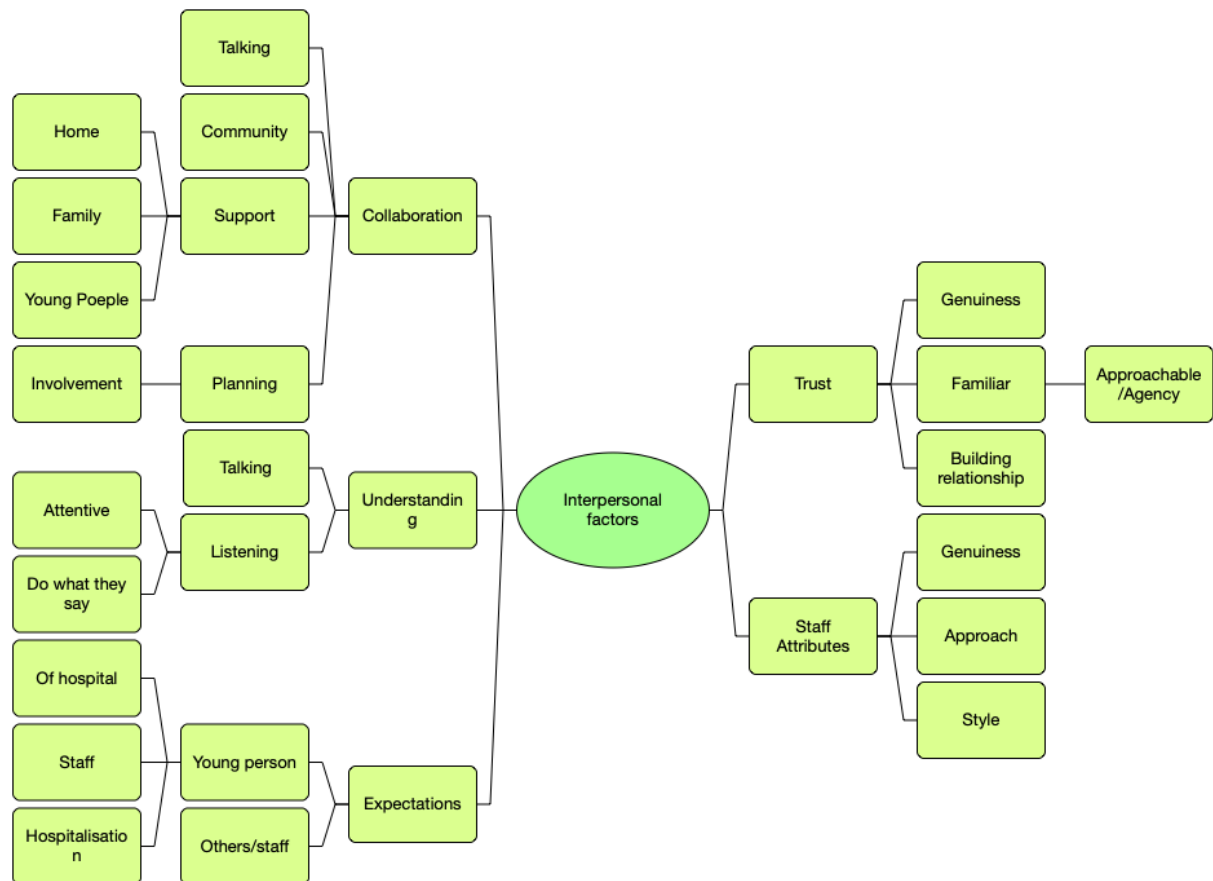
- Is there anything else that you would like to say/add?

State the interview has ended. Thank the young person for taking part. Verbally re-affirm that the service user is happy for you to use their interview in the research.

Appendix 12: Memo extract

Clustering memo:

Relationships: There are several codes relating to interpersonal factors. To get started in trying to understand this I'm hoping to organise the material. It's an attempt to chart the relationships and perhaps significance of the different components. I'm starting with codes that may fit well in what I'm terming 'interpersonal factors' for now and noticing any possible connections that come to the fore.



Interpersonal factors are references to the service users' emphasis on relational factors. There is something about the links to others. It seems that there is a willingness to collaborate with others. Noting there are relationships to peers too. Working together has highlighted a need for a trusting relationship, this seems only possible, in the view of the young people, if there is genuiness in the responses and interactions. Working together is further facilitated through increased opportunities to talk. There is an additional component that relates more to how others behave which makes them either approachable or not or allows the young people to feel understood. These seem to relate to personal attributes or 'qualities'.

There are further links to expectations but also how this plays out in terms of being able to engage, acknowledge feelings and remain motivated to participate in what is on offer. In addition, there needs to be some exploration on how this has an impact on the young peoples' sense of involvement in their care (and care-plans).

Categories and connections:

There is a sense that this is an important category linked essentially to what constitutes being

Appendix 12: Memo extract

human, the ability to form trusting relationships and to work together towards a common goal. To feel understood (something internal perhaps too) seems to acknowledge the self and to be “seen” – this was a concept in Lindgren et al. I recall.

Theory development:

In relation to how interpersonal factors, as an initial example, might hang within the 'theory', There is something about the ‘humanness’ on the subject that feels relevant and likely works alongside other factors which are more internal. Looking at relationships between staff, family and the young people, this seems intrinsically linked to the overall experience. I’d go further and suggest that it fits within the constructivist epistemology which marries well with Charmaz’ grounded theory methodology.