A QUALITATIVE INVESTIGATION INTO THE LIVED EXPERIENCE OF PSYCHOSOCIAL ASSESSMENT FOLLOWING SELF-HARM

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SCHOOL OF MEDICINE
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ABSTRACT

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A Qualitative Investigation into the Lived Experience of Psychosocial Assessment following Self-harm

This thesis investigated the experience of taking part in a psychosocial assessment following an episode of self-harm from the service user perspective. Psychosocial assessments are a key aspect of self-harm management in secondary care, designed to identify needs and risk and determine further care. This study utilised interpretative phenomenological analysis to privilege the voices of service users and produce in-depth, contextualised understandings of the experience of assessment and its impact on future help-seeking and engagement with services. Data collection consisted of semi-structured interviews with thirteen participants soon after their hospital attendance; follow-up semi-structured interviews were also completed with seven participants three months later, to explore patient-derived outcomes from assessment and hospital attendance.

The lived experiences of participants were characterised by two main features: experiences of life as a struggle and of the self as “less than”. As a result of these struggles and experiences of powerlessness and devaluation, participants mostly saw self-harm and suicide as a natural progression in their narratives. Expressions of suicidal intent reflected a struggle between a desperate desire for change and hopelessness in the face of current circumstances.

The key message gained from participants’ accounts of assessment was that the interaction with staff had the power to reinforce or challenge hopelessness and negative self-evaluations. In addition, the way an assessment was conducted had influence beyond the hospital: as an experience which created or reinforced expectations for future instances of help-seeking; as a deterrent or an encouragement to seek help; and as the first step along the path to change. Unfortunately, participants’ experiences of aftercare were dominated by a sense of stagnation due to the failure of services to follow through with promises of aftercare, which affected their attitudes towards future help-seeking and towards themselves.

This thesis is the first study to utilise an in-depth idiographic methodology to explore and contextualise the service user experience of psychosocial assessment following self-harm within the wider circumstances of their lives. It demonstrates how patient-staff interactions within the hospital and after discharge can affect future help-seeking through reinforcing or challenging the hopelessness and self-negativity of patients.
DECLARATION

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CHAPTER 1: EXPERIENCING SELF-HARM

1 Introducing self-harm
In order to understand the experience of psychosocial assessment from the service user perspective, it is vital to consider how self-harm is understood and experienced by those who self-harm and the healthcare professionals who work with them.

Self-harm is a complex phenomenon which can present in several ways: it has “many faces” (Turp, 2002, p197). In this chapter, three facets of self-harm will be discussed. Section 1.1 introduces the debate around defining self-harm and defines it in light of this study’s aims. Secondly, from epidemiological and survey research, researchers have gleaned potential risk and protective factors for self-harm – clinical, psychological, social, demographic and cultural factors which are more or less likely to be associated with self-harm. Section 1.2 discusses some of the prominent factors associated with self-harm.

Finally, it is important to understand the meaning of self-harm for those who hurt themselves, and the functions the act performs. As Larkin, Watts and Clifton (2006, p105) pointed out, we are situated beings, “persons-in-context”, and the context in which we live forms our perspective on the world (Bracken & Thomas, 2005; Gadamer, 1979). The functions and meanings of self-harm both have an influence on how, why and if people seek help from services. Section 1.3 covers the functions and meanings of self-harm in detail.

1.1 Different conceptions of self-harm
Consensus identifies Emerson (1913-1914) as the earliest reference to self-harm in the clinical literature (Shaw, 2002). This psychoanalytical case study explored reasons for self-mutilation in a young girl, focusing on dysfunctional familial relationships (Shaw, 2002). This study exemplifies three insights into the clinical conceptualisation of self-harm. First, clinical research initially defines a problem, and then attempts to understand it. This focus on classification reflects a model of scientific practice drawn from positivist epistemology – self-harm is conceptualised as a disease entity which can be defined and its boundaries specified (Bentall, 2004; Johnstone, 1997).
Secondly, as Shaw (2002) points out, self-harm has been gendered since the beginning of clinical consideration of it. The idea that self-harm is primarily a “young, white, female” concern (e.g., Favazza & Conterio, 1988; Simpson, 1975) can operate to delimit self-harm and dismiss it as “attention-seeking” and “neurotic” (Pembroke, 1994). Self-harm research has been dominated by a focus on women, especially adolescents (Shaw, 2002), although this is increasingly challenged.

Finally, the researcher or clinician’s framework has a powerful impact on how self-harm is defined and interpreted. As Emerson (1913-1914) approached self-harm psychoanalytically, so others have viewed it cognitively (e.g. Castille et al., 2007), behaviourally (e.g., Walsh & Rosen, 1988), socially (e.g., Adler & Adler, 2007; Burstow, 1992), culturally (e.g., Favazza, 1996) and psychiatrically (e.g., Sansone et al., 1998). As Kleinman pointed out:

> Psychiatric concepts, research methodologies and even data are embedded in social systems (Kleinman, 1988, p3-4)

Conceptualisations of self-harm found in the literature are embedded in the social world. The ways in which self-harm is approached, studied and framed reflect the researchers’ orientations and the social context of research. The choice of terminology and the debates around definition all reveal underlying assumptions and conditions for knowledge production in this field (McAllister, 2003). As Walsh and Rosen stated:

> The debate over terminology is… no mere quibbling over words. At stake is how SMB [self-mutilative behaviours] should be understood, described, diagnosed and treated (Walsh & Rosen, 1988, p21)

Further discussion of defining self-harm and the impact of different definitions are included in appendix 1. For the purposes of this study, it is important to note that the definition of self-harm and the terminology used by clinicians and service users is debated and contested, as the way in which an act is framed affects how it is approached, and under whose purview it falls. Describing self-harm as “deliberate”, which is hotly contested, carries connotations of manipulation and intent (Pembroke, 1994); service users have felt stigmatised by this terminology (Royal College of Psychiatrists, 2004). Describing self-harm as “attempted suicide” or “parasuicide” places it firmly under the umbrella of
suicide intervention and prevention, which some service users have argued is unhelpful and diminishing (Harrison, 1995; National Institute for Health and Clinical Excellence, 2004). It creates a contrast between self-harm and suicide whereby self-harm is positioned as less serious and less genuine (Cresswell & Karimova, 2010), and the term “attempted” implies failure (Pembroke, 1994; Spandler, 1996).

With the caveat that any definition will have limitations and carry underlying assumptions about the problem discussed, the following section introduces and justifies the terminology chosen for this research.

1.1.1 Operational definition

Herein, the term “self-harm”, defined as “intentional self-poisoning or self-injury, irrespective of motivation” (Hawton et al., 2003; Kapur et al., 2008), was adopted. This was chosen because it encompasses the broad spectrum of behaviours which may present at the emergency department, and because it is viewed by service users as preferable to “deliberate self-harm” or “self-mutilation” (e.g., Pembroke, 1994). This definition includes those who have self-harmed with avowed suicidal intent as well as those without. It was felt to be of clinical interest to examine whether the way the person frames the episode in terms of intent impacts upon their experience of treatment. For example, framing self-harm as a survivalist, coping mechanism may have implications for assessments which partially focus on suicide risk.

This operational definition is commonly used in the multi-centre monitoring project, which includes the location of this study (Hawton et al., 2007; Kapur et al., 2008). This standardisation of definition should enable greater comparability of the study results with other sites. In addition, as this definition is used in hospitals to make clinical decisions, it plays a part in determining which people are seen to be in need of a psychosocial assessment following self-harm (2004). This definition also avoids making explanatory statements, unlike the survivor definition of “self-injury”, or the clinical definition of “deliberate self-harm syndrome”\(^1\). In addition, the intention was to work from...

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\(^1\) The psychiatric committee of the DSM-V, the commonly utilised diagnostic manual for psychiatrists, propose a new category “non-suicidal self-injury”. The main thrust of their
this broad definition towards individualised, in-depth understandings of self-harm, by asking participants about their meaning-making and experiences.

1.1.2 Summary
The adopted terminology is descriptive rather than conceptual, in that it does not theorise as to the purpose of the act or the nature of the behaviour. It was chosen for its neutrality, to avoid negative connotations of other terms, and breadth, to reflect clinical practice.

1.2 Who Self-harms?
This section focuses on factors commonly associated with self-harm, identified from epidemiological research (see Kapur & Gask, 2006; Skegg, 2005). Variables such as gender, age and ethnicity are discussed separately, but the contextual inter-dependent character of these variables is acknowledged, as they interact and impact upon each other and their significance for the individual changes throughout the life course (Payne et al., 2008; Shiner et al., 2009).

1.2.1 Gender and Sexuality
Self-harm is traditionally associated with women more than men (Canetto & Sakinofsky, 1998; Shaw, 2002), with epidemiological research in Western countries finding rates of self-harm to be at least two times higher in women (Kerkhof, 2000; Schmidtk et al., 1996) and rates of suicide to be higher in men (Cantor, 2000). This “gender paradox” has led to substantial debate over how gender and self-harm interact (Canetto & Sakinofsky, 1998, p1; Hawton, 2000; Jaworski, 2010).

This debate is complicated by the methods used to establish self-harm rates (Kapur & Gask, 2006). Accurate rates are difficult to determine owing to gender differences in help-seeking behaviours (Moscicki, 1994; Williams, 1997); variation in the clinical identification of behaviours as self-harm (Canetto & Sakinofsky, 1998); and a paucity of centres which consistently collect self-harm

rationale seems to be to differentiate this behaviour from suicidal behaviours, and thereby reduce the costly, and unnecessary use of health services by those who self-harm without suicidal intent. This is more in line with the survivor definition, but it is worrying that this differentiation seems driven by pragmatic research and health service utilisation concerns rather than by clinical utility.
data (Kerkhof, 2000). The gender ratio also varies as a result of how self-harm is defined and which age groups are surveyed (Hawton & Harriss, 2008a).

Recent data from hospitals in three English cities found that 43% of individuals attending with self-harm were male (Hawton et al., 2007). Kapur and Gask (2006) note that there has been a steady decrease in the gender difference over time within the UK. Hawton and Harriss (2008a), examining hospital presentations between 1995 and 2004, found substantial differences in the gender ratio across age groups. During adolescence, the female to male ratio was at its highest, peaking at 8:1. However, this ratio steadily decreased after adolescence, and favoured men between ages 50-69 and over 80 (Hawton & Harriss, 2008a). This research emphasises the need to view gender as an “inter-dependent variable that connects with, and impacts on, other influences”, such as age (Payne et al., 2008, p24).

One such influence is discussed by Canetto and Sakinofsky (1998). They argue that variations in self-harm rates across different countries and ethnic groups may arise due to available cultural scripts determining the acceptability of self-harm and suicide for different groups. It is well-established that men tend to use more violent methods than women (Beautrais, 2002; Gunnell et al., 2000a; Murphy, 1998). Cultural scripts theory suggests that choice of method is influenced by gendered associations, e.g., violent methods may be thought more “masculine”, displaying courage and aggression (Canetto, 1991; Swami et al., 2008).

Canetto (1991, p605) also suggests that differential rates of alcohol abuse and self-poisoning across gender in America may reflect “psychologically equivalent but gender-specialized forms of self-injurious behaviors”. This theory is supported by qualitative work in Sri Lanka which connects the ingestion of pesticides and alcohol abuse with community attitudes towards these behaviours (Konradsen et al., 2006). The increase in alcohol abuse and violence in female self-harm patients could also be seen as reflecting changing patterns of, and attitudes towards, female alcohol use in Britain (Hawton et al., 2003).
Another reason for the gender bias relates to the structural conditions of women’s lives (Burstow, 1992; Harrison, 1995). Women are more likely to be victims of sexual violence and abuse, two issues associated with higher risk of self-harm (Van der Kolk et al., 1991, see 1.2.6; Walsh & Rosen, 1988). In addition, women may also be disadvantaged in a patriarchal society which rewards “masculine” ideals of rationality and self-determination (Waterhouse, 1993). Further, women who have been socialised to hide their emotions and subsume their needs for others may have no other outlet for distress and anger that is deemed “unfeminine” (Harrison, 1995; Ussher, 1991). Supporting the idea of self-harm as a way of coping with oppression (Burstow, 1992), are high rates of self-harm within institutions such as prisons or forensic psychiatric units (e.g., Jeglic et al., 2005; Liebling et al., 1997; Singleton et al., 1998) and in socially disadvantaged groups such as the homeless (e.g., Cullum et al., 1995; Tyler et al., 2003).

The gender debate reveals that the relationship between self-harm and gender is not straightforward, with both being impacted upon by the socio-cultural environment. Cultural attitudes towards self-harm and gender influence whether or not self-harm is viewed as a feasible behavioural response. Life events which contribute to psychological distress may differentially affect societal groups. In addition, structural issues may influence the ways in which people can cope (or perceive themselves able to cope) with distress.

The association between sexual orientation and self-harm demonstrates similar complexity. In recent years, greater risk for self-harm and suicide has been identified in men and women of lesbian, gay or bisexual orientation (D'Augelli & Herschberger, 1993; Skegg et al., 2003). In a British school-based survey, worry about sexual orientation was associated with significantly increased risk of repeated self-harm (O' Connor et al., 2009). Likewise, in a birth cohort of young adults in New Zealand, those identifying as gay, lesbian or bisexual were at greater risk of psychological disorders, suicidal ideation, and suicide attempts (Fergusson et al., 1999). The increased risk of suicide attempts in gay, lesbian and bisexual people seems robust despite methodological difficulties in identifying and reaching this population (King et al., 2008; Russell, 2003).
Disclosure of sexuality is likely to be subject to social desirability biases and influenced by the internal and external conflicts over sexuality which may themselves increase risk (Almeida et al., 2009; King et al., 2008). An ethnographic study in Japan found that the external pressures and social stigma associated with being a sexual minority were factors contributing to increased suicidal thoughts and self-harm. Both disclosure and concealment of sexuality were sources of distress (DiStefano, 2008). The conflict between being true to one’s sexual identity and the social and personal consequences of that identity echoes the conflict between the intrinsic and extrinsic self in Adams and colleagues (2005) online study of self-harm.

In Russell’s (2003) review of sexuality and suicide risk, general risk factors associated with adolescent suicide (depression, substance abuse, recent suicide or suicide attempts of family members, and parental conflict) were experienced in high rates by homosexual and bisexual adolescents, and these factors largely explained the elevated risk in this group. However, the additional factors of sexuality-related victimisation, homophobia, non-conformity to traditional gender roles, and conflicts related to disclosure, may also impact on risk of suicide and self-harm both directly and indirectly (D’Augelli et al., 2001; Paul et al., 2002). Almeida and colleagues (2009) found that perceived discrimination in lesbian, gay and bisexual adolescents accounted for increased levels of depressive symptoms in both sexes and increased risk of self-harm in males. Another study found that sexual orientation was a major factor associated with suicide attempts in adolescents, with those who experienced parental verbal abuse and discouragement of non-conformity to gender roles most likely to attempt suicide (D’Augelli et al., 2005).

Most studies have focused on adolescents, who may experience different issues to adults, relating to developmental challenges being accompanied by coming to terms with same-sex attraction (Rotheram-Borus & Fernandez, 1995). In Paul and colleagues’ (2002) survey of gay and bisexual men, those who attempted suicide after adolescence were more likely to have experienced childhood sexual or physical abuse and familial substance abuse, factors often associated with self-harm (Gratz, 2003). Alexander and Clare’s (2004) qualitative study of lesbian and bisexual women, found that “feeling different”
was one influence of sexuality on self-harm, which was often compounded by
the adoption of self-harm as a coping strategy. However, these women also
experienced invalidating and abusive experiences unrelated to their sexual
identity which contributed to self-harm, and in some cases their sexual identity
was a source of positive self-esteem and belongingness. DiStefano (2008)
found that unemployment, debt, and victimisation, both sexuality-specific and
not, were risk factors for people of sexual minority groups – and that
unemployment and victimisation in particular may be influenced by societal
attitudes towards sexual minorities.

These studies point to the social environs as instrumental in contributing to
emotional distress in sexual minorities. In those lesbian, gay and bisexual
adolescents who experienced high levels of family support and self-acceptance,
the effect of victimisation on mental health was mediated (Hershberger &
D'Augelli, 1995). In Alexander and Clare (2004), when the women’s
circumstances and relationships became more supportive, self-harm was often
reduced. The ways in which social environments, at both micro- and macro-
levels, impact upon individuals and their experiences of sexuality and self-harm
needs to be further investigated.

1.2.2 Age and Self-harm Across the Life-course
In the UK, two thirds of all patients presenting to hospital following self-harm are
under 35, with the highest self-harm rates occurring in 15-19 year old females,
and 20-24 year old males. As age increases, self-harm rates decline (Hawton
et al., 2007). Repetition of self-harm is most common in the middle years (ages
25-54), although this figure is based on repeat hospital attendances (Kapur et
al., 2006). It is likely that repetition rates in the community are higher, as
community surveys indicate a substantial proportion of people do not seek help
after self-harm (Hawton et al., 2002; Meltzer et al., 2002). In a questionnaire
study of over 30,000 15 and 16 year olds in Europe and Australia, over half who
had self-harmed in the previous year had self-harmed more than once in their
lifetime, and most did not seek help (Madge et al., 2008).

Differences in self-harm rates across the life cycle suggest that the motivations
and meanings of self-harm can vary with age (Hawton & Harriss, 2008c). One
striking difference is the connection between self-harm and suicide across age groups. With older adults (over 60), self-harm is associated with greater suicidal intent and lethality (Hawton & Harriss, 2006; Salib et al., 2001), and the rate-ratio of self-harm episodes to completed suicides is lower compared to younger age groups (De Leo et al., 2001; Hawton & Harriss, 2008c). It is argued that for older adults, it is more accurate to assume self-harm indicates failed suicide attempts, as they are similar in character to completed suicides (Draper, 1996; Salib et al., 2001).

An interesting issue to consider is the longer-term outcomes of self-harm across the life-course. There is little evidence to suggest that the high rates observed in teenagers and young adults in the past 20 years are translating into higher rates in adults as the cohort ages (Dickson et al., 2009), although Hawton and colleagues (2003) found a possible cohort effect in males aged 25-34 in response to an earlier peak in 15-24 year olds. It is difficult to conduct follow-up studies on this population owing to low research participation rates (Clarke et al., 2004; Hawton & Sinclair, 2003), and most follow-up studies are limited to data on hospital attendances and mortality (Sinclair et al., 2010). In a six-year follow-up study of hospital attendances for self-harm, quality of life was found to be lower than expected comparative to the general population, and morbidity, mortality and alcohol abuse were significantly worse for those who self-harmed (Sinclair et al., 2010).

Two qualitative studies have investigated the process of discontinuing self-harm (Bergmans et al., 2009; Sinclair & Green, 2005). Sinclair and Green (2005) identified three stories of resolution in 20 interviews with people who had stopped self-harming for over two years. The first story involved the resolution of adolescent distress in light of powerlessness and invalidation within the family; the second involved the realisation that alcohol was a contributing factor to self-harming behaviour; and the third related to recognising self-harm as a symptom of untreated depression. In Bergmans and colleagues’ (2009) study, 16 young adults were interviewed following engagement with an intervention. They found that their participants characterised recovery as a gradual process of building up a tolerance of emotions, an awareness of options other than death and realising a desire to live (Bergmans et al., 2009). Both these studies
point to an internal process of realisation and change which impacts upon the individual's relationship with self-harm, and highlight the importance of the lived context in understanding this relationship.

The life events and priorities of individuals who self-harm are likely to change over time. Sinclair and Green (2005) demonstrate the role of resolution in two key areas – adolescent-familial relationships and alcohol use – in reducing or ceasing self-harm. The differences in rates across age groups are likely to reflect a number of factors: age-related attitudes and norms around coping with life; changing meanings of self-harm with age; differential access to social support; and the life events and relationships experienced are all potential influences.

1.2.3 Ethnicity and Culture

Recent studies by the World Health Organisation highlight self-harm as a global phenomenon (Schmidtke et al., 1996; World Health Organisation, 2006). Self-harm and suicide show variation in the prevalence in different cultural groups and methods used across different countries. Choice of method is influenced by the availability, familiarity and perceived acceptability of different methods (Farmer & Rohde, 1980; Gunnell et al., 2000a). Media reporting can also influence the adoption of a particular method, as witnessed in Hong Kong following a widely reported case of suicide by charcoal-burning (Chung & Leung, 2001). In an ethnographic study of survivors of charcoal-burning suicide attempts, knowledge of the method through the media was an influential factor in choosing this method (Chan et al., 2005).

Cultural factors which impact on self-harm are difficult to investigate as the ethnic categories used in research often encompass a wide variety of religious beliefs, cultural norms, nationalities and immigration statuses (Borrill et al., 2010). In addition, ethnicity data and information on immigration status is not consistently collected or determined (Bhui et al., 2007; Hawton et al., 2007). Within the UK, there has been recent awareness of higher self-harm rates in young South Asian women compared to White women, and South Asian men (Bhui et al., 2007; Cooper et al., 2006). Cooper and colleagues (2006) also found lower rates of self-harm in South Asian men than in their White
counterparts, and suggested there may be cultural differences in vulnerability to self-harm (e.g. lower rates of alcohol use, and religious beliefs). However, these factors would also apply to South Asian women, indicating that there may be a unique profile of risk relating to gender, ethnicity and culture in UK-based South Asian women.

Several qualitative studies in England have sought to further our understanding of self-harm in South Asian women’s lives (Chantler et al., 2003; Chantler et al., 2001; Chew-Graham et al., 2002; Marshall & Yazdani, 1999). Bhardwaj (2001) and Marshall and Yazdani (1999) stemmed from an inner-city project in London, focusing on the experiences of young South Asian women in Britain, whilst the work by Chantler and colleagues was conducted in Manchester investigating service responses to South Asian women who self-harm (Chantler et al., 2003; Chantler et al., 2001; Chew-Graham et al., 2002). Participants in both projects emphasised self-harm as a coping strategy and a way of taking control, which are oft-cited functions of self-harm (e.g., Babiker & Arnold, 1997; Gratz, 2003; Klonsky, 2007). Domestic violence, abuse, loss and social isolation also featured prominently in these accounts (Chantler et al., 2001; Marshall & Yazdani, 1999) and in the wider self-harm literature (Arnold, 1995; Skegg, 2005; Walsh & Rosen, 1988).

Notably, there were ways in which emotional distress was heightened as a result of cultural factors, such as Izzat, or honour, which appeared to affect women in particular within South Asian families. Structural factors also played a role, such as racism and discrimination in society; difficulty accessing help due to rules around immigration; and cultural insensitivity in services. Women had to negotiate gendered inequalities within local communities whilst facing both race- and gender-related disadvantage within Western society (Chantler et al., 2001). The importance of placing our understanding of ethnicity within the wider social environs is reinforced by Neeleman and colleagues’ investigation into ethnic density, which found that the relative size of an ethnic minority within an area had an impact on self-harm rates. Factors such as help-seeking outside the community, racial abuse, discrimination and difficulties accessing services may impact on the ways in which membership of an ethnic minority affects self-harm rates (Neeleman et al., 2001).
Favazza (1996) was instrumental in introducing culture into the clinical understanding of self-harm, but culture is often disregarded unless linked to ethnic minorities, and can be used to singularise and pathologise these minorities (Marshall & Yazdani, 1999). Marshall and Yazdani (1999) argued that there is little discussion of Western cultural influences on self-harm, although there is a developing literature challenging the dominant medical (and arguably, masculine) model of mental illness and its impact on societal responses to self-harm (Brickman, 2004; Harrison, 1995; Johnstone, 1997). In addition, qualitative research is beginning to draw attention to the ways that traditional Western views of gender impact on self-harm in men (e.g., Biong & Ravndal, 2007; Russell et al., 2010; Taylor, 2003) and women (e.g., Arnold, 1995; Harrison, 1995).

These studies highlight the interactions between gender, ethnicity and society, with differential accessibility of services dependent on ethnicity and gender, and both culture-specific and general socio-cultural factors influencing the mental health of South Asian women (Chantler et al., 2003; Chantler et al., 2001; Chew-Graham et al., 2002; Marshall & Yazdani, 1999). These studies indicate the importance of attending to individual experience, whilst locating accounts within the wider socio-cultural and political environs (Chantler et al., 2001; Marshall & Yazdani, 1999).

1.2.4 Unemployment, Deprivation and Social Integration
Self-harm is not confined to any particular group in society, but there is a strong association between self-harm and socioeconomic disadvantage (Gunnell et al., 1995; Gunnell et al., 2000b; Johnston et al., 2006). Poorer educational attainment, relative poverty and lower socioeconomic status are associated with higher self-harm rates (Gunnell et al., 2000b; Hawton et al., 2001). The multicentre monitoring study consistently reports higher rates of self-harm in Manchester than in Leeds and Oxford, a finding which may be attributable to Manchester’s greater levels of socioeconomic deprivation (Hawton et al., 2007). This association has also been found in children and adolescents, suggesting the connection cannot be explained by socioeconomic drift due to mental illness, although this may be a factor at the parental level (Ayton et al., 2003).
Rates of self-harm in the unemployed are significantly higher than rates in the employed, but unemployment is not often cited as a precipitant by service users (Morgan et al., 1975; Platt, 1984). In a population-based survey of 18-20 year olds in Scotland, those who were unemployed, sick or outside the labour market were most at risk of self-harm (Young et al., 2007). Adults who are unemployed for over a year are 26-36 times more likely to self-harm than those who are employed (Hawton, 2004). Areas with high unemployment typically have higher rates of self-harm and suicide, although it is worth noting that these areas tend to be areas of multiple deprivation (Owen & Watson, 1995; Smith, 1985). In a prospective cohort study in Manchester, unemployment was an independent predictor of both self-harm and repetition of self-harm, accounting for 20% of those repeating within 6 months (Johnston et al., 2006).

There is consensus that the association between unemployment and self-harm is robust, but the nature of the association is debated (Gunnell et al., 2009; Hawton, 2004; Platt & Hawton, 2000). It is likely that unemployment relates to self-harm in more than one way: through impacting negatively on mental health; through those with poorer mental health being more likely to become unemployed; and through other factors such as poverty, substance abuse and marital problems associated with unemployment (Dooley et al., 2000; Gunnell et al., 2004; Gunnell et al., 2009; Owen & Watson, 1995; Platt & Hawton, 2000).

Durkheim argued that suicide rates could be explained by two separate interacting factors: social integration and social regulation. He proposed four typologies of suicide which reflected imbalances in these two factors: egoistic and altruistic suicides are people who are poorly integrated and highly integrated respectively; anomic and fatalistic suicides are people who are under regulated or overly regulated respectively (O’Connor & Sheehy, 2000). Congdon (1996) developed a social fragmentation index using variables from census data to approximate a lack of social integration. Self-harm in London wards was associated with both higher levels of socioeconomic deprivation and higher scores on this social fragmentation index (Congdon, 1996). Hawton and colleagues (2001) also found an association between social fragmentation and self-harm in Oxford. In this study, the impact of social fragmentation was
reduced when social deprivation was controlled for (Hawton et al., 2001). An Irish nationwide survey found geographical differences in self-harm rates which could be accounted for by levels of deprivation, fragmentation, and differences in age and gender (Corcoran et al., 2007).

Social isolation is associated with higher risk of self-harm and suicide, with those who are single or divorced being more likely to self-harm (Johnston et al., 2006; Skegg, 2005). In older adults with depression, poor social support is associated with self-harm and suicidal thoughts (Dennis et al., 2005; Harrison et al., 2010). A community survey also found an association between suicidal thoughts and poor social support (Gunnell et al., 2004). Poor social support is also associated with an increased risk of repetition (Ojehagen et al., 1991). In addition, coping with isolation was often cited as a reason for self-harm by South Asian women (Chantler et al., 2001; Marshall & Yazdani, 1999).

The social context has emerged as hugely influential for those who self-harm. However, the impact of social factors on self-harm is complex, as these factors inter-relate with each other and with psychiatric, psychological, and demographic characteristics. For instance, those who are socially isolated may be more vulnerable to psychological and environmental stressors due to their isolation. Social support may be protective against the effects of negative life events, such as unemployment or illness. However, these events themselves may reduce an individual’s access to social support. In addition, social isolation may be the outcome of relational strife which causes emotional distress e.g. relationship breakdown, bereavement or separation. The resultant lack of social support may then increase the likelihood of self-harm.

1.2.5 Mental Illness and Alcohol/Drug Abuse
Self-harm is strongly associated with several psychiatric and psychological disorders (Haw et al., 2001; Suominen et al., 1996), and in people who attend hospital with self-harm, a previous history of psychiatric treatment is predictive of suicide (Cooper et al., 2005). 92% of people in Haw and colleagues’ (2001) hospital-based survey had at least one ICD-10 psychiatric disorder at the time of presentation, with mood disorders, especially depression, being the most prevalent. Schizophrenia is associated with increased risk of self-harm,
repetition, and suicide (Colman et al., 2004; Hunt et al.; Pompili et al., 2007). High levels of co-morbidity have been found in hospital studies (Haw et al., 2001; Suominen et al., 1996) and co-morbidity is associated with increased suicide risk (Foster et al., 1997).

Outside of hospital studies, it is difficult to ascertain rates of psychiatric and personality disorders in those who self-harm. In a systematic review, Fliege and colleagues (2009) concluded there was both associative and predictive evidence that anxiety, depression and aggression had a role in self-harm. However, the majority of studies sampled participants from clinical settings. Community-based studies tended to involve adolescents or university students, indicating a bias towards younger participants in research. One community-based survey which sampled 16 to 74 year olds in Britain found that those who exhibited current symptoms of mental illness were up to 20 times more likely to have self-harmed in their lifetime (Meltzer et al., 2002). In this sample, 25-30% of those with phobia, obsessive compulsive disorder and depressive disorder had attempted suicide, compared to 2% of those not meeting the diagnostic criteria for a neurotic disorder (Meltzer et al., 2002). This study is indicative as the survey assessed the presence, duration and severity of symptoms rather than inquiring about current known diagnoses.

Self-harm is often associated with personality disorders, notably borderline personality disorder (BPD). In Haw and colleagues (2001), 45.9% of self-harm patients were diagnosed with a personality disorder. Whilst the debate surrounding personality disorders is beyond the scope of this chapter, it is of interest to mention two points. First, diagnosing personality disorders in those who self-harm can have the unhelpful effect of pathologising the individual whilst obscuring the sources of underlying distress (Johnstone, 1997; National Institute for Mental Health in England, 2003b). Secondly, medical diagnosis can close off discussion of the aetiology and meaning of self-harm, by focusing psychiatric attention on the diagnosed illness (Johnstone, 1997). Paris (2005) suggested that the relationship between self-harm and BPD is best understood in terms of the functions self-harm performs, and its association with certain psychological traits (such as impulsivity) and life experiences (such as trauma). This approach may also apply to other psychiatric diagnoses, for example, in
the way childhood sexual abuse (Gladstone et al., 2004) and hopelessness (Salter & Platt, 1990) have been observed to mediate the link between depression and suicidality.

Alcohol and drug misuse are also well-established risk factors for self-harm and suicide (Boenisch et al., 2010; Kolves et al., 2006). Over a quarter of people attending hospital with self-harm demonstrate alcohol dependence or harmful use (Haw et al., 2001). Alcohol misuse is an independent predictor of further self-harm and eventual suicide (Cooper et al., 2005; Kapur et al., 2006; Ojehagen et al., 1992), and it is common for people to self-harm under the influence of drugs and/or alcohol (Hawton et al., 2007; Touquet et al., 2008). Crawford and colleagues (2010) found that repetition of self-harm was strongly associated with alcohol consumption in both arms of a randomised controlled intervention.

Hufford (2001) argued that alcohol was both a proximal and distal factor in suicidal behaviour. Alcoholics, especially those with co-morbid alcohol misuse and depression, demonstrate increased lifetime risk of both suicide attempts and eventual suicide (O’Connor & Sheehy, 2000). Alcohol can also act as a precipitating factor for self-harm, by increasing levels of emotional distress; lessening inhibitions against acting upon suicidal thoughts; and contributing to a myopic cognitive state (Hufford, 2001). Alcohol use can increase the lethality of self-harm, both through increased aggression and impulsivity (Suominen et al., 1997), and through interactions with substances taken (Hawton et al., 2007).

Substance abuse is also associated with increased risk of suicide (Harris & Barraclough, 1997). In Manchester, 16% of those assessed following self-harm meet the criteria for substance abuse, with substance abuse being most common in men under 35 (Dickson et al., 2009). The mechanisms by which substance abuse affects self-harm rates are likely to be complex. O’Connor and Sheehy (2000) suggested that the negative impact of substance abuse on interpersonal relationships, cognition and mood are all ways in which it can increase risk of suicide. In addition, substance abuse disorder is often co-morbid with mood disorders in those who attempt suicide (Bronisch & Wittchen, 1994). Substance abuse can perform a similar function to self-harm, and may
be a means of coping with stressful life events or mental illness (Canetto, 1991). It can also be a causal factor in the development of mood disorders, e.g. substance-induced mood disorder (Elliott et al., 1996). Both alcohol and drug use may be influenced by the presence of stressful life events, which in turn may be exacerbated by substance abuse.

The role of social factors within the relationship between mental illness and self-harm should also be considered. A systematic review found that indicators of social deprivation such as educational attainment, employment status and material circumstances (e.g. income) were also associated with higher rates of mental illness (Fryers et al., 2003). Self-harm is also associated with unemployment and social deprivation (see 1.2.4). These findings suggest that the prevalence of self-harm and mental illness cannot be divorced from its social context.

1.2.6 Abuse, Violence and Invalidation
A substantial proportion of research has focused on the link between self-harm and childhood trauma, especially in women (Low et al., 2000; Romans et al., 1995; Van der Kolk et al., 1991). Gratz (2003) identified a number of childhood events associated with self-harm, including sexual and physical abuse, separation and loss, and insecure attachments to caregivers. An extensive review found a link between childhood trauma and self-harm, but considerable variability in the size of the association – an issue which was compounded by methodological variation in the included studies (Mina & Gallop, 1998). Identifying accurate rates of self-harm in those who were abused or experienced childhood trauma, and likewise, accurate rates of childhood trauma in those who self-harm, is methodologically challenging owing to the retrospective nature of most studies, and the impact of the sampling approach on the likelihood of disclosure (Mina & Gallop, 1998).

A recent meta-analysis of 43 studies challenged the size and importance of the link between childhood sexual abuse and self-harm, arguing that the relationship between the two was minor, and likely to be inflated by publication bias (Klonsky & Moyer, 2008). It could be argued that quantitative studies may be more prone to under-reporting bias, owing to the sensitive and often hidden
nature of abuse and self-harm. In qualitative research, the association tends to be stronger, for example, two-thirds of women in Arnold’s (1995) survey cited childhood experiences of trauma, abuse, and neglect as instrumental in their self-harm. However, this type of research may over-represent the presence of abuse in self-harm, as Arnold drew her sample from women connected to the Bristol Crisis Service for Women (Arnold, 1995).

Skegg (2005, p1474) notes in her review that “adverse experiences tend to cluster”. Both Arnold (1995) and van der Kolk and colleagues (1991) found that most participants reported multiple traumatic childhood experiences, and the latter study found an association between the severity of the trauma and the severity of self-harm. This association was repeated in a hospital survey of 257 consecutive cases of overdose in women, with multiple repeaters reporting more severe and extended abuse (Coll et al., 1998). In Brent and colleagues’ (2002) investigation into familial transmission of suicide risk, the offspring of adult suicide attempters were at greatest risk of suicide attempts where there was also a history of sexual abuse, mood disorders and impulsive aggression in the family.

Linehan (1993) theorised that childhood invalidating environments, such as that created by an abusive or neglecting parent, when combined with biological vulnerabilities lead to emotional dysregulation in women diagnosed with BPD. Self-harm is then used as an external means of regulating emotions (see 1.3.2.1). Another effect of trauma is suggested by Herman (1992). The traumatised individual tries to deny and speak the truth, and this conflict emerges in complex psychological symptoms which both detract and attract attention from the trauma (Herman, 1992). Self-harm could be considered such a symptom, a “bright red scream”, speaking the unspeakable whilst hiding it from view (Babiker & Arnold, 1997; Strong, 1998). The experience of abuse can also trigger intense negative reactions towards the self as the vessel of abuse, which can manifest in a desire to self-punish or dissociate from one’s body (see 1.3.2.1).

The picture which emerges suggests multiple pathways through which childhood trauma can lead to self-harm, and multiple ways in which self-harm
functions for those with these experiences. A longitudinal study comparing women with a history of childhood sexual abuse to controls, found that survivors of abuse were almost four times more likely to have engaged in self-harm and were significantly more likely to have suffered further victimisation, including rape and domestic violence (Noll et al., 2003). The authors suggested a mechanism whereby childhood abuse increases an individual’s vulnerability to further abuse through an over-reliance on dissociation as a coping mechanism, and self-harm is then used both as a response to trauma and as a way to end dissociative states (Klonsky, 2007; Noll et al., 2003).

It is likely that there is a sub-group for whom self-harm is tied to childhood traumatic experiences (Brown et al., 2002; Van der Kolk et al., 1991; Weber, 2002), but there are also people who self-harm without these experiences, and not all who are abused go on to self-harm (Romans et al., 1995). However, these pathways to self-harm could apply to any experience which traumatises or invalidates the individual (Herman, 1992; Linehan, 1993). The experiences of domestic violence exacerbated by communal and institutional silence in Chantler’s work with South Asian women (Chantler et al., 2003; Chantler et al., 2001; Chew-Graham et al., 2002) resemble the experiences of women having suffered childhood sexual abuse, in that the body acts both as a site of loathing and resistance (Burstow, 1992; Harris, 2000; Harrison, 1995). Humphreys and Thiara (2003) present extensive evidence of the devastating impact of domestic violence on the mental health of women, even in the absence of childhood abuse. This impact is observed in high rates of self-harm, post-traumatic stress, depression and suicide (Humphreys & Thiara, 2003). Likewise, self-harm within institutions can be in response to an invalidating environment, with people feeling incapable of effecting change and silenced by staff (Borrill et al., 2005; Liebling et al., 1997).

Another form of invalidation is stigma (Goffman, 1963). Stigma and discrimination are often reported by those who self-harm or suffer from mental illness (Dinos et al., 2004; Pompili et al., 2003). Perceived stigma and discrimination can negatively impact on the well-being of people with mental illness, affecting acceptance of diagnosis, help-seeking behaviours and social functioning (Dinos et al., 2004; Link et al., 1997; Pompili et al., 2003).
1.2.7 Summary

It becomes clear as one delves into the literature on self-harm and its characteristics that self-harm is a complex and over-determined behaviour, with multiple pathways leading to it (Leenaars, 2002; Van Heeringen et al., 2000). Clinicians and researchers need to move beyond a risk factor mentality to examine how different characteristics and events interact and form the context in which self-harm occurs for the individual.

The research on South Asian women in recent years demonstrates this complexity vividly in the intersection of gender, ethnicity and socio-political environment in self-harm (Chantler et al., 2001). Likewise, the intersection between mental disorders, substance abuse and social disadvantage highlights the importance of viewing individual accounts of self-harm and experiences of mental distress within the wider social context.

1.3 The Meaning of Self-harm

Epidemiological research on self-harm is essentially descriptive: it focuses on the scope rather than the meaning(s) of self-harm (McDowell & MacLean, 1998). The following sections explore three components of meaning for those who self-harm. First, life events and difficulties which precede self-harm are considered. Both acute and chronic difficulties can lead to self-harm, and section 1.3.1 unpacks the literature on these precipitants.

Secondly, functions of self-harm are discussed in section 1.3.2. A function is defined as the role or purpose self-harm serves for the individual. Self-harm can be seen as a behavioural response to a state of affairs; the change self-harm is employed to effect would be its functional meaning. Owing to its importance in terms of services, the relationship between self-harm and suicide is explicated separately in section 1.3.3. The final aspect of meaning addressed is the psychology of self-harm, which could be construed alternatively as cognitive predispositions or biases that increase the likelihood of self-harm and suicidality. This is discussed in section 1.3.4.

1.3.1 Life Events
The life events which precede self-harm are varied and depend to an extent on the socio-demographic characteristics of the individual. Haw and Hawton (2008) examined hospital data in Oxford and found differences in the problems patients reported across age groups, gender and expressed suicidal intent. Men reported more difficulties with employment, finances, housing, and alcohol/drugs. Women reported more difficulties with family, psychiatric disorders, eating and childhood sexual abuse. Employment difficulties were more common in younger age groups, and social isolation, psychiatric disorders and physical ill-health were more common in the elderly. Personality disorders were associated with an increased number of difficulties, though psychiatric disorders were not (Haw & Hawton, 2008).

Relationship difficulties with a spouse or partner were the most common problem cited by patients (Haw & Hawton, 2008), which is supported in a number of comparable studies (e.g., Bancroft et al., 1979; Dickson et al., 2009; Milnes et al., 2002). In children, the most common problem reported prior to self-harm is arguments with parents (Kerfoot et al., 1995). With teenagers and young adults, the most common problem tends to be relationship difficulties with partners, with academic stress, childhood abuse and relationship difficulties with friends and family also common (Beautrais et al., 1997; Bolger et al., 2004; Hurry, 2000; Young et al., 2007). It is perhaps not surprising that relationship difficulties precede most episodes of self-harm, given the importance of personal relationships in both mental health and emotional and social development (Pilgrim et al., 2009).

It is likely that the nature of relationship problems across the life-course would differ, although to date little research has refined this category. In a sociological autopsy of 100 suicides, the ways in which social bonds impacted on each case was examined, highlighting differences in relationship difficulties experienced across age groups. For instance, those in middle life (ages 25-54) were more likely to have experienced relationship breakdown and separation from children, which the authors suggested may have contributed to suicidality through higher levels of personal investment in family within this age group (Shiner et al., 2009). In older adults, bereavement, loss and physical ill-health were more common (Shiner et al., 2009), a finding reflected in research on self-harm and
attempted suicide in this group (Harrison et al., 2010; Hawton & Harriss, 2006). Psychological factors influencing the individual’s responses to conflict may also play a role in the likelihood of self-harm (see 1.3.4), as may early childhood experiences which impact on later relationships (see 1.2.6).

Most people who attend hospital with self-harm present with multiple and intersecting difficulties (Haw & Hawton, 2008; Milnes et al., 2002). Farmer and Creed (1989) interviewed 82 people following self-poisoning and found an increase in severe life events in the weeks before the episode. Two-thirds of patients in a cross-sectional study identified at least one of their problems as insoluble, i.e. beyond their control to change, and this perception of insolubility was accompanied by higher levels of hopelessness and suicidal intent (Milnes et al., 2002). A similar theme arises in a qualitative study of 50 people with histories of self-poisoning from a deprived area of Scotland. Echoing the concept of learned helplessness, the limited environment and a perceived lack of agency led participants to construct an unbridgeable gap between the life desired and the life possible, and attempts to change these circumstances were perceived as predestined to fail (Redley, 2003).

There are also identifiable differences between those who self-harm repeatedly and those who do not repeat, although studies tend to be limited to short follow-up periods; draw their samples from hospital presentations; and use hospital repetition as the outcome measure (Colman et al., 2004; Hawton et al., 1999; Kapur et al., 2006; O’Connor et al., 2000; Owens et al., 1994). Typically, repetition is associated with unemployment, financial difficulties, previous psychiatric history, including a history of self-harm, poorer social support, divorce, separation and violent relationships (Bille-Brahe & Jessen, 1994; Colman et al., 2004; Kapur et al., 2006; Ojehagen et al., 1991; Owens et al., 1994). It seems that those who repeat may more often experience life difficulties in the presence of relationship conflict or absence of social support.

In a study of fifty hospital attendances for attempted suicide, repeaters were less relieved and more angry at surviving, and more likely to view the attempt as aggressively directed towards themselves or others (O’Connor et al., 2000). Sakinofsky and Roberts (1990) found that those who repeated tended to
perceive their problems as more severe, were less able to tolerate frustration, and experienced greater powerlessness, regardless of whether they had resolved their problems or not. Repeaters were also younger when they started self-harming, and had a history of more frequent episodes, which the authors suggested could reflect the use of self-harm as an early maladaptive coping strategy (Sakinofsky et al., 1990).

1.3.2 Functions
Some functions of self-harm have already been touched upon, as the meaning of self-harm is inextricably linked to how self-harm is defined, and what group of people is being discussed. Likewise, sections 1.3.3 and 1.3.4 address aspects of the functions of self-harm, from the perspective of its relationship to suicide and the psychological tendencies of those who self-harm. Here, the main functions identified in both clinical and service user literature will be discussed in more depth.

1.3.2.1 Affect regulation & Dissociation – coping with intolerable states
A comprehensive review by Klonsky (2007) found support for an affect regulation function in research on self-injury. Affect regulation refers to the use of self-harm in order to cope with overwhelming negative emotion. Support for this function can be found in studies with both clinical and non-clinical samples (Alexander & Clare, 2004; Bancroft et al., 1979; Brown et al., 2002; Laye-Gindhu & Schonert-Reichi, 2005; Nixon et al., 2002); using self-report questionnaires and qualitative interviews (Alexander & Clare, 2004; Favazza & Conterio, 1988; Harris, 2000; Huband & Tantam, 2004; Nock & Prinstein, 2004); and from psycho-physiological studies examining the physical effect of self-injury (Brain et al., 1998; Cameron, 2007; Haines et al., 1995). Service user accounts often mention the release of anger or “pressure” through self-harm (Babiker & Arnold, 1997; Harrison, 1995; Spandler, 1996).

The Experiential Avoidance Model (EAM) proposed by Chapman and colleagues (2006) positions self-harm as a negatively reinforced behavioural response to subjectively intolerable emotional arousal. In people with poor self-regulation, low tolerance to aversive arousal and/or heightened emotional sensitivity, self-harm is used to escape intense emotional states. This
behaviour is reinforced by the temporary relief felt after self-harm (e.g., Cameron, 2007; Harris, 2000; Herpertz, 1995; Huband & Tantam, 2004). EAM proposes a pathway by which self-harm performs a function and is maintained by the outcome of its performance.

The EAM summarises rather than explains certain features of self-harm, e.g., it does not explain how an individual initiates the behaviour, although other research suggests that self-harm may be learnt from family or friends (Adler & Adler, 2007; Hawton et al., 2002), and that some people discover self-harm after accidental injury provides physical release (Hodgson, 2004). It also does not address whether particular types of emotional experience are more likely to lead to self-harm – extreme positive arousal could also trigger self-harm within this model. Finally, the EAM is reductionist, as it does not address the role of cognitive appraisals in emotional experience, or of social factors in the initiation or maintenance of the behaviour.

The function of relieving an intolerable state is often expressed in those who self-poison as well as those who self-cut (Konradsen et al., 2006; Rodham et al., 2004). In Dorer and colleagues’ interview study (1999), 25.6% of adolescents who had recently self-poisoned described overdose as a way of escaping painful feelings. However, self-poisoning may regulate emotion by a different mechanism, e.g., by extinction rather than physical release. As Baumeister (1990) argued, the goal of escape can be achieved by both suicide attempts and suicide, albeit the escape is temporary in the former case. Alcohol and drug abuse are also used as means to escape a situation emotionally, sometimes called “self-medication” by service users (Babiker & Arnold, 1997; Biong & Ravndal, 2007). Whilst the phenomenological experience of the behaviour may differ, the underlying motivation of experiential avoidance may be the same.

Ending dissociative states is a function not cited as often as affect regulation, although it seems to be common amongst women with BPD and/or histories of childhood trauma (Brown et al., 2002; Klonsky, 2007; Low et al., 2000). Dissociation is described as a protective response to overwhelming distress, usually in the context of childhood abuse (Hall, 2003), but also common in adult
victims of trauma (Dyer & Dorahy, 2009). Low and colleagues (2000) suggested women experienced dissociation as a result of trauma, and self-harm was used to resolve this aversive state. Self-harm to end dissociation is not limited to women: in a qualitative study of four men, this function was evident across accounts (Russell et al., 2010). In psychodynamic theory, it is proposed that self-harm (specifically cutting) re-affirms the bodily boundary between self and other that is damaged by traumatic experiences, especially when childhood trauma has interfered with the development of self-other awareness (Burstow, 1992; Miller, 1994; Rao, 2006; Suyemoto, 1998).

Horne and Csipke (2009) developed a functional theory of self-harm based on e-mail interviews with people who cut or burn themselves. Their aim was to reconcile the contradiction of self-harm both to end dissociative states and to release emotional distress. Their model, developed using grounded theory principles, proposed that self-harm is “an act that manipulates the way in which the body contributes to the experience of emotion” (Horne & Csipke, 2009, p665). The body’s failure to appropriately experience or express emotion negatively impacts upon an individual’s sense of self, sense of reality, and/or sense of others. Self-harm as a physical act reconnects the individual with a sense of self/reality/others, by normalising emotional awareness, and grounding emotion in the experience of bodily sensation.

Whilst this model was developed from participant accounts where both functions were present and the sample was predominantly white, female and British, it is indirectly supported by qualitative research revealing the embodied nature of self-harm (e.g. Alexander & Clare, 2004; Harris, 2000; Marshall & Yazdani, 1999; Rao, 2006), and by the success of dialectical behavioural therapy, which has core components of mindfulness and emotional validation, in treating women who self-harm (Linehan et al., 2007; Perseius et al., 2003). Further research is required to test the proposed links between the body’s role in the experience of emotion and its impact on the individual’s awareness of self, reality and others. The integrative nature of the model and its emphasis on embodied emotion is a welcome move beyond reductionist theories such as EAM (Chapman et al., 2006) and away from artificial separation of emotion and cognition (Williams, 2000).
1.3.2.2 Self-punishment, Self-purging, Self-soothing

Self-punishment was also identified by Klonsky (2007) as a common reason for self-injury. Self-punishment is often mentioned in relation to those abused as children and/or adults (Bywaters & Rolfe, 2002; Spandler, 1996; Van der Kolk, 1989), and one study found that female self-cutters were more likely to report self-punishment as a motivation than male self-cutters, suggesting a possible gender difference in reasons for self-harm (Rodham et al., 2004).

Feldman (1988) theorised that hurting the self was an expression of internalised rage. The object of said rage could not be hurt owing to fear of retribution, and so the person self-harms. Miller (1994) and van der Kolk (1989) both suggest that this type of anger stemmed from trauma, usually childhood abuse. The psychological impact of abuse can manifest in low self-worth, self-loathing and a desire to punish one’s body, seen as complicit in the abuse (Fliege et al., 2009; Low et al., 2000; Noll et al., 2003). A study of female prisoners found that bodily shame partially mediated the effect of childhood sexual abuse on self-harm (Milligan & Andrews, 2005).

Self-harm can also be cleansing for those who express self-hatred or the desire to “cut the bad out” (Harris, 2000, p164). These accounts tend to refer to self-cutting, and blood is seen as symbolic of the “bad” being purged (e.g., Alexander & Clare, 2004; Pembroke, 1994; Scott, 2006). In a survey of 64 young adults who self-cut, just over half identified seeing blood as a functional aspect of their self-harm. These individuals were more likely to express affect regulation and/or self-punishment as reasons for their self-harm than those who did not view blood as significant (Glenn & Klonsky, 2010).

Some people also take comfort in tending to their physical wounds, which may be a secondary “self-soothing” function (e.g., Gallop, 2002; Solomon & Farrand, 1996). This self-soothing function could be operating on several levels: Rao (2006) argues that cutting itself can be soothing because it transforms something intolerable into a physically located and controllable pain. In an hermeneutic phenomenological study utilising observations, interviews, and texts, self-injury was interpreted as a means of self-care, as it ended an
unpleasant state of disconnection from the world (Schoppmann et al., 2007). For others, self-harm may be the only way they can justify seeking help or solace, or giving such solace to themselves. One participant expressed this as:

> [Self-care following self-harm] might be a substitute for somebody else not caring, you keep it clean and you do all these nice things to yourself like make sure you rest and you cook yourself something nice for dinner. You’re treating yourself like an invalid and you’re being kind to yourself (Liz, in Solomon & Farrand, 1996, p115)

It seems that the process of self-harm and self-care may act as a substitute for supportive relationships. The lack of such relationships is a significant risk factor in self-harm. Here, it is of note that some people may feel the need to be physically injured in order to self-care. This may be learnt as the result of poor caring relationships in early life (Gratz, 2003), but it is likely that societal views and attitudes towards the mental are also influential. In Western society, the Cartesian separation of mental and physical, and the dominance of the medical model of mental illness create an implicit hierarchy which favours the physical over the mental (Williams, 2000). In some ways, the emergency department is an exemplar of this societal ordering of needs (Jeffery, 1979, see 2.3.1; Malone, 1998).

### 1.3.2.3 Achieving interpersonal goals

Possibly the most contested function of self-harm is interpersonal influence, or communicating distress to others (Klonsky & Muehlenkamp, 2007; O’Connor & Sheehy, 2000; Reder et al., 1991). Farberow and Shneidman (1961) introduced the concept of suicidal behaviour as a “cry for help”, intended to elicit a response from a caregiver. It is common for service users to say that self-injury takes the place of words (Strong, 1998). In a study of female forensic inpatients, 63% agreed that “cutting is a way to let other people know of my distress” (Liebling et al., 1997, p 431). In Rodham and colleagues’ (2004) study of adolescents, one of the most common reasons chosen for self-harming was the desire to show how desperate they felt.

This type of communication is often seen as “manipulative”. Walsh and Rosen (1988) recommended not reinforcing self-harm with attention in order to prevent repetition, based on ideas of behavioural reinforcement and fears of dependency, and this recommendation has infiltrated practice (Cresswell &
However, it is clear that self-harm is embedded within the social world of the individual – with early experiences of care and the nature of interpersonal relationships of primary importance in its aetiology and maintenance. Self-harm is relational in a complex and continuous way which reflects our nature as social beings. In addition, the idea that self-harm could be resolved through negative reinforcement is an over-simplification which risks exacerbating pre-existing distress and potentially escalating the situation. Service users have sometimes felt self-harm was necessary in order to feel seen by staff or to get access to services (Arnold, 1995; Bywaters & Rolfe, 2002). This response to a subjectively desperate need for help can unhelpfully reinforce the perception of self-harmers as manipulative (Feldman, 1988; James & Hawton, 1985).

Finally, healthcare professionals need to ask why an individual feels the need to communicate in such a drastic way. Herman (1992) suggested a dual desire to deny and to speak of trauma could result in self-harm. Another contributing factor may be the psychological character of the individual: some researchers have noted a difficulty verbalising emotions in those who self-harm (Brown et al., 2002; Gratz, 2006). In addition, service users may have histories of invalidation which could foster a belief that verbal communication is not effective (Babiker & Arnold, 1997; Evans et al., 2005). Similarly, the perception of control may be important: those who feel they cannot change their circumstances (e.g. prisoners, asylum seekers, victims of abuse or crime) may view self-harm as the only possible outlet for their distress. Knizek and Hjelmeland (2007) describe suicidal behaviour as a normal way to respond to extreme situations, rather than as an abnormal way to communicate. In a powerful account from a teenage girl of a deprived background, this translation of powerlessness into self-harm was evident:

One day, [my sisters] were just beating [my mother] down. I was screaming 'cause blood was coming from [my mother's] nose, her teeth. And so I couldn’t stop them. So I started beating on the wall in my house. And I was just, I don’t know, I just lost it, and I punched my arm through the glass (Abrams & Gordon, 2003, p437)

Within the same study, two teenage participants experienced temporary alleviation of distressing circumstances as a result of self-harm; the implication being that self-harm was a more effective communicative strategy than
verbalisation (Abrams & Gordon, 2003). The issue of how effective self-harm is in performing the desired function, be it cessation of emotional distress or negative circumstances, is one of particular significance for those working with this client group.

1.3.2.4 Discussion
The functions appearing in the literature reflect to an extent the types of questions asked about self-harm, the circumstances under which self-harm is discussed, and the people who are canvassed for their views. Bancroft and colleagues’ (1976, 1979) early studies utilised a list of reasons developed from clinical practice, and research based on pre-established lists needs to be treated with caution as people may report different stories spontaneously. Likewise, the association of trauma with particular functions may be limited in terms of wider applicability, as it refers to a specific sub-group of people, usually women. It would be useful to further explore service user attitudes towards self-harm, their beliefs about its functions and functionality, and their perceptions of peer attitudes towards self-harm, as these are all factors which can influence future intent to self-harm (see O'Connor et al., 2006).

The function of affect regulation has the widest support across the literature, although it is less supported in methods other than self-cutting. With self-cutting, affect regulation may be of more explanatory value as a maintenance function than an initial reason for self-harm, as there are physical outcomes of the act that may propagate it. In addition, what is defined as an act of affect regulation can be highly subjective, e.g., self-poisoning could also be defined as functioning to regulate emotions. The use of substances to regulate mood is commonly accepted in addiction literature, but self-poisoning is still often conflated with attempted suicide, which may overshadow potentially powerful motivators behind the behaviour.

Finally, method switching within individuals is reportedly common but under-researched (Lilley et al., 2008). Little is known about why some people present with different behaviours at different times, and the majority of research addressing functions has focused on a single type of behaviour, and has not
attempted to tease apart differences in meaning beyond that of suicidal intent. As Horne and Csipke (2009, p.656) pointed out:

One of the reasons self-harm is so difficult to replace as an antidote to psychological distress is that any individual act can arise from a number of motives, and at the same time fulfill several apparently distinct functions

This picture is inevitably complicated by the presence of multiple behaviours within the same individual. Further research which can address the nuances of behaviour choice, function and precipitating events is needed across the range of people who self-harm.

1.3.3 Self-harm and Suicide

The relationship between self-harm and suicide is not straightforward. This is reflected in the different, but overlapping, risk profiles for suicide and self-harm (Kapur & Gask, 2006). Both suicide and self-harm are “multifarious events”, events influenced by multiple factors, and so it is likely that self-harm and suicide will relate to each other in equally complex ways (Appleby, 2004; Leenaars, 2002, p19).

Some have argued self-harm is preparatory for suicide, for example, Joiner’s (2005) theory of capability to enact lethal self-injury. This theory is indirectly supported by the increasing risk of suicide associated with repetition (Riberio & Joiner, 2009), although further research is needed to test the theory directly. Shneidman (1996) proposed the concept “psych-ache” (meaning unbearable psychological pain) as a mediator between psychological vulnerabilities and eventual suicide, a concept which echoes the most common function of self-harm, affect regulation (see 1.3.2.1). Self-harm and suicide may be different responses to “psych-ache”, with behavioural choice being determined by further psychological and social factors, such as defeat, hopelessness and perception of help availability (see 1.3.4).

Self-harm is one of the strongest predictors of completed suicide (Cooper et al., 2005; Owens et al., 2002), but not all suicides have a known history of self-harm and self-harm is often not suicidal in intent. Suicide is a rare event, with 5,706 suicides in Britain in 2008 (Office of National Statistics, 2010).
Comparatively, around 2,500 people present to hospitals in Manchester with self-harm per year (Dickson et al., 2009). Service users often disagree with the association of self-harm with suicide (e.g., Bywaters & Rolfe, 2002; Pembroke, 1994; Spandler & Warner, 2007), as self-harm is positioned as a survival mechanism (Nathan, 2006). In a qualitative study conducted by correspondence, one woman stated:

I am totally in control of my life and my self-harm…To me self-harm is the total opposite of suicide. I have never wanted or attempted to kill myself. It is all about coping (Harris, 2000, p170)

This distinction between self-harm and suicide has also been made by participants in other qualitative research (e.g., Bywaters & Rolfe, 2002; Solomon & Farrand, 1996). The individual may use this distinction as a means of reconciling a potentially stigmatised behaviour with personal beliefs and desires as well as social, cultural and religious attitudes.

It seems likely that the relationship between self-harm and suicide is often more ambiguous than this distinction permits. In Spandler’s study of self-harm in young people, some participants indicated self-harm did not always achieve its intended purpose. When this happened, it pushed people towards a suicide attempt, or as one person put it: “anything to make me feel better” (Spandler, 1996, p39). In Solomon and Farrand’s (1996) study, one participant described her behaviour transitioning from self-harm to suicide as she lost control of her actions. Self-harm is often associated with staying in control or taking control in qualitative studies (Harris, 2000; Harrison, 1995; Marshall & Yazdani, 1999; Pembroke, 1994).

Both clinicians and patients face real difficulty in determining suicidal intent after the event (1977; Salter & Platt, 1990). In Solomon and Farrand (1996), one young woman states that she falsely admitted to suicidal intent in assessment owing to her confused mental state, and a perceived pressure from staff to express suicidality. In another qualitative study, one participant said:

She asked me if I felt suicidal still and I knew if I said, ‘yeah’ then she’d put me on a psychiatric ward, I just said, ‘no I’m not, I haven’t got any thoughts of self-harm’ and at the time I didn’t because I felt really, really stupid for what I’d done… but I think I worded it that I didn’t want to ever go through this again but I meant the hospital side of things (Horrocks et al., 2005, p19)
The perceived consequences of admitting suicidal intent and the patient's emotional response to their actions add further complexity to assessing suicidal intent (Hawton & Catalan, 1987; National Institute for Health and Clinical Excellence, 2004). Wiklander and colleagues conducted a secondary analysis of interviews with inpatients following suicide attempts to examine the experience of shame. Shame was often accompanied by the desire to flee the hospital or avoid people, and this desire may discourage engagement with staff (Wiklander et al., 2003).

Harriss, Hawton and Zahl (2005) found that suicidal intent (as measured by the Beck Suicidal Intent Scale) at the time of self-harm was associated with a higher risk of completed suicide, especially within the following year. In Salter and Platt (1990), suicidal intent was seen to change with elapsed time from admittance with self-poisoning to time of interview. Those who self-harm with suicidal intent may experience certain types of problems, for instance, Haw and Hawton (2008) found that those with high suicidal intent were more likely to report psychiatric problems and social isolation. Lethality of method tends to be associated with suicidal intent, but is an unreliable indicator as it is mediated by factors such as knowledge of and access to means, alongside personal and cultural preferences (Gunnell et al., 2000a; Harriss et al., 2005). Likewise, the circumstances of self-harm, e.g., attempts to avoid discovery, premeditation, and suicide notes, are associated with higher risk of eventual suicide, but the absence of these factors does not preclude suicidal intent (Barr et al., 2007; Cooper et al., 2005). Further, the presence of another motive for self-harm does not preclude suicidal intent. In a prospective study on repetition by Hjelmleland and colleagues (1998), unclear motivation for index episode of self-harm was predictive of future suicide in women but not in men. Socio-cultural factors may influence the nature and expression of suicidal intent, and the relationship between self-harm and suicide within individual accounts.

1.3.4 Psychology of Self-harm

One further aspect to consider is what makes one person self-harm and not another? Whilst those who self-harm more severely and more frequently may have multiple, complex difficulties, it is equally true that not everyone will turn to
self-harm. To address this issue, researchers have sought to identify psychological factors that may differentiate between people with similar life events and socio-demographic characteristics.

A number of psychological factors have been proposed to differentiate between people who self-harm and controls. Studies have found that those who self-harm or report suicidal thoughts have poor problem-solving skills (Nock & Mendes, 2008; Schotte & Clum, 1987; Williams et al., 2005). Whilst the majority of these studies focus on self-harm with suicidal intent, Nock and Mendes (2008) found that a sample of adolescents who self-injured without suicidal intent also displayed difficulties coping with negative physiological arousal during a distressing task and showed deficits on both a measure of self-efficacy and in the quality of responses chosen compared to controls. The self-injuring adolescents seemed capable of generating solutions to problems but saw themselves as less able to implement these solutions.

Schotte and Clum (1987) found that the combination of an increase in negative life events and poor problem-solving were associated with greater suicidal risk. This seems to indicate that the more problems one faces, the more difficult the task of problem-solving may appear to the individual. This study’s conclusion highlights one potential difficulty with this type of research, namely an absence of consideration of the social environment. It makes sense that multiple problems would increase the actual difficulty of problem-solving, not only because this might overwhelm someone with poor problem-solving ability but because the problems might impact upon each other, and be indicative of a complex and hostile social environment. In addition, sometimes a problem may be unsolvable for the individual – such as in the case of asylum seekers without control over their circumstances, or children and adolescents, who are legally and financially dependent upon their families or guardians.

People in hospital after self-poisoning generally perform poorly on tasks where they need to report specific memories in response to word cues, and this seems to be related to past experience of negative life events (Williams & Pollock, 2000; Williams, 1997). Williams and Pollock (2000) argue that autobiographical memory is important as people utilise their histories to decide present and
future behaviours. The more specific the memories, the better they are as a resource for deciding how to respond to present difficulties.

Another influence on decision-making is hopelessness. Hopelessness is associated with higher levels of suicidal intent, independent of depression (Dixon et al., 1991; O'Connor & Sheehy, 2000; Salter & Platt, 1990). MacLeod and colleagues have conducted several studies to elaborate on the mechanism by which hopelessness impacts on behaviour (MacLeod et al., 1997; MacLeod et al., 1993; MacLeod & Tarbuck, 1994). They consistently found that patients admitted with self-poisoning had difficulties conceiving of positive events in the future, although their levels of negativity about future events were no greater than controls. This deficit in future positivity was found independently of depression levels (MacLeod et al., 1997), and has been replicated by Hunter and O’Connor (2003).

A significant contribution to theory in this field is the cry of pain model (Williams & Pollock, 2000; Williams, 1997). This model proposes that suicidal behaviour is a response to a stressful event which signals to the individual, who experiences feelings of defeat as a result of said event, that they are trapped with no possibility of escape or rescue (O’Connor, 2003; Williams & Pollock, 2000; Williams, 1997). The evaluation of escape or rescue possibilities is influenced by the psychological characteristics and cognitive capabilities of the individual, including problem-solving skills, ability to foresee positive future events and autobiographical memory (O’Connor, 2003). A trait such as perfectionism could increase the likelihood of an individual perceiving defeat or rejection within a situation (O’Connor et al., 2007; Rasmussen et al., 2008), and perceptions of social support influence the assessment of rescue potential (O’Connor, 2003; Williams, 2001).

This model has received empirical support, from research which found people hospitalised following self-harm experienced higher levels of defeat, and reported lower levels of possibility for escape or rescue when compared with hospital controls (O’Connor, 2003). In addition, research has demonstrated trends for high levels of perfectionism, over-general memory, and poor future positive thinking in those who self-harm (Hunter & O’Connor, 2003; O’Connor,
A recent study adopted structural equation modelling techniques to assess the role of defeat and entrapment (defined as desire and perception of ability to escape) in suicidality in 93 university students. Both defeat and entrapment mediated the pathway between cognitive appraisals and suicidality, providing further support for the model (Taylor et al., 2010b).

One difficulty with evaluating such a model is that most research is cross-sectional in nature, applying scales at one time-point to measure complex and potentially variable characteristics (O'Connor, 2003). One benefit of structural equation modelling as adopted by Taylor and colleagues (2010b) is that it facilitates the assessment of hypothesised mediating and moderating relationships between variables. However, this particular study was limited by its use of a small non-clinical sample. In addition, it could be argued that the measurement of scales for such characteristics as defeat, entrapment, and cognitive appraisals in the absence of a current suicidal crisis is of limited clinical relevance. There may be an important role for qualitative research alongside psychological measurement in testing the fit of such models to real-life application, through in-depth analysis of service user accounts of suicidal crises.

1.3.5 Summary
Section 1.3 explicated the current status of knowledge around the reasons for, meanings of and psychological states experienced prior to self-harm or suicidal behaviour. It is evident there is still much to learn about self-harm and suicidal behaviour, and that both theoretical models and epidemiological findings would benefit from further research into how different aspects (psychological, social, cultural, historical, and psychiatric) of these behaviours inter-relate and are meaningful to service users. In addition, qualitative research into the functions and meanings of self-harm needs to be synthesised with sensitivity to contextual factors so that it can be utilised in both the development and assessment of theory and intervention effectively.

Differences in the use of terminology continue to make research difficult to synthesise, and this is particularly evident in the functions literature. With
recent research broaching uncharted territories such as method switching, the issues around definition and description of samples within studies become increasingly important to address.

1.4 Conclusion
This chapter has focused on exploring the lived complexity of self-harm. The range of perspectives, debates and experiences presented reflect the heterogeneity of self-harm and its over-determined character as an act, with multiple pathways to it, and multiple meanings surrounding it (Leenaars, 2002; Van Heeringen et al., 2000). The individual’s pathway to self-harm is an important issue in relation to services as it both impacts upon how and why people seek help from the hospital and also forms the context from within which the individual communicates with staff. Greater understanding of these issues can inform the assessor on appropriate care and intervention for those who present to hospital with self-harm.
CHAPTER 2: SELF-HARM AND SERVICES

2 Why study self-harm?

The challenge of managing and responding to self-harm effectively is manifest in the myriad accounts of people’s experiences with services (Taylor et al., 2007; 2009, see 2.3.2), the difficulties staff report working with this patient group (see 2.3.1), and the lack of robust evidence for the effectiveness of interventions with those who self-harm (see Crawford et al., 2007; Hawton et al., 1998). In this chapter, self-harm is considered in light of the health-care services within the UK. Firstly, the current context of self-harm in the UK is introduced in 2.1. Secondly, 2.2 outlines policy regarding the management of self-harm at hospital, and includes an in-depth discussion of psychosocial assessment, the aspect of management which forms the heart of this research. Finally, the attitudes towards and experiences of self-harm in hospital will be scrutinised from the perspective of both staff and service users in 2.3.

2.1 Self-harm as major health priority

Self-harm represents a major health priority in the UK and more widely for two reasons: its increasing prevalence and the associated risk of suicide. The continued need for research is stimulated by the pressure on services to find effective ways to manage self-harm (National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 1994, 2004, 2010), and by the global imperative to prevent suicide (Department of Health, 2002; Lewis et al., 1997; Mann et al., 2005; Maris, 2002).

In the UK, the number of people seen in hospital after self-harm rose dramatically in the 1960s (1987), and this trend was also noted elsewhere (Kerkhof, 2000). Prevalence studies of suicide attempts in recent years have found rates in different countries to be as high as 462 per 100 000 population and as low as 45 per 100 000, with the UK having some of the highest rates for both sexes (Hawton et al., 2003; Schmidtke et al., 1996).

A recent multi-centre report analysed data on 7,344 people, accounting for 10,498 episodes of self-harm presenting to hospital over 18 months (2007). Self-harm trends were similar across three centres (Manchester, Oxford and
Leeds), with more women than men presenting, two-thirds being under 35 years of age, and the majority presenting with self-poisoning (approximately 80%). The age-standardised rates in Manchester were higher than in other centres: in Manchester, the rate in males was 460 per 100,000, and in females, the rate was 587 per 100,000. More recently, rates in Manchester have significantly declined, to an average 447 per 100,000 per year, but this still represents one of the highest known rates in Europe (see Dickson et al., 2009). Extrapolating from multi-centre data, the authors have argued there could be as many as 220,000 presentations by 150,000 individuals to English hospitals per year (2007).

Effective management is a major priority for hospitals given the prevalence of self-harm (National Institute for Health and Clinical Excellence, 2004). Episodes of self-harm are one of the top five causes of acute medical admissions (Gunnell et al., 1996; 1992). A recent cost-analysis incidence study by Sinclair and colleagues (in press) found that 69% of mean resource costs during the year following self-harm were attributable to psychiatric care, indicating a key role of mental health resources in the current management of self-harm. Resource costs were highest for patients with a history of five or more attendances. A large proportion of episodes seen in hospitals are repeat episodes, with the incidence of repetition being estimated at 15% within a year (Owens et al., 2002). Recent multi-centre work utilising recurrent event analysis to examine repetition rates asserted that this estimate was likely to be low: their findings indicated 1 in 3 hospital attendees repeat within a year (Lilley et al., 2008).

Repetition tends to occur quickly after initial presentation (Boyes, 1994; Gilbody et al., 1997). In a prospective cohort study by Kapur and colleagues (2006), one in ten repeaters did so within 5 days, and the median time to first repetition was 73.5 days. These studies only reviewed hospital presentations, and it is likely that a proportion of people repeat but do not re-attend (Bolger et al., 2004; 2004). Such high repetition rates, alongside the resource cost to services of each episode, highlight the importance of the initial secondary care contact. This contact forms a significant opportunity to engage people in services (Crawford & Wessely, 1998; National Institute for Health and Clinical Excellence, 2004).
2.2 Policy of Self-harm Management

Several policy documents have been published in recent years to address the issue of best practice in secondary care (National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2004, 2010). When someone attends the emergency department following self-harm, the initial priority is their physical health (National Institute for Health and Clinical Excellence, 2004). Owing to the risk of further self-harm and eventual suicide, there is an additional need for staff to assess risk whilst the patient remains in the hospital (Cooper et al., 2007; Royal College of Psychiatrists, 2004, 2010). Assessing and managing risk is a complex issue (Cooper & Kapur, 2004; Royal College of Psychiatrists, 2010) and there is variation in practice across hospitals (Gunnell et al., 2005; Hawley et al., 2006; Kapur et al., 1998). Within the UK, there is an independent organisation called the National Institute for Health and Clinical Excellence (NICE) that produces evidence-based guidance commonly adopted within the National Health Service (NHS). According to NICE, psychosocial assessments are recommended as a key aspect of managing self-harm in the emergency department (National Institute for Health and Clinical Excellence, 2004). In the following sections, the purpose and place of the psychosocial assessment within the NHS and the management of self-harm will be explicated, paying attention to the meaning of the terms used, and the evidence upon which current practice is based.

The evidence base of policy from NICE (2004) and the Royal College of Psychiatrists should be mentioned to contextualise their recommendations. The Royal College of Psychiatrists council reports CR32 (1994) and CR122 (2004) both dealt with general management and assessment of self-harm at a secondary care level, and were written by psychiatrists to represent consensus guidelines within the profession. CR158 (2010) focused on experiences of self-harm from different perspectives: service users, carers, healthcare professionals and third-sector workers. The working group on CR158 consisted of psychiatrists, service users, voluntary sector and academic workers. The NICE guidelines were developed following pre-established protocols, and involved the creation of a Guideline Development Group (GDG) which consisted of psychiatrists, researchers, staff from voluntary and statutory organisations,
service users and carers, and healthcare professionals involved in the care of those who self-harm (National Institute for Health and Clinical Excellence, 2004). The GDG formed sub-committees led by experts in relevant topics, which fed research findings back to the group. There was also a panel of advisors, who gave advice on specific aspects of their expertise. Evidence was graded in terms of methodological and clinical value: within this system, as is standard, randomised controlled trials were considered the most robust form of evidence (Eccles & Mason, 2001; National Institute for Health and Clinical Excellence, 2004).

A notable feature of the NICE guidelines was the effort to incorporate service user experiences into its recommendations. A comprehensive review of qualitative studies relating to experiences of services was conducted, alongside service user focus groups and interviews. In addition, consultation with service users and other stakeholders took place before finalising the guidelines. However, owing to methodological variation in the qualitative literature, content analysis was used in the review (National Institute for Health and Clinical Excellence, 2004). The quotations used to support recommendations were rarely contextualised and there was little discussion of the strengths and weaknesses of the reviewed qualitative studies. This absence of context reduces the value of the review as an evidence-base (Williamson, 2009). In addition, the hierarchical ranking of evidence within the guidelines assumes a positivistic value system, which both devalues and does not truly integrate qualitative research (Faulkner & Thomas, 2002).

In general, the guidelines agree that despite the proliferation of research on self-harm, there is still a substantial amount of research required, particularly into effective interventions and into understanding self-harm and the experience of service provision from the user perspective (National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2010). Notably, NICE are producing further guidelines on the longer-term management of self-harm for publication in late 2011, which will incorporate evidence on medium and long-term care and management of self-harm.
Since the publication of the NICE guidelines, there has been debate over their comprehensiveness and utility (Pitman & Tyrer, 2008; Simpson, 2006). Pitman and Tyrer (2008) argued that the reliance on consensus limits the overall value of the guidelines. Barker and Buchanan-Barker (cited in Simpson, 2006) expressed concerns that the guidelines treated self-harm and attempted suicide as the same phenomenon. The guidelines deliberately adopted a broad definition as the clarity desired by Barker and Buchanan-Barker is rarely present within the literature. Strict delineations between self-harm and attempted suicide are often not clinically possible, limiting the scope for guidelines made specifically for circumstances when distinctions can be made. Whilst the NICE guidelines acknowledged the heterogeneity and complexity of self-harm, the difficulty remains that the general nature of the recommendations limits their utility for guiding effective practice and targeting populations for intervention (Pitman & Tyrer, 2008).

Outstanding issues raised by the Critical Psychiatry Network during consultation highlight further limitations of the NICE guidelines (Thomas & Hopker, 2003). They criticise NICE for failing to adequately critique the bio-psychosocial model of self-harm, and for prioritising “technological evidence over and above the ethical basis of clinical practice” (Thomas & Hopker, 2003). A deeper debate embedded within this criticism exists around the appropriate roles for NICE and mainstream mental health services to adopt in the treatment of self-harm, given increasing awareness of the socio-political aspects of self-harm (Chantler et al., 2003; Cresswell, 2006; Simpson, 2006). Psychosocial assessment as the key management strategy for self-harm rests at the heart of this issue, especially in light of its twin components: the psychological and the social.

2.2.1 Defining the Psychosocial Assessment
psychosocial assessment in terms of its main components: it is described as a combination of an assessment of needs and an assessment of risks. The hybrid word “psychosocial” is used to indicate that both psychological characteristics and social circumstances form part of these assessments.

What is evident upon reading these guidelines, and the concomitant guidelines of the Royal College of Psychiatrists (2004), is that there is no standardised protocol for conducting a psychosocial assessment. Each acute trust within the NHS is expected to “set the standards of assessment and care” for those who self-harm, preferably through the convening of a self-harm service planning group (Royal College of Psychiatrists, 2004, p14). The concept of “psychosocial assessment” does not correspond to a structured, defined protocol to be adopted across services. One reason for such flexibility is that the evidence base on effective management and treatment of self-harm is still relatively weak. Given this paucity, the guidelines identify the core elements of management to be integrative needs and risk assessments which result in an agreed aftercare plan (National Institute for Health and Clinical Excellence, 2004).

The purpose of the needs assessment is to identify areas in which the patient requires treatment or aid. The recommended areas to consider include:

1. Social circumstances of the patient
2. Recent events or stressors which may be precipitants
3. Current relationships with significant others, in particular any problems within those relationships
4. Patient’s history of contact with mental health services, for psychiatric problems, alcohol and/or substance abuse and self-harm
5. Current mental state examination
6. Any known enduring psychological risk factors such as history of trauma/abuse, history of parental relationship difficulties, early loss or separation.
This information should then be used to produce a formulation of the pathway to the self-harm episode. This includes consideration of the long-term characteristics which either protect against or predispose the person to self-harm, the short-term stressors that have increased the likelihood of self-harm, and the immediate precipitants and conditions of the episode.

The risk assessment element aims to predict the likelihood of future self-harm and/or suicide. Numerous actuarial scales for assessing suicide and self-harm risk have been developed, but different localities tend to adopt different techniques. Any risk assessment is based on some combination of:

1. Distal and proximal psychological risk factors, such as mental illness, personality traits, history of self-harm/psychiatric treatment, hopelessness, current mental state
2. Distal and proximal social circumstances, for example, homelessness, financial difficulty, relationship issues, bereavement, social deprivation and isolation

In conducting a risk assessment, it is also recommended that possible protective factors be considered (Gask & Morriss, 2006), although these factors tend to be under-researched (Skegg, 2005).

Risk assessment is complicated by a number of factors. Both suicide and self-harm are over-determined behaviours, which means that there is no one causal pathway to either outcome (Van Heeringen et al., 2000). Individual risk factors for self-harm are seen to have poor positive predictive value (Owens et al., 1994), whilst suicide remains a rare occurrence even with those who self-harm (Cooper et al., 2005; Kapur & House, 1998). Risk itself is a dynamic concept – it changes across time, and within individuals (2000). Reid (2003) argued that the utility of risk assessment was to group people according to relatively higher or lower risk, but not to predict actual behaviour in individuals. NICE (2004) recommend that risk assessment be viewed as “a useful means of identifying a small group of very high risk people”, but not relied on to target particular groups for intervention.
Recently, the focus of assessment has moved from risk to needs, as a high risk approach tends to exclude the majority of repeaters, due to the low predictive value of most risk assessment tools (Kapur, 2005; Kapur et al., 2005; Kapur & House, 1998). In theory, combining both needs and risk means that the identification of risks can be used to inform and tailor the conversation about potential needs, and the needs can be accorded greater or lesser importance and urgency for treatment dependent on their association with short-term or long-term risk (National Institute for Health and Clinical Excellence, 2004).

The needs and risk factors to be considered cover a range of clinical, demographic, social, cultural and psychological characteristics, and there is evident cross-over between the two aspects of assessment. A significant barrier to conducting efficient and accurate assessments is the amount of potentially relevant information to be considered. For an assessment to achieve its goals, the assessor needs to collate multiple pieces of information to create a coherent understanding of the individual and their circumstances. This task requires a high level of skill, knowledge and engagement. Both NICE (2004) and the Royal College of Psychiatrists (2004) stress the importance of adequate and ongoing training for staff in contact with this patient group.

Interestingly, the NICE guidelines envisage assessment as an instrumental part of a “therapeutic process to understand and engage the service user” (National Institute for Health and Clinical Excellence, 2004, p64). One aim of assessment is therefore to engage service users with services, both at the time of assessment and after discharge. This idea of therapeutic engagement is only alluded to in the guidelines, but will be discussed in light of research on how patients and staff experience assessment, and its potential as a process to fulfil this therapeutic role.

2.2.2 Assessment in practice
The guidelines on psychosocial assessment have been implemented with considerable variability across the UK (Barr et al., 2005; Hughes & Kosky, 2007; Kapur et al., 2008; Slinn et al., 2001). In this section, assessment in practice will be discussed, paying attention to the staff conducting assessment, the
patients receiving assessment and what effects, if any, assessment has on clinical outcomes.

2.2.2.1 Who conducts assessment?
Early guidelines recommended that psychiatrists conducted assessments; it soon became evident that pressures on staff and resources made this stricture impractical and costly, with a consequent impact on the number of assessments taking place (Burn et al., 1990; National Institute for Health and Clinical Excellence, 2004). It is now recommended that assessment can be undertaken by other disciplines, if training and supervision are provided (National Institute for Health and Clinical Excellence, 2004).

Early research on the suitability of other disciplines found that social workers, physicians, and nurses were capable of carrying out adequate assessments of overdose patients compared with psychiatrists (Blake & Bramble, 1979; Catalan et al., 1980; Gardner et al., 1982; Newson-Smith & Hirsch, 1979). In general, different disciplines were found to be more cautious than psychiatrists with regards to their judgements around discharge, further management and diagnosis. Most of this research relies on comparisons of practice with psychiatrists, and does not consider outcomes or patients’ experiences of assessment.

Psychiatrists, by virtue of their expertise in mental health, are often ultimately accountable for the hospital-based management of people who self-harm. Several studies suggest this sense of responsibility is evident in psychiatric decisions with self-harm patients. In a recent comparison of assessments by mental health nurses and psychiatrists, psychiatrists were significantly more likely to admit patients deemed to be at high risk than nurses. This difference occurred despite the mental health nurses being able to request inpatient admission, suggesting different professional practices around risk (Murphy et al., 2011; also, Russell et al., 2010). A Spanish study found that psychiatrists often based their decisions to admit patients on the presence of self-report suicidal intent and planning, and were less likely to admit when patients expressed relief or instrumental functions for self-harm (Baca-Garcia et al., 2004). This study suggests a prioritisation of suicidal risk over other
motivational factors. One reason for an emphasis on mental illness and risk may be that social factors such as unemployment are not seen as open to intervention, unlike psychiatric diagnoses such as depression. However, this focus on the psychiatric propagates a biomedical approach to self-harm, and can sideline the social problems self-harming patients may experience (Barr et al., 2004c; Johnstone, 1997).

Recent research has focused attention on frontline staff in the emergency department to improve assessment rates prior to discharge (Crawford & Wessely, 1998; Kapur et al., 2008). Simple measures such as checklists have been shown to improve the quality of assessments conducted by emergency department staff (Dennis et al., 2001). A training package developed in Manchester for non-specialist staff demonstrated that eight hours of training could significantly improve the confidence and attitudes of staff towards conducting assessments. There was also an improvement in the ability to assess and manage suicide risk, although this was not significant in all evaluations conducted (Appleby et al., 2000; Gask et al., 2006). The authors voiced concerns that without continued learning, these improvements would not be maintained: the potential impact of the organisational culture on the acceptance, maintenance and integration of skills into practice warrants further investigation (Gask et al., 2006; Grol & Grimshaw, 2003).

In practice, most psychosocial assessments continue to be conducted by junior psychiatrists, although there is a trend in several UK-based hospitals for psychiatric nurses to be responsible for assessment during traditional working hours (Kapur et al., 2008; Taylor, 1998). As attendances for self-harm peak between the hours of 5pm and 9am, the majority of attendees are likely to see on-call junior psychiatrists, unless they are admitted in overnight (Bergen & Hawton, 2007; Hawton et al., 2003; Kapur et al., 2008). The influx of episodes during the night has implications for both patients, who are likely to endure longer waits, and junior psychiatrists, who may be less experienced and under considerable pressure (Kapur et al., 2008; Woodall et al., 2006).

Given the complexity and heterogeneity of self-harm, it seems likely that assessments conducted by different disciplines, and from different theoretical
frameworks, may offer substantially different experiences to patients. However, the focus of research continues to be on the accuracy of risk assessment and the identification of mental illness. The existing hierarchy in many UK hospitals is still such that the majority of responsibility for self-harm assessments rests with junior psychiatrists and psychiatric nurses. Frontline staff in the emergency department can be trained, and often are trained, to conduct assessments, but the support structures may not be in place to ensure these skills are maintained and staff supported.

2.2.2.2 Who receives assessments?
Between 42% and 71% of self-harm attendances receive a specialist psychosocial assessment at hospital (Barr et al., 2005; Kapur et al., 2008). In Manchester, assessment rates are bolstered by a proportion of assessments being conducted by non-specialist staff, yet still fall below national guidelines (Kapur et al., 2008; Murphy et al., 2010). As those who leave without assessment are less likely to receive follow-up care, this shortfall is of concern (Kapur et al., 1998; Owens et al., 1997; Suokas & Lonnqvist, 1991).

In a multi-centre study in the UK, trends in those most likely to receive psychosocial assessment were identified (Kapur et al., 2008). The factors associated with an increased likelihood of receiving assessment were being older (over 55 years of age), in receipt of current psychiatric care, admitted to a medical ward, and overdosing on antidepressants. Some of these factors reflect current knowledge of risk for suicide or further self-harm, for instance, the heightened likelihood of suicidal intent in older adults (see 1.2.2). Higher assessment rates in those admitted to hospital may reflect both the medical seriousness of the act, and sustained presence in the hospital, allowing more time for assessment to occur. Worryingly, some of the factors associated with a decreased likelihood of assessment are also known risk factors for further self-harm – for example, unemployment, self-cutting and younger age (Cooper et al., 2005; Hickey et al., 2001; Zahl & Hawton, 2004).

Hickey and colleagues (2001) found that compared to assessed patients, non-assessed patients had higher rates of self-harm at follow-up, suggesting that those not being assessed are at greater risk of repetition. A Welsh study found
that those with repeated presentations were less likely to receive an assessment (Barr et al., 2005). Lilley and colleagues (2008) found that those who cut themselves more often had a history of self-harm and contact with mental health services than those who self-poisoned but were still less likely to receive a psychosocial assessment. Those who self-cut also had higher rates of repetition, suggesting this bias in assessment was unjustified from a clinical point of view (Barr et al., 2005; Lilley et al., 2008).

Barr and colleagues (2004c) also found that self-harm patients presenting without symptoms of mental illness were more likely to receive a lower standard of care, and less likely to receive a psychosocial assessment, than those with an identifiable mental health difficulty. They argue that there is an unjustified assumption within current practice that self-harm is mainly a mental health issue, and this assumption has led to the neglect of a proportion of those in need (Barr et al., 2004c).

There is an existing discrepancy around the service provided and the service potentially needed by those who self-harm, in terms of both the availability and conduct of assessments (Barr et al., 2004c; Kapur et al., 2008; Lilley et al., 2008). There seems to be a bias towards a risk-focused approach, which may leave substantial numbers of patients without appropriate management and aftercare referrals. The logic behind who receives assessment is likely to be influenced by organisational demands. Within a culture that focuses on risk, those factors associated with increased risk are likely to be prioritised (Cutcliffe & Barker, 2006; Rose, 1998). However, the dynamic nature of risk, the different levels at which “risk” can be defined (e.g., individual, familial, organisational or social levels), and the complexity of self-harm all problematise a simple relationship between individual risk factors and behavioural outcome, suggesting that a risk-focused strategy is by no means straightforward (Kapur, 2000; Rose, 1996).

2.2.2.3 What impact does assessment have?
The evidence that psychosocial assessment alone has an impact on repetition rates following self-harm is limited and equivocal (Kapur et al., 2002; Kapur et al., 2008). Repetition as a clinical outcome tends to be privileged owing to the
associated risk of completed suicide (Cooper et al., 2005; Zahl & Hawton, 2004), and the service implications of multiple attendances to hospital (Kapur et al., 2006; Sinclair et al., in press). In addition, if self-harm is seen as a way of coping with distress or intolerable emotion, then repetition may be a reasonable indicator of continued unmet need (e.g., Sakinofsky et al., 1990).

A prospective cohort study of self-poisoning in the UK found that those who received an assessment were half as likely to repeat as those who did not, an association which held after common risk factors were accounted for statistically (Kapur et al., 2002). In a larger study by Kapur and colleagues (2008), no clear association was found between assessment and repetition. However, individual hospital sites differed: the hospital with the highest assessment rates displayed an associated decreased risk of repetition, whilst the hospital with the lowest rates showed the inverse relationship. In the latter hospital, this association was thought to reflect a high-risk management strategy, whereby only those who were likely to be at high risk were assessed by a member of the psychiatric team (Kapur et al., 2008).

Differences between these two studies may also offer clues as to the difference in impact: in the first study, only self-poisoning episodes were considered, which are more likely to result in hospital attendances, admittance to a hospital ward and psychosocial assessment (Hawton et al., 2007; Kapur et al., 2008; Lilley et al., 2008). In addition, repetition not resulting in hospital attendance was not accounted for in either study; both may be under-estimating rates of repetition within their cohorts. It is also worth remembering that poor interactions with staff at hospital have been associated with a reluctance to engage in further use of services (e.g., Bolger et al., 2004; Palmer et al., 2007; Spandler, 1996), and a positive engagement could result in more attendances (Owens, 2010). In these cases, repetition as measured by hospital attendance alone is likely to be a poor indicator of outcome. The meaning of repetition and re-attendance at hospital, in the context of the lives of patients, is currently poorly understood.

Psychosocial assessment has demonstrated benefits, such as improved access to aftercare (Barr et al., 2005), and the identification of psychological disorders for treatment (Isacsson & Rich, 2001), which are likely to influence patient
outcomes. In Whitehead (2002), a small effect was found in the reduction of hopelessness in those who received assessment compared to those who had not yet received assessment. Whilst this was not a robust finding, it pointed to other factors which may be impacted upon by psychosocial assessment, and which are not commonly monitored. Repetition has typically been the focus of research on assessment outcomes, and there may be a number of important patient-derived outcomes that should be explored, e.g., resultant psychological state or satisfaction with care.

2.2.3 Therapeutic Potential of Assessment

An important feature of the NICE guidelines is the recommendation that psychosocial assessment should be undertaken as part of a “therapeutic process to understand and engage the service user” (National Institute for Health and Clinical Excellence, 2004, p64). Healthcare professionals are encouraged to view assessment as an opportunity to engage patients in their healthcare (Hawton & Catalan, 1987; Kapur et al., 2008). NICE do not expand upon this recommendation theoretically or practically; each NHS trust is given the freedom and responsibility to develop their own practice (National Institute for Health and Clinical Excellence, 2004). This recommendation warrants further examination, in order to unpick the assumptions underlying it and to consider the nature of assessment as a potentially therapeutic encounter.

First, there is an assumption that special effort is required to engage those who self-harm with services. Whilst it is true that self-harm intervention studies often observe losses to follow-up (e.g., Hawton et al., 1998; Nordentoft & Sogaard, 2005; Van Heeringen et al., 1995), it is questionable whether these rates are higher in those who self-harm than in other clinical groups (Murphy et al., 2010). Sokero and colleagues (2008) investigated differences in adherence to, and attitudes towards, treatment in severely depressed patients with and without suicidality, and found that suicidal behaviour did not have a significant impact on adherence or attitudes. Rates of uptake may be affected a number of factors, such as the type of treatment offered, its perceived suitability, and by the presence of co-morbidities such as depression (Hume & Platt, 2007; Hvid & Wang, 2009; Murphy et al., 2010). Failure to comply with treatment does not simply translate to recalcitrance in this patient group.
In fact, the sheer numbers of hospital attendances each year belie this assumption of disengagement – one could argue instead that services are failing to meet these patients’ needs, as high numbers of patients leave hospital without assessment or referral (Crawford & Wessely, 2000; Kapur et al., 2008), and a substantial number are simply re-referred to existing care plans or their general practitioners (Haw et al., 2002; Kapur et al., 2008). In addition, there is a bias towards judging engagement with treatment to be indicated by compliance and reduction in service use, when these outcomes may not relate to the patient’s perceived needs (Owens, 2010).

There is an historical prejudice that self-harm patients are “difficult”, possibly even treatment-resistant (Breeze & Repper, 1998; Clarke et al., 2004; Cresswell & Karimova, 2010; Jeffery, 1979; Shaw, 2002), and this warrants further attention. This prejudice may arise from discordance in the perspectives of staff and patients. Jack and Williams (1991) argue that a mismatch of attributions between staff and patient, i.e., how they both perceive and explain an event, can influence both the patient’s attitudes towards future help-seeking and their receptiveness to treatment. If both assessor and assessed are working at cross-purposes, the outcome is likely to be dissatisfactory for both parties. A recent review of perspectives on self-harm suggested that it was common to find such discordance (Bosman & Van Meijel, 2008).

Secondly, there is an assumption that a primary goal of assessment should be to understand the service user. This goal is more complex than it seems, as the purpose of the assessor’s efforts to understand affects the way the assessor interacts with the patient. For instance, if the goal of assessment is to prevent further self-harm, the service user’s own concerns and goals could be sidelined (Crowe & Carlyle, 2003). As Owens (2010) points out, the way in which staff conceptualise repetition and repeat attendance could be a powerful barrier to engagement. How the assessor positions the patient also has an effect, and the ways patients are positioned within the healthcare system are influenced by organisational and political objectives (Salmon & Hall, 2003). An example of this is Waterhouse’s (1993) critique of Rogerian psychotherapy for rape victims. The view of the patient as responsible for their own problems can translate into...
a “subtle form of ‘victim blaming’” which fails to account for the influence of structural constraints in these women’s lives (Waterhouse, 1993, p63). The current emphasis on patient empowerment, notably in the recovery model, can also construct the patient as self-determining, and conversely, responsible for the failure to “recover” in a prescribed way (Mills, 2010). The professional perception of self-harmers as “difficult”, on one level, may stem from this sort of positioning.

The final assumption lies at the heart of the matter: that assessment can and should be part of a therapeutic process. In general, to be therapeutic means to be curative or beneficial, to encourage some sort of desirable change. With regards to psychosocial assessment, little research has addressed what features may be therapeutic for the service user. The recommendation for assessment to be therapeutic comes from the idea that the encounter may act similarly to a counselling session, giving patients time and space to talk, and offering them the opportunity to engage with further care (Hawton & Catalan, 1987; Kachur, 1989; Kapur et al., 2008; Whitehead & Royles, 2002). Generally, the assumption is that talking about the incident may in itself be therapeutic; specifically, that talking to a mental health professional, with specialist knowledge and experience of self-harm, will help the patient to recover from the crisis.

Within the psy-complex (Rose, 1999), there is a long-standing interest in the idea of a therapeutic relationship, and a recognition that the relationship between staff and patient has the power to impact upon outcomes (Beutler & Harwood, 2002; Brien, 2001; Howgego et al., 2003; McCabe & Priebe, 2004; Welch, 2005). A review found that therapeutic alliance was often formed early on in treatment, and was strongly predictive of later positive outcomes (Hilsenroth & Cromer, 2007). A comparison of a therapeutic (TA) and information-gathering model (IG) of psychological assessment found that TA seemed to decrease the numbers who terminated treatment against clinical advice (Ackerman et al., 2000). Elements of TA thought to be influential were the depth of assessment, the focus on alliance-building, and the creation of a safe space for the patient. The amount of time assessments took was roughly equivalent for each model. These findings suggest that initial encounters with
staff can be sufficient for patients to form a relationship with staff, and to affect later outcomes from treatment.

Interviews with forty mental health patients who had a history of disengagement with services indicated that patients valued staff who demonstrated commitment to helping them, gave time to the process, engaged them as partners in their care, and did not focus on medication. When patients felt staff were not interested in their stories, or felt that their independence, and ability to be “normal”, was threatened by treatment or staff attitudes, they were more likely to disengage (Priebe et al., 2005). Frustration at not feeling heard, and being treated like a child were two key features of being misunderstood that disrupted therapeutic relationships for mental health patients in Gaillard and colleagues’ (2009) qualitative study. The extent to which a particular treatment type or healthcare professional can meet the patients’ desires for partnership, time and commitment may be affected by the theoretical basis of the treatment and the staff member’s personal and professional proclivities.

The relationship between staff and patient is not simply an exchange of information: it is instead a complex social interaction through which the staff have power to re-position the patient. In a discourse analysis of psychiatric interviews, it was argued that psychiatrists tend to position their patients in roles which are most congruent with the medical model of diagnosis and treatment. These roles require the patients to give facts, to evaluate options, and, to an extent, to detach from their experiences to aid diagnosis (Ziółkowska, 2009). The way in which questions are posed (or indeed, not asked) within an interview forces the patient to consider and answer from certain perspectives, which may be incongruent with the notion of providing therapeutic benefit.

One issue this raises is whether the aims of psychosocial assessment – specifically, the identification of risk – are concordant with the aim of providing a therapeutic encounter. Being misunderstood or positioned as passive and incapable were both threatening to engagement with services, and a focus on risk has the potential to over-ride a patient’s autonomy in these ways (Crowe & Carlyle, 2003). To subvert Spandler’s (1996) influential re-phrasing of the self-harm problem, the question should be “who’s helping who?” during a
psychosocial assessment following self-harm – who stands to gain the most from psychosocial assessment, if risk assessment is the primary focus?

2.3 Staff Attitudes & Patient Experiences
The following sections review the literature specific to staff attitudes towards people who self-harm, and the experiences of services reported by people who self-harm. In recent years, there has been a proliferation of studies examining staff attitudes towards self-harm, as an important aspect of appropriate service provision and suicide prevention (Anderson et al., 2003; National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2010). The findings and implications of these studies are discussed in 2.3.1.

Patient experiences have also come to the forefront of policy discussions and research, as part of the NHS bid to promote service user inclusion in all aspects of care, including planning and evaluation (Department of Health, 2000; National Institute for Health and Clinical Excellence, 2004), and as part of a growing service user movement critical of current practice (Bracken & Thomas, 2001; Cresswell, 2005; Harrison, 1997; Pembroke, 1994; Spandler & Warner, 2007). Psychosocial assessment occurs within the context of a participant’s previous experiences of services and their expectations of care. It also occurs within the wider tapestry of that person’s experiences of self-harm and its meaning. In 2.3.2, the experiences of people who self-harm will be considered in more depth.

2.3.1 Staff attitudes
The attitudes of staff towards those who self-harm or attempt suicide are a crucial aspect of services. Attitudes are likely to influence both the effectiveness of any treatment offered and the patient’s engagement with services (e.g. Hume & Platt, 2007; Suokas & Lonnqvist, 1989a; Taylor et al., 2007). The therapeutic potential of an encounter between staff and service user begins with the relationship, or rapport, between the two – the non-specific elements of therapy oft cited as influential (Beutler & Harwood, 2002).

The nature of the encounter and its potential to impact on the patient’s behaviour are influenced by factors such as the relationship between psychiatry
and mental health, particularly self-harm; the organisational structure of the emergency department and its role in the care of people with mental health difficulties; healthcare professionals’ perceptions of their professional roles and capabilities; and the current status of evidence for the treatment of self-harm.

2.3.1.1 Role of Psychiatry
Psychiatry is a contested discipline (Bracken & Thomas, 2005; Rose, 1996). Marred by a number of discredited practices throughout its history, psychiatry holds an arguably unique position as contested both for its lack of authority and exercise of power (Barker & Stevenson, 2000). In recent years, border conflicts with other disciplines have raised questions as to the appropriateness of psychiatry as the bastion of mental health knowledge and authority (Barker & Stevenson, 2000).

The power of psychiatry over its service users has attracted much attention and criticism. No other discipline exercises such absolute power over the recipients of its service, and this power has increasingly been questioned by the survivor movement and other disciplines (Barker & Stevenson, 2000; Bracken & Thomas, 2001). Recent policy changes support a move towards autonomous and discerning service users, involved in decision-making and self-determination, to counterbalance this historical inequality (Department of Health, 2000). However, this view still draws on ideas of moral self-governance that stem from an individualist perspective, one which can shift both blame and responsibility onto patients for their illnesses (Salmon & Hall, 2003). The power to define and determine the rights of individuals still lies in the hands of psychiatry when it comes to mental illness:

They called me mad, and I called them mad, and damn them, they outvoted me (attributed to Nathaniel Lee, cited in Byrne, 2001, p281)

From the perspective of psychosocial assessment for those who self-harm, this power differential is crucial. Psychiatry has the power to define the nature of someone’s distress and their level of personal responsibility for said distress, and makes the moral judgement as to whether a patient is worthy of help (Bracken & Thomas, 2001; Cresswell & Karimova, 2010).
Rose argues that there has been a gradual shift in psychiatry towards a “risk culture”, based on social concern with the governance of those deemed “risky”, and a growing culture of blame (Rose, 1996, 1998). The management of risk and resources form two potentially competing responsibilities for psychiatrists in the care of those who self-harm. The implications of this “risk culture” are increased accountability for psychiatrists with regards to decisions involving patients, and increased pressure on psychiatrists to accurately predict future behaviours and protect both patients and society (Rose, 1998). This accountability to wider society can run counter to the therapeutic role traditionally associated with psychiatry, and psychiatry, uniquely, has the legal power to prioritise risk management over the individual rights of the patient (Bracken & Thomas, 2001).

Self-harm challenges these roles of risk governance and resource management, with high rates of repetition (Kapur et al., 2006; Owens et al., 2002) and intensive resource use (Sinclair et al., in press). In addition, the relative lack of evidence for effective interventions which reduce repetition challenges psychiatry’s authority, and can create a sense of therapeutic pessimism around treating those who self-harm (Cresswell & Karimova, 2010; Spandler, 1996; Watts & Morgan, 1994). Watts and Morgan (1994) reflect that the psychiatrist’s expectation to “heal” people can deteriorate into a loss of sympathy for and stigmatising of patients who are difficult to treat (Shepperd & McAllister, 2003). This aspect, the challenge to professional roles, can be difficult for psychiatrists to cope with, as it calls into question their sense of competence (Hoifodt & Talseth, 2006; Radley, 1994; Talseth et al., 1997).

2.3.1.2 Role of the Emergency Department

Accident and emergency are in a key position to make a difference to the course of a cycle of self-harm (Pembroke, 1994, p49)

The emergency department plays a key role in the management of self-harm, as it can form the only point of contact with services for people who self-harm (Crawford & Wessely, 1998). Attendance at the emergency department with self-harm forms an important opportunity for services to engage patients in further care.
The emergency department, however, provides particular challenges for the care of those who self-harm. The ethos of most emergency departments involves a focus on urgent physical treatment and thus, on physical problems readily treated (e.g., Hadfield et al., 2009). The “open door” nature of emergency departments means that healthcare professionals working in this environment have little control over work-load, and an entire spectrum of problems and patients, of varying complexities and urgency, may present at any given time (Pearsall & Ryan, 2004). Increasingly there has been a political shift towards improved efficiency in emergency departments, with a drive towards shorter waiting times, lower costs and a reduction in “inappropriate” service use (Malone, 1998). The issue of what constitutes “inappropriate” service use is contested. Pearsall and Ryan (2004) contend that the public position emergency departments as the appropriate site for crisis intervention, regardless of whether the crisis is physical or psychological. Yet research such as Jeffrey (1979) and Hopkins (2002, p150) seem to suggest that staff see self-harm patients as inappropriate attendances, creating “blockage[s]” in the efficient running of services. With their complex needs and often repeated attendances, self-harm patients can be argued to violate the “institutional discourse” of “efficiency, economy and time pressure” in the emergency department (Nystrom et al., 2003, p768).

Crowley (2000) conducted a year-long action research project embedded in an emergency department, and concluded that the organisational culture assigned mental health issues low status, through the design and layout of the department, the valuing of skills related to speed and efficiency, and a focus on training provision related to physical health. Despite the number of patients attending with self-harm, studies of emergency department nurses indicate that few have attended specific training to deal with self-harm (Crawford et al., 2003; Friedman et al., 2006; McAllister et al., 2002; McCann et al., 2007; Sun et al., 2007). In the fast-paced trauma environment, mental health skills such as talking and active listening were considered non-essential, able to be sidelined in favour of swift physical response (Crowley, 2000).

Cresswell and Karimova (2010) make the point that this prioritisation of physical over mental is inherently value-laden. The emergency department, positioned
between the public and specialist services, acts as both a gateway and a barrier (Pearsall & Ryan, 2004; Pembroke, 1994). As potentially the first point of disclosure, the attitudes of staff and treatment decisions made could have a huge impact on patients’ future choices.

2.3.1.3 Staff Attitudes

Attitudes and emotional reactions towards patient may be due to both patient dependent and staff dependent factors (Suominen et al., 2007, p391)

Staff attitudes to self-harm in general seem to be mediated by several patient-specific characteristics, implying that implicit moral judgements are made about the patient’s deservingness:

- Perceived motivation for the act (Hadfield et al., 2009; Mackay & Barrowclough, 2005; , 1975);
- Intent behind the act (Morgan, 1979; Ramon et al., 1975);
- Frequency of attendance (Hadfield et al., 2009; Ojehagen et al., 1991; Pallikkathayil & Morgan, 1988); and
- Patient characteristics such as use of alcohol, presence of physical illness, and aggressive behaviour (Dickinson et al., 2009; Hickey et al., 2001; Jeffery, 1979)

These factors reflect the criteria set out by Radley (1994) as influential in healthcare encounters. Radley (1994) conceptualises the healthcare encounter as one where the patient petitions to be seen as legitimately in need, and the healthcare professional makes a judgement about the legitimacy of the patient’s claim. With regards to self-harm, both the act itself and the patient’s characteristics impact on this judgement.

Depressive motives are often deemed more acceptable and evoke more sympathy than so-called manipulative motivations relating to interpersonal communication (Dickinson et al., 2009; Ramon et al., 1975; Rund, 1984). Morgan (1979) found that some medical staff distinguished between “genuine” and “non-genuine” suicide attempts, with interpersonal functions such as getting back at someone, seen as less genuine. Judgements about suicidal intent could also impact on staff attitudes (Ramon et al., 1975).
Mackay and Barrowclough (2005) conducted a study applying Weiner’s attributional model of helping behaviour to emergency department staff’s care of self-harm patients. Attributions of controllability and the belief that the patient would repeat were associated with higher levels of irritation amongst staff and less helping behaviour. Several other studies suggest that the perception of controllability influences attitudes (Dingwall & Murray, 1983; Jeffery, 1979; Mackay & Barrowclough, 2005; Markham & Trower, 2003). Wheatley and Austin-Payne (2009) adapted Mackay and Barrowclough’s (2005) methodology to examine the attitudes of nursing staff on inpatient wards. They found that greater helping behaviour was associated with more optimism about treatment and attribution of self-harm to external rather than internal factors. In addition, greater perceived controllability was associated with less pity and sympathy. The perception of controllability as a mediating factor is interesting as it is value-laden – in Mackay and Barrowclough (2005), controllability was varied by either stating the “death of a close friend” (as an uncontrollable event) or “financial debt” (as a controllable event) was the precipitant of the self-harm episode. This idea of controllability may also lie behind negative attitudes towards those abusing alcohol and positive attitudes to those suffering from physical illnesses (Dickinson et al., 2009; Hickey et al., 2001).

Repeat attenders were generally liked less than those who had not been seen before (Hadfield et al., 2009; Ojehagen et al., 1991; Pallikkathayil & Morgan, 1988). In Hadfield and colleagues’ (2009) qualitative study, emergency department doctors felt frustrated and helpless when dealing with frequent attenders, and sometimes blamed psychiatric staff for reinforcing their feelings of incompetence and helplessness. This study demonstrated how therapeutic pessimism could pervade the culture of care: here, dealing with frequent attenders became a “heart-sink” activity as psychiatrists authorised discharges despite acknowledged risk:

> If I do get through to [psychiatry]... the response, I think it’s fair to say, more often than not, more than half the time is... “No, no, no, they can just go home” [participant] “Well, are we going to manage anything?” [Mental health professional] “No, no, no, they’re always like this” (Hadfield et al., 2009, p759)

In contrast, emergency department doctors were anxious to help first-time attenders, to prevent further attendances (Hadfield et al., 2009). Here, the
negativity seemed to stem from what the patients represented to the doctor emotionally and professionally.

Staff attitudes have been found to be associated with levels of training and staff responsibilities in patient care. For example, in Suokas and Lonnqvist (1989b), those working in the emergency department were more likely to have a negative attitude towards patients than those working in intensive care. Suggested reasons for this are the pressure of being the first point of contact, and the lack of time or resources to develop a rapport with patients. In Friedman and colleagues’ study of emergency department attitudes towards self-cutting (2006), those who had not received self-harm training, and had been working in the emergency department longer, had higher levels of anger towards the patients. Brunero and colleagues (2008) also found that non-mental health professionals trained in suicide prevention were more positive than those who had received no such training.

Dickinson and colleagues (2009) investigated the attitudes of registered and non-registered nursing staff towards young people who self-harm and found no significant difference with regards to registered status, but did find a difference that corresponded with specific education about self-harm. Other studies have found that brief training can have a positive effect on skills, knowledge and attitudes in healthcare professionals when dealing with self-harm (Appleby et al., 2000; Berlim et al., 2007; Gask et al., 2006; Morriss et al., 1999; Samuelsson & Asberg, 2002). It is unclear whether these changes in attitude are maintained over time (Brunero et al., 2008). Many studies asking staff about their training and confidence to work with self-harm find that staff feel inadequately trained (Crawford et al., 2003; Friedman et al., 2006; Gibb et al., 2010; McAllister et al., 2002; McCann et al., 2006; McLaughlin, 1995; Samuelsson et al., 1997).

Hadfield and colleagues (2009) conducted an in-depth IPA study of emergency department doctors’ attitudes towards working with self-harm. As most studies focus on nursing attitudes (e.g., Anderson, 1997; Elliot et al., 1992; McAllister et al., 2002; McCann et al., 2007; McCarthy & Gijbels, 2010; McKinlay et al., 2001; McLaughlin, 1999; Samuelsson et al., 1997; Sun et al., 2007), or have a
disproportionate representation of nurses (Gibb et al., 2010; Suokas et al., 2009; Suominen et al., 2007), this study targets a group whose attitudes have been under-investigated. The emphasis on physical treatment in the emergency department contributed to a sense of frustration and helplessness around the emotional aspects of self-harm, and led to the doctors silencing or repressing their personal responses to self-harm. Staff wanted to respond more therapeutically but felt they were not able to in the emergency department milieu.

The impact of the environment on attitudes can be seen in other areas of the hospital. Nursing staff on inpatient wards felt restricted in their ability to respond therapeutically by a lack of time, the dominance of medical model and the range of client needs (O'Donovan & Gijbels, 2006; Sun et al., 2006). 68% of nurses in McCarthy and Gijbels' (2010) survey of an Irish trauma unit agreed that the hospital system itself impeded therapeutic work. McKinlay and colleagues (2001) found that nurses' beliefs regarding the attitudes of others predicted their behavioural intentions towards self-poisoning patients, demonstrating that staff can take cues from the environment as to how to behave towards patients.

Carers may relieve their disappointment and frustration with the patient by stigmatising her as bad, attention seeking or manipulative, terms which have no explanatory value but do subtly devalue the patient's distress and can sometimes be used to justify either harsh or indifferent treatment (Tantam & Whittaker, 1992, p459)

Working with self-harm or suicidal patients tends to evoke a variety of emotions in staff, such as frustration (Boyes, 1994), ambivalence (Hemmings, 1999), distrust (Talseth et al., 1997), anger (Friedman et al., 2006), and helplessness (Hadfield et al., 2009; Hopkins, 2002). Nurses and doctors may withdraw from self-harming patients due to a lack of confidence in treating them (Gibb et al., 2010; McAllister et al., 2002), and a fear of emotional involvement (Cutcliffe & Stevenson, 2008; , 1995; Wolk-Wasserman, 1985). The blame culture can increase staff discomfort when dealing with self-harm (Smith, 2002). Staff may also blame patients for creating these negative experiences and for challenging their professional identity. Patients can be positioned as “rubbish” or “difficult” patients for failing to comply with the expectations of staff, in terms of how the patient should respond to care, and what the staff member should be able to
achieve (Breeze & Repper, 1998; Jeffery, 1979; McHale & Felton, 2010; Shaw, 2004).

Some studies have linked length of time in profession to negative attitudes, especially when accompanied by a lack of specific mental health training, which could be indicative of the cumulative emotional burden of dealing with self-harm patients (Brunero et al., 2008; McCarthy & Gijbels, 2010; Watts & Morgan, 1994). Gibb and colleagues (2010) found that negative attitudes were associated with low levels of personal accomplishment and a greater degree of burnout. Conversely, McKinlay and colleagues (2001) found more positive attitudes in nurses were associated with higher valuing of emotional involvement and empathy with patients. The aspect of this work which is most taxing, the emotional involvement, can also be the most rewarding for staff and patients (Cutcliffe & Stevenson, 2008). The impact of the organisational culture on the healthcare professional’s ability to positively engage with patients on an emotional level, and on the support available for this sort of work, requires further research.

There is a notable absence of studies looking at attitudes towards black and minority ethnic (BME) groups who self-harm. Research has shown that BME groups are less likely to receive psychiatric assessment, but they are also less likely to re-attend (Cooper et al., 2010), and BME groups tend to experience poorer standards of psychiatric care (National Institute for Mental Health in England, 2003a). Research on staff attitudes tends to homogenise an incredibly diverse and complex issue, and does not tease apart differences in attitudes towards particular groups who self-harm, or towards particular behaviours under the self-harm umbrella.

2.3.2 Patient Experiences
2.3.2.1 Experiences of Hospital
The National Service Framework recommended that emergency departments have safe and private facilities for assessment on site (Department of Health, 1999). It is common for self-harm patients to feel anxious and exposed in the emergency department (1999), and these feelings can be compounded by a lack of privacy to talk to staff (2005). In Palmer and colleagues’ (2007)
nationwide online survey of self-harm, several respondents stressed the need for a confidential space in which to talk about their injuries. Similarly, patients being assessed by a mental health liaison service mentioned privacy as an important aspect of care, with some specifying that the room should be physically apart from the emergency department (Callaghan et al., 2002). A lack of privacy seems to be a common element of care in the emergency department, and may be in part due to the nature of the service (Karro et al., 2005). These patients may suffer from high levels of shame and embarrassment around seeking help for a self-inflicted reason (Wolk-Wasserman, 1985), and these feelings may form a barrier to frank disclosure in a public setting, such as an open ward or waiting area (Wiklander et al., 2003). Conversely, being taken to a private room can lead to increased feelings of isolation if the patients feel "shoved out of sight" and forgotten by staff (2005, p9). A qualitative study of suicidal men in America found that private rooms in the emergency department could be experienced punitively, and that the isolation could escalate distress in already distressed patients (Strike et al., 2008).

Service users often express a need to have their self-harm treated with sensitivity, with staff regularly keeping them informed about the process whilst they wait to be seen (Horrocks et al., 2005; National Institute for Health and Clinical Excellence, 2004; Palmer et al., 2007; Pembroke, 1994; Taylor et al., 2007). A review of the literature on general patient experience in emergency departments found that communication and information about what was happening were key features desired by patients (Nairn et al., 2004). They argued that:

The way waiting is managed is as important as the wait itself (Nairn et al., 2004, p161)

Service users in a qualitative study of hospital care often expressed anxiety whilst waiting without knowing what was happening:

It’s unbelievable the time you have to wait because you never know, you might collapse or something (Horrocks et al., 2005, p9)

Whilst staff may have evaluated these patients as low priority physically, the service users themselves did not always have a good understanding of their
physical condition, leading to a state of “psychological urgency” reflecting this uncertainty (Horrocks et al., 2005, p9). In addition, patients sometimes interpreted waiting times to be punitive, reflecting negative judgements made by staff about self-harmers (Bywaters & Rolfe, 2002; Pembroke, 1994).

Another aspect of the hospital experience to consider is the inpatient ward. Fifty-three percent of people were admitted into hospital following self-harm in a multi-centre study (Lilley et al., 2008). These figures vary dependent on location in the UK, the facilities available, the age of the patient, the perceived risk of the patient and the type of self-harm (Hawton et al., 2007; Lilley et al., 2008). In some locations, for example, Oxford, the majority of cases are routinely admitted to allow time for psychosocial assessment to take place (Hawton et al., 2007). Admission onto a ward is likely to be a common experience for people who self-harm, and so it is worth considering how this experience might impact on service users’ experiences, satisfaction and compliance with further care.

The ward environment could be considered a microcosm within the hospital, with its own social rules, regulations, and expectations. A psychiatric inpatient ward is likely to differ substantially compared to a general medical ward, owing to the mixture of clientele, the staff roles and expectations and the unique nature of psychiatric care as opposed to medical care. Two studies illustrate these differences in action. The first, an ethnographic study based on a medical admissions unit, focused on the experiences of nurses working with suicidal patients (Hopkins, 2002). The presence of suicidal patients on the ward, waiting to be seen by psychiatrists, prevented the nurses from meeting bureaucratic targets that were interpreted as symbols of their efficiency and competency, and these patients were seen to be demanding in ways which fell outside the legitimate scope of need on the ward (Hopkins, 2002). Whilst this study would have benefited from a longer period of observation and data collection, it demonstrates how the environmental and administrative pressures on nurses can translate into behaviours:

Staff nurse: You would give them the attention until they are medically fit but then, later on, when they are getting over that stage and are just waiting to see the psychiatrist, that’s when I think things start to change,
we wouldn’t prioritise time to spend with those patients (Hopkins, 2002, p150)

The second study, also utilising participant observation and interviews, was a more substantial examination of psychiatric wards incorporating both psychiatric nurse and patient perspectives (Sun et al., 2006). A recent review of mental health patients’ expectations with regards to psychiatric inpatient care found that patients expressed the desire for the ward environment to be a place of safety and support, emphasising their autonomy in treatment decisions and involving mutual trusting relationships with staff (Hopkins et al., 2009). Sun and colleagues’ (2006) study highlighted the difficulties in providing an environment which is both secure and liberal, as patients praised the quiet and safety provided by the ward, and also complained about the lack of privacy and freedom. The removal of ligature points, for example, was welcomed by some patients wishing to escape their suicidal urges but was seen by others as a means of infantilising patients (also, Brophy, 2006; Smith, 2002; Sun et al., 2006). This dilemma of demonstrating trust balanced with prevention echoes the earlier discussion over the split priorities of psychiatry. In several studies, psychiatric patients have emphasised their desire to be engaged in a relationship of mutuality and trust with staff, given responsibility for their own actions and treatments, and yet patients may also seek the constructed and structured safety of the ward which removes their capacity to hurt themselves (Cutcliffe & Barker, 2006; Cutcliffe & Happell, 2009; Dunleavey, 1992; Samuelsson et al., 2000; Talseth et al., 1999; Taylor et al., 2009; Wiklander et al., 2003).

Psychiatric patients seem to expect and hope for a personal bond with psychiatric staff, which extends beyond the idea of medical treatment. The concept of security in Samuelsson and colleagues’ qualitative study of psychiatric inpatients who attempted suicide is tied to the idea of care:

Being in their care gave me a sense of security. That was probably the first impression, which made me feel comfortable here. The atmosphere was more relaxed with more chatting, laughter and jokes (Samuelsson et al., 2000, p638)

This need for personal connection seems to influence patient satisfaction with treatment (Dunleavey, 1992; Taylor et al., 2009). A key example exists in the
case of constant observation, a method used on psychiatric wards to prevent suicide in those perceived to be at risk. Cardell and Pitula (1999) interviewed 20 suicidal inpatients in America who had experienced constant observation\(^2\). In this study, constant observation could be experienced as threatening and unhelpful by patients, but it could also alleviate a patient’s distress and calm them down. The determining factor seemed to be the interaction between patient and observer. In circumstances where the observer maintained a physical and psychological distance from the patient, patients often reported an increase in their distress. When the observer engaged in conversation and were optimistic and hopeful about the patient’s recovery, this stimulated the patients to re-consider their suicidality. In a review of observation research, Cutcliffe and Stevenson (2008) argued that it was the engagement with the patient that was experienced as therapeutic rather than the activity of being observed itself. However, they also acknowledged that there often seemed to be a focus on the preventative aspect of observation, with security staff or support staff being placed in the role of observer (Cutcliffe & Stevenson, 2008).

2.3.2.2 Experiences of Assessment
Previous research has hinted at the potential interaction occurring between the timing of the assessment, and the satisfaction of the patient with this experience (1988; , 2004). Several sources stress that the timing of the assessment following the self-harm event is important as people need to feel recovered from the effects of the self-harm or its medical treatment to benefit (Hawton & Catalan, 1987; National Institute for Health and Clinical Excellence, 2004; Royal College of Psychiatrists, 2004; Whitehead, 2002). This is echoed in the literature on patients’ experiences, as they often felt that assessments took place too soon, and that they were not psychologically or physically prepared for the assessment (Hengeveld et al., 1988; , 2005; Palmer et al., 2007; Pembroke, 1994; Taylor et al., 2007). Almost half of the participants in a hospital survey had extremely poor recollection of the consultation with the psychiatrist (Hengeveld et al., 1988). This factor alone might negatively

\(^2\) “Constant observation” is the term used by Cardell and Pitula, but Cutcliffe and Stevenson (2008) point out that other terms are used for essentially the same activity in other countries, for example arms-length observations, one-to-ones and close observations. The term used in the UK is close observations.
influence engagement with aftercare simply because the patient does not clearly recollect the arrangements made.

In several studies, there was a general recognition amongst respondents that the assessment was something that the staff “had” to do, but people often felt frustration at “being processed” and rushed by staff (Hengeveld et al., 1988; Horrocks et al., 2005; Whitehead, 2002). When patients were given information and prepared for the assessment, it seemed to be received more positively (2007; , 2004). Patients often welcomed the opportunity to talk, but felt that they were not always given enough time to do so (1988; , 2005; National Institute for Health and Clinical Excellence, 2004). One indicative comment was made in Carrigan’s exploratory study on the psychosocial needs of those who overdose:

  There was plenty I could have told them if they went about it a different way (Carrigan, 1994, p639)

This sentiment was echoed in the Royal College of Psychiatrist’s online survey of self-harm:

  [It] really helped me to speak to someone who seemed to understand me. It got me to open up about my feelings which I hadn’t done before (Palmer et al., 2007, p32)

The sentiment expressed demonstrates the relational nature of assessment: whilst staff may see the patient as petitioning for help, the patient may also be assessing whether the staff member can be trusted to provide such help. As self-harm and mental illness can carry stigma for the patient, this need to feel comfortable and able to open up might be related to a fear of judgement and further stigmatisation. Adolescents who had attended hospital after overdose often expressed anxiety about how staff would perceive and judge them, and were relieved when the staff were non-judgemental (Dorer et al., 1999). Dunleavey (1992), in a study of 17 attempted suicide patients on hospital wards, found that patients often felt inhibited by the fear of stigma.

When patients felt they had time and space to talk, they were more likely to open up and reveal more information about what led to their attendance (Carrigan, 1994; Hengeveld et al., 1988; Horrocks et al., 2005). Conversely, feeling ignored or judged by staff could have the opposite effect (Horrocks et al.,
When staff gave them options and involved them in treatment decisions, this was appreciated by patients (2007; Taylor et al., 2009). It was also important to service users that they were given a choice with regards to the assessor and the circumstances of the assessment (Crockwell & Burford, 1995; , 2005; Taylor et al., 2007). This issue of choice could be crucial in circumstances where there are pre-existing social, cultural or psychological barriers to engagement with assessment (Chantler et al., 2003; Chantler et al., 2001; Crockwell & Burford, 1995; Reece, 1998).

Louise Pembroke (2007) describes a pivotal moment when a healthcare professional took time to explain harm minimisation without judgement; this helped free her from a cycle of traumatic visits to the emergency department (see also, Harrison, 1995; Pembroke, 1994; Reece, 1998). In Breeze and Repper’s (1998) study of “difficult” patients (self-harm being one of the main identified criteria for being perceived as “difficult” by staff), patients understood that their viewpoint might not be acted upon, but appreciated being listened to and having the reasons for any decisions explained. Choice can be a way of encouraging the patients to feel they have “ownership” over their own care (Palmer et al., 2007, p32), just as a lack of choice can lead to disengagement with the process, struggle against staff and feelings of defeat (Breeze & Repper, 1998). As one participant expresses:

> If I have a say of what goes into it [the treatment plan] I know what I'm supposed to be doing and if I can, if I've any chance of doing it

(Breeze & Repper, 1998, p1305)

Suominen and colleagues (2004) examined the attitudes of patients towards the psychiatric consultation. A third of their sample stated that they were indifferent about the assessment prior to its occurrence. The authors found that high levels of hopelessness and the assessment timing being perceived as too early were the only two factors that explained this indifference to assessment. Given the admitted limitations of the sample size (53 out of a possible 73 people agreed to evaluate their assessment), this finding is suggestive. It makes psychological sense that those who express hopeless ideas will be less likely to feel positive about the possibility of receiving help, and the idea of feeling ready for assessment could be linked to the patient’s mood at the time. As high levels
of hopelessness is a recognised risk factor for eventual suicide (Dixon et al., 1991; O’Connor & Sheehy, 2000; Salter & Platt, 1990; Williams & Pollock, 2000), those who feel indifferent towards assessment due to hopelessness may be an important sub-group to target for engagement. Clarke and colleagues (2004) conducted a study of treatment compliance in young people after attendance at an emergency department for self-harm. One of only two significant factors influencing compliance was the patient’s belief about whether counselling, the proposed treatment, would help. One possible interpretation is that those who did not believe it would help (and who were less likely to attend) held that belief in part due to their levels of hopelessness.

Service user experiences are greatly influenced by the attitudes of the staff they come into contact with. The other side of this interaction is how the patient themselves feel about the staff and the process of seeking help. Patients often report difficulties opening up to staff, as a function of the environment (Dunleavey, 1992), their perception of staff’s attitudes (McGaughey et al., 1995), and an inability to verbalise their distress (Simpson, 1975; Spandler, 1996; Weber, 2002). Fear of being sectioned or kept involuntarily in the hospital existed for a number of participants (Horrocks et al., 2005; Palmer et al., 2007). Palmer and colleagues (2007) found that 36% of participants cite this fear as the reason they did not re-attend hospital. One participant admitted:

[The assessor] asked me if I felt suicidal still and I knew if I said, ‘yeah’ then she’d put me on a psychiatric ward, I just said, ‘no I’m not, ‘ haven’t got any thoughts of self-harm’ and at the time I didn’t because I felt really, really stupid for what I’d done, it was extremely embarrassing especially when I realised I couldn’t overdose on the stuff I’d taken... but I think I worded it that I didn’t want to ever go through this again but I meant the hospital side of things (Horrocks et al., 2005, p19)

Fear of the consequences of disclosing suicidal feelings has the potential to impact on the patient’s honesty during assessment. In addition, avowals that one is no longer suicidal may be influenced by the emotional impact of having to seek help. Similarly, other emotional responses such as shame, numbness and anxiety can also impede the conduct of assessment (Dunleavey, 1992; Horrocks et al., 2005; Whitehead, 2002; Wiklander et al., 2003).
Another factor which complicates and influences the experience of assessment is the use of alcohol and/or drugs. A high percentage of self-harm episodes involve alcohol – 54.9% in a multi-centre study (Hawton et al., 2007). In Hume and Platt (2007), fourteen patients were interviewed about their experience of, and attitudes towards, different interventions following self-harm. Those who had alcohol problems or were drunk on attendance at hospital tended to report higher levels of dissatisfaction, and admitted that being drunk on attendance negatively affected the encounter. Those who have been drinking prior to hospital attendance are more likely to self-discharge, presenting a particular challenge for engagement (Barr et al., 2004b; Bennewith et al., 2005).

2.3.3 Who Speaks? Who is Heard?
In the growing service user literature, it has become evident that certain views are represented more than others. Many studies have focused on adolescents or young adults, reflecting concerns about the numbers of young people who self-harm (e.g., Bolger et al., 2004; Burgess et al., 1998; Bywaters & Rolfe, 2002; Dorer et al., 1999; Dower et al., 2000; Hawton et al., 2002; Spandler, 1996; Spandler & Warner, 2007). Another subset of research focuses on the experience of women, either by design or due to sampling issues (e.g., Arnold, 1995; Harris, 2000; Harrison, 1995; Perseius et al., 2003; Weber, 2002). It seems likely that some voices are not being heard with regards to self-harm services.

Studies have shown that the accounts of South Asian women share similarities with the accounts of other groups, e.g., miscommunication with healthcare staff, and unhappiness with psychiatric labels seem to be common themes for those who self-harm. However, there are also significant differences, for example, around cultural “matching” (Chantler et al., 2003; Chantler et al., 2001). Older people tend to be underrepresented in research about self-harm and services, as do men, although there are exceptions (e.g., Allan & Dixon, 2009; Barr et al., 2004a; Crocker et al., 2006; Russell et al., 2010; Shiner et al., 2009; Strike et al., 2006; Taylor, 2003).

Crocker and colleagues (2006) interviewed 15 older people who had attempted suicide (aged between 65 and 91) about the experience of attempting suicide.
They found that increased visibility and integration was an important outcome of the attempt. These participants experienced struggle with the ageing process, and in accepting the stigmatised identity of “elderly”. This may be an influential part of older people’s experiences of services. Older women with depression often expressed loneliness, isolation and self-loathing – when attending hospital, the experience of being understood by someone, be it staff or patient, was invaluable (Allan & Dixon, 2009). These women sought validation and connection with staff:

[It} comes back again to trust, because you see when we get depressed we start to doubt our own abilities. We have ceased to trust ourselves and our own abilities. And then we cease to trust other people and we don’t believe what they say about us. We think that they’re just trying to soften us up (Allan & Dixon, 2009, p871)

This study highlighted the impact of depression on the women’s ability to form relationships with staff, and to sustain self-esteem, factors which may influence their engagement with services and aftercare.

The themes in studies of men’s experiences tend to echo those discussed in 2.3.2, in that they wanted to be more involved in their own care, understood by staff, and given enough time to engage in assessment (Strike et al., 2006). Strike and colleagues (2006) interviewed 15 men with histories of self-harm and aggressive behaviours, and found that these men often experienced negative cycling in and out of services, avoiding seeking help due to previous experiences and inevitably ending up in the same situation. Communication difficulties with staff and assumptions made around the “appropriate” display of distress frustrated and silenced the men (Strike et al., 2006). Men who self-harm often felt there were gendered assumptions made about how distress should be demonstrated, which created barriers between patients and staff (Russell et al., 2010; Strike et al., 2006; Taylor, 2003).

2.4 Conclusion
The idea of psychosocial assessment as potentially therapeutic has not yet been adequately addressed within the psychiatric literature. There is an assumption that psychiatrists will possess the requisite skills and knowledge to engage patients therapeutically as part of their normal clinical practice. However, there are organisational and structural issues which may impede the
optimisation of assessment’s therapeutic potential. In addition, staff attitudes towards patients who self-harm are influenced by the culture within which they work, and the limitations of the service they can provide. Staff seem to struggle with the conflicting emotional and professional demands of working effectively but therapeutically with those who self-harm.

Patients tend to appreciate the opportunity to talk, and being given time to do so in privacy is valued. The experience does not take place in isolation: service users bring with them their fears, attitudes and previous experiences of services. Assessments take place at a time when the emotional states of service users are likely to be in some turmoil, and these feelings can have an impact on the patient’s ability, desire and readiness to disclose information. Service user experiences highlight both negative and positive features of services. Some patients seem to present to hospital hoping for or expecting the staff to engage with them, but are met with hostility, misunderstandings and haste. Whilst the experience of psychosocial assessment has not yet been addressed in depth, existing research suggests that patient experiences are affected by a number of organisational, psychological, relational and environmental factors, and that patients are sensitive to the attitudes of the staff they engage with.

Several authors point out that further research is needed into psychosocial assessment, in order to tease out the ways in which particular aspects of the process (who assesses, what they assess, and how) and the outcomes of assessment impact upon patient experience of and satisfaction with services (Kapur et al., 2008; National Institute for Health and Clinical Excellence, 2004; Whitehead, 2002). Most studies examining the experience of assessment have employed cross-sectional and questionnaire-based methods which are unsuited to unpicking the complexities of process and outcome (e.g., Hengeveld et al., 1988; Palmer et al., 2007; Suominen et al., 2004; Whitehead, 2002). To date, no qualitative research has addressed the impact of assessment on the patient beyond the hospital attendance.
CHAPTER 3: METHODOLOGY

3 Introduction
This chapter positions the research within its ethical, methodological and epistemological framework. The following sections discuss the chosen approach and the rationale behind this choice. Following from Robson (1993) and other research texts (e.g., Bryman, 2001; Coyle & Lyons, 2007; Smith et al., 2009; Willig, 2008), the choice of method and methodology has been guided by the research question, but the research question itself has been influenced by the researcher's experiences and beliefs, the policy context, and both practical and ethical considerations (Faulkner, 2004; Mauthner et al., 2002). Whilst this chapter focuses on philosophical and personal aspects of research design, chapter 4 describes the practical process of research and chapter 8 will critique the research product in light of its fit with both method and aims.

3.1 Research aims & questions
The motivation for this research arose from the NICE (2004) guidelines on the short-term management of self-harm in primary and secondary settings. Further research was needed into the experience and impact of assessment from the service user perspective, which would increase our understanding of how psychosocial assessment is viewed and made sense of by those it most affects, and also highlight ways in which assessment could fulfil a therapeutic role for service users. The idea of psychosocial assessment as therapeutic has existed for some time and psychosocial assessment has emerged as an important aspect of care in research exploring the experiences of service users at the emergency department (see Taylor et al., 2009), but the experience of psychosocial assessment had not yet been explored in-depth from the service user perspective.

The aims for this project were:

- To explore the experience of psychosocial assessment after self-harm from the service user perspective
- To identify differences in these accounts which impact upon the immediate and longer-term "outcomes" following the assessment ("outcomes" as defined by participants)
• To relate service users’ concerns regarding assessment to current policy, in order to produce practical suggestions for feedback into service provision.

In order to gain a service user-focused insight into the nature of psychosocial assessment, this research asked the following questions:

• What is the experience of being assessed following self-harm like for those who undergo it?
• Does this experience (or elements of it) impact on outcomes and if so, how?
• In what ways can these accounts inform our understanding of psychosocial assessment as experienced by service users?

To address these aims, a number of methodological, epistemological and practical decisions had to be made. This chapter focuses on transparently presenting the epistemological and philosophical roots of the research.

3.2 The Nature of Science and Knowledge

Firstly, the nature of science and knowledge will be discussed, as this research takes an epistemological stance which both influences the type of product it can produce and the way in which it should be judged by its intended recipients.

3.2.1 Science & Knowledge as Situated

All research projects begin with a question of interest to the researcher. The choice of method should stem from the question, and be best suited to answer it. However, our epistemological positioning as individuals in a social and cultural milieu influences what sorts of questions we ask (Willig, 2008). What is meant to be a linear, logical process from question to method is complicated by the researcher’s presence, who is affected by both previous experience and personal beliefs about the world (Morse, 1994).

A quote from Karl Popper (1980) encapsulates this difficulty:

The empirical basis of objective science has … nothing 'absolute' about it. Science does not rest upon solid bedrock. The bold structure of its theories rises, as it were, above a swamp.
What Popper expresses is a concern that the physical sciences cannot achieve objectivity through scientific method, as every inquiry rests on pre-existing assumptions about the world and object of interest. This maze of assumptions, implicit and explicit, forms the “swamp” from which scientific theories arise. Some of these assumptions are “objective” statements derived from empirical research, and some are based on subjective experience: formed from an interaction between the scientist’s intellect and the evidence presented. The most deeply rooted assumptions, those which underlie both our “objective” and subjective ideas, are those which relate to our beliefs about the nature and reality of the world, and our ability to obtain knowledge of the world. These beliefs are our ontological and epistemological beliefs, respectively.

This idea of a set of underlying assumptions which govern the practice of science, determining the methods used, the questions asked, and the way findings can be interpreted, can be expressed using the Kuhnian term “paradigm” (Kuhn, 1970). A “paradigm” is defined broadly as:

A philosophical or theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated (Merriam-Webster Online Dictionary, 2010)

The term incorporates an awareness of the socio-historical nature of any human activity and acknowledges the influence of such a framework on the possibilities for knowledge. As scientists, and human beings, we always operate from within a philosophical or theoretical framework, which both allows for and delimits the possibility of knowledge. Guba and Lincoln (1994, p105) reinforced this with their definition of a research paradigm as a:

…basic belief system or world view that guides the investigation not only in choices of method but ontologically and epistemologically in fundamental ways

This view of science and knowledge as inherently situated is itself an epistemological stance. It rejects the realist belief that scientific method can objectively “discover” or “reveal” truth, although it does not necessarily deny the existence of an absolute reality. Instead, it avers that reality has a “human face”
knowledge always emerges from a perspective. According to Madill and colleagues, this is "contextualism", defined as:

The position that all knowledge is local, provisional, and situation dependent (Madill et al., 2000, p9)

The implications of this position on the practical process of research are discussed in later sections.

### 3.2.2 Knowledge within Psychology

The way in which a discipline emerges in history plays a role in defining the conditions for knowledge within that discipline. Van Langenhove (1995) argued that when the human sciences started to emerge as a set of practices, there were two available paradigms for the study of self and society. The first paradigm was that of the natural sciences, based on a belief in an objective reality, accessed through empirical study and scientific neutrality. The second was that of hermeneutics, based on the view that access to the meaning of texts was mediated and requires interpretation to be understood. The natural sciences model was widely adopted by psychology and psychiatry; a model which focused on observable phenomena, and utilised the experimental method to produce its evidence base. This model’s dominance in psychology has been challenged by a range of theorists (e.g., Bruner, 1990; Gergen, 1999; Giorgi, 1985; Parker, 2007; Smith et al., 1995b). Whilst these theorists propose different solutions to the problems they perceive with psychology, all argue that psychology is limited as a discipline by this approach.

The main problem with the natural science model is that it does not adequately address the subject matter of psychologists. This subject matter could be defined as “humans, their experiences and their actions” (Martin & Thompson, 1997, p629). As Dilthey and others have argued, the study of human beings does not fit neatly into the natural sciences model (Bruner, 1990; Dilthey, 1976; Radley & Chamberlain, 2001). In addition, the development of knowledge within psychology has been hampered by an over-zealous limitation of method in pursuit of the status of “scientific” knowledge (Koch, 1981). This type of knowledge cannot talk about the inherently human qualities of intentionality, relatedness and self-awareness (Smedslund, 2009). As illustrated with Popper’s quote, and argued for by Karlsson (1992) among others, even this
belief in the scientific method as a gold standard for knowledge can be questioned, as the natural sciences model itself is a socially constructed practice.

So far, several arguments have been made about the nature of science, psychology, and knowledge. It has been argued that all science is a product of a socio-historical context, and as such, is both limited by its context and responsible for defining the possibilities for knowledge within that context. Secondly, the historical position of psychology within the natural sciences model has hindered psychology’s development as a discipline seeking to understand human beings and their actions. Finally, psychology’s pursuit of objective knowledge through the natural sciences model is misguided, as unmediated access to a real world is not possible.

3.2.3 Researching Human Beings
There are several proposed approaches to the problems psychology faces as a discipline. Smith, Harre and Van Langenhove (1995b) argue that this diversity and pluralism is an essential part of rethinking psychology as a discipline, opening up new ways of knowing. One of these ways was proposed by Dilthey (1976). It was argued that the study of human beings requires understanding (or Verstehen), and that understanding as a method of inquiry was different from, but no less valid than, the methods of measurement and quantification (Dilthey, 1976; Moran, 2000).

Both Gadamer (1979) and Heidegger (1962) saw understanding not as a method of inquiry, but as a fundamental aspect of being. Understanding became an ontological issue rather than an epistemological one. As Gadamer and Heidegger saw it:

Understanding is a prerequisite of human life (Moran, 2000, p251).

On this perspective, human beings are seen as fundamentally engaged in understanding (Martin & Sugarman, 2001). We are always involved in making sense of the world, from a position of being in and of the world (Heidegger, 1962; Larkin et al., 2006). This sense of being embedded in the world challenges the assumption that we can know anything about the world separate
The central point rests with this idea of a meaningful world. As Bruner (1990) argued, people are meaning-making beings: the objects we interact with, the actions we perform, and the behaviours we exhibit are all meaningful to us. No object depends on us for its existence, but its meaning is found in the encounter between the person and the object (Heidegger, 1962; Husserl, 1965). Psychology as the study of human beings should be concerned with these relations between person and object (where this object could be another person), which constitute a meaningful reality (Langdridge, 2007; Larkin et al., 2006; Smedslund, 2009).

This idea renders problematic any pursuit of “objective”, immutable truths. It implicates people in the construction of knowledge as the world is mediated through our engagement with it (Moran, 2000); it renders the world meaningful through engagement – intentionality being understood as awareness of something (Hunter, 2010; Langdridge, 2007; Larkin et al., 2006); and it makes subjectivity the central quality and condition for knowledge, as anything that can be known is known from a standpoint (Gadamer, 1979). The distinction between objective and subjective knowledge is dissolved, as:

All understanding, including scientific explanation, is historically conditioned, is partial, and always comes from a point of view (Moran, 2000, p251)

Scientific knowledge becomes simply another type of subjective knowledge (Parker, 2004b).

3.2.4 Self-harm as Lived Experience
In this study, the goal was to develop a contextualised understanding of the lived experience of psychosocial assessment following self-harm. The desired product was a knowledge situated within the lived worlds of the people interviewed, relatable to our wider understandings of self-harm and the factors
associated with it in the literature, and sufficiently in-depth to offer insight into the significant aspects of experience which may transcend the individual (Smith, 2004).

A large proportion of research has focused on the quantifiable aspects of self-harm and suicide. Whilst this research is informative about trends in self-harm and suicide, factors commonly associated with both, and the means by which people self-harm, they are less informative about the lived experience of these issues. In order to understand self-harm and suicide as human acts, a different approach is required. As Leenaars states:

Suicide and suicidal behavior are multifarious events. There are biological, psychological, intrapsychic, interpersonal, cognitive, conscious and unconscious, sociological, cultural and philosophical elements in the events. Thus, research in suicide cannot be reduced to a single approach. This complexity indicates the necessity of a parallel complexity in study (Leenaars, 2002, p19).

What Leenaars (2002) and Cutcliffe (2003) argue is that research is needed into the individual experience, the idiographic aspects of suicide and suicidal acts. The idiographic approach involves the in-depth study of individuals, and is most commonly associated with qualitative methodology (Smith et al., 1995a). It is contrasted with the nomothetic approach, which is concerned with trends across individuals, with shared characteristics instead of differences (Leenaars, 2002).

The literature reviewed in the preceding chapters clearly demonstrates the validity of Leenaars’ assertion that suicidal behaviour is complex and varied, requiring a similar complexity in research. The growing voices of service users, survivors, and research participants reveal the value and challenges of the idiographic approach, and the need for both circumspection and boldness in navigating the complexities of self-harm as a lived experience. Current psychiatric conceptions of self-harm can be contradictory and damaging, and the lack of coherence and agreement within the field is both limiting and illuminating. To avoid the pitfalls of presumptions based on clinical experience and socio-cultural ideas which pervade healthcare settings, the decision was made to investigate the phenomenon of interest from the service user perspective, positioning people who self-harm as “experts by experience”
(Faulkner, 1998, p6) To take into account the complexity of self-harm, a qualitative idiographic approach was adopted.

### 3.2.5 Different Ways of Constructing Knowledge

Within qualitative research, there is a range of analytic techniques, tied in varying degrees to theoretical positions on knowledge and reality, and the role of language (Ashworth, 2008; Madill et al., 2000; Willig, 2008). As Polkinghorne defines it, qualitative research:

...is inquiry aimed at describing and clarifying human experience as it appears in people’s lives (Polkinghorne, 2005, p157)

Different approaches to data collection, analysis and dissemination create different types of knowledge about “humans, their experiences and their actions” (Martin & Thompson, 1997, p629). Approaches such as discourse analysis and conversation analysis focus on language and its use in constructing the social world. Conversation analysis is primarily interested in naturally occurring speech, and how people use language during the course of social interactions (Drew, 1995). Discourse analysis (DA) can be defined as the study of “the way versions of the world, of society, events, and inner psychological worlds are produced in discourse” (Potter, 2004, p202), and there are several branches of DA which focus on different aspects of the role language plays in social interaction (Willig, 2008).

Owing to the contested nature of self-harm, and the power relations involved in hospital attendances, DA could create useful insights into the process of assessment. However, an explicit focus on discourse is not compatible with the aim to prioritise those who are “experts by experience”, and give primacy to that experience to inform service recommendations, as DA questions the validity of a link between language and cognition (Willig, 2008). Whilst there are limitations to a reliance on retrospective self-report, and the relationship between linguistic expression and experience is by no means straight-forward, it is felt that the content, as well as the form, of reported experiences are an important source of knowledge for services (Kirkegaard Thomsen & Brinkmann, 2009; Polkinghorne, 2005). Similarly, as the topic of this thesis was the impact of assessment on the individual, conversation analysis, with its focus on the use of language in interaction, did not seem the most suitable approach.
Another option was grounded theory. This is a qualitative approach, often but not exclusively based in a realist epistemology, which aims to develop theoretical understanding through rigorous and thorough description of social phenomena (Charmaz, 1995; Timlin-Scalera et al., 2003). It is a useful methodology when a subject is under-researched, as its theoretical sampling, use of constant comparison and comprehensive coding process aim to achieve “saturation”, i.e., to fully describe the phenomena of interest (Lingard et al., 2008; Morse, 1995). Whilst the possibility of saturation is debated (Charmaz, 1990), elements of grounded theory are often adopted in a circumscribed way because of the rigour and transparency associated with the different procedures. It has been used within self-harm research to describe the ward environment as experienced by suicidal patients and staff (Sun et al., 2006); to explore staff perceptions of suicidal young people (Anderson et al., 2003); to address the paradox of multiple functions for self-harm (Horne & Csipke, 2009); and to examine the lived experience of self-cutting (Simpson, 2004).

In this research, a phenomenological approach was preferred over a grounded theory approach for several reasons. The first reason was that grounded theory focuses on explicating social processes, rather than on understanding the meaning of individual experiences (Starks & Brown Trinidad, 2007). Phenomenology seemed to offer an explicit focus on the idiographic (Cutcliffe, 2003; Leenaars, 2002). Secondly, phenomenology allows for the use of pre-existing theory in analysis, whereas grounded theory historically does not (Larkin et al., 2006; Willig, 2008). With a field as researched as self-harm, the flexibility offered by phenomenology seemed both prudent and essential. Thirdly, a hermeneutic phenomenological approach such as interpretative phenomenological analysis (or IPA), explicitly acknowledges the influence of the researcher and their theoretical position, whereas traditional grounded theory typically assumes that themes are discovered during analysis, and the influence of the researcher is minimised (Braun & Clarke, 2006). It was felt to be ethically imperative to acknowledge the interpretive nature of the findings in a study committed to both creating service user-relevant recommendations and remaining sensitive to the wider context of the research.
In the end, the choice of approach is as much a reflection of the researcher and the context of the research as it is of the specific research question. A research question can be phrased in different ways, creating emphases which suggest different methods (Starks & Brown Trinidad, 2007). In addition, each of the approaches discussed above contains a multiplicity of different approaches, for example, Charmaz’s (1990) social constructionist version of grounded theory. This multiplicity blurs the distinction between different approaches. From my perspective, as the researcher, the chosen method appealed due to its flexibility, its diverse theoretical background, its clear analytic technique, its idiographic nature, its acknowledgement of the centrality of interpretation and its positioning within psychology. These persuasive features of IPA will be expounded in greater detail below.

3.3 IPA

IPA is a member of the phenomenological family of qualitative approaches (Langdridge, 2007). It has been developed within psychology, especially social and health psychology, over the past 15 years (Smith et al., 2009). It has four important theoretical strands: phenomenology, hermeneutics, idiography, and to a lesser extent, symbolic interactionism (Larkin et al., 2006; Smith, 1996a; Smith et al., 2009; Willig, 2008).

3.3.1 IPA – Phenomenology

Phenomenology as a term has been in use since the eighteenth century, but it was not until Husserl in the early twentieth century that phenomenology was developed as a systematic approach (Moran, 2000; Smith et al., 2009). Husserl believed that the natural sciences were failing to produce rigorous knowledge, as their research rested on the unchallenged assumption that there was a natural world. Husserl called this the “natural attitude” (Langdridge, 2007). The aim of phenomenology was to “go back to the things themselves” by putting aside the natural attitude and engaging with objects as they are. Thus, Husserlian phenomenology placed the philosopher as the gateway to knowledge, gained through phenomenological reduction and engagement with objects as they appear (Smith et al., 2009). Phenomenological reduction required “bracketing” the natural attitude, so that things were perceived only as
they were experienced, without prior assumptions (Ashworth, 1999; Langdridge, 2007).

The phenomenological theory underpinning this thesis more closely aligns with the hermeneutic phenomenology of Heidegger and Gadamer (Gadamer, 1979; Heidegger, 1962; Smith et al., 2009). The concept of going “back to the things themselves” is set aside in order to focus on understanding the meaning of these things in interaction with the meaning-making being (Langdridge, 2007). From this perspective, our phenomenological focus becomes the experience of objects, rather than revealing the essence of objects in experience. People are viewed as embedded “persons-in-context” who are always actively engaged in and inseparable from the world (Larkin et al., 2006, p105). The impact of this on our approach to phenomenology is that it becomes inextricably entwined with the process of interpretation, or hermeneutics.

3.3.2 IPA – Hermeneutics

Hermeneutics refers to the study of interpretation, originating from readings of biblical text (Schmidt, 2006). For Schleiermacher, interpretation was seen as an essential craft involving two elements: a grammatical understanding of the words used, and a psychological understanding of the speaker (Smith, 2007). It involved engaging in the “hermeneutic circle”:

[which] states that one cannot understand the whole until one has understood the parts, but that one cannot understand the parts until one has understood the whole (Schmidt, 2006, p16).

In IPA, Smith and colleagues argue that understanding any text requires interpretation (Smith, 2007; Smith & Eatough, 2006; Smith et al., 2009). Interviews are seen to employ a “double hermeneutic”, in that:

The participant …. trying to make sense of their personal and social world; the researcher … trying to make sense of the participant trying to make sense of their personal and social world (Smith, 2004, p40).

Analysis of talk involves a balance between the phenomenological concern of bracketing (Langdridge, 2007) and the interpretative concern of making sense and understanding “persons-in-context” (Larkin et al., 2006, p106). The interpretative aspect explicitly relies on the researcher as its implement: without our individual understandings, our “receptivity” to others, we cannot make
meaning from another person’s account (Smith et al., 2009). Smith describes this balancing act as a circle, with the researcher on one side, and the participant on the other:

I start where I am at one point on the circle, caught up in my concerns, influenced by my preconceptions, shaped by my experience and expertise. In moving from this position, I attempt to either bracket or at least acknowledge my preconceptions before I go round to an encounter with a research participant at the other end of the circle (Smith, 2007, p6)

The process requires a two-way engagement with oneself and one’s participant (Finlay, 2002b, 2008). In this process, the position of the researcher constantly shifts, as the researcher’s preconceptions are revealed by ongoing engagement with the participant’s accounts (Gadamer, 1979; Smith, 2007; Smith et al., 2009).

IPA places the self at the heart of knowledge production. Without ourselves as participants in interactions with others, without our “horizon” of knowledge and experience (Gadamer, 1979, p269), understanding cannot be achieved. In this view, knowledge is inherently relational, formed through interaction (Finlay, 2002a). The social aspect of understanding comes to the fore, demonstrated further by IPA’s employment of symbolic interactionism (Smith, 1996a).

3.3.3 IPA – Symbolic interactionism, language and cognition

Symbolic interactionism refers to Herbert Blumer’s theory that the way people act towards objects is based on the meaning they ascribe to those objects and that meaning arises out of, or stems from, social interaction (Smith, 1996a). The influence this theory has on IPA is not often discussed in the literature. It forms the basis of IPA’s knowledge claims about people’s behaviours: if people act towards objects on the basis of their ascribed meaning, and that meaning can be accessed through interviews, then inferences can be made about behaviour on the basis of accounts created in interviews. It also argues that meaning arises out of social interaction, and that by investigating meaning making, we can learn about social processes and discourse (Smith, 1996a). IPA is placed as a means to examine cognitions and emotions underlying experience (Brocki & Wearden, 2006), and also as a way to learn more about “persons-in-context” (Larkin et al., 2006, p106). DeVisser and Smith argue that:
A focus on subjective experience cannot help but reveal information about the individual’s broader social context (de Visser & Smith, 2007, p599)

There are a number of claims made here. One is that meaning is a social construct – it develops dynamically from people interacting with the world. Secondly, the way people act towards objects is indicative of its meaning for them – such action includes thought, linguistic expression and behaviour. Finally, IPA places cognition and emotion, language and action as interconnected features of lived experience. A rebuttal of Willig’s (2001) claim that a concern with cognition is not truly phenomenological argued that:

Cognition [is] a complex, nuanced process of sense- and meaning-making... this conceptualization of cognition is dilemmatic, affective and embodied. It is complex, changeable, and can be hard to pin down, but it is cognition none the less (Smith et al., 2009, p191)

Inspired by Bruner (1990), Smith and colleagues are trying to move beyond a traditional understanding of cognition as a separate and distinct information-processing function to a broader use of cognition as “dynamic, emotional and embodied” (Smith et al., 2009, p194). The distinction between cognition and emotion is blurred - both form part of the essentially embodied and social activity of meaning-making.

IPA studies tend to be dominated by textual data in the form of interviews and focus groups. This reliance on linguistic expression is perhaps inevitable when attempting to access another person’s lived experience, but is problematic given postmodern debates about the role of language in social interaction, such as research (e.g., Ashworth, 2008; Denzin & Lincoln, 2003; Lincoln & Guba, 2000; Polkinghorne, 2005). One of Willig’s concerns with phenomenology as a research method arises from this reliance on language (Willig, 2007, 2008). Willig argues that understanding derived through participant’s verbal accounts of an experience is limited by language, as language “precedes and therefore shapes experience” (Willig, 2008, p67).

In IPA, a weak form of social constructionism is adopted, meaning that whilst it is accepted reality is constructed socially, people have the ability to re-shape this construction through their engagement in the world (Smith et al., 2009).
People are meaning-making beings who use language to “[reveal] the world and our relationship to it” (Langdridge, 2007, p161). This is acknowledged to be an imperfect and mediated means by which to reveal experience, and is not the only role language plays in social interactions (the discursive uses of language are also of interest in IPA, e.g., de Visser & Smith, 2007; Eatough & Smith, 2008), but IPA argues that this use of language gives insight into the experienced phenomena and its social context because language is a meaning-making tool, which people employ to construct and understand their lives (Smith et al., 2009).

3.3.4 IPA – moving from the particular to the general

A central feature of IPA is its focus on the idiographic, the individual case (Smith, 1996b, 2004; Smith et al., 2009; Smith et al., 1995a). This focus on the idiographic, Smith argues, allows a greater understanding of the general features of a phenomenon to be developed. As he writes:

... the very detail of the individual also brings us closer to significant aspects of a shared humanity (Smith, 2004, p43)

It is through the combined focus on phenomenology and hermeneutics that the particular case can shed light on general phenomena. Phenomenologically rich, “thick description” of experience (Geertz, 1973, p3) provides the nuanced detail required to relate aspects of individual experience to different circumstances and others experiencing the same phenomenon. The hermeneutic side places the experience described in its situated, socio-historical context, which includes the interview context through which the account was co-created. In this way, the particular case sheds light on the general, using our “shared humanity” as the background which makes interpretation and extrapolation possible (Smith, 2004, p43).

Husserl argued that people are the philosophical tools through which the world can be understood (Husserl, 1965). Warnock’s exploration of memory, which Smith (2004) cites, states that it is the combination of memory and imagination that allow people to learn from experience:

The imagination… is that which can draw out general implications from individual instances, can see, and cause others to see, the universal in the particular (Warnock, 1987, pviii)
If it were not for the visions afforded by memories of one’s own life, one would not be able to understand the lives of others (Warnock, 1987, p143)

For Warnock, telling the story of one’s life is a reconstruction, an activity which requires both (albeit flawed) memory and imagination. It is through imaginative engagement with another’s story that the researcher is able to see a truth beyond the individual instance, and it is because of our own humanness, our individual memories, that we are able to engage in this way (Warnock, 1987).

3.3.5 The homogeneity criterion
It is a general criterion of IPA that the sample be purposive and homogeneous (Langdridge, 2007; Smith et al., 2009; Willig, 2008), and the issue of homogeneity is one which causes considerable debate. Purposive sampling simply requires that the sample is selected in order to answer the research question (Robson, 1993). In the case of this study, that requires all participants sampled to have experience of psychosocial assessment following self-harm. The homogeneity criterion states that the sample should all share experience of a phenomenon, to allow comparison across accounts and development of a general understanding of that phenomenon (Smith et al., 2009). This is sometimes extended to include homogeneity with regards to other characteristics which may influence the experiences people recount, e.g., the experience of becoming a parent may differ for men and women given the different socio-cultural expectations and positions men and women are likely to encounter.

The homogeneity criterion is both an interpretative and a practical issue (Smith et al., 2009). Any variance in the sample along the lines of gender, ethnicity, age, and other formative characteristics is likely to impact upon the interpretative process. As part of the analysis, the researcher will need to account for differences across participants that may have impacted upon the experience of interest. When this experience itself involves an interaction, as is the case in this study, the ways in which characteristics may impact upon that interaction also requires reflection and consideration.
Practically, small samples are recommended in IPA because the analytic process is intensive and idiographic, and therefore time-consuming (Smith, 2004; Smith et al., 2009). The idiographic and context-bound analysis can be impeded by larger samples, as detail is sacrificed for broader cross-case themes. However, sample sizes vary widely in IPA studies (Brocki & Wearden, 2006; Smith, 2004), and depend on considerations such as time, resources, method of data management, recruitment strategy and research question (Smith et al., 2009). Decisions about sample size and homogeneity should be made in the context of each individual study (Smith et al., 2009).

As has been discussed, self-harm is a complex issue, crossing boundaries of age, gender, sexuality, ethnicity and social circumstance. This complexity is apparent in the accounts of people’s lived experiences of services and of self-harm. When designing this study, the problem of self-harm as multi-faceted and complex kept recurring. Along which lines should the sample be constructed in order to meet the criterion of homogeneity? Which characteristics will impact upon the experience of psychosocial assessment?

Two factors influenced the final decision to sample for homogeneity of experience (i.e. only interviewing those with experience of psychosocial assessment) but to remain otherwise heterogeneous with regards to socio-demographic characteristics. Practically, recruiting people who self-harm to research or engaging them with services is generally acknowledged to be difficult (Hawton & Sinclair, 2003; Horrocks et al., 2005). In order to increase the likelihood of developing insight into the experience of psychosocial assessment, a broad recruitment strategy was employed (see 4.3).

The second factor was more theoretical in nature:

Many dimensions of sameness and difference can be operating at any given moment. And where two people may claim commonality on one dimension, they may fall apart on another (Song & Parker, 1995, p246)

In IPA, the researcher attempts to set aside their assumptions about the nature of an experience prior to investigation, and to utilise reflexive practice (see 3.4.2) to account for their influence in the research process. As Song and Parker express, the interview situation is one which cannot be predicted on the
basis of shared characteristics: the “dimensions of sameness and difference” are dynamic, unpredictable and complicate the interaction. This same complexity is present in psychosocial assessment, itself an interaction.

Sampling for homogeneity along known socio-demographic characteristics caused concern because it seemed that by doing so, implicit assumptions would be made about the ways these characteristics might affect accounts of psychosocial assessment. Feminist research has been instrumental in problematising these types of assumptions based on socio-demographic characteristics, and in highlighting the ways in which exclusions and prejudices are reinforced by such assumptions (e.g. Wilkinson & Kitzinger, 1996). An example is Chantler’s work on South Asian women who self-harm, which highlighted the dangers of de-contextualised health service policies that aim to account for cultural influences but can generate and reinforce stereotype (Chantler et al., 2003; Chantler et al., 2001). In order to avoid making such assumptions in this study, sampling was deliberately heterogeneous. However, the practices of intensive inductive analysis and reflexivity were employed to explore the impact of the individual and socio-cultural characteristics of the participant, the researcher, the assessor and assessment environment, on the accounts generated in interview (Finlay & Gough, 2003; Hertz, 1997; Smith, 2004).

3.3.6 IPA and the service user
The issue of service user involvement and expertise was a central concern when designing and conducting this study. This commitment arose from several personal, political and ethical beliefs held by the researcher. These are:

1) Service user experience is valuable in research
Several authors and policy makers stress the value of drawing on the knowledge and expertise of service users in designing and evaluating services (Beresford, 2002; Branfield et al., 2006; Department of Health, 2000; Faulkner, 1998, 2004; Faulkner & Thomas, 2002; Rose, 2001; Tait & Lester, 2005; Townend & Braithwaite, 2002). As Tait and Lester summarise:

By definition, no one else, no matter how well trained or qualified, can possibly have had the same experience of the onset of illness, the same contact with services or the same journey through the health system.
These experiences are an important resource that can help to improve individual packages of care as well as services generally (Tait & Lester, 2005, p171).

2) *This value extends beyond the idea of research validation*

Townend and Braithwaite (2002) point out that the experiences of service users can add depth to research, as they have personal knowledge of services and of the effects of living with mental illness. Other benefits include building relationships between services and service users, reducing the negative impact of previous contacts with services, and improving the balance of trust between researchers and service users (Davis & Braithwaite, 2001). Including service user knowledge and expertise as an integral aspect of service evaluation and planning, instead of as an addendum to support a priori research claims, creates recommendations of both increased practical utility and authenticity (Manning, 1997).

3) *There is an ethical imperative to hear the voices of those marginalised within society*

A political commitment of qualitative research is to challenge the dominance of the mainstream paradigm and its claims to knowledge (Parker, 2004b; Zavos & Biglia, 2009). Feminist research highlights the ways in which the context of knowledge production influence the type of knowledge produced, and the ways in which these knowledge structures create exclusions and inequalities (e.g. Burman, 1992; Fine et al., 1994; Haraway, 1988; Mather Saul, 2003; Wilkinson & Kitzinger, 1996). Foucault’s pivotal work on the history of madness demonstrated how society constructs madness and defines what it means to be mad within the confines of the social world (Foucault, 2001). For many years, those with mental health difficulties have been positioned within our society as something to fear and control (Barker & Stevenson, 2000; Laurence, 2003). The voices of those who suffer from mental health problems were marginalised because they were positioned as irrational or discountable by those in a position of power (Barker & Stevenson, 2000). Experience was devalued as a source of knowledge in the face of the mainstream scientism of psychiatry (e.g. Johnstone, 1997). Those who self-harm have experienced this marginalisation, and whilst recent years have seen political and social movement towards service user
inclusion (Cresswell, 2005; Palmer et al., 2007; Pembroke, 1994; Royal College of Psychiatrists, 2010; Spandler, 1996; Spandler & Warner, 2007), more needs to be done to repair and re-shape the relationship between psychiatry and self-harm.

4) **There is an equal ethical imperative to be aware of the complex nature of representation and service user involvement**

Beresford (2002) points out that service users can sometimes feel “consulted out”, as a result of research which involves much effort with little personal gain. It is therefore important to approach the inclusion of service users carefully, with attention paid to the political and personal impact that the research could have on the group (Beresford, 2002). The ethical commitment to the service user extends beyond the interview to the mode of research and the methods of dissemination – in particular, the issue of representation (Wilkinson & Kitzinger, 1996). There is a danger of service user knowledge and experience being co-opted by researchers and clinicians as a means of making authoritative claims, and meeting political targets (see Burman, 1992; Wilson & Beresford, 2000). There is a need for transparency and political sensitivity when utilising the stories and views of service users within and beyond research studies (Fine et al., 1994; Gillies & Alldred, 2002; Wilkinson & Kitzinger, 1996). In addition, the service user needs to be recognised as an active agent within research, and not positioned as a passive “other” (Bhavnani, 1990; Thapar-Bjorkert & Henry, 2004).

Intuitively, IPA seems to fit well with a user-focused approach to research. It prioritises in-depth, detailed analysis of each individual’s account (Eatough & Smith, 2006; Larkin et al., 2006; Smith, 2004; Smith & Eatough, 2006; Smith & Osborn, 2008); its phenomenological stance values the “insider’s perspective” (Conrad, 1987, cited in Smith, 1996a); it acknowledges the role of the researcher in the creation of the research product (Smith, 2007); and it promotes transparency by requiring the researcher’s interpretations to be grounded in verbatim quotes (Smith & Eatough, 2006; Smith & Osborn, 2008).
There are identifiable limitations of IPA for user-focused research. Whilst it values the individual account, with a growing focus on case studies (Eatough & Smith, 2006; Smith, 2004; Smith et al., 2009), this valuing of the idiographic in itself does not reflect a political commitment to hear marginalised voices in the way that feminist or participatory action research may claim to do (for example, Marshall et al., 1998). The interpretative stance can also be a double-edged sword for user-focused research, as certain aspects of the hermeneutic tradition take one further away from the participant’s perspective. The example in mind is the hermeneutics of suspicion, where meaning is interrogated from beneath the text (Langdridge, 2007). The researcher has an ethical responsibility to protect the participants from potentially harmful interpretations which may reflect the researcher’s personal or political biases (see Langdridge & Flowers, 2005, for an example). IPA is compatible with several different levels of interpretation, and is sometimes employed alongside pre-existing theories such as psychoanalysis (see Smith, 1995; Smith, 2004; Smith et al., 2009). A sensitive engagement with the processes of reflexivity and bracketing (Ahern, 1999; Finlay, 2008; Finlay & Gough, 2003) throughout the research project and the use of techniques to encourage rigorous, systematic practice (Mason, 2002; Seale & Silverman, 1997) are ways to guard against such issues.

To sum up, although IPA lacks an explicit political commitment to service users, it can be used to give voice to the lived experiences of participants (Larkin et al., 2006). IPA has been utilised with groups who may be considered marginalised, such as lesbian and bisexual women (Alexander & Clare, 2004; Touroni & Coyle, 2002), gay men (Flowers et al., 1999), those who hear voices (Knudson & Coyle, 2002), people with chronic or rare health problems (see Brocki & Wearden, 2006, for a review) and immigrants (Timotijevic & Breakwell, 2000). By being attentive to the challenges that working for/with service users brings, and engaging with issues such as reflexivity, ownership and voice, it is possible for IPA research to be user-focused, politically sensitive and socially responsible (see 4.6).

3.4 Criteria for quality
The following section will address the issue of quality criteria in general, and establish the standards adopted through reflection on the aims of this research,
the methodology chosen, and the ethical and epistemological commitments previously outlined. Section 3.4.2 critically discusses reflexivity, specifically in relation to the hermeneutic nature of IPA and the interview situation.

3.4.1 The Criteriology Debate
There is considerable debate around the extent to which standards for quality in qualitative research are required, desired and possible, with researchers arguing that criteria can restrict the aspects of qualitative research which are most valuable (Bochner, 2000; Parker, 2004a; Richardson, 2000). It is common to read concerns about over-rigidity, methodolatry and over-simplification of qualitative research by the application of general criteria (e.g. Barbour, 2001; Bochner, 2000; Chamberlain, 2000; Garratt & Hodkinson, 1998; Parker, 2004a). However, it is also argued that pragmatic agreement on standards is required in order to strengthen the case for qualitative research’s position within the current evidence-based approach to healthcare (Williamson, 2009; Yardley, 2000).

Although there are existing concerns about evidence-based practice, it could be construed an ethical and social responsibility for researchers to frame their work in ways to maximise its impact and benefit for the target population and wider society. Clear, concise and mutually agreed criteria to judge the quality of the process and product of research ensures to an extent that research is comparable within relevant academic and real-world settings, and its benefits and limitations are clearly delineated.

Given this practical incentive to establish clear and comparable criteria for quality, it is still necessary to contextualise such criteria with regards to the methodology chosen, the questions driving the research and the ethical, political and epistemological goals of the research (Yardley, 2000). The pluralistic nature of qualitative research is one of its strengths, as it offers multiple perspectives on the complex social world and enables a polyvocality that avoids reductionist, and often harmful, generalisations (Hertz, 1997; Stanley, 2004). It also challenges assumptions of authorial authority when multiple voices and perspectives are sought (Hertz, 1997; Marshall et al., 1998; Wilkinson & Kitzinger, 1996). This pluralism demands a comparable flexibility when it comes to assessing quality (Barbour, 2001; Yardley, 2000).
The starting point for establishing criteria was to re-visit the aims and methodology of the research. IPA was felt to be an appropriate approach given the aim to produce contextualised understandings of service user experiences. As a methodology, IPA requires a high level of reflexive awareness from the researcher, owing to the engagement with hermeneutics (Finlay, 2005, 2008; Smith et al., 2009; Willig, 2007, 2008). The next section discusses reflexivity in more detail. Smith and colleagues’ (2009) recent IPA textbook draws on Yardley’s (2000) flexible criteria of sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. These principles recognise the need for adaptation to the individual research aims, whilst remaining aware of the practical context of research.

The next chapter will illustrate ways in which this study has sought to meet Yardley’s (2000) criteria (see 4.8.1). Here, the background of each principle is discussed in further detail.

*Sensitivity to context*

Any well-planned and conducted qualitative study should demonstrate an awareness of, and sensitivity to the context within which it occurs (Yardley, 2000). This context includes the theoretical and academic context of the research, the interpersonal and social context of data generation and analysis, the ethical issues which the process of research raises, and the wider socio-cultural setting of the research (Finlay, 2002b; Kvale, 1996; Mauthner et al., 2002; Smith et al., 2009; Yardley, 2000). The level of theoretical and academic knowledge expected may differ dependent on the research topic and the chosen methodology, e.g., a grounded theory study which advocates entering the field with as little fore-knowledge of the topic as possible would expect this knowledge base to develop through engagement in field work (Willig, 2008). Sensitivity to this type of context is typically demonstrated in a thesis or paper in the background literature and the discussions of findings, as the researcher seeks to set the research in the context of current knowledge, and relate the findings to relevant theory (Murray, 2006; Wolcott, 2003).
The interpersonal and social context of data generation and analysis is an issue which has received more attention in recent years (Arendell, 1997; Birch & Miller, 2000; Burns, 2003; Cooper, 1999; Finlay, 2002b, 2006; Finlay & Gough, 2003; Kirkevold & Bergland, 2007; Kvale, 1996; Lee, 1993; Oakley, 1981; Richards & Emslie, 2000; Rosenblatt, 1999; Schwalbe & Wolkomir, 2001). IPA holds that the interview is an interaction, which involves both the researcher and the participant creating the account together (Reid et al., 2005; Smith et al., 2009). When the researcher creates outputs from the research, this is done with the proviso that what is presented is not the unmediated “voice” of the participants, but an interpretation from the researcher’s professional and personal perspective (Smith et al., 2009). Smith, Flowers and Larkin (2009) recommend contextualising each interview with relevant background details, to aid the process of interpretation. The use of reflexivity as a tool for contextualising and reflecting upon the interpersonal and social context of interviews is also recommended (Smith et al., 2009; Yardley, 2000).

When interviewing those who are considered vulnerable, such as those with mental health issues, it is important to consider the power differential between researcher and the researched (Faulkner, 2004; Hoffman, 2007; Richards & Emslie, 2000; Rose, 1997; Thapar-Bjorkert & Henry, 2004) and reflexivity is a useful tool for considering how the participant is positioning the researcher within the context of their health-care and the interview, and how the researcher may be positioning the participant (e.g. Arendell, 1997; Deverell, 1998; Etherington, 2007; Hunter, 2010; Lee, 1997; Manderson et al., 2006; Oakley, 1981; Richards & Emslie, 2000; Salmon & Hall, 2003). The ethical considerations presented in sections 3.3.6 and 4.6 demonstrate sensitivity to the nature of interviewing vulnerable participants. Hunter (2010) offers further insight into the emotional and inter-subjective nature of interviewing people who self-harm, and explores the issue of reflexivity in IPA in more detail (see appendix 9).

Commitment and Rigour

Yardley argues that her suggested criteria:

... correspond to the usual expectations for thoroughness in data collection, analysis and reporting in any kind of research (Yardley, 2000, p221)
The key contribution of Yardley (2000) is that she re-frames the requirements for “thoroughness in data collection, analysis and reporting” in light of the methodology chosen. Demonstrating rigour in data collection and analysis, for example, will depend on the choice of method and the researcher’s commitment to particular methodological and ethical principles. Rigour relates to the completeness of the research endeavour: the sample size and the sampling technique, the data collected and the analytic process (Yardley, 2000). How completeness is judged will depend partly on the project’s aims and the methodological requirements (Armour et al., 2009).

Within IPA, rigour should be demonstrated through the use of theoretically-driven sampling, the adequacy of the sample size for offering insight into the targeted phenomenon, the commitment to idiographic depth in analysis, the completeness of the analysis, including both individual and cross-case consideration of themes, and the account produced of the research and its findings (Smith et al., 2009). Rigour involves a commitment to and a demonstration of general principles for qualitative research, which includes consideration of the epistemological and theoretical basis (and the limitations of said basis) of the research (Mays & Pope, 1995, 2000; Seale & Silverman, 1997).

Commitment is a wider concept which refers to the commitment of the researcher to the research, at both theoretical and practical levels. Commitment is demonstrable indirectly through the other criteria Yardley suggests, such as rigorous practice, transparency of process and coherence of the narrative presented (Smith et al., 2009).

Transparency and Coherence
Transparency relates to the research process and the presentation of the research product (Kuper et al., 2008; Yardley, 2000). The researcher needs to demonstrate transparency when reporting the research, presenting an audit trail of decisions and accounting for the development of findings through reflexivity and explicit analytic methods (Smith et al., 2009; Yardley, 2000). IPA presents
an explicit process for analysis, offering ways to conceptualise different levels of analysis and development of themes (Smith, 2004; Smith et al., 2009).

Coherence refers to the way the research is presented. Whilst contradictions and ambiguities are expected in qualitative research, as human experience is complex, the onus is on the researcher to present a coherent argument in research outputs. This coherence is both structural and theoretical, and should engage the reader in the perspective presented (Smith et al., 2009; Yardley, 2000). Whilst not prescriptive, the methods explicated in Smith and colleagues (2009) are grounded in the theoretical commitments to phenomenology, hermeneutics and idiography, which contributes to the coherence of the analysis. In terms of structural coherence, this requires skill and engagement on the part of the researcher with the practice of writing, which is an integral part of qualitative analysis (Byrne-Armstrong et al., 2001; Wolcott, 2003, 2009). The style of writing and the type of narrative presented should also cohere to the researcher’s political, theoretical and ethical commitments in the research, e.g., when working within a postmodern paradigm, the types of knowledge claims made and the use of language in research reports should reflect this paradigm (Richardson, 2000).

Impact and Importance

Yardley (2000) pinpoints three levels on which the impact and importance of qualitative research should be considered:

1. Theoretical: Does it contribute to our substantive understanding of the phenomenon?
2. Socio-cultural: Does it have a wider impact on the socio-cultural world of our research participants and ourselves? Do the findings have a political dimension?
3. Practical: Does it demonstrate practical relevance for those with professional investments in the phenomenon?

Yardley’s principle of impact and importance corresponds to Lincoln and Guba’s concept of authenticity within research (Lincoln & Guba, 2000). As qualitative researchers, we explicitly acknowledge that research has social, political and cultural implications, and takes place within a socio-historical setting. A commitment to authenticity seeks to assess the value of research given its
social, political and cultural context (Lincoln & Guba, 2000), and this commitment extends beyond the research setting to the ways in which the research is disseminated and transferred to real world settings.

These criteria are set out as guidelines for researchers to consider and incorporate into research design and practice given the context within which the research is conducted (Yardley, 2000). These criteria are not rigid or pre-determined, therefore embracing the strength of qualitative methods as flexible and creative (Barbour, 2001), and they interconnect with each other in meaningful ways which corresponds to the demanding, often “messy” nature of research design and process (Smart, 2009b; Yardley, 2000). Like the issues that qualitative researchers attempt to address, judgements about the quality and impact of research are complex and multi-layered, requiring a comparably complex, contextually sensitive approach (Smart, 2009b).

3.4.2 Reflexivity

The scientific observer is part and parcel of the setting, context and culture he or she is trying to understand and represent (Altheide & Johnson, 1994, p486)

This belief that the researcher is implicated in the research setting underpins most qualitative research. In quantitative psychological research, effort is expended to reduce researcher “bias”, an exercise which acknowledges that the researcher always has an impact on research, especially when it involves interaction between researcher and researched. In qualitative research, this influence is viewed in a different way, as a source of data and insight:

The challenge is not to eliminate ‘bias’ … but to use it as a focus for more intense insight (Frank, 1997, p89)

Reflexivity is the by-word for how researchers transform their unavoidable implication in the creation of data into useful theoretical and practical insights. Whilst it is a debated term, it can generally be understood as the process of engaging in “critical self-reflection” about the impact of the researcher, their background, their assumptions and their relationships with participants, on the research product (Finlay & Gough, 2003, pxi). It is “a way of working with subjectivity” in an explicit, accountable manner (Parker, 2004b, p25). Reflexively accounting for the researcher’s influence is a powerful way of
demonstrating sensitivity to context, transparency of process, commitment and rigour within a study (Yardley, 2000).

We are multi-positioned, implicated in unequally empowered ways of understanding and doing (Arber, 2000, p45)

Reflexivity has an ethical dimension in research which involves interactions between the researcher and the researched. As Arber (2000) argues, we are implicated in power relations with our research participants, and these power relations are not fixed, pre-determined or necessarily predictable (Bondi, 2003; Song & Parker, 1995). The power to position the researcher or the participant in a particular way does not only rest with the researcher, as several authors have commented (Arber, 2000; Bhavnani, 1990; Deverell, 1998; Oakley, 1981; Richards & Emslie, 2000; Rosenblatt, 1999). The participant is an active agent in the interaction, and identities and positions are negotiated through and within the relationships formed during research (Rose, 1997). Reflexivity can be used as a means to assess the relational nature of research, and the ways in which both the researcher and the participant are constructed in interaction. As Finlay explains:

The relational space between participant and researcher is the site of disclosure of the Other (Finlay, 2005, p287)

This type of reflexivity is called “inter-subjective”, as the ways in which the interaction creates the data, and both the researcher and the participant are disclosed through the interaction, are attended to by the researcher (Finlay, 2003). This reflection on the interaction coheres with the central commitment of IPA to hermeneutics (Finlay, 2005, 2008; Shaw, 2010; Smith, 2007; Smith et al., 2009). Hermeneutic reflexivity is a fundamental tool in conducting IPA research (Shaw, 2010). Reflexivity should be an ongoing process, through each stage of the research project, as the researchers’ perspectives shift in response to continued engagement with the research (Brocki & Wearden, 2006; Hunter, 2010; Shaw, 2010). As Martin and Sugerman (2001, p196) describe it, the researcher’s “horizon of intelligibility”, the way we understand each other, is changed through our engagements with others and the process of living.
There is an emotional aspect to this reflexive practice, as we respond to interviewees on an embodied level (Burns, 2003; Finlay, 2005). Kleinman and Copp (1993) reflected on the emotional work required by researchers when conducting fieldwork. When researching sensitive topics, the emotional burden of fieldwork can be substantial (e.g., Blee, 1998; Bourne, 1998; Rosenblatt, 1999; Smart, 2009b). However, Finlay and others would argue that emotional work is an important source of insight and a powerful way in which researchers can challenge preconceptions and assumptions about a topic or a situation (Finlay, 2005; Hoffman, 2007; Jaggar, 1989). Emotional responses and reactions to material are informative of underlying prejudices, and offer insights into the social and political contexts of research (Hunter, 2010). For instance, they can reveal assumptions of shared experience, drawing attention to the ways in which research may implicitly reinforce particular viewpoints (Hunter, 2010; Hurd & McIntyre, 1996; Mazzei, 2008).

Wilkinson’s (1988) descriptions of personal, functional and disciplinary reflexivities form a useful framework for considering the critical reflection that enhances our engagement with research. The personal side requires reflection on the researcher’s personal characteristics and background – those features which form the researcher’s horizon of intelligibility (Martin & Sugarman, 2001). Functional reflexivity refers to the responsibility of the researcher to consider the form and function of the research (Wilkinson, 1988). This corresponds to Yardley’s (2000) exhortation that researchers attend to context and consider the impact and importance of the research.

With regards to disciplinary reflexivity, especially in qualitative psychological research, there is a political and epistemic responsibility for researchers to consider the implications of the discipline within which research is conducted and situated (Wilkinson, 1988; Willig, 2008). As Henwood (2008) argues, reflexive practice is a powerful epistemic tool with an important political role of determining and challenging the boundaries of the marginalised. The types of research practice advocated, the ways in which researchers operating within certain disciplines frame research questions, have political and social implications for those we research.
The boundaries between different types of reflexivity are not strictly delineated. When reflexive practice is engaged with, it is unlikely that each type will be neatly bracketed and dealt with individually. In addition, the limitations of what any individual researcher can reflect upon and critique must be acknowledged: total reflexive awareness is unattainable (Rose, 1997). Reflexivity is not simply a self-conscious endeavour which researchers must engage in, a form of self-indulgent “navel-gazing” (Finlay, 2002b, p541). It is, first and foremost, a normal social practice in which people engage on an everyday basis. In the context of research, it is a useful tool due to what it can teach about the phenomenon of interest, the socio-cultural world in which the phenomenon occurs, and the relational way in which knowledge is constructed.

3.5 Summary
The questions of methodology, epistemology, ethics and praxis are interconnected. To answer the question of why a research study has been conducted in a particular way, or why a particular research question has been posed, requires a consideration of the personal, the political, the practical and the theoretical. In this chapter, I have outlined my commitment to the ideas that knowledge is constructed; psychology’s subject matter (human beings) is socio-historically situated; the research process is a microcosm of knowledge construction; and human beings, be they researchers or participants, are active meaning-making beings for whom interpretation, reflection, and change through interaction, are natural parts of life. These ideas have shaped each decision within the research process, and the explicit ways in which the research has been conducted in light of my “horizon of intelligibility”, as presented here, will be discussed in the following chapter.
CHAPTER 4: METHODS

4 Introduction
This chapter focuses on the methods used within this study. The design of the overall project will be described and the methods detailed. Each stage of the project will be discussed, including the setting, the recruitment process, data collection and analysis techniques, and the ethical issues identified.

4.1 Design
This study was a retrospective study, involving qualitative semi-structured interviews with people who have undergone psychosocial assessment following self-harm. Interviews were conducted as soon as possible after a psychosocial assessment took place, with follow-up interviews three months later. Potential participants were identified and screened for eligibility by a specialist self-harm service based at a local urban hospital. People were invited to take part by letter by this team, and an information sheet and short interview guide were included in the invitation pack.

The researcher could only contact participants if they responded to the invitation pack by returning a reply slip. Interview times and dates were arranged by telephone, or if a telephone number was not provided, by letter. The interview primarily focused on the experience of being assessed, but also touched upon the immediate circumstances before self-harm and attending hospital, and on outcomes of assessment. The interview guide is provided in appendix 3.

After the first interview, the researcher discussed the rationale for a follow-up interview with the participant. Participants signed a second consent form (see appendix 5) if they were happy to be contacted approximately three months later. The three month follow-up period was chosen to reflect repetition trends for self-harm as identified in the epidemiological literature (Gilbody et al., 1997; Kapur et al., 2006). This agreement to be contacted did not constitute consent to take part in the follow-up interview; consent was sought prior to the interview itself. This second contact focused on the intervening period of time, and on any positive or negative outcomes of hospital attendance experienced by the participants (see appendix 4). In the interests of maintaining a transparent
relationship with the participants, the follow-up interview guide was modified in light of the first interview, and it was stressed that the interviewee could introduce any topics they felt relevant to their experience.

The data gathered was retrospective: participants were asked about an experience which had occurred in the past. To counter-act the difficulties around retrospective inquiry, letters were sent to participants as soon as possible after the episode in hospital. As the interest was in garnering phenomenological detail, it was crucial that the first interview take place as soon as feasible to encourage rich meaningful reconstructions from the interviewees (Smith et al., 2009). There was no assumption that closeness to the event would encourage a more reliable or valid account from the participant. The swift recruitment was designed to capture a snapshot of the participant’s meaning-making around self-harm and seeking help from services, in order to enrich our understanding of the role of psychosocial assessment.

4.2 Setting
The setting was an urban teaching hospital in Manchester, one of three sites of data collection for MASH since 1997. At these sites, MASH forms are completed after the majority of psychosocial assessments (see appendix 2), and collected by MASH staff to be entered into a database of episodes of self-harm in Manchester. MASH also collects data on episodes which do not receive a psychosocial assessment, and uses a variety of methods to check that the relevant episodes are captured.

When designing this study, considerable debate went into the issue of recruitment. The hospital chosen was a large urban hospital, which had a diverse range of attendees, including at risk groups such as the homeless, asylum seekers and refugees. In the period between September 2003 and August 2007, the average number of patients seeking help at this hospital for self-harm was 1084 per year, or 90 people per month (Dickson et al., 2009; Murphy et al., 2007). It was felt that recruiting from this hospital over a period of six months would produce an adequate sample. In addition, sampling from one hospital created a more experientially homogeneous sample as each participant would experience the same hospital facilities and procedures upon attendance.
The service configuration for those who self-harm is a significant aspect of the setting. The hospital had a small specialist self-harm service consisting of psychiatric nurses, who were available during standard working hours to carry out assessments. This service was not available at the other hospitals involved in MASH, although it is recommended that all hospitals have a dedicated self-harm service for service planning and self-harm management (National Institute for Health and Clinical Excellence, 2004). According to service audits in England, it is common for hospitals to fall below the standards set by NICE (Hughes & Kosky, 2007; Kapur et al., 2008).

In addition to the specialist team, this hospital had a mental health liaison team of psychiatric nurses, available 7 days a week until 11 pm. This is a significant difference in service configuration when compared to the hospitals of Oxford and Leeds which monitored self-harm episodes. Both Oxford and Leeds had dedicated specialist self-harm services which comprised of psychiatric nurses and junior psychiatrists (in Leeds, this service included social workers). The hospitals in all three locations relied on junior psychiatrists to conduct assessments out of hours (Kapur et al., 2008).

The specialist self-harm service in Manchester had another role in addition to conducting assessments during office hours. The team were also instrumental in contacting those who left without assessment and fell in the hospital catchment area; offered home-based assessments to those who were not assessed, and up to four sessions of psychodynamic interpersonal therapy with a psychiatric nurse to suitable candidates. A small randomised intervention study of this therapy for self-harm patients found a significant reduction in suicidal thought and a reduction in reported repetition in those who received the therapy (Guthrie et al., 2001). Whilst the numbers receiving this treatment are low, it was a distinct possibility that some people contacted to take part would have experience of contact with or treatment from the specialist self-harm team (Murphy et al., 2010).

It should be noted that Manchester has relatively high rates of socioeconomic deprivation, and high rates of self-harm and suicide (Hawton et al., 2007).
hospital from which the sample was drawn encompassed a large catchment area, which included a mixed range of urban areas, both substantially deprived and relatively affluent. Owing to its centrality, it was also likely to gain a number of patients who did not nominally fall into its catchment area. The catchment area also included a large itinerant population of students, and several areas with established black and minority ethnic communities. These features are likely to have had an impact on the participants recruited and the themes generated through the study. The particular challenges the hospital faces in coping with such a diverse population will also create differences in the matrix of hospital services and priorities, and in the skill base and pressures on staff. These socio-demographic, geographical and structural issues influence the recommendations generated from this study.

4.3 Recruitment and participants

The recruitment method also generated substantial debate and consideration. The decision made had to reflect the ethical considerations of conducting research with a vulnerable group, as well as ensure the goals outlined in the research aims could be achieved.

The major consideration with regards to recruitment involved how to access participants. Within the UK, any study involving patients of the National Health Service (NHS) requires ethical approval from an NHS research ethics committee prior to commencement. It was felt to be important that a non-clinical researcher conducted this study, to encourage service user engagement with the project. Because of this, it was essential that links were formed with NHS clinicians who could act as gate-keepers to patient information. Whilst it is possible to receive ethical approval to directly access patient information, it was thought to be in the patients’ interests, from both a data protection and ethical point of view, to have the invitations sent by a clinical team with routine access to this information. This allowed the patients time and distance from the researcher to consider participation. As potential participants were known to have recently attended hospital for self-harm, it was likely that there were emotional stressors and difficulties in their lives which might make it difficult for them to take part in research. For this reason, only one letter was sent to each
eligible participant throughout the recruitment period, to reduce the likelihood of additional distress and feelings of coercion.

There were several options available in terms of potential gate-keepers. One possibility was to recruit through general practitioners (GPs) in the local area. This method would have been useful as a way to separate the research from the hospital setting, as those who had negative hospital experiences may be disinclined to respond to a letter sent from hospital. However, despite NICE (2004) recommending that GPs are informed when their patients attend hospital with self-harm, a recent audit has shown that poor communication rates between primary and secondary care are common (Cooper et al., 2008). In addition, it was felt that to achieve the required sample, this method might become labour intensive for the GPs.

A second possibility was to recruit via emergency department clinicians. This method would enable recruitment to occur close to the time of assessment, as the staff would have information about eligible participants immediately. This method also met the ethical concern around patient information remaining with clinical teams, as their service has access to this information routinely. In the end, this approach was rejected, as it was felt that involving the clinicians directly responsible for patient care might introduce a recruitment bias, as the clinicians may change their practice due to being conscious of the study, and they may screen potential participants to include those who have a particular viewpoint of services (Mauthner et al., 2002). In addition, it was possible that a letter sent from the emergency department may cause anxiety, especially if the experience of care had been negative.

Recruiting from the community was also considered, as it was possible that any contact from the hospital would limit participation. However, there were few existing community groups in Manchester which focused on the issue of self-harm. It was felt that adverts in local press and other locations would be an inefficient way to target those with the experience of interest, making purposive sampling extremely difficult to achieve. By targeting those who were known to have recently received an assessment, the recruitment strategy was focused and involved only those of interest to the study.
It was decided to stay with the hospital approach, and a suitable gate-keeper was found in a specialist self-harm service based at the hospital. This team were committed to the ethos of engaging self-harm patients in services, and had a keen interest in aiding research in this area. This team were further removed from direct care than emergency department clinicians, as their main remit involved assertive outreach to those who did not receive an assessment at hospital (Murphy et al., 2010).

A low response rate was expected, in light of similar research (e.g. Horrocks et al., 2005); the possible psychological characteristics of the patients; and the varied experiences of services previously reported in the literature. In Horrocks and colleagues’ (2005) qualitative study, which also sent letters to people who self-harmed via hospital, only 10% of those contacted took part. In an idiographic study with a small sampling frame, a low response rate is not an insurmountable difficulty. In fact, the smaller the sample generated, the greater idiographic depth possible in analysis (Smith et al., 2009). However, from the perspective of producing service recommendations, it is important to attend to the issue of variance, and key sample characteristics were recorded for this purpose.

4.3.1 Inclusion Criteria
The inclusion criteria for eligible participants were:

- Anyone over 18 years of age who attended the emergency department at the study hospital following an episode of self-harm and
- Who received a psychosocial assessment before discharge

The inclusion criteria were broad to reflect the ethical concern to give the opportunity to take part to a wide range of participants (Faulkner, 2004). There are a number of ways in which mental health patients can be foreclosed from research by gatekeepers and others involved in their care without being given the opportunity to consider information and decide for themselves, and it was felt strongly that people who self-harm should not automatically be deemed vulnerable or unstable on the basis of their behaviour or the perceived risk of repetition (Faulkner, 1998, 2004). As several survivors argue, self-harm can be
an important coping strategy which enables people to function in other aspects of their lives (Harrison, 1995; Pembroke, 1994). In addition, those with mental health difficulties have often been spoken for by those in the mental health field, and there is an ethical and social responsibility for researchers to contribute to the centring of service users in service evaluation and planning (Department of Health, 2000; Faulkner, 2004).

Owing to the diversity of the population who attend the study hospital (see Dickson et al., 2009; Murphy et al., 2007), it was stressed on the letter that any person who was not an English speaker and wished to know more about the study should contact the researcher. Interpreters could be arranged for instances when individuals did not speak English but wished to take part. Whilst the use of interpreters in qualitative research raises additional issues around representation, language and ethics, especially in such a text- and detail-oriented method as IPA (Raval & Smith, 2003; Smith et al., 2009), it was felt that the option should be provided as part of the study commitment to service user engagement.

4.3.2 Exclusion Criteria
The exclusion criteria for the study were as follows:

- People of no fixed abode who cannot be reached by letter
- People who did not receive a psychosocial assessment (e.g., those who do not wait for treatment)
- People who were not capable of fully informed consent
- People under the age of 18

People under 18 were excluded, as the service configuration for children and adolescents is considerably different to that of adults (see Royal College of Psychiatrists, 2004). In addition, a substantial number of studies have focused on self-harm in children and young adults (e.g., Dorer et al., 1999; Hawton & Harriss, 2008b; Hawton et al., 2002; Lloyd-Richardson et al., 2007; Wood et al., 2001). The experiences of adults who self-harm tends to be under-represented in the literature in comparison.
The services for those over 65 are also configured differently to those of adults, but it was felt that owing to high levels of suicidal intent often found in the elderly who self-harm (Dennis et al., 2007; Hawton & Harriss, 2006), this was an important group to offer the opportunity to take part. The issue of age, as a potentially important aspect of the lived experience of those who self-harm, was considered during the analysis of each case.

The specialist self-harm service acted as gatekeepers with respect to issues surrounding consent. They only sent out invitation letters to people that they perceived to be capable of informed consent from the hospital record of most recent attendance for self-harm. Each interview also began with a read-through of the information sheet and a discussion of it to ensure the participants understood the reasons for the interview, and their rights as an interviewee to withdraw at any time.

In instances where there was no record of psychosocial assessment being conducted, these people were excluded from the recruitment process. It is possible that the same people may have attended hospital more than once during the recruitment period and received an assessment at one attendance and not another. Service users were considered eligible if they had received a psychosocial assessment during the episode preceding the invitation letter, but all potential participants were only contacted once, regardless of total number of attendances.

The reason for excluding those with no fixed abode was one of practicality rather than choice. As recruitment was via letter, it was not possible to contact those who had no fixed address. This group are known to be at risk for self-harm and yet are a neglected population with respect to this issue (Cullum et al., 1995; Partis, 2003). However, it fell beyond the remit of this study to target this group.

4.4 Sampling
The sampling strategy was purposive, reflecting the aims of the research question (Robson, 1993) and the sampling practice of the methodological approach (Smith et al., 2009). As the focus was psychosocial assessment, all
participants needed to have experience of this process. In addition, sampling was purposively drawn from one hospital site, so that the experience of the hospital setting was more likely to be homogeneous. All those contacted for interview had received a psychosocial assessment from staff at the same hospital, so that service availability and practice would be comparable.

Within this sample, it was expected that the nature of this experience would differ according to a number of predictable and unpredictable variables. As this was an exploratory study into the nature of this experience, it was felt inappropriate to make judgements about which characteristics would influence the experience prior to data collection. For this reason, the sample was not homogenised in terms of age, gender, sexuality or ethnicity, variables which are often used to limit the variability within a sample in IPA studies (e.g., Alexander & Clare, 2004; Brocki & Wearden, 2006; Crouch & Wright, 2004). Following Smith and Osborn (2008), a pragmatic approach was adopted with regards to sampling.

Conducting intensive idiographic analyses on interviews is an involved process, which requires thorough transcription of the semantic content of the interview (Smith & Osborn, 2008), detailed reading and re-reading of the transcript (Smith et al., 1999), and extensive coding focused on experiential meaning (Smith et al., 2009). The entire analytic process can require a week to two weeks for one interview depending on the richness of the transcript, the particular focus of the analysis and the researcher’s stamina. With IPA, there is no assumption that what is produced at the close of the project is representative, or that it reveals a universal feature of an experience for a particular group. The aim is to gain an understanding of a person’s lived experience as the person sees it, via an interpretive engagement of the researcher with that person’s account. During the analytic process, the potential impact of demographic characteristics such as age, gender, sexuality and ethnicity were considered in light of the existing literature, on an idiographic and cross-case basis.
4.5 Data collection
Data collection was by semi-structured interviews which took place as soon as possible after the index episode of self-harm and assessment, with additional follow-up interviews three months later in a selection of cases.

4.5.1 Semi-structured Interviews
Semi-structured interviews are a common method of data collection in IPA studies (Brocki & Wearden, 2006; Smith et al., 2009). This format is intuitively understandable to respondents, in what is sometimes referred to as the modern “interview culture” (Fontana & Frey, 2000; Kvale, 1996). The interview offers the chance for the respondent and the researcher to interact, and to form a rapport which may encourage a more natural, conversation-like experience.

Owing to the sensitive nature of the topic, individual interviews with the participants were felt to be the most appropriate approach. Whilst there are arguments for focus groups as useful to facilitate disclosure (Smith, 2004), in this instance the emphasis was on the individual experience of assessment, and a focus group could have potentially clouded individual differences with the group dynamics influencing who speaks, and how people present their experiences. There is a danger of the research becoming dominated by a particular agenda in the group setting, as people’s views can become homogenised, or silenced (Memon & Bull, 1999). In addition, it is harder to maintain confidentiality in a setting where multiple people are present, which was an important ethical consideration.

Other methods of data collection, for example, diaries and memory work, would have offered interesting insights, but these are both labour intensive methods, requiring more commitment from participants than interviews (Willig, 2001). In addition, whilst using a diary method could be argued to allow participants freer expression of their inner experiences, it may be a less effective method over time due to usually high attrition rates on diary entries (Robson, 1993). A diary method would also impact upon the type of participant willing to take part, as it requires substantial commitment, literacy, and concentration. It is a less familiar form of communication, and one which may be uncomfortable or difficult for those less confident with writing. From an ethical point of view, it can also leave
the participant open to research-related distress without the researcher present to respond. With an interview, it is possible to respond to distress as it arises (see 4.6).

A structured interview was not thought suitable for exploratory research, as all of the questions and possible answers are pre-specified (Smith & Osborn, 2008). In addition, structured interviews reinforce the power of the researcher in the research setting and the participant has little control over the interview’s progress. This powerlessness has the potential to translate into several negative consequences, particularly if the subject matter is sensitive, and does not fit with the ethos to respect and hear the service user experience (Smith, 1995).

The flexibility of the semi-structured interview means that unexpected topics can arise in the interview (Lee, 1993). One benefit of using a semi-structured approach was that the participant can open up avenues of talk which provide unexpected insight. Further, the interview is guided by an overall goal and structure, which both participant and researcher are aware of. Following from Smith and Osborn (2008), the use of an interview guide allows the interviewer to hone their thoughts and protect against potential difficulties. By thinking through the wording and structure of the guide, the researcher engages with the topic at hand, the problems that could arise, and their preconceptions regarding what to expect. Without this preparation, the likelihood of badly phrasing a question or using loaded language is higher (Smith & Eatough, 2006; Smith & Osborn, 2008). This engagement is a means of demonstrating commitment and sensitivity (Yardley, 2000).

Owing to the sensitive and personal nature of the potential questions, the interview guide was sent to participants with the invitation letter explaining the study. This approach was chosen to enable the participants to have a greater sense of control over the situation, and hopefully as a result, less anxiety when considering taking part. In addition, this approach allowed the participants to make an informed decision about whether their experience was relevant to the study, and to reflect on what it would be like to take part prior to the interview. The aim was to treat participants as partners and experts within the interview.
situation (Kvale, 1996), and as co-creators of knowledge (Lowes & Prowse, 2001).

Kvale argued that:

An interview inquiry is a moral enterprise: the personal interaction in the interview affects the interviewee, and the knowledge produced by the interview affects our understanding of the human situation (Kvale, 1996, p109)

The researcher’s position within the interview context is important to address as it is likely to affect both the quality of the interaction and the quality of the data. Richards and Emslie (2000) discussed the implications of researcher characteristics on interviews: professional status, gender and age were all variables that impacted upon the interview experience. They argued that it is important for the researcher to be transparent about their position with the interviewee and with themselves in analysis, as the interview is always a social interaction as well as a data collection method. Cooper (1999), reflecting on the ethical issues in interviewing bereaved family members, acknowledged that her position as both mental health professional and researcher made an equal relationship with participants difficult to achieve. This awareness of the power differential between researcher and researched, especially when the topic is emotionally provocative, is essential to sensitive, ethical interviewing. The process of gaining consent, and giving the participant time to reflect and ask questions regarding the interview, are two ways in which transparency of process can be promoted (Cooper, 1999; Kvale, 1996). Another way of trying to equalise the relationship is by allowing the participant to choose the location of the interview. Whilst many participants feel more relaxed in their own homes, it is important to offer a choice, as not all homes will be safe or private environments.

An interview is a site of active meaning-making, as the interview data is co-constructed by participant and researcher (Hoffman, 2007; Kvale, 1996; Lowes & Prowse, 2001). The interview itself is thus a site of interest to the researcher, as it reveals important information about not only the phenomenon of interest, but also about the researcher, the participant, and the nature of social interaction between the two. Attending to these experiences is an essential
aspect of the analytic process (Finlay, 2002b, 2005, 2006), and so each interview was followed by reflection on the interview process to capture some of these dynamics. As a psychosocial assessment could be construed as a comparable process to an interview about assessment, the importance of this reflexive engagement was heightened owing to its potential to shed light on the phenomenon of interest.

4.5.2 Interview guide development

There were two strands to interview guide development. These strands were: a thorough literature review, alongside training on interviewing, and service user consultation with volunteers drawn from three settings.

The interview guide was developed in accordance to what was already known about the assessment experience. Certain aspects of the experience, such as the attitudes of staff, the timing of assessment and the setting for assessment, have been highlighted as factors which impact upon the experience for patients (Hawton & Catalan, 1987; Horrocks et al., 2005; Palmer et al., 2007; Pembroke, 1994; Taylor et al., 2009; Whitehead, 2002). These themes were incorporated into the interview guide as open-ended questions or prompts to encourage detailed accounts (Smith et al., 1999; Smith & Osborn, 2008). The guide was developed in accordance to advice in IPA books and workshops, starting with general open-ended questions to encourage rapport and allow the participant to take control of the interview direction, and prompts based on specific areas to stimulate the participant if they had difficulty answering questions (e.g. Eatough & Smith, 2008; Smith, 2008; Smith & Eatough, 2006, 2007; Smith et al., 2009; Smith et al., 1999; Smith & Osborn, 2008). Any leads opened up by the participant were followed where it was perceived to be important to the participant or relevant to the experience of assessment. The guide was designed to avoid asking directly about the person’s life history, as it was likely that participants may have experienced traumatic or distressing events which they may not wish to talk about. However, the initial question, usually “could you tell me a bit about what was going on in your life at the time you attended the emergency department?”, allowed the participant to bring up any aspects of their experience which they felt relevant to the hospital attendance, and this often led to discussion of the participants’ pasts.
A review of the issues around interviewing people about sensitive issues and people who might be considered vulnerable, was also conducted to guide interview development. It was especially important to consider the potential impact of an interview, as these participants were only recently in contact with services. Studies which had involved those who self-harmed or had severe mental illnesses found that participants often found it beneficial, therapeutic, and positive to talk about their experiences, especially when they had had difficulties talking to mental health professionals about the same issues (Alexander & Clare, 2004; Coggan et al., 1997; Faulkner & Layzell, 2000; Spandler, 1996; Taylor et al., 2010a). Faulkner, in her thoughtful exploration of the ethics of survivor research, stated:

> It is worth pointing out that people within mental health services rarely have the opportunity to speak for an hour about themselves or to tell their story, and this in itself can often be a positive experience (Faulkner, 2004, p8)

Faulkner (2004) also advised researchers to be aware that distress within an interview is not equivalent to causing harm to a participant. As Rosenblatt (1999) found in his research with grieving families, it was common for participants to cry or become distressed during interview but to want to continue, as the opportunity to talk was valued. In addition, Kennedy (2005) argued that caution is required to ensure that we are not stereotyping the individual or denying them a chance to express their views due to an assumption of vulnerability. We need to ask ourselves who we are protecting when we end an interview due to participant distress, and what message we are conveying to the participant when we close off an avenue of conversation due to their emotional responses (Kennedy, 2005). These issues were incorporated into the protocol developed for dealing with distress within the interview (see 4.6).

Once the first draft of an interview guide had been established, service users were involved in consultation. A pack was prepared containing the invitation letter, the participant information sheet, and the interview guides. Three sets of service users were invited to take part: the Community Mental Health Liaison Group in the University of Manchester, people attending a self-help self-harm
group I facilitate, and some personal acquaintances with experience of self-harm. In total, five people agreed to read over and comment on this information, three men and two women. An additional person agreed initially, but felt unable to contribute to the process at that time. The age range ran from early twenties to late fifties. Most of the five service users were Caucasian, and all of them British. These service users offered their perspective on the suitability of the questions, phrasing of the questions and information provided and on ways to be sensitive and approach distress (Faulkner, 2004).

The Community Mental Health Liaison group were the easiest to engage, as this consultation fell within the remit of their normal practice. A meeting was held with them, and the suggestions made from this meeting were incorporated into the research protocol. These suggestions were:

- Remove technical terms such as “NICE guidelines” and “psychosocial”. It was felt technical language may provoke anxiety and discourage participation
- Condense the information sheet, and emphasise the principles of confidentiality and anonymity. The information sheet at that time was thought to be verbose, which they felt may discourage people from reading it
- Emphasise and make clear that participation was voluntary
- Initially the invitation letter stated that hospital records were used to identify participants, but the service users felt this wording made the interview seem tied to treatment
- One participant thought it would be important to ask about how people got home - it was a significant issue in his experience of hospital services

An emphasis was placed on the idea of choice by both the Community Mental Health Liaison group, and by the acquaintance I contacted. It was pointed out that the person undergoing the assessment may feel too anxious to specify their needs, and so the onus lay with the staff member to enquire. The importance of the invitation letters arriving unmarked so as to protect confidentiality in the home was also raised. In addition, the possible impact of assessor characteristics on the process of assessment was also highlighted. Issues
around matching interviewer and interviewee characteristics are prevalent in both clinical and research practice, and consideration of the likely effects of assessor characteristics, and in turn, researcher characteristics, was incorporated into the analytic process through the use of reflexivity.

Contacting people through the voluntary group was difficult. There was a delay of several months owing to the disorganised state of the service: the previous facilitator had left so I stepped into the role. At that point, I had to build up attendance at the group with my co-facilitator and so could not ask people for their input. There was some resistance to the research within the organisation, due to a concern that as a student, I would not be reliable in the role of facilitator. After several months, I was granted permission by the organisation to ask service users whether they were interested in offering their advice. At this point, only one group member was able to comment on the research. Her viewpoint was positive on the whole, and she stressed the importance of staff attitudes from her experience at hospital.

On reflection, the issues raised by the service users were helpful in clarifying the information used in recruitment, and their concerns were similar to those raised in the literature. There were difficulties in gaining access through the voluntary sector, as the organisation approached felt a responsibility to evaluate the utility of the research, and the authenticity of my involvement. It was interesting that an organisation ostensibly set up to promote service user autonomy (through the principles of self-help and user-led groups) acted as gatekeepers in this way. All the service users who had input to the interview guide and information were remunerated modestly for their time, and each was offered a report of the findings.

4.5.3 Feedback and Transcript Review
Following each interview, participants were given feedback forms and stamped addressed envelopes so that they could reflect on the process of taking part and anonymously contribute their thoughts and feelings about the interview. They were asked to rank their levels of anxiety prior to and after the interview, and to respond to open questions about the experience of taking part (see appendix 6).
The purpose of the feedback forms was to assess the impact of interviewing on the participants and to allow the participants to contribute further in two ways. The first was by contributing to an ongoing evaluation of the conduct of research, with questions about the experience of being interviewed. The second was by offering an anonymous way to add any further information to the research that the participant might not have felt comfortable talking about in person.

Participants were also offered a copy of their interview transcripts and the opportunity to comment on the transcript. The purpose of offering the transcripts to the participants was not respondent validation, as IPA is explicit about the findings being interpretative, rather than an accurate representation of the participants’ experiences. It was instead a means of giving participants more control over their contribution to the research, and to aid the process of protecting the participant’s identity. It also acted as a way to maintain rapport and trust between the participant and researcher, as the process was made transparent for the participant.

4.6 Ethics
The main ethical issues identified were:
- Ensuring confidentiality and anonymity for the participants
- Ensuring consent is fully informed
- Safeguarding participants from emotional distress
- Maintaining the safety of the researcher in the field

The issues of privacy, anonymity and confidentiality were of utmost importance considering the sensitive nature of the topic. There are difficulties in guaranteeing confidentiality of information and anonymity of persons when in-depth qualitative data are gathered, and in particular, when verbatim quotes are employed throughout written reports.

To protect the participants, the data was handled in accordance to the principles outlined in the Data Protection Act (1998). All recordings were kept in a locked filing cabinet in the university office, and any information stored on computers
was kept on a password-protected secure internal network. Patient names and addresses were kept separately from transcripts and interview data, either physically locked away or on a secure network, so that one set of information could not be mapped onto the other. Upon transcription, names, places, dates and any other potentially identifying markers were taken out or changed, ensuring that there was no loss or change of substantive meaning. It was emphasised on the information sheets that verbatim quotes from the data-set would be used in writing reports. Throughout reports, participants were referred to using agreed markers, for example, “participant 1, male, 30s”, to protect their identities.

One ethical concern was that the sample was drawn from one hospital only, which may have increased the possibility of the participants being recognisable in the reports. It was felt that this hospital received enough attendances per year to render this possibility extremely small, and careful consideration was given to removing or altering potentially identifying aspects of the described hospital experiences, such as date or time of visit, detailed descriptions of staff, and references to distinct individuals.

To ensure informed consent, the information sheet was read through prior to the interview and also given to the participants to read prior to consent being taken. Questions were encouraged prior to taking consent, and it was stressed that the participant could withdraw at any time. With qualitative interviewing, the researcher needs to remain aware of ethical issues throughout, as ethical issues may change or emerge as a product of the interaction (Charmaz, 2008; Cutcliffe & Ramcharan, 2002). Cutcliffe and Ramcharan (2002) suggest that an “ethics-as-process” stance be taken, acknowledging the dynamic nature of the research. Consent is thus viewed as context-dependent, and involves a continuing negotiation throughout the research. By being aware of the embodied aspects of the research (Finlay, 2006), and attending to oneself, the interviewee and the relational dynamics which develop, emergent issues can be responded to as they arise (Charmaz, 2008). The participants were also shown the interview guide prior to interview, which allowed them to be well-informed about the nature of the questions and the type of interview that would be conducted. The intention with “ethics-as-process” was to periodically check that
participants were still happy with the process, and to respect their autonomy of decision.

There was a protocol in place to manage distress during interview. The boundaries of the research interview were clearly delineated on the information sheet (see appendix 3) and verbally prior to interview. In the event of distress, the first step was to endeavour to talk through the situation with the participant, and offer breaks or stop the interview if this was the source of the distress (Cowles, 1988). Additional advice was to be sought from the supervisory team if it was felt that a further response was required.

In the event of distress, the researcher would endeavour to stay with a participant until they felt better, or there was a participant-agreed plan of action. These eventualities were discussed with the participant prior to any interview, so that they were aware and in agreement with this process. Dependent on the level of distress, and the participant’s preferred contact, additional help would be sought from friends/family, GPs, key workers, or mental health professionals responsible for the care of the individual, in a tiered fashion. All participants were given time at the end of the interview to reflect on what the interview was like for them, and a list of useful contacts was left with them for future reference. The researcher contact details were also left with participants at the end of the interview, and participants had the opportunity to provide anonymous feedback.

The potential impact of the research on the researcher was also considered (e.g., Beale et al., 2004; Bourne, 1998; Hubbard et al., 2001; Johnson & Macleod Clarke, 2003; Kleinman & Copp, 1993; Smart, 2009a). There was a framework in place for support in the field and afterwards during analysis. Whilst in the field, there was an emergency contact number for one of the supervisory team at all times, and there were both regular and on-request debriefing contacts available. Physical safety issues were also taken into account, with an established lone working protocol for interviewing.

During transcription and analysis, supervisory support was made available at both regular intervals and on request. The emotional nature of this work did not end with data collection, and this was recognised and supported within the
supervisory team. Supervision and keeping a reflexive journal were used both as analytical tools and as emotional support (Hunter, 2010; see 4.8.2; appendices 9 and 10).

4.7 Qualitative Analysis

The interviews were transcribed by the researcher, focusing on semantic detail. IPA was the chosen analytic approach, as described by Smith and colleagues (Eatough & Smith, 2008; Smith, 2004, 2008; Smith & Eatough, 2006, 2007; Smith et al., 2009; Smith et al., 1999; Smith & Osborn, 2008). Whilst they emphasise that the proposed method of analysis is not prescriptive, it is a valuable tool in understanding how to analyse data as an interpretive researcher. The process they suggest is as follows:

1. Several readings of the transcript with initial notes on themes
2. Development of themes
3. Creation of higher order themes (which connect previous themes together)
4. Creation of a master list of themes, with quotations to illustrate
5. Creation of group themes across cases

Worked examples of each stage of analysis are provided in appendix 7.

First, several readings of the text are a means of immersing oneself in the interpretive process and the lived experience of the participant – this corresponds to Schleiermacher’s concept of entering into the hermeneutic circle, by getting a sense of the “whole” before addressing the “parts” (Schmidt, 2006; Smith, 2007). Initial notes focus on the researcher’s immediate impressions of the text, and act as a means of capturing the researcher’s fore-understandings (Smith, 2007). Smith, Flowers and Larkin (2009) expand on previous descriptions of this stage to include features which may be commented upon:

1. Descriptive – key words, phrases or explanations are highlighted
2. Linguistic – language use, including hesitations, repetitions, contradictions, metaphor, tone of speech
3. Conceptual – interpretive themes, reflecting the interplay between the participant’s expressions and your own experiential and professional knowledge and awareness

These initial notes can be used to explore an evolving sense of the participant which the parts, the detail of the transcript, reveal. The researcher is trying to pinpoint the important aspects of the experience through a careful consideration of the descriptive, linguistic and conceptual content of the transcript. The initial thoughts, feelings and reactions to the text on the part of the researcher can also be used to interrogate the ways in which meaning is created in the interview and analytic process.

After this stage, the researcher engages more fully in the interpretive process, by refining and interrogating those initial impressions into themes. The themes at first are more descriptive in nature, but as one develops the higher order themes, the process becomes more interpretative. My impression is that this engagement, and the move between description and interpretation, are highly context- and person-dependent, and this stage involves moving back and forth through the hermeneutic circle of participant and researcher (Smith, 2007).

For this stage, QSR International’s NVivo7 software was used to code each transcript for initial themes, with my initial notes and impressions recorded as annotations within each transcript (QSR International, 2006). I found it most productive in stimulating thought and reflection to use a combination of paper and computer methods when developing my analysis, which, although time-consuming, meant that I was challenging myself to look at the data in different ways. Smith, Flowers and Larkin (2009) strongly recommend that researchers use the paper method when first analysing, to develop an intuitive grasp of the process and the data, but they also acknowledge that each individual will have their preferred style. Many different methods are used within the literature: paper and pen methods, Microsoft Excel and Word, NVivo, Atlas.ti and MaxQda, and each method has both benefits and drawbacks (Smith et al., 2009). In keeping with the ethos of hermeneutics, transparency and awareness of the process by which interpretations are developed is encouraged over rigidity of method.
Once each transcript was coded in-depth using NVivo7 (QSR International, 2006), the third stage of analysis, the development of higher-order (otherwise called super-ordinate) themes, was engaged with. Smith, Flowers and Larkin (2009) delineate a number of processes by which initial themes could be developed into higher-order themes. These are:

1. Abstraction – grouping similar themes together under an overarching theme
2. Subsumption – using an existing theme to group together other themes
3. Polarization – examining themes for oppositional relationships
4. Contextualisation – grouping themes which occur at particular moments, or in particular contexts within the narrative of the participant
5. Numeration – examining the frequency of themes and what this might mean
6. Function – producing super-ordinate themes based on the function of a set of themes

These processes are not mutually exclusive; nor are these an exhaustive list of how this stage can be conducted. Smith and colleagues (2009) recommend that the researcher spends time over this process, and that the researcher sees the analysis as an iterative process (i.e. involving movement between stages, back and forth from text to interpretation). This in-depth involvement with the process should help the researcher elucidate the key super-ordinate themes for the individual.

In order to create higher-order, or super-ordinate, themes from initial themes, I produced individual participant coding reports using the reports function in NVivo7 (Bazeley, 2007; Lewins & Silver, 2007). These coding reports contained all the initial themes (codes) for that particular participant, along with portions of the text which the codes referred to. Reading through this report, and revisiting the transcript to clarify context, I examined the codes for meaningful relationships, using Smith and colleagues’ (2009) processes as guidelines.
In the fourth stage, the researcher returns to the transcripts, to check that the interpretation is grounded in the data. Quotations are usually accompanied by markers indicating their positions in the transcripts to ease the process of moving back and forth from theme to text. A master list was created for each participant, with examples from the text used to demonstrate the themes within the transcript.

After each transcript is individually analysed and a master list for each is created, the final stage in the IPA project is the group master list. This is developed through analysing the individual master lists and exploring the similarities and differences between the accounts in much the same way as is done to identify super-ordinate themes from initial themes in the third stage. However, this time the aim is to develop an over-arching understanding of the concepts and patterns which transcend the individual accounts. It is not necessary for these group themes to indicate agreement across individuals, as it may be that individuals have a markedly different experience of the same theme, and these differences can illuminate the deeper meaning behind the super-ordinate theme.

In summary, each individual transcript was analysed separately, developing lists of sub-themes and super-ordinate themes for each transcript. These formed the individual master-lists (see appendix 7 for an example of a partial individual master list). Sub-themes tended to be more descriptive, concrete themes derived from the specific instances recounted by participants. Super-ordinate themes were developed by evaluating and engaging with these sub-themes, attempting to distil the sub-themes into broader and more abstract categories. These super-ordinate themes on the individual master lists were exhaustive, with the aim of capturing the nuances of meaning and contradiction within the individual account. Once each transcript had its own master list, all the master lists were engaged with together, in order to develop the group super-ordinate and sub-themes (see appendix 7 for an example).

The creation of a group master list involves the same processes as the development of individual master lists (e.g., abstraction, subsumption, polarization and the like, as outlined in Smith, Flowers and Larkin’s book),
except that the aim at this point is to develop themes which have wider significance across participants, i.e. to relate the individual accounts to one another to derive the essential aspects of experience. Developing themes of wider significance tends to produce themes that relate to a substantial number of participants, rather than one or two, but the aim at all times during this type of analysis is to focus on the salience and importance of themes to the individual. Salience can be indicated by recurrence within an account, or across accounts, but this is not the only indicator of salience (other possible indicators could be the use of language or the emotion displayed by the participant during interview).

Super-ordinate themes tend to be at a further abstraction from the data than sub-themes, and therefore often capture meanings which relate to a number of the participants. Sub-themes typically capture both convergence and divergence within a super-ordinate theme, in that they offer more specific, varying ways in which a super-ordinate theme appears within and across accounts. It is possible for a sub-theme or a super-ordinate theme to derive from only one account, if that particular account is rich in detail and carries a salience and resonance that, whilst unrepresented in other accounts, is essential to the comprehension and expression of that individual’s experience. This is unlikely to occur in most IPA studies, as sampling is homogeneous around the experience of interest, and analysis takes place alongside recruitment, to allow for emergent themes to be explored and tested in further interviews. In addition, the focus of cross-case analysis is to create nuanced accounts of patterns of meanings, so that super-ordinate themes can speak of both the shared and divergent aspects of an experience across cases (Smith et al., 2009).

Analysis of the follow-up interviews required consideration of the temporal issues with respect to these accounts (Flowers, 2008; Smith et al., 2009). Initially, analysis followed the same process as outlined above: detailed reading and coding, and grouping themes into higher-order themes to create individual master lists. As the interviews focused on outcomes from assessment, several new themes emerged from analysis. When checking the interpretation was grounded in the data, comparisons were conducted across themes from first
and second interviews, as well as re-examining both transcripts. Where themes from the follow-up interviews added depth or understanding to initial themes, these were subsumed or transformed across master lists to reflect this. Where themes or details contradicted one another across interviews, these were carefully re-analysed to identify what this meant for the experience or the participant’s continual meaning-making across time. There was an expectation of change over time, as the participant’s perspective should change with new experiences, such as further follow-up from services. This change was not seen as problematic; it was seen to reflect and shed light upon the shifting nature of understanding over time. This dynamic process of meaning-making was considered and interrogated throughout analysis for its potential meaning for services.

4.8 Criteria for quality
Section 3.4 outlined the theoretical and practical basis for the quality criteria adopted within this study. In the next two sections, the practical application of these criteria in the context of the study will be described.

4.8.1 Application of Yardley’s Criteria
Table 4.1 on the following page provides a detailed description of how the current study attempted to demonstrate each of Yardley’s criteria for quality, as initially presented in Yardley (2000) and elaborated upon in the context of IPA by Smith and colleagues (2009).
Table 4.1: Demonstration of Quality Criteria

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
<th>Source</th>
<th>Demonstrated by</th>
</tr>
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<tbody>
<tr>
<td>Transferability</td>
<td>Demonstrate findings can transfer to different settings</td>
<td>Lincoln &amp; Dubin (2000)</td>
<td>- Use of thick description in write-up</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>- Idiographic attention to detail, theoretical transferability (Smith et al., 2009)</td>
</tr>
<tr>
<td>Commitment</td>
<td>Demonstrate commitment to research</td>
<td>Yardley (2000)</td>
<td>- Time and effort expended on research</td>
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<td></td>
<td></td>
<td></td>
<td>- Detailed, thorough analysis &amp; research practice (transparency and rigour)</td>
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<td></td>
<td></td>
<td>- Completion of project to a high standard</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Clear plan for dissemination of research</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Voluntary work to maintain contact with service users</td>
</tr>
<tr>
<td>Transparency</td>
<td>Demonstrate process of research clearly</td>
<td>Yardley (2000)</td>
<td>- Step-by-step explicit analytic process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Reflexivity as tool to attend to process of research &amp; impact of researcher on process and interpretations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Meeting standards of academic community in defense of work</td>
</tr>
<tr>
<td>Sensitivity to Context</td>
<td>Demonstrate awareness of the social, political, and theoretical context of research</td>
<td>Lincoln &amp; Dubin (2000); Yardley (2000)</td>
<td>- Reflexive practice to identify influence of context on research</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Idiographic focus attends to individual context</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Thorough and up-to-date literature review, including socio-political context (e.g. governmental policy; current practice)</td>
</tr>
<tr>
<td>Rigour</td>
<td>Demonstrate research has been conducted rigorously</td>
<td>Yardley (2000); Braun &amp; Clarke (2000)</td>
<td>- Reflexive practice during stages of analysis to account for decisions made</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Explicitly interpretive</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Grounding themes in the data</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Careful, detailed transcription</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Iteration throughout analysis</td>
</tr>
<tr>
<td>Coherence of Account</td>
<td>Demonstrate structural and theoretical cohesion in research accounts</td>
<td>Yardley (2000)</td>
<td>- Careful attention to the line between interpretation and description</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Reflexive practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Clear contextualisation of findings in light of current theory</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Concise, clear, unambiguous language</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Presentation of coherent argument linking aims, methods, findings and conclusions clearly</td>
</tr>
<tr>
<td>Impact &amp; Importance</td>
<td>Demonstrate wider relevance of research</td>
<td>Yardley (2000)</td>
<td>- Dissemination of findings</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Clear identification of relevance in discussion</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Clear demonstration of findings as novel and original, placing in light of current knowledge</td>
</tr>
</tbody>
</table>
4.8.2 Integrated Reflexivity

The main uses of reflexivity were:

- keeping a reflexive journal
- writing memos during analysis
- use of annotations during analysis

The reflexive journal was kept in several ways as the project evolved. Initially, thoughts and reflections were recorded after each interview using Microsoft Outlook. This automatically filed these accounts by date, and was done after each interview. Both data protection and lone worker policies ensured that the priority following interviews was to return to the university in order to store the audio-recording of the interview securely, and to store documentation such as consent forms in a separate location. At this point, I also took the opportunity to think about the issues that were raised in each interview, my immediate impressions of the participant, our interaction and rapport in interview (see table 4.2). It was also a valuable time to reflect on the interview conduct, and how the procedure, questions and manner in which they were conducted could be improved for future interviews.

Table 4.2: Extract from Reflexive Journal

<table>
<thead>
<tr>
<th>First Interview with Participant 6</th>
</tr>
</thead>
</table>
| … I thought the ppt was very articulate and very self-aware but that the account itself was quite harrowing. I felt at a loss as to how to respond to this. I felt reassured that the ppt didn't seem to need me to respond in any particular way, as they were in a safe place, and just wanted to help by sharing their experience, but even so, this was quite distressing to here, that they had been left in a waiting room all night with no comfort, not even a cup of tea, and imagining where people have to be to go to hospital, to seek help for suicidal urges, and yet to be left to wait, to be told there are no beds, there is no help other than the community help, when you feel you're a danger to yourself - to be asked "why haven't you killed yourself yet?" - it feels depressing just hearing about it.

But things emerge again like before - this idea of hospital of sanctuary, but the conflict between hope and reality - the lesser of two evils, I think sums it up, in possibly a slightly harsh way - you go to seek shelter, to get away from the pain outside, the possibility of worse - and you get sent home. That feeling, on the way home, after hours in A&E, I can just imagine it - when it's back to just being you and your problems, except so much worse now because you've been banished from where you felt safe |
The second time the reflexive journal was used was during transcription. The period of time when I typed up the interviews was time-consuming, often frustrating, but also stimulating. An hour of interview tended to take ten hours to transcribe fully. Listening to the recording and typing the transcript stimulated reflection on the issues arising in the interview; the participant’s story and the key features of it gleaned through talk and action; the conduct of the interview; and my reactions to the participant’s story. Pre-suppositions about these issues often emerged as they were challenged and changed by this work (Hunter, 2010; Smith, 2007; Smith et al., 2009). This work could also be emotionally challenging, as the closeness of listening to the recording gave a different encounter with the participant than the interview situation could. During interview, a researcher needs to balance between two positions: listening and being with the participant, and being outside the encounter to assess what issues still need to be addressed. Bondi (2003) describes this as balancing between observation and participation, whereas Smith (2007) would refer to this as the hermeneutic circle. I found that during transcription, the distance between myself and the participant lessened, and I became more engaged in the lived experience of the participant than possible during interview. This engagement was written up as Microsoft Outlook notes as well, so that there was a timeline of my thoughts and reflections from interviews through transcription.

Table 4.3: Extract from Transcription Memo

<table>
<thead>
<tr>
<th>Interview with Participant 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>On page 27, he said that when you're in hospital, you're powerless. I thought this was an interesting phrase - it indicates that the position of the patient can be very insecure in a mental health ward (elsewhere as well?) - this idea of powerlessness - where does it come from? Why would anyone feel that way? Is it common? I would suspect so, but what does it mean? Some of it ties into ideas about sectioning (I wonder if anyone's done work on the psychological impact of being sectioned), and people's fears that they can be kept in without their consent - but how common is this really? But he still felt powerless, like he had left his autonomy at the door by coming for help, and I wonder what this attitude says about services and getting help for suicidal thoughts and the like</td>
</tr>
</tbody>
</table>
Memos written during analysis tended to be more theoretical, identifying concepts which arose through analysis and making notes on themes and the reflections they stimulate (see tables 4.4 and 4.5). These memos were kept within NVivo7, along with an analysis journal, which recounted day-to-day tasks and progress. The annotation process is actually a stage of analysis as outlined by Smith and colleagues (2009), whereby initial notes and thoughts are recorded on the transcript. Using NVivo7 meant that these notes were stored as annotations, and could be looked at alongside the transcript whilst coding (Bazeley, 2007; Lewins & Silver, 2007).

Tables 4.4 & 4.5: Extracts from Analysis Memos

4.4: First Interview with Participant 10

**Chronic disability/illness**

On pages 19-20 of the tabulated transcript (lines 340-366 on here) he describes this visceral sense of lived experience - it might be useful to draw on some of the literature on what it's like to live with chronic illness - Smith's work with patients on dialysis might also be useful. That sense of not being whole, of being damaged - its impact on your sense of identity - and the gap it unleashes between you and others who don't know what it's like to live in that way, to have the shadow of ever-increasing infirmity hanging over you.

4.5: Second Interview with Participant 11

**Getting there**

I toyed around with this theme, but have included it. I think we severely underestimate the difficulty faced by those with depression/mental illness/self-harm/suicidal ideation in getting to the hospital - the practical, emotional, and experiential barriers to accessing care. For example, ppt 11 talks about how the doctor says she didn't take any tablets. To her, the very fact of going to the hospital speaks to her need to be seen. Why would she have gone through all that if she didn't need help? It is not a casual thing for her to attend. Participant 5 talks about how she could not have gone on her own, and participant 6 also talks of difficulty communicating, standing up for herself and getting the needed care at hospital. Maybe there is a theme around this idea of getting there? "Barriers to accessing care"

The ostensible purpose of these reflexive accounts was to aid my analysis and account for my positioning within the research. The act of writing down thoughts on an issue had the effect of shaping and transforming these thoughts, so that writing itself became an important aspect of the analytic process. The
ability to look back over time on my thoughts and feelings during the project also had personal implications, and encouraged deeper reflection on the project to develop over time (see appendix 10).

With the topic of self-harm, it was expected that the material would often be emotionally challenging and this was found to be the case. Reading around reflexivity helped me to process and place these emotional responses within the wider social setting and address the methodological implications of the personal (e.g. Burman & Chantler, 2004; Etherington, 2007; Finlay, 2006, 2008; Finlay & Gough, 2003; Hertz, 1997; Kleinman & Copp, 1993; Parker, 2004b; Richards & Emslie, 2000; Shaw, 2010; Wilkinson & Kitzinger, 1996). In particular, Parker’s expression that reflexivity is “a way of working with subjectivity” (2004b, p25) encapsulated the idea of reflexivity as a research tool, not an end in itself, which drove my consideration of it. My paper, Hunter (2010), discussed reflexivity as a means to engage with the theoretical demands of phenomenological research, and examined emotional responses during interviews as an initial analytic stage (see appendix 9).

Reflexivity, for me, was an integrated part of the research at each stage – from planning the research, through engaging with the literature (often, repeatedly, as the interviews challenged or deepened my understanding of previous work), through to considering ways to disseminate the research and to incorporate the lessons learnt from this process into future research and endeavours. One of the reasons I chose IPA as the methodological approach was because it placed reflexivity, and the process of reaching understanding through iterative engagement with the topic, the interviewees, and the impact upon and of the self, at the heart of knowledge creation.
CHAPTER 5: FINDINGS

Introducing the participants and their pathways to self-harm

“I can’t bring it into my own mind, why it’s all happened, why it could’ve happened at that time” (P12)

5 Introduction

The purpose of this chapter is to introduce the participants and enable the reader to place participants’ experiences of services (see chapters 6 and 7) into the context of their lives at the time of the index episode.

5.1 Recruitment

Recruitment lasted for nine months. Table 5.1 compares the number of people sent invitations with the number of respondents and interviewees. The sample of respondents and interviewees has a higher ratio of men to women than would be expected based on the hospital data. Almost 12% of those invited to take part replied expressing interest. Of these people, almost 57% took part in the first interview, meaning that the percentage of those invited to take part that completed the first interview was 6.6%.

Table 5.1: Recruitment

<table>
<thead>
<tr>
<th>Gender</th>
<th>No. individuals presenting to hospital site in one year (%)</th>
<th>No. individuals sent invite letter (%)</th>
<th>No. responding to invite (%)</th>
<th>Interviewees (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>1065 (41.4)</td>
<td>88 (44.4)</td>
<td>12 (52.2)</td>
<td>7 (53.8)</td>
</tr>
<tr>
<td>Female</td>
<td>1509 (58.6)</td>
<td>110 (55.6)</td>
<td>11 (47.8)</td>
<td>6 (46.2)</td>
</tr>
<tr>
<td>Total</td>
<td>2574</td>
<td>198</td>
<td>23</td>
<td>13</td>
</tr>
</tbody>
</table>

5.2 Participant characteristics

In total, thirteen participants completed the first interview, which focused on their most recent experience of being assessed following self-harm. On average, the first interview was completed 5 weeks after the assessment in question (range: 1 -11 weeks). Table 5.2 shows basic demographic information on each participant.
The age range was extensive, with four participants in their 20s, three participants in their 30s, one participant in his 40s, three in their 50s and the final two participants in their early 60s. Only one participant was not from Britain originally: participant 9 was an asylum seeker who had lived in the UK for several years and his account reflects this difference in status within the country (see further below). Most participants had lived in Britain all their lives, and it is likely that their concerns and difficulties in part will differ from those who have immigrated into the UK.

In comparison with the wider self-harming population in Manchester, as analysed by the MASH project (Dickson et al., 2011), the study sample had a higher proportion of men than expected (54%, compared with 41%). Likewise, the study sample had a higher proportion of people over 30 (9 out of 13, or 69%) than would be expected given rates of self-harm in Manchester in general. Typically, the highest rates of self-harm in Manchester are found in males and females, aged 15-19, with an age range of 9-93 (median age = 30). The trend towards older participants within the study sample may partly reflect the sampling strategy, which aimed for variation across age, and excluded children.

Table 5.2: Basic demographics

<table>
<thead>
<tr>
<th>Participant</th>
<th>Gender</th>
<th>Age</th>
<th>Marital Status</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Male</td>
<td>30s</td>
<td>Single</td>
<td>White British/Italian</td>
</tr>
<tr>
<td>P2</td>
<td>Male</td>
<td>30s</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>P3</td>
<td>Female</td>
<td>20s</td>
<td>Partner</td>
<td>White British</td>
</tr>
<tr>
<td>P4</td>
<td>Male</td>
<td>40s</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>P5</td>
<td>Female</td>
<td>20s</td>
<td>Partner</td>
<td>White British</td>
</tr>
<tr>
<td>P6</td>
<td>Female</td>
<td>30s</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>P7</td>
<td>Female</td>
<td>50s</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>P8</td>
<td>Male</td>
<td>50s</td>
<td>Married</td>
<td>White British</td>
</tr>
<tr>
<td>P9</td>
<td>Male</td>
<td>20s</td>
<td>Single</td>
<td>Palestinian</td>
</tr>
<tr>
<td>P10</td>
<td>Male</td>
<td>60s</td>
<td>Single</td>
<td>White British</td>
</tr>
<tr>
<td>P11</td>
<td>Female</td>
<td>60s</td>
<td>Widowed</td>
<td>White British</td>
</tr>
<tr>
<td>P12</td>
<td>Male</td>
<td>50s</td>
<td>Divorced</td>
<td>White British</td>
</tr>
<tr>
<td>P13</td>
<td>Female</td>
<td>20s</td>
<td>Partner</td>
<td>White British</td>
</tr>
</tbody>
</table>
and teenagers. In 2008 and 2009, self-harm in men aged 35 and older was seen to significantly increase in Manchester, which would coincide with data collection for the study.

69% of the Manchester self-harm cohort was single; 21% married or in relationships. The study sample reflects a similar trend, with 54% (7 out of 13) self-reporting as single and 31% (4 out of 13) self-reporting as partnered or married. 54% (7 out of 13) of the study sample also lived alone, which is a much higher percentage than expected compared to the Manchester cohort (20%). This may reflect the trend towards older participants, who tended to be alone, and report loneliness as a significant factor in their accounts. In addition, the exclusion of younger participants from the study may have had an impact, as younger participants are less likely to live alone.

With regards to ethnicity, the study sample is skewed, as it is mainly white British (92%, or 12 out of 13). In the Manchester cohort of 2008 and 2009, 86% were white, with 14% being from Black and Minority Ethnic groups (BME). Cooper and colleagues (Cooper et al., 2010) have found that BME patients are less likely to receive psychosocial assessment in comparison with white patients. This factor will have contributed to the skewed sample, as only patients who received a psychosocial assessment were invited to take part.

5.3 Characteristics of episodes
The interviewees were diverse in intent, method of harm and previous experience of services and self-harm (see table 5.3 below). Over half reported suicidal intent during the interview, although as interviews took place approximately a month after the event, this needs to be placed into the context of their full account (see 5.8 for discussion of suicidal intent within the participants' accounts).
Table 5.3: Characteristics of index episodes

<table>
<thead>
<tr>
<th>Participant</th>
<th>Method</th>
<th>Staff Seen</th>
<th>Previous Self-Harm</th>
<th>Previous Attendance</th>
<th>Self-Report Intent</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Cutting</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Flashbacks/Suicidal</td>
</tr>
<tr>
<td>P2</td>
<td>Overdose</td>
<td>Self-harm service &amp; psychiatrist</td>
<td>No</td>
<td>No</td>
<td>Accidental/ambiguous</td>
</tr>
<tr>
<td>P3</td>
<td>Cutting</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Drink/Overwhelm</td>
</tr>
<tr>
<td>P4</td>
<td>Cutting</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Suicidal</td>
</tr>
<tr>
<td>P5</td>
<td>Cutting</td>
<td>Psychiatric nurse</td>
<td>Yes</td>
<td>No</td>
<td>Relieve frustration</td>
</tr>
<tr>
<td>P6</td>
<td>Cutting; overdose</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Suicidal</td>
</tr>
<tr>
<td>P7</td>
<td>Scratches</td>
<td>Psychiatric nurse</td>
<td>Yes</td>
<td>Yes</td>
<td>Despair</td>
</tr>
<tr>
<td>P8</td>
<td>Overdose</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Suicidal</td>
</tr>
<tr>
<td>P9</td>
<td>Suicidal Ideation</td>
<td>Psychiatrist</td>
<td>No</td>
<td>No</td>
<td>Thoughts only</td>
</tr>
<tr>
<td>P10</td>
<td>Overdose</td>
<td>Psychiatric nurse</td>
<td>No</td>
<td>No</td>
<td>Suicidal</td>
</tr>
<tr>
<td>P11</td>
<td>Overdose</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>Yes</td>
<td>Ambiguous/unsure</td>
</tr>
<tr>
<td>P12</td>
<td>Cutting</td>
<td>Psychiatrist</td>
<td>No</td>
<td>No</td>
<td>Suicidal</td>
</tr>
<tr>
<td>P13</td>
<td>Overdose</td>
<td>Psychiatrist</td>
<td>Yes</td>
<td>No</td>
<td>Suicidal</td>
</tr>
</tbody>
</table>

Data from the MASH project indicates that 75% of episodes at the study hospital are self-poisoning episodes. Self-injury by cutting or piercing was the second most frequent method occurring in 21% of cases. In those interviewed, these two methods predominated: five participants overdosed, and five cut themselves (differing in both severity and intent). Another participant attended twice in a short period, alternating between these two methods.

Nine participants indicated that they had previously self-harmed, and seven had attended hospital with self-harm. The two participants, who had not sought help at hospital, stated that at the time they did not require medical attention. As
participant 5 said, this episode was “probably one of the worst ones I’ve done”, necessitating her seeking help at the emergency department. Of the three participants who self-harmed for the first time, two expressed definite suicidal intent. Participant 2, who had never self-harmed before, had previously attended hospital for accidental overdoses. During the interview, it became clear that the boundary between self-harm and accidental overdose were blurred for the participant:

It’s a bit of a fine line innit, saying do you self-harm or intentionally or unin-I know, I know cutting your wrists is intentionally, isn’t it? But I mean, going out and taking drugs is still like erm, I think it’s pretty intentional, isn’t it?

For this reason, his account is included here, as the participant’s struggle with the issue of intent is both relevant and informative for services, which are likely to see other patients engaged in this struggle.

In comparison with the Manchester self-harm cohort, the study sample had similar rates of previous self-harm (as self-reported): 64% in the Manchester cohort compared with 69% (or 9 out of 13) of the study sample. It is likely that the cohort figures are an under-estimate, as only 53% of cases included this information. Many of the participants had previously attended hospital for self-harm at some point in the past (54%, or 7 out of 13). Within a two-year period in Manchester, 33% of episodes count as repeat attendances – it is likely that the lifetime prevalence of repetition and re-attendance is higher. Meltzer and colleagues (Meltzer et al., 2002), in a UK-wide community survey, found that approximately 50% of people who had self-harmed or attempted suicide sought help afterwards, although only a third sought medical attention. The study sample is likely to be skewed towards those who seek help at hospital rather than elsewhere, as an artefact of the recruitment process.

5.4 Precipitants & Potential Risk Factors
The precipitants and potential risk factors identified in participants’ accounts are presented below to facilitate comparison with the existing literature on precipitating events and risk. Table 5.4 summarizes each participant’s key precipitating events and risk factors as might be considered during a psychosocial assessment. The MASH form, which is used in the study hospital
by staff conducting assessments, was the model for the categories included (see appendix 2). The table demonstrates the variation within the sample with regards to common precipitants and risk factors for self-harm and suicide.

The column “nature of the self-harm act” includes four characteristics of a self-harm act seen to be associated with greater suicidal intent. These are: attempt to avoid discovery, premeditation, writing a suicide note and wanting to die during the episode (Cooper et al., 2005; Harriss et al., 2005). In terms of premeditation, the event was only deemed premeditated if the participant had planned to carry out the act in advance. Here, participant 12’s suicide attempt counts as the only premeditated act as he bought a knife for the specific purpose of attempting suicide and chose a location in order to avoid discovery. The other participants, whilst they usually thought about self-harm for a time before action, used tablets already in the house or cut using what was available. Each characteristic is insufficient to determine suicidal intent alone or in combination, as determining suicidal intent is complicated by issues such as ambivalence, lack of knowledge of medical seriousness, and social desirability (Salter & Platt, 1990). They act instead as markers which suggest a greater probability of suicidal intent at the time.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Precipitants</th>
<th>Nature of self-harm act</th>
<th>Potential Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Direct response to mental symptoms</td>
<td>Wanted to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Male&lt;br&gt;Single&lt;br&gt;Supported housing&lt;br&gt;Registered sick&lt;br&gt;Previous self-harm&lt;br&gt;Current psychiatric treatment</td>
</tr>
<tr>
<td>P2</td>
<td>Relationship problems (ex-partner)&lt;br&gt;Drug/alcohol abuse</td>
<td>Ambivalence around intent, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Male&lt;br&gt;Single&lt;br&gt;Lives alone&lt;br&gt;Unemployed&lt;br&gt;Current alcohol/drug use&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P3</td>
<td>Depression&lt;br&gt;Alcohol abuse</td>
<td>Did not want to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Female&lt;br&gt;Unemployed&lt;br&gt;Current alcohol use&lt;br&gt;Previous self-harm&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P4</td>
<td>Bereavement&lt;br&gt;Physical health problem&lt;br&gt;Alcohol abuse&lt;br&gt;Depression&lt;br&gt;Other – loneliness</td>
<td>Wanted to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Male&lt;br&gt;Single&lt;br&gt;Lives alone&lt;br&gt;Registered sick&lt;br&gt;Current alcohol use&lt;br&gt;Previous self-harm&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P5</td>
<td>Employment/study problem&lt;br&gt;Depression</td>
<td>Did not want to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Female&lt;br&gt;Previous self-harm&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P6</td>
<td>Physical health problem&lt;br&gt;Depression</td>
<td>Wanted to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Female&lt;br&gt;Single&lt;br&gt;Lives alone&lt;br&gt;Previous self-harm&lt;br&gt;Current psychiatric treatment</td>
</tr>
<tr>
<td>Participant</td>
<td>Precipitants identifiable in account</td>
<td>Nature of self-harm act</td>
<td>Potential Risk Factors</td>
</tr>
<tr>
<td>-------------</td>
<td>------------------------------------</td>
<td>-------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>P7</td>
<td>Mental health problem</td>
<td>Did not want to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Female&lt;br&gt;Single&lt;br&gt;Supported housing&lt;br&gt;Registered sick&lt;br&gt;Previous self-harm&lt;br&gt;Current psychiatric treatment</td>
</tr>
<tr>
<td>P8</td>
<td>Legal problem (involved in legal case)&lt;br&gt;Alcohol abuse&lt;br&gt;Mental health problem (trauma)</td>
<td>Wanted to die, tried to avoid discovery, wrote suicide note, not premeditated</td>
<td>Male&lt;br&gt;Registered sick&lt;br&gt;Current alcohol use&lt;br&gt;Previous self-harm&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P9</td>
<td>Legal problem (asylum seeking)&lt;br&gt;Intimidation/racism&lt;br&gt;Housing problem&lt;br&gt;Depression</td>
<td>Wanted to die – no action taken</td>
<td>Male&lt;br&gt;Single&lt;br&gt;Lives alone&lt;br&gt;Unemployed (not allowed legally)&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P10</td>
<td>Bereavement&lt;br&gt;Physical health problem&lt;br&gt;Depression&lt;br&gt;Other - loneliness</td>
<td>Wanted to die, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Male&lt;br&gt;Single&lt;br&gt;Lives alone&lt;br&gt;Retired&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P11</td>
<td>Relationship problems (daughter)&lt;br&gt;Physical health problem&lt;br&gt;Depression&lt;br&gt;Other - loneliness</td>
<td>Ambivalence around intent, not premeditated, did not try to avoid discovery, no suicide note</td>
<td>Female&lt;br&gt;Widowed&lt;br&gt;Lives alone&lt;br&gt;Retired&lt;br&gt;Previous self-harm&lt;br&gt;Previous psychiatric treatment</td>
</tr>
<tr>
<td>P12</td>
<td>Legal problem (drink-driving)&lt;br&gt;Alcohol abuse&lt;br&gt;Financial problems</td>
<td>Wanted to die, premeditated, tried to avoid discovery, no suicide note</td>
<td>Male&lt;br&gt;Separated&lt;br&gt;Unemployed</td>
</tr>
<tr>
<td>P13</td>
<td>Relationship problem (boyfriend)&lt;br&gt;Relationship problem (family)</td>
<td>Wanted to die, not premeditated, did not try to avoid discovery, wrote suicide note</td>
<td>Female&lt;br&gt;Lives alone&lt;br&gt;Student&lt;br&gt;Previous self-harm&lt;br&gt;Current drug use</td>
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</tbody>
</table>
A range of precipitating events can be identified within the participants’ accounts, and these events were also temporally variable. For example, for participants 4 and 10, bereavement and loss were huge factors in their current mental states as identified by the participants themselves:

Imagine some of your closest friends, and then one year you lose a whole bunch of friends, it was a hugely difficult thing to cope with (P10)

So you sit and watch these programmes and you think am I a jinx on everybody? You know, while I’m here, everybody seems to be dying (P4)

The events the participants refer to were temporally distant – the deaths of participant 10’s friends occurred over a decade ago, and participant 4’s losses were likewise awhile before the index episode. These events were precipitants in the sense that rumination on them was present at the time of self-harm and they are mentioned as significant by the participants.

Other precipitants, such as the relationship difficulties of participants 11 and 13, were both chronic difficulties and acute triggers for the episode in question. Most participants had pre-existing mental health problems (typically depression or drugs and/or alcohol abuse), and a number also had chronic physical health difficulties which acted as triggers or contributing factors at the time of self-harm. Participant 9, as an asylum seeker with an indeterminate status, had a unique lived experience within the sample. Indeterminate asylum status is notable for its absence as an individual precipitant on the MASH form, although it could loosely be placed under the category of “legal problems”. This case highlights a limitation of the MASH form: its brevity, which aids its use as a clinical tool, necessitates a focus on commonly recognised precipitants that may exclude significant but uncommon precipitants such as asylum status.

A significant feature of the sample was that the majority of participants (85%, or 11 out of 13) identified multiple precipitants of their self-harm. This is higher than would be expected in comparison with the Manchester cohort (59% reported multiple precipitants). Over half of the study sample identified depression as a major factor in their self-harm, but only participants 3 and 5 saw it as an independent factor. Participants 4, 6, 9, 10 and 11 saw depression
as a condition arising from the circumstances of their lives, which included alcohol abuse and loneliness (P4), asylum seeking and racism (P9) and physical health problems (P6, P10, and P11). In comparison with the MASH data, depression rates seem high (54%, or 7 out of 13, compared with 33% in the Manchester cohort), but this may partly reflect the poor recording of diagnoses on the MASH forms (information was only available for 41% of the individuals who had received assessments).

The range of precipitants reflects those found in the wider Manchester population (Dickson et al., 2011), although relationship problems with partners are less often cited in the study sample, which may reflect the older age group, and the number who reported living alone (54%). Drug and/or alcohol abuse was common, with 38% (or 5 out of 13) reporting substance abuse. This is similar to the rates reported in the Manchester cohort (36% of individuals seen to be misusing substances at the time of presentation). These figures should be interpreted cautiously, as the MASH form presents an objective measure of misuse (7 or more units a day), and the study sample reflects the participant's subjective evaluation of use (see 5.6.1 for further discussion).

Whilst the numbers are too small to make a robust comparison, there was a general trend towards men in the study sample reporting legal problems, financial difficulties and alcohol/drug abuse, which is similar to the trend seen in recent Manchester cohort data (Dickson et al., 2011). Physical health problems were reported by 31% of the study sample (4 out of 13), which is higher than the rates seen in the Manchester cohort data (under 20%). This again may reflect the bias towards older participants in the study sample.

The rest of the chapter will focus on the narrative findings from the participants’ interviews.

5.5 Narrative Account of Precipitants
In order to enable the experience of services and psychosocial assessment to be understood in context, a narrative account of the precipitating events and experiences of the participants, as developed through the analysis, is presented. By looking at the psychological impact of events within the
participants’ lives, how these lead to self-harm or attempted suicide and the meanings around the episode itself, we can develop a nuanced and detailed understanding of the participants that will aid interpretation of their experience of services.

Two super-ordinate themes about the participants’ lives prior to self-harm emerged from cross-case analysis of the first interviews:

- Life as a struggle
- Life as less than

A final super-ordinate theme relating to the participants’ experiences of self-harm and attempted suicide also emerged:

- Meanings of self-harm and suicide

These three themes are discussed in more depth in the following pages.

5.6 Super-ordinate theme 1: “Life as a struggle”

All but one of the participants exemplified in some way the theme of life as a struggle. These struggles and difficulties are notable both because they are causal or contributory to the participant’s need to self-harm or desire to die, and because they are typically perceived to be insurmountable by the participant. Box 5.5 illustrates the sub-themes and the super-ordinate theme of “Life as a struggle”. “Life as a struggle” is an abstraction of the five sub-themes, as it captures the shared meaning of these disparate life events, relationships, and circumstances. That shared meaning is struggle and difficulty coping. Each sub-theme will be discussed in turn below.

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3 Master lists for each super-ordinate theme described in chapters 5, 6 and 7 can be found in appendix 8
4 Participant 7 was a notable exception due to the “thin” nature of the data gathered through interview. Participant 7 had particular mental health difficulties which impeded her ability and willingness to talk in any emotional depth, and her account is characterised by statements of facts, such as names and places, and a pervading anger about the use of restraint on a psychiatric ward. The former is discussed further in 8.5, whereas the latter is discussed in section 6.3
Box 5.5: Sub-themes of “Life as a Struggle”

<table>
<thead>
<tr>
<th>Super-ordinate theme</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life as a struggle</td>
<td>Struggle with addiction</td>
</tr>
<tr>
<td>Encompassing different circumstances &amp; life events which</td>
<td>Addiction as all-consuming,</td>
</tr>
<tr>
<td>create a sense of struggle &amp; difficulty coping for participants</td>
<td>psychologically &amp; socially</td>
</tr>
<tr>
<td></td>
<td>Struggle with loss &amp; loneliness</td>
</tr>
<tr>
<td></td>
<td>Difficulties coping due to loss, grief, social rejection</td>
</tr>
<tr>
<td></td>
<td>Struggle to cope with illness</td>
</tr>
<tr>
<td></td>
<td>Difficulty coping with mental and/or physical illness &amp; its effects</td>
</tr>
<tr>
<td></td>
<td>Overwhelmed – external pressures</td>
</tr>
<tr>
<td></td>
<td>Sense of pressure from external sources such as work, family</td>
</tr>
<tr>
<td></td>
<td>Conflicts with others</td>
</tr>
<tr>
<td></td>
<td>Conflicts with families, friends and others which create sense of burden</td>
</tr>
</tbody>
</table>

5.6.1 Sub-theme 1.1: “Struggle with addiction”

A sub-sample of participants had problems with alcohol and/or drug use. Only three of this sub-sample saw their addiction as something which they struggled against. For the remaining two participants, alcohol use was seen alternately as illness “alcoholism, alcohol dependency, they’re all illnesses [yeah], right, and they’re all legal illnesses” (P8), or as habit “I don’t get cravings for a pint, I just go cos it’s a daily habit” (P12). Participant 12 was notably resistant to the idea that his alcohol use was a problem: “I do drink a lot [yeah] but drinking never makes me feel at all like I’d kill myself”, and he did not see any link between depression and alcohol use in his circumstances. Participant 8 self-identified as “alcohol dependent” and the impression he gave was of alcohol use as a constant, to the point where there is no discernable time when he is not drinking: “I drink about 14, 15 pints of stella, a day, every day, seven days a week”.

For the remaining three participants, alcohol and drug use has played a significant negative role in their lives. Participant 10, a recovering drug addict,
described addiction as “the most godawful place to be, it is horrendous, drugs are just the most awful thing, they rip you apart, they destroy you”. For him, the struggle with addiction was rooted in a deeper struggle with himself:

I was the problem, and you can run anywhere, I could’ve run anywhere in the world, and I wouldn’t have solved the problem, because I didn’t start to tackle any of the deep issues that I had in my whole life.

His drug addiction started in response to a relationship breakdown and his inability to cope with the loneliness that followed: “I couldn’t bear the thought of going home to the empty house [yeah] so any, any distraction”, and it had the effect of separating him further from family, work and a normal life. Since undergoing detoxification treatment, his struggles with addiction have continued in a different form:

[In the local shop] a couple of alcoholic drug addicts who recognized me, [started asking] you couldn’t buy us a can of super lager, you know, and I just about fell through the floor (second interview)

This anecdote demonstrates one of the reasons for participant 10’s continued unhappiness and struggle. He went on to add “I don’t feel very safe”. As he still lived near places where people he took drugs with congregate, he felt under threat psychologically and physically from the potential presence of other drug users in his life. Their presence was a constant reminder of a lifestyle and choices he regretted, and a stigmatised identity which he wished to dissociate from (see 5.7.3).

For participants 2 and 4, alcohol was the biggest threat to their mental and physical well-being, as they continued to struggle daily with addiction. Both participants were fully aware of the negative impact addiction had on their lives:

Your life’s in jeopardy and you’re still doing it, it’s, well, it’s a version of insanity isn’t it? (P2)

[alcohol] don’t do me any good, it makes me worse so (P4)

For reasons that they struggled to understand, both kept returning to alcohol after detoxification treatment, and it was the cycle of relapse that had the biggest impact on them. For participant 2, his sense of hopelessness and powerlessness over his actions, “It’s pretty depressing, kind of no-win situation
for me”, even when he knows it might kill him, left him struggling to believe that anyone could help him:

If you keep going out and doing the same thing, they can only do so much… they can’t like strap you down to a bed and not be, go out in the world

He knew that it was up to him to change, but it was increasingly difficult for him to maintain hope in the face of relapse. Likewise, with participant 4, the experience of relapse was a blow to his self-esteem, leading him to punish himself by self-harming:

I’d been through a detox programme and then I’d gone back onto it, you see, and I hated myself for doing it really

5.6.2 Sub-theme 1.2: “Struggle with loss and loneliness”

For three of the older participants, loneliness was a particular difficulty they faced, and they identified loneliness and social isolation as significant precipitants for their recent overdoses. As touched on in 5.6.1, participant 10 had turned to drugs after a relationships breakdown, because he struggled with the loss:

He announced he was leaving me and I was absolutely crushed, I don’t know whether I even grieved properly, and that was the onset of quite serious depression

For participant 10, this pivotal moment was the beginning of his spiral downwards into depression and drug use, which eventually led him to Manchester (“I thought I might meet somebody else”). Along with other losses in his life, such as the deaths of close friends and the estrangement of his family, he expressed a tremendous amount of grief and loneliness:

It's too hard out there, erm, the reality of what's happening, because I feel lonely and isolated, it's almost like an envy thing, I feel like somebody pressing their nose against a window looking at other people’s joys

This sense of being on the outside looking in made it harder for him to motivate himself to try to engage with other people, which he referred to as a “Catch-22”:

I remember one day I went to bed, and I slept, I stayed in bed all day, I woke up and I thought… I don’t want to get up, what is there to get up for? And I just felt so desperate
He realized that he might feel better if his social isolation was reduced, but he found it difficult to maintain any hope in a change, given the combined problems of his mental and physical ill-health. At one point during our second meeting, he bleakly joked “I must put [a personal] ad in, in the paper you know, must be able to use a hoist, change a nappy (laughs)”. He saw society as a whole becoming increasingly disinterested in him, as he aged and became trapped by his disability, and the contrast between the past (“I had that incredible lifestyle” “I’ve had a good life, a full life”) and his life now led him to conclude that his life was no longer worth living: “this is hell on earth, this is just a living hell”.

Participant 4 expressed similar levels of loneliness and isolation. He summarised his life as follows:

It's basically sitting here and looking at four walls on my own

He recounted a suicide attempt which occurred soon after the index episode that led to his involvement in this study but prior to our meeting (he called it “the classic, overdose with pills”). This attempt was motivated by a TV episode which resonated with his experiences of family bereavement. He stated:

I think to myself, when I was watching that, I thought to myself, I might as well go and join my gran and my auntie, that's what stupidity goes through your brain

Whilst he expressed regret afterwards, his intention at the time was to die and “join” his family. These bereavements and his fear that he will lose the remaining members of his family brought his isolation into sharp relief: “if they die, I’m basically on my own now”.

I’m just contented in one way, the way I am, but in another way I’m so damn lonely (P11)

Participant 11 was ambivalent about the issue of loneliness. During our second meeting, she stated “you just get real real lonely [yeah] and you can’t go any further down so you just want to go away”, but when she talked previously about having someone in her life, she was adamant: “I just don’t want anybody in my house, I want this to be mine”. This reluctance to let people into her home may partly follow from her two negative experiences of marriage:
There’s always been somebody else there [yeah] you do this, you do that, like, both my husbands, one husband, oh kick you to the death, the other husband, just to be left on his own, he’d say here’s £100, go see your children

She was wary about staying in hospital, and she absconded on the first night of her admission. When asked why she left, she admitted:

I get settled, as though it’s my home [yeah] and it’s I don’t like it, I don’t like the idea of that because this is my home, not an hospital … When I had [physical health difficulties] I was contented there, I didn’t want to come home, I didn’t want to come home to an empty house

To protect herself from the pain of returning home to a lonely life, she tried to avoid any sort of attachment: “keep myself to myself”.

Participant 9, an asylum seeker, had suffered losses on a different scale to the other participants. For him, leaving his country had cost him everything he had:

I lost my wife, my family, left my country, lost everything [yeah] so very hard, can’t really for you, how much it’s hard, like I’m blind [uhuh] I don’t understand, like children

Since entering the UK, he had struggled with the difficulties of learning an unknown language, pleading his case for the Home Office and any organisation that might help him, and living on the barest allowance from the government, whilst feeling alone and forever separated from everything he knew. However, the greatest impact on his psychological state was the gradual erosion of his identity as a human being as he saw the possibility of change or a future rendered distant and “indeterminate” like his status in the country:

When I can have life, when I can start, can’t start, have to start for nothing? When I can have money to pay for my own house, own car, have my wife, my children? [yeah] when I can have all these things?

All the things he valued as part of being human had been stripped away from him by a system that did not allow him to work, to choose his home, or to plan for the future. He disengaged from a potential relationship because “I have no life to stay with them forever”. He had essentially been separated by his indeterminate status from everyone else, and saw himself as only existing: “this (is) not life, absolutely that’s not life”. What he had lost, and the loss he struggled with the most, was the possibility of a future like anyone else.
5.6.3 Sub-theme 1.3: “Struggle to cope with illness”

The impact of physical and mental illness on one’s ability to cope was a significant theme for three participants. For participant 1, who experienced voice-hearing and visual disturbances (at the time of interview, his diagnosis was under dispute within his care team), what led him to seek help was the struggle to cope with these symptoms:

I can’t handle it anymore, I just can’t handle it, you know what I mean can’t handle

He explained his suicidality as follows: “when I get suicidal and am having flashbacks, it’s just my flashbacks, I can’t, I can’t do [you can’t do?] erm, I can’t, I can’t get rid of them”. For him, the struggle to cope with frightening and overwhelming mental disturbances led him to thoughts of suicide.

Likewise, for participant 6, her suicidality was tied to her struggle with illness, although in her case it was both physical and mental illness. She described the circumstances that led her to attend hospital with self-harm:

I had a very severe attack of one of my disabilities, my [physical illness] [right] and I was very very very ill, unable to work, unable to get out of the house, unable to do anything, and I had to get carers in, it was a really bad attack and erm, around this time I just got completely hopeless that I was ever going to get better again

This debilitating attack caused a sudden drop in her mood which led to suicidal thoughts and feelings before she could access her normal pathways of care: “I’d normally identify the signs, go to my psychiatrist, and there wouldn’t necessarily be much of a problem”. The sudden and unexpected nature of the attack made it impossible for her to cope with in her usual way, leaving her desperate and in need of emergency help.

Both participants 6 and 10 suffered from depression and a debilitating illness, and it was difficult to pry the two apart. As participant 10 acknowledged:

It’s that kind of thing that’s you know, I see myself here for example, wanted a cup of tea and it’s been an hour later when I’ve managed to get myself off of the sofa [ok] to go into the kitchen, but that could be partly the depression as well [yeah], that could be a dual thing, you know how when you’re depressed, everything’s an effort
The physical consequences of illness made everyday activities a struggle, but the depression compounded the situation, making it even harder to motivate oneself. For participant 10, an additional aspect of the struggle was his awareness that his physical difficulties were only going to worsen over time, and he was frightened of the suffering he faced. The prospect of future dependency terrified him, especially given his isolation:

I am a single gay man, so I’ve no no family [yeah], erm, I actually thought in that situation, I fear for my future, I fear that when I get sick, if I get sick, and I will get sick, and these liver problems turn to cancer perhaps, and what’s it going to be like? And I’m scared, I’m frightened, and I just want to get off the bus before that happens

5.6.4 Sub-theme 1.4: “Overwhelmed – external pressures”
A theme that emerged from half of the accounts was being overwhelmed by external events. These events included work pressures, money worries and family pressures, and were perceived in some way to be out of their control. For instance, for participant 5, the central difficulty she faced at the time of self-harming was her work situation. She felt under pressure and unsupported by her boss, who had not responded to her pleas for change. Within her family, she stated it was always “work, work, work”, and she felt unable to take time off or leave the position:

I wouldn’t even have thought of taking time off work [yeah] you know, I would’ve just thought of coping with it, and having to cope with it, and there’d be no choice

She felt that her frustration with work and with other aspects of her life were “just building up and building up” to the point where it became overwhelming and led to self-harm.

Likewise for participant 12, there was a tipping point where everything seemed to come to a head all at once:

I just felt as though everything in the world was letting me down, why was this happening to me, sort of thing, you know [yeah], it’s bad and it’s a struggle waiting a fortnight to get some money [yeah] and then at the end of the fortnight when you get it you haven’t got it [yeah] and it just, you know, I just didn’t know what to do

The event which tipped him into this state of uncertainty and despair was beyond his control: he lost the money he had withdrawn for his fortnightly job.
seeker’s allowance, and as he puts it, the crisis “destroyed my confidence in myself”. In the context of recent life events (being imprisoned for drink driving and losing his job), this one incident seemed to overwhelm him and left him thinking about suicide:

I’m normally quite a jovial person, and everything, I just, I just cope, and just everything, everything just seemed to get on top of me that day, I don’t know what it was, I really can’t explain what brought it on

Some participants were less willing or able to describe in detail the events that led to their self-harm, but used terms such as “pressure” (P8) or “things just get on top of me” (P3), which suggested that they had been similarly overwhelmed by something in their lives.

5.6.5 Sub-theme 1.5: “Conflicts with others”

Some participants explicitly linked their current mental states to interpersonal conflicts and their relationships with others. Participant 11 recounted an argument with her daughter hours before her overdose:

I was lay there, I was thinking about what [younger daughter] had said and she hadn’t whispered it, she’d shouted it… she was shouting when she was telling me about her father, and I felt ashamed for him, and ashamed for myself that I didn’t know

Her relationship with her youngest daughter was characterised by conflict, mainly around the topic of her father. Years previously, participant 11 had split up from her husband, who had frequently beat her and taken her money. She mentioned something from the past that she “never knew”, which was the root of her daughter’s anger and caused the participant distress and feelings of shame, but she was reluctant to talk further on the topic, saying “I think we had a couple of words, I don’t rightly know, because when I came out of the hospital, she said mam, we had a difference of opinion, she said we didn’t argue”. What was clear from her account was her struggle to come to terms with her daughter’s anger and accusations.

Participant 13 described incidents of bullying or intimidating behaviour extending over a period of time. At the time of the overdose, she stated that: “I was focusing a lot on signs of erm rejection from friends and people that I cared about, and signs that they erm, didn’t really care about me and who I was.” She
described her life as “a repeat of rejection” and experienced difficulty trusting people because “I never really know where I am with people”. She had an argument with her boyfriend just before the overdose, which seemed to stem from her feelings of rejection and her sensitivity to rejection at the time. She described needing him to show that he cared, to prove that she was important to him, and felt let down when he was emotionally inexpressive. Whilst she recognised that he “obviously did have deep emotions”, his inability or unwillingness to express them fed into her insecurity and her rumination on signs of rejection from others.

Racist attacks were a regular part of participant 9’s life as an asylum seeker in the UK. In the area he lived in, he had recently been attacked by teenagers on several occasions, and when he took his concern to the police, it seemed that they were unable or unwilling to help:

They told me, we can’t, why have you got a problem, problem in this area? [yeah] I told them I got about 8 fights with racist people in this area [right] also the police has come here, and I told them [yeah] what I have qualification, what I have problem with the teenagers, and if the police told me, we can’t sort out the problem with teenagers

This conflict, which seemed beyond his control to resolve, increased his sense of feeling trapped in his situation. The absurdity of the police’s advice to call them when something happens was met with derision that expressed his sense of futility:

P9: They told me, yeah, teenagers are everywhere [yeah] the main thing, we can’t help you, when you have fighting with them, ring us
I: Yeah
P9: Ho, it’s stupid, for somebody punch me, and hold on one second, call the police, and carry on [yeah] does not work [yeah] they don’t wait, alright, hold the fight, tell them why, be one minute, two minutes, then they’re finished

All three participants experienced conflicts within their lives that had a negative impact on their mental states. Participant 11 felt guilt and shame after arguments with her daughter and this increased her sense of her own worthlessness. Participant 13, having experienced repeated bullying behaviour, was hyper-sensitive to rejection and looked to others to bolster her self-esteem: “I find myself always subconsciously looking to people around me, to erm, you know, assess erm, how much you’re really worth”. This interpersonal
dilemma, of seeking validation and expecting rejection, frustrated the participant, who wanted to learn how to “stand straight for myself to erm know how, to know how good I am, and then to, generally just to be able to value myself”. The additional stressor in participant 9’s life of violent racist attacks outside his accommodation added to his feelings of helplessness, as he was unable to effect change in his circumstances.

5.6.6 Summary
Most participants identified more than one precipitant for the index episode which led to their hospital visit. This suggests that this sample of participants reflects the general view of self-harm as a “multifarious event” (Appleby, 2004; Leenaars, 2002), which can be reached by more than one pathway. It also reflects the complexity of working with this patient group – patients are likely to present with multiple problems and needs –both psychological and social in nature.

This theme has discussed the various ways in which participants struggle in their lives. “Struggle” both implies difficulty coping and the need for help. In various ways, participants demonstrated problems coping with addiction, illness, relationships, loss and social isolation. In some cases, problems in one area (e.g., addiction) led to the difficulties in another (e.g., isolation). This interactivity can indicate a hierarchy of need, but also highlights the importance of a holistic understanding of the individual’s lived experience.

5.7 Super-ordinate theme 2: “Life as less than”
There were multiple ways in which the circumstances of their lives and their encounters with others served to devalue the participants and leave them feeling somehow “less than”. In addition, negative self-appraisals were brought into their encounters and were sometimes reinforced by their experiences. Three sub-themes below demonstrate different layers of this experience of being devalued and invalidated by life experiences, others, and one’s feelings towards oneself (see also, box 5.6). These are:

- Powerlessness
- Self-hatred and low self-esteem
- Stigmatised identities
5.7.1 Sub-theme 2.1: “Powerlessness”

Feelings of powerlessness over one’s circumstances were common amongst the participants’ accounts. Conditions which impact or were perceived to impact on the person’s ability to change their circumstances, such as disabling illness, addiction and asylum seeking, led to feelings of powerlessness and hopelessness. The participants felt “less than” because they were less able to help themselves and less able to affect change in their lives even with the help of others. They could also feel “less than” because they failed to meet a (real or imagined) external standard or internally set goal for their involvement in the recovery process or in life changes.

For those struggling with addiction, the cycle of recovery and relapse was a dominating influence on their perception of self-control:

Without the help, I probably would have carried on doing that and wasting away basically (P4)

I do feel powerless, you know, I feel powerless where I’m going to end up (P2)

For participant 5, who had a history of self-harm, repetition was construed as failure:

I didn’t want to talk about it either, because I’d been through it, and I’d kind of came out of it, and everyone was dead happy and so I didn’t want to tell anyone that [Yeah] you know, that I’d fallen back into it
Participants often directly expressed a sense of powerlessness over their actions: “I can’t have control over it, because I’ve been warned, I’ve been told, but I still go back to it” (P2); “when I’m doing it, I have absolutely no control over it whatsoever” (P5). These feelings of powerlessness over one’s actions, made it extremely difficult for them to maintain hope for the future or, in participant 2’s case, to see the benefit of engaging in assessment or therapy:

I’ve had chats before and it’s, it’s not done me, you know, I’ve done, I’ve gone back to the same thing, so I was thinking is it worth it, do you know what I mean, is it worth this chat again?

For participants 2 and 5, their sense of powerlessness was over themselves and their actions - they both felt strongly that their actions reflected a weakness in them, an inability to control themselves. Both placed the blame for their actions and the responsibility to change on their own shoulders:

I didn’t need to do that, you know, there could have been something else I could have done (P5)

P2: The answer lies within me
I: The answer lies within you?
P2: Yeah, do you know what I mean, the answer, I know, I kind of know what the answer is, but erm, why do I keep doing it you know like

This attitude of self-blame and adoption of responsibility may in part reflect their beliefs about self-harm and addiction. Any episode of self-harm or addiction necessitated a judgement about their competency and their ability to master their own lives, which can serve to reinforce low self-worth (see 5.7.2) and hopelessness (see 5.8.5).

Interestingly, participant 2 never referred to alcoholism as an illness, an interpretation which can remove blame from the participant for their actions. Participant 5 recounted that she found it difficult to accept that she had a valid claim to help from the mental health team, and the relief she expressed when the psychiatric nurse told her “genuinely, you are ill” may be in part due to the same principle (in that it relieves her of the blame for her self-harm).

For some of the other participants, feelings of powerlessness arose from the structural or material reality of their lives. Three participants struggled with
debilitating physical illnesses, which took over their lives and impacted on their sense of self and self-control. A consequence of having a chronic illness identified by the participants was a sense of powerlessness over one’s life. A stimulus for the episode of self-harm which led to participant 6 seeking help was a sudden bout of illness that left her “unable to work, unable to get out of the house, unable to do anything”. Her ability to cope with and manage her illness and her depression on a day-to-day basis was important to participant 6:

Your control, mental control over both illnesses erm, is what kind of holds them in check, you need a very positive attitude to be able to fight the fatigue and pain of [illness] day by day (second interview)

When this control was taken away from her by her worsened condition, she plummeted into a state of hopelessness:

I just got completely hopeless that I was ever going to get better again, and everything just kind of came crashing in, and I felt like I was just never going to get out of it [right] and that there just wasn’t any point in going on anymore

Being at the mercy of the vagaries of illness was a deeply unsettling state, and its impact on her mental health was acknowledged by participant 6 in our second meeting: “if my pain and my [illness] are very bad, I’m very tired, I’m in a lot of pain, I tend to get depressed as well” (second interview). Likewise, she acknowledged the impact of her depression on her ability to cope: “you control chronic pain and constant pain with mental control… once that starts to go because you’re depressed, everything gets worse” (second interview).

Both participants 10 and 11 stated that there was no chance their health could be improved:

I’m going to get progressively worse, progressively worse and progressively weaker… nothing’s going to change (P10, second interview)

All the talk in the world can’t help it, all the tablets in the world will never stop it (P11, second interview)

Participant 10, suffering from more than one chronic illness, worried that eventually he will be dependent on hospitals for his care, and he feared maltreatment: “you’re in the hospital, and you’re totally powerless when you’re in there, you know [right] you’ve got no voice at all”. He wanted “to get off the
bus before that happens", meaning end his life, whilst he still had enough control over it to make that decision:

[My friend] said to me, clearly you’ve spoken to [another person] about going to Switzerland [the euthanasia clinic], if you have the money and you have the choice, and you were given the opportunity, would you go? And my answer would be yes, I would go, and I hope that’s not going to put me, you know (laugh) back into the psychiatric unit, but I, I don’t see a light at the end of the tunnel, I don’t, I don’t

In his second interview, participant 10 spoke of rejecting the offer of home help from social services following his overdose, despite his self-acknowledged struggle with everyday life. He stated: “I’m only [in my 60s], which isn’t that old in the grand scheme of things [yeah] and to have carers and things coming in, and lots of support like that, erm, perhaps that might have… an adverse effect on my psychology”. He was concerned that accepting help may reduce his independence and subsequently his motivation to self-care.

The uncertainty inherent in her physical illness (epilepsy) was of concern to participant 11. She called it “frightening” and “terrible” that she could have a fit and not realise where she was or how she got there. Participant 10 likewise acknowledged that one of the consequences of physical illness was a loss of control over one’s life: “a life of uncertainty”. Participant 10 was the only one out of the three participants to explicitly talk about how illness impacted on his sense of self: “when I became disabled… my life changed overnight, what a terrifying prospect of living with this severe disability which means I would never be able to run, walk properly”. This disjunction between who he was and who he now saw himself as (“an old crippled ugly man”) was perhaps more difficult to reconcile due to his older age when he became ill. Both participants 6 and 11 have had their physical difficulties since they were young, and they employed language such as “living with”, “controlling”, or “managing” illness when they spoke: “my [illness] is far more under control now” (P6, second interview); “it’s just something you’ve got to live with, isn’t it?” (P11, second interview).

Powerlessness and hopelessness were closely entwined within the participants’ accounts. Feeling incapable of effecting change in one’s life made it difficult to
envisage a future which was better than the present. This was most powerfully exemplified by participant 9’s account of life as an asylum seeker in England:

All this kind of thing, for me, is finished, I don’t need to suicide, because I am depressed or something like this [yeah]. Because what I need to do, I can’t do. What I am looking for, I can’t do it

He viewed his life as non-existent, trapped by the Home Office’s refusal to make a decision about his case and by the precarious legal position of asylum seekers in the UK: “it’s illegal to work, it’s illegal to travel [yeah], everything is illegal, all they need from you, just to stay at home, sleeping, eating, and that’s it [yeah] that’s not life”. He was powerless to effect any change in his circumstances until his legal status was resolved by the Home Office:

I can’t go anywhere, ok, if they give me document to say I’m refused, I can contact people, like the human rights, something like this, to send me to other country [yes] many people, they do this, because they have document they are refused [yeah] but the Home office say no, ok, no refused, or no here, what do they need? [yeah] I have to finish, understand what I mean

In both interviews, he used metaphors such as “my hands like handcuffs” and “they put me inside a circle” to convey his sense of being trapped by circumstances, a prisoner in his own life. In the second interview, taking place three months after the first, he summed up eloquently what life as an asylum seeker is like:

My life is like, like fish inside the pond [uhuh] the fish, you can put the fish inside the pond [yeah] this fish get to swimming, can’t swim more than like half metre inside this pond [yeah] but if you take this same fish to the river, the fish can like travel, swim wherever he needs [yeah] my life like this like this fish [fish in the pond?] people, people like home office, they put my, left me inside this country [uhuh] I can’t go wherever I need, I can’t work, I can’t study, I can’t do anything I need [uhuh] or I want, at the same time, I need like to be in the river, like this fish, I need to be in a river, have my life, think about myself [uhuh], I haven’t got the right to do it

In different ways, each participant felt powerless to live the life they desired, but in participant 9’s account, the feelings of powerlessness extended across every aspect of his life.

5.7.2 Sub-theme 2.2: “Self-hatred and low self-worth”
Almost half of the participants expressed long-standing negativity about themselves, and deemed themselves “unworthy” (P13), “stupid” (P11), or struggling with feelings of “emptiness” (P10). The motivations for self-hatred or devaluation were varied, but included homosexuality, relapse into drug or alcohol use, perceived lack of intelligence, dissatisfaction with appearance and perceived social failure.

Participant 4 directly referred to the source of his self-hatred as his alcohol use: “I went on a binge and I hated myself for doing it”. This self-hatred is an acute trigger for his self-harm:

That’s why I was just lashing my arms, and ended up to [hospital]...I felt like I’d let myself down

He knew he needs to stop drinking because “it makes everything worse”. Here, there was a direct relationship between his failure to stop drinking and his self-esteem. Participant 4 derogated himself for his relapse, and physically wanted to punish himself. The experience of relapse could be detrimental to an individual’s sense of self and their self-acceptance. Not only did it challenge a person’s sense of self-mastery and hopefulness, but it could also lead to self-blame and self-punishment. This reaction to relapse ties in with the attitudes towards drug and alcohol abuse (and also, self-harm behaviours) discussed in section 5.7.1. These are activities which the participants feel responsible for, in that they are actions performed on the self by the self: “I might have had my own self to blame for that, for doing what I did” (P10, second interview); “…what I’d done to myself” (P12); “I’ve gone back to the same thing” (P2); “I’m doing it again” (P5). When they position responsibility within themselves, the action can have a detrimental impact on their self-esteem: “it was me frustrated with myself” (P5); “I was thinking, if you hadn’t taken that damn overdose, you wouldn’t be here” (P10); “I’d let myself down more than anybody else” (P11, second interview).

I always had this low self-esteem, always had feelings of being less than (P10, second interview)

I’ve never felt whole (P10, first interview)
Participant 10 was one of the few participants who placed his overdose in the context of his life history, as well as his current circumstances. One of the key features of his account was a persistent sense of low self-worth and feeling “less than” other people. He pinpointed specific events and factors that he considered as influential in the formation of his self-esteem. His mother’s mental illness when he was a child was instrumental in two ways. First, his mother’s breakdown after his birth was blamed on him: “She said, she used to say to me my whole life, I wish you’d never been born, if it wasn’t for you”. Secondly, the stigma associated with having a mentally ill family member affected him: “In those days I remember children in the streets used to say your mother’s a loony and things like this, and it’s all very hard”. The other aspect of his life that he identified as of particular import in terms of self-esteem was his sexuality: “at the age of about <early teens> realised I was different, in the sense that I was a gay man [uhuh], and this was at a time when being homosexual was really not accepted”. He reported feeling as if he had let down his parents: “I went through life feeling that I failed my mother” and “I felt I’d let my father down badly because he had <number of> daughters and one son [right], and he was always throwing footballs at me and things like that, and I wasn’t interested”. From an early age, he felt that he had failed to meet the expectations and hopes of his parents, and he identified these “deep issues” as a major contributing factor in his subsequent drug abuse, which in turn affected his self-perception:

When I took the drugs up, it was almost as if my, it was like a coin had maybe flipped up and suddenly I saw myself not as being the person who’d [been a professional] all these years, but rather like the drug addict, and I had very low self-esteem

Participant 9 shared deep-seated issues with regards to his sexuality. He identified himself as bisexual, but he was ambivalent about his attraction to men as it was irrevocably linked in his mind to repeated sexual abuse as a child. As he explained:

My life, been raped, and if I do it, ok, good boy, if I’m not do it, I’ll be killed, so even I know it’s wrong, I don’t want it, but I have to, I can’t choice, no choice for me, only one choice, do it or killed, ok, to stay alive you have to do it, but you do it one time, ok, twice, maybe ok, but three times, three four times, maybe done it a thousand times, your body starts feeling a different way (P9, second interview)
He believed that homosexuality was the result of mental illness, not just in his case, but in general: “everyone who gave me story, can say all of them, not same story of course, cos different people, different situations [yeah] but all of them, they give me the same point of thing… without treatment they get like mental health reason, all of this thing, make them have their sexuality” (P9, second interview). His sexuality and his history of abuse were inextricably intertwined for him, and were a source of considerable distress and self-loathing, to the extent that he attempted to change his sexuality:

I did change my life, from my country to here, I did change my language, changed my food, my clothes, everything [uhuh] why not change my sexuality?… I am only with woman, I can’t tell you I enjoy it a thousand percent, but like, I’m sorry for that like, erm sexual thing, can’t tell you I enjoy like same as man, but at least, I have better life, I think I have better life, with woman (P9, second interview)

Participants 5, 11, and 13 all expressed low self-esteem around particular aspects of themselves. For participant 11, her inability to read due to a disrupted education as a child was a source of distress in her dealings with the outside world. She explained how she felt when she received letters from services:

It’s just, you know having to ex-, when you phone them up, and having to explain to them you can’t read the letter, and that’s why you’re phoning up, it always makes me feel so little

This also emerged as a concern in face-to-face contacts: “I even tell me doctor, would you slow down please, and tell me properly, don’t use them big words because you know I’m illiterate and I can’t understand them”. She was sensitive about the fact that she can’t read, and it left her feeling less than, “so little”, compared to other people.

I felt frustrated because I felt like I couldn’t possibly open up, open up to my boyfriend about why I was so fucked up (P13)

Participant 13 recounted points of contention with herself: “Erm, the fact that I’ve never belonged to any actual social group, and I’m a very isolated person, I go through quite a few nervous things, and psychotic moments”. Her belief that she doesn’t belong anywhere was repeated throughout the interview, and was accompanied by reference to her unworthiness: “I felt a bit unworthy, like I didn’t
understand why they should like me so much”. She cannot see in herself what her friends or partner sees, just as participant 5 struggled to accept her boyfriend’s love: “he’s just totally like I love you and I wouldn’t be going out with you if I didn’t like you, so, I kind of have to accept he’s got no standards” (second interview). Participant 5 detailed numerous physical aspects of herself that she disliked:

I don’t like myself, if I could afford it, I’d get my nose done, I’d get my boobs done, I’d get lipo, I’d just go on a diet, I’d get my hair done, my nails done, I’d get my eyes lifted, my bum lifted, I’d get my thighs done, so much I would get done to myself, so much I hate about myself that I want to just get done (second interview)

She also repeatedly stated “I am not smart”, being self-critical in terms of both appearance and intelligence. Whilst neither participant 5 nor participant 13 offered a reason for or an historical root of such low self-esteem (unlike participants 10 and 11), the issues they were concerned with are major sources of self-esteem more generally. What was notable in the interviews was the presence of repeated negative self-evaluations without prompting, which suggests that these thought patterns are well established. In participant 13’s account, she “mathematically” assessed the value of her life:

I think about how much pain and suffering life causes, and then I think, I weigh that against how much actual value my life and things that I have in my life, and I have very little value, care or interest in much

Intrinsically, she did not value herself or her life – she instead sought external validation from others. Both participant 5 and 13 seemed to set impossibly high standards for themselves and their lives, which could reflect an underlying tendency towards perfectionism. These self-criticisms could also reflect the increasingly impossible standards propagated in the media and elsewhere.

5.7.3 Sub-theme 2.3: “Stigmatised identities”
The concept of stigma was a recurrent theme in over half of the interviews. The idea of a “stigmatised identity” is an identity which carries a negative social meaning or outcome for the participant. It may be one that they themselves identify with, or one that they deny. The perception of stigma can be enough to cause an identity to become “spoiled” for the participant, i.e., to cause them distress and a sense of being “less than”. In this way, the participant’s own understandings around what identities should be stigmatised and why, were just
as important as the actual responses of individuals around them. This seems particularly true in the case of self-harm, where some participants were intensely private about their self-harm due to the shame they felt: “because it was more me being ashamed of it [right] so I didn’t want people to see it” (P5). This shame could predate the experience of any reactions to their behaviour socially. The experience of seeking help therefore was balanced between an opportunity to receive help to change and acceptance from others and an opportunity to be further stigmatised and have pre-existing negative self-appraisals reinforced.

Living with stigmatised identities such as that of a self-harmer (P5), a drug addict or alcoholic (P2, P4, P8 and P10), someone with mental illness (P1 and P6), someone with disabilities (P10 and P6) or an asylum seeker (P9) created an atmosphere where the participant felt devalued socially and less able to seek help for fear of judgement or disbelief. A stigmatised identity was a source of shame, embarrassment and guilt. It could isolate the individual, either because of the way people perceive and treat them (e.g., P10 found that “a lot of the young men (on the inpatient ward) didn’t like me because of my sexuality, they refused to share a… room with me”), or because of their fears around how they will be perceived if they share with others (e.g., P5 talking about her self-harm: “I didn’t want people to sort of just say oh she’s trying to get attention… I didn’t want people to sort of, insinuate just because I’m a goth I have to cut myself”). Exposure to scrutiny at the hospital could be a harrowing experience for the individual, as participant 1 described in his second interview:

I know I miss my injection but I don’t like to be over there, because everyone knows why you're at [hospital] [yeah] and they just start laughing and then they start whispering to one another in there

Participant 1 was describing the impact of his perception of stigma on his compliance with medication, in this case, with the depot injection for schizophrenia. Regardless of whether people actually do laugh or stare when he attends, he was uncomfortably aware that the depot marked him as someone with mental illness, and this made it an ordeal for him to attend.

Several participants had experienced interactions with people in the community where they were treated differently by virtue of one of the characteristics
mentioned above. For instance, participant 9 had experienced violence and intimidation in the community as a result of his nationality: “I got about 8 fights with racist people in this area”. His experience of treatment in England due to his asylum status led him to conclude that the government “make racist group between the people and the asylum seeker”, by leading people to believe that their tax money pays for asylum seekers.

Participant 9 also felt excluded from the acceptance of society by his sexuality. As mentioned in section 5.7.2, he believed he would have a “better life” if he were heterosexual:

I’m looking for the light in the damn thing about sexuality, even I enjoy both man or woman, but I feel myself, man and man, or woman and woman, no way to have children [uhuh] also, I am looking for, for old people to have, bisexual, that are 50 years old or 60 or 70 year olds, they are alone [sorry?] they are alone, living alone, because they have nothing [right] no-one will live with them, and I am looking for all straight people, they have better life

Participant 10 also pointed to the lack of a traditional family structure as a factor in his current social isolation:

I often wonder why out of the family, three of them have succeeded so well, and I… found life incredibly hard, maybe it’s the sexuality thing [yeah] erm, the loneliness. Would I have made a good dad if things had been different? Would I have changed? I’d have been a grandfather, wouldn’t I? I’d have been sitting with my wife on the sofa, looking forward to a nice holiday (participant laughs) I’m talking rubbish!

Both participants felt that their sexuality excluded them from a lifestyle which could protect them from negative outcomes such as loneliness, stigma, and feelings of being “less than” other people. As bisexual or homosexual, they felt that they could expect to end up alone and abandoned by a society which focuses its energy on “family, family values, family values” (P10).

Several participants were concerned about the reactions of society to mental illness and self-harm. Participant 9 had been told by people he knew that a suicide attempt would affect future employment chances. He stated “my medical history is killed me” and this belief led him to cease his studies. Likewise, other participants were concerned about being penalised in their social lives for suffering from mental illness, which could discourage them from
being open. Having an aspect of yourself which you felt needed to be hidden from others can foster a sense of being “less than” other people. Every encounter with others will perforce be less genuine and more anxiety-provoking as you try to protect yourself from stigma (Goffman, 1963).

With physical illness, it can be very difficult to hide disability from the outside world. Participant 10 spoke of his experiences in the gay community as being visible yet invisible: “going into the village with a stick and people coming up me and saying what’s wrong with you, what’s wrong with, going into a pub, and nobody coming and approaching you, or speaking to me”. He described disabled people as being “somehow not regarded as being whole”. This metaphor of not being “whole” echoes the broader theme of “life as less than”, as each participant in some way (and sometimes, as in the case of participant 10, in several ways) felt less than a ‘normal’ person, felt reduced or handicapped socially by their experiences and their circumstances.

The impact of experiencing oneself as “less than”, less worthy of care or open to revulsion, was that participants were often concerned that asking for help would have negative personal and social consequences, e.g., being rejected by services outright. In this section, only experiences of stigma in the community have been touched upon, but participants also had multiple experiences of stigma whilst using services (discussed further in 6.5.3).

5.7.4 Summary

This theme highlighted the ways in which participants felt reduced by their circumstances, societal attitudes, their interactions and their perception of self. It draws attention to the nature of people as social beings, creating our self-perception in interaction with others, and created by others in how they perceive us. The three sub-themes can be summed up as addressing our relationships with ourselves, self-with-others and self-in-society. “Life as less than” reflects the participants’ desire to be valued as individuals and to value themselves intrinsically. Without intrinsic and extrinsic value, it was difficult for the participants to motivate themselves to live a life characterised by struggle.
5.8 Super-ordinate theme 3: “Meanings of Self-harm and Suicide”

When reading the accounts above, it becomes clear that each participant had reasons to feel unhappy or distressed with their lives. Given these circumstances, what did the participants believe self-harm or suicide would achieve for them? What function did the act of overdose or self-cutting serve? In this section, the meanings self-harm and suicide held for the participants in general and specifically at the time of the index episode will be discussed in detail. Five sub-themes have been identified:

- Self-harm as way of coping with negative emotions
- Self-harm to hurt the self/self-punishment
- Suicide as way to escape or to end suffering
- Suicide as logical response to life’s difficulties
- Giving up – hopelessness

Box 5.7 below illustrates these sub-themes in relation to the super-ordinate theme: “Meanings of self-harm and suicide”. Whilst each sub-theme does not share an underlying experiential essence (such as “struggle” in super-ordinate theme 5.6.1), they are functionally related, as they are all ways in which the participants make sense of their actions (specifically, self-harm or suicide attempt). They relate to the beliefs and intentions participants held with regards to their self-harming behaviour. These beliefs and intentions are further explored within each sub-theme below.
One general feature of the participants’ accounts was considerable variation and ambivalence expressed around suicidal intent. Most participants who expressed suicidal intent also expressed a desire for change, or a desire to live. This ambivalence complicates any discrete differentiation between those who professed suicidal intent during interview and those who did not. As previous researchers have asserted, suicidal intent is difficult to determine after the event, as intent can change rapidly, and both the social consequences of the act (e.g. family or staff responses, expectations of treatment) and the personal implications (e.g. impact on self-esteem or self-perception) are likely to impact on a person’s decision to disclose, and even on their ability to admit suicidal intent to themselves. As the interviews took place a substantial period of time after the hospital visit, any expressions of intent (suicidal or otherwise) should be viewed as the product of the participant engaging in sense-making after the event, in light of its personal and social consequences.
In some cases, the interview itself seemed to offer an opportunity for the participants to make sense of the episode in terms of motivation and subsequent implications for their future, and this was evident in the way they answered questions – with hesitancy, ambiguity and/or self-contradictions. The five sub-themes discussed below can therefore be viewed as emerging from participants’ constructed accounts of meaning after the event in question, and sometimes reveal more about their expectations, pre-conceptions and assumptions about self-harm, suicide and societal responses to them, than they reveal of the lived experience of a suicidal or self-harming act. Where the data allow, this complex of influences on meaning-making will be unpicked within the narrative.

5.8.1 Sub-theme 3.1: “Self-harm as way of coping with negative emotions”
In keeping with the literature (see 1.3.2), one of the main reasons for self-harm expressed by participants was emotion regulation. Four participants identified emotion regulation or coping with emotions as part of their motivation for self-harming at the time of the episode or as a possible motivation for self-harm. Within this sub-theme, there was variation in terms of what the participant felt they were coping with, and in the effectiveness of self-harm in fulfilling this function. For participant 5 in particular, there was variation over the life course of her self-harming behaviour. She stated that when she first engaged in self-harm:

It was sort of like an emotional outburst [yeah] and you know, you’ve got all these sad feelings in your head, and they in a way, make you want to cut yourself

Whereas her current self-harm revolved around:

Frustation. All of it just building up and building up [right]… it just led me to (self-harm) because it was sort of a release

For participant 5, this function of “release” was served both physically and visually by the act of self-harm. She described the experience of cutting herself as “it’s like you’ve physically taken it out of your body, and put it into something else” and emphasizes the importance of seeing the injury: “it’s more of a visual than a pain sort of thing”. The meaning of “seeing” the self-harm in her account is discussed elsewhere in relation to her experiences of services (see 6.2.2).
Even though the emotions motivating her self-harm had shifted over time from “sadness and… really tearful” to “frustration” and “uncontrollable rage” (second interview), the function of self-harm had remained the same: “getting it out of your mind, and when you can see it in the physical it’s like it’s gone out of your mind” (second interview). All of her extensive attempts to find a suitable alternative to her self-harm had focused on this physical and visual need to remove something from within: knitting, drawing, making crafts and painting had all helped to a varying degree because of their physicality whereas the elastic band method was seen to be useful but “it wasn’t quite the same [no] because erm, with your leg as you’re doing it, you kind of see what you’re doing, and you see - it’s like a physical sort of thing, cos as you’re seeing the cuts going on, you can feel the release”.

I felt I was going to a point of despair (P7)
Participant 7 described her recent episode of self-harm as driven by feeling “desperate” and “very anxious”. She scratched herself in response to these feelings: “I just did it, at the time when I was, when I really felt down, when I really felt it”. In her account, she expressed discomfort around talking about her self-harm, saying “I feel a bit, yeah, quite a bit uncomfortable, it just brings memories flooding back”, and she seemed to indicate both by this discomfort and by the snippets she was willing to share that self-harm was a response to emotions she struggled to deal with. Its utility as a means of coping with emotion was not touched upon by participant 7, although both participants 1 and 5 indicated that for them, self-harm was partially effective at releasing emotion: “it releases it a little bit” (P5); “it goes away for 12, a few hours” (P1).

Participant 1’s use of self-harm to cope with emotion was motivated by his underlying mental health difficulties, most notably voices and visual disturbances he experienced. Coping with the voices and visual disturbances sometimes became overwhelming. In his second interview, he specifically referred to the emotional impact of his experiences:

P1: [When he goes to hospital] I'm in crisis
I: And erm, what’s a crisis like for you?
P1: It’s like, it’s like, just like disturbs me… disturbing voices
I: Is it the voices that disturb you or is it something else?
P1: The voices and seeing things
During the second interview, he became distressed at several points, experiencing “flashbacks” involving myself and his key worker who was present:

   It’s just happened to you now, and [his key worker], it’s just happened to you now and I’m terrified

His agitation seemed to stem from the content of his “flashback”, and when asked directly whether he self-harms as a result of what he hears, he stated: “yeah, I don’t like what I’m hearing”. Both his self-harm and his hospital visits were motivated by a desire to “get rid” of the voices. In particular, when asked what helps him cope with the voices, he stated: “when I’ve been in hospital they seem to go away” (second interview), suggesting a possible motivation for his insistence on hospital care.

An interesting feature of the way this common function of emotion regulation manifested in this sample was that the emotions the participants were attempting to manage or release stemmed from different sources. Participant 5 was perhaps most straightforwardly self-harming to cope with emotions – her emotions at the time of the first interview were the product of a negative work environment, and placing herself under too much pressure with college courses and work. Participant 1 was also trying regulate emotion, namely his distress felt in response to disruptive voices and visual experiences. Both participants tried to use other methods suggested by counsellors and key workers to fulfill the same function, with varying levels of success. For participant 7, a barrier to understanding her account was her reluctance to discuss emotional content – it is possible that this reluctance was part of a deeper difficulty with social communication as she was receiving full-time support for her mental health problems.

5.8.2 Sub-theme 3.2: “Self-harm to hurt the self/self-punishment”
Participant 5 also saw her self-harm as a “vicious circle”\(^5\). It was a “vicious circle” because “you realise what you’ve done and there’s that sort of that feeling of shame after you’ve done it”. The shame she felt from self-harming had the negative impact of encouraging further self-harm in response to her

\(^5\) A term also used by service user activists such as Diane Harrison (1995)
lack of self-control. In her second interview, she talked more about the “uncontrollable rage” that sometimes preceded the desire to self-harm:

It’s just you’re so angry you just want to lash out and hit someone, you don’t want to hurt yourself anymore [right] but you want to hurt someone else

She identified a recent change in the target for her anger, switching from a desire to hurt herself to a desire to hurt others. Again, the issue of self-control was of utmost importance to her – although she had not acted on the outward aggression she feels, she was constantly fearful that she would:

it’s scary and it’s confusing, and you’re always on edge because if you go somewhere and all of a sudden you get these thoughts [yeah] you know you’re not gonna be like really, erm, good with them.

This issue of self-directed aggression as a substitute for other-directed aggression arose in participant 3’s account of her self-harm. Her self-harm was often linked to drinking alcohol and feelings of being overwhelmed (“things just get on top of me”), and she stated at one point that “if I don’t hurt me, I’d probably end up hurting someone else, that’s why I do it to myself”. Both participants felt hindered and frustrated by the lack of a suitable outlet for their feelings of anger.

Participant 4 seemed to want to punish himself rather than others: “I wanted to harm myself to be quite honest, wanted to punish myself, so that was just a case of slashing my arms”. He felt that he had failed himself when he started drinking again after detoxification treatment. He self-harmed whilst he was drinking, a scenario which may have compounded his feelings of guilt and self-loathing as a result of his relapse. The function of self-punishment seemed to be a chronic factor for him, and not just an acute response to the relapse, as he stated: “I just want to hurt myself… physically and mentally. I mean, years ago, when I first started, I er, used to punch my face and things like that, and make a mess of it”. The method of punching his face seems to reflect brutally the function of self-punishment, as the face is a powerful marker of identity.

Within this theme, the two female participants self-harmed as an act of aggression towards themselves, which both participants identified as at least sometimes a substitute for aggression towards others. The male participant
was adamantly self-loathing and wished to cause himself both physical and mental pain.

**5.8.3 Sub-theme 3.3: “Suicide as way to escape or to end suffering”**

Seven participants expressed suicidal intent as a motive for the index episode. Out of these seven, four identified suicide as a way to escape or end suffering. For the remaining three, the motivations were not as clearly indicated.

Participant 1 stated he often felt suicidal as a result of his voices and visual disturbances, but the balance in his interviews seemed to indicate that this feeling was a response to the negative emotions he experienced (“I can’t handle it anymore”; see 5.8.1), and he also self-harmed and sought hospital admission as ways to cope with the voices. Participant 8 who indicated suicidal intent (“I did intend to kill myself”), talked about his experiences in the army and “flashbacks” to that time which have haunted him for years. However, within the interview, he only stated that he was “under a lot of pressure” and had “had enough” when this issue was probed. Participant 4 talked about an overdose he took between the index episode and our interview, which was motivated by grief and loneliness: “I thought to myself, I might as well go and join my (dead relatives whom he was close to)”. At the same time, he refuted the sincerity of his attempt: “I’ve had the thoughts of committing suicide [yeah] but I’d never go through with it, I just want to punish myself that’s all. If I wanted to commit suicide, I would’ve done it years and years ago, and I don’t obviously”. This ambivalence was also reflected in his choice of overdose tablets (mainly vitamins) and in his seeking help immediately, and highlights the importance of examining the meaning of both suicidal thoughts and actions.

Just get it over and done with, don’t face the music (P12)

For participant 12, his suicidal actions were motivated by a desire to avoid the consequences of losing his unemployment benefit money on the day of payment: “it’s a struggle waiting a fortnight to get some money… and then at the end of the fortnight when you get it you haven’t got it [yeah] and… I just didn’t know what to do”. As he explained:

I was sort of travelling home and I thought well what can I say? How do I explain the fact that I just haven’t got any money?... and I thought well I’ll finish it, I don’t have to explain to anybody then
Afterwards, whilst he recovered in hospital, he struggled to pinpoint why this particular event triggered such an extreme response:

I can’t bring it into my own mind, why it’s all happened, why it could’ve happened at that time, I’ve been without money before… I’ve been without friends, I’ve been without a place to live, I was on the street for three months, I never thought about doing it then… why did it come about this time?

For some reason, the confluence of events at that time brought him to contemplate suicide as a way out of his circumstances, and one factor of his account which may have influenced this timing was his recent stay in prison. Whilst there, he was told a method of suicide which was guaranteed to work “within 20 minutes”. It is possible that his decision-making was influenced by this salient recollection.

For participant 13, suicide was seen as a way to escape her “state of mind”.

When asked to describe that state of mind, she responded:

…it was like being in a trap and trying to find a thousand ways out of it, but no matter you know, what way I tried, I’d always find myself trapped again by another thought

Unlike participant 12, she was trying to escape something internal to herself, rather than avoid confronting something external. She tried a number of tactics to soothe this “frantic state of mind”: she tried to distract herself by cleaning, writing, and watching TV, she took drugs to try to improve her mood, before finally taking “painkillers”. She saw the overdose as:

…the only way to erm, escape my state of mind, and the life I had in general that I just didn’t value anymore because it was too much pain for me

The value of living was something that emerged from participant 10’s account as well:

It’s probably better if you just put me down, because I suffer a lot of pain

From 5.6.3 and 5.7.1, it becomes clear that a major factor in participant 10’s decision to overdose was the present he faced and the future he feared as a result of chronic illness. He wanted to die “with as much dignity as possible”. He thought about suicide because he didn’t want to suffer:
We all want to go quickly in the night, don’t we, in our sleep…is there an easy way… that’s how I felt

I’m frightened of pain you see

Conversely, in our discussion of life with chronic illness, he started to talk about his desire to live:

Some people, rather than go through more chemo, they think, no, I’ve had enough now, I want a quality of life… I’d rather be well than sick all the time… and this is the kind of irony really, the exact antithesis of what I’ve been saying, cos I thought, I don’t want to die, I want to live [yeah] I want to be happy again

For him, suicide was not about a desire to die or to stop living. It was about having a quality of life that makes life worth living, and being able to choose whether or not he suffers before he dies.

When I decided to… kill myself, it felt very clear and like I was doing something positive because there just wasn’t anywhere else to go (second interview)

Participant 6, like participant 10, suffered from chronic and worsening illness. Suicide became the way out from this suffering, as she said “there just wasn’t anywhere else to go”. She found herself having “night terrors… really vivid horrific pictures in my head” and “waking up… horrifically suicidal”. She sought help because she did not feel she could cope with these “night terrors” and the emotions they evoked, but when she struggled to get the help she needed, she made the decision that suicide was the way to solve her problems: “I was quite happy in a kind of, you get, I felt completely past scared, or angry” (second interview). The decision to die made everything clear: “it felt a bit like a moment of lucidity when I felt suicidal… because everything felt fuzzy and clouded and difficult in between”.

The clarity participant 6 felt may stem from the fact that once she made that decision, she knew there was an end to her suffering. Likewise, participant 13 felt “relieved and… scared” about dying, relieved because suicide offered a way to escape “everything that I was dreading, everything that would cause me pain and misery”. It is important to note that at the time of the suicide attempt, it was
a decision the participants made, a choice between an envisaged future and their ability and desire to live it.

5.8.4 Sub-theme 3.4: “Suicide as logical response to life’s difficulties”
Closely related to this idea of choosing between the imagined future and death, the sub-theme “suicide as logical response to life’s difficulties” captures the rationalisation process that some participants (P9, P10, and P13) engaged in when thinking about suicide.

I think I’m being the most logical that I can be when I think about that, because I think about how much pain and suffering life causes, and then… I weigh that against how much actual value my life and things that I have in my life (have)... mathematically, that makes life not worth living (P13)

I was very very lucky… I had all that, I had that incredible lifestyle and I thought, you know what… <60+ years> is quite long enough (P10)

If you sort out all your problems, you will not have depression or thinking about suicide (P9)

Each participant manifests the concept of suicide as a logical decision in different ways, which may partly reflect their differences in age, experiences and backgrounds. For participant 13, only in her twenties, she saw suicide as a “logical” decision based on mathematical consideration of how much life is worth and how much life cost her. This type of rationalisation seemed to be a product of her depressive outlook rather than an objective accounting of her life, and as discussed in 6.3.4, it only requires a change in perspective to encourage her to re-think her decision.

For participant 10, his decision to kill himself was seen as a logical choice given his current circumstances. He also compared his life now to the life he has had, and in the comparison, felt that his life had already been lived: “I’ve had a great life, I’ve achieved a lot”. It is both the unfavourable comparison of past with the present and the fear he had of the future that led him to consider suicide: “all these things, coming into my head, made me feel my life isn’t worth living [right], it’s hell on earth, I hate it, I want out"
Participant 9 shared participant 10’s reflection on the life lived and the life that could be: “I don’t need to suicide because I am depressed or something like this… (but) because what I need to do, I can’t do”. It is the constrained nature of his life that made suicide the logical decision. Being trapped by his asylum status has left participant 9 in a position of powerlessness over his life. When he received a letter from the Home Office denying him a definitive answer on the issue of asylum and yet giving him no recourse to question or complain about his treatment, he stated: “If I can’t work, I can’t have life, I can’t, I have nothing. What I have to survive for? ... I’m thinking, I’m thinking, this not life, absolutely that’s not life”. Without a reason to live, he saw suicide as an option because life no longer seems different to death: “I’m dying here every day slowly”.

5.8.5 Sub-theme 3.5: “Giving up – hopelessness”

Hopelessness seems to be the underlying psychological construct in almost half of the sample. Hopelessness was expressed in different ways – with participant 13, her defeatist rationalising that life was “not worth living” seems indicative of a hopeless outlook on the future. During her suicide attempt, this absence of hope was reinforced by the return of hopefulness:

I started to write a suicide note… and during it, I started realising that I wanted to regain my natural trust and belief in and empathy for the world and people in it, erm, because I knew it was still there inside of me.

She goes from “you may as well just give up on them and everything else” to “I started to care again… I wanted to be ok” in the time it took her to compose a suicide note after taking an overdose, suggesting that her hopelessness was a transitory mood rather than a chronic condition. Participant 6 also exhibited hopelessness in this transitory way:

I just got completely hopeless that I was ever going to get better again, and everything just kind of came crashing in, and I felt like I was just never going to get out of it [right] and that there just wasn’t any point in going on anymore, and it happened very quickly.

Participant 6 saw this hopelessness as part of her depression, which she was used to living with and coping with: “one thing I’ve been taught since I’ve been through this kind of cyclic depression is that… you recognise the signs, all you need to do is go along, get help”. Despite her desire to kill herself, she sought
help: “I want to do this (kill herself) but it’s not really… I know it’s not the right thing to do” (second interview). In both interviews, she talked about depression as something that needs to be managed, something that she was aware of as “cyclic”. When asked about the most difficult part of the three months following our first interview, she stated:

I think really it’s to keep… facing the idea that you are going to get better eventually

She saw maintaining hope as a vital and challenging aspect of continuing to live her life.

I thought this is it, right, I’ve had enough (P8)

My life for me is finished (P9)

I’ve lost my fight, I’ve lost, my inner spirit’s gone, I feel like a shell, an empty shell (P10)

There was a greater sense of “giving up” in the accounts of participants 8, 9 and 10. Each participant had struggled in their lives with alcohol or drug addiction (P8 and P10), physical illness (P10), trauma (P8 and P9), and feelings of being trapped in their lives (P8, P9, and P10). Both participants 8 and 10 talked about being ready to die: “I was so calm… and when I took them, I was at peace… I knew what I was doing” (P10); “I just thought, I’m gonna take the lot” (P8). Their hopelessness seemed to have been a gradual development, with the passing of time being a decisive factor in their decision-making: participant 9’s “energy is finished”, participant 10 is “very tired” (second interview), and participant 8 has “had enough”. They were all weary of life, and struggled to believe in a better future. Participant 10 saw only a future where life got worse, he lost his independence and the choice over life and death got taken away from him. Participant 8 still had “flashbacks” of traumatic events that took place 20 years ago (“It’s something you can’t forget”) and held little hope that he would ever stop drinking: “I don’t think I can (give up alcohol), because of what I’ve been through [yeah] over the last sort of 20 years and that”. Participant 9 used a powerful metaphor to describe how he felt:

If I put you in this room, with lion… he’d attack you, what are you going to do, you will find any small hole just to get out… but if you can’t… and you get tired, go to lion, fair enough, eat me, that’s it [yeah] and that’s what happened to me
This metaphor was an evocative description of his lived experience. Years of trauma, a reduced existence as an asylum seeker (“other than stay alive… I can’t do anything”) and the prospect of an indeterminate number of years before any decision was made on his case had brought him to the point where he felt that life is simply a “different style of suicide” (second interview).

5.8.6 Summary

Self-harm was perceived variously by participants to be an outlet for negative emotions and a means to self-punish. Suicide was perceived to be a way out or an escape from an undesired circumstance. It was sometimes seen as a logical response to an intolerable life. Many participants expressed the intent to die, but also expressed ambivalence in terms of action, function and emotional response to the attempt. Hope often co-existed with hopelessness, self-harm co-existed with suicidality.

It is possible to identify ways in which self-harm and suicide formed a natural progression from the participants’ life histories. In some cases, it is self-harm’s ability to relieve problems that make it a useful, if only partially effective, coping mechanism. In other cases, the participants’ struggles become overwhelming, and motivate desperate measures to escape. In these cases, those experiences of powerlessness and hopelessness within one’s life can make suicide seem like a logical choice.

This chapter has introduced the participants, their pathways to self-harm and suicide and their beliefs, perceptions and emotions. These form the horizon through which a participant’s experience of services is viewed, the back-drop to their engagement with staff.
CHAPTER 6: FINDINGS
The lived experience of psychosocial assessment and the hospital

“But the main thing was that he did look as if he actually cared, that’s it, and he wanted, he really wanted to help me, and so that was a very positive thing” (P4)

6 Introduction
In this chapter, the focus is on themes that have emerged around psychosocial assessment and experiences of services. Whilst some participants had little to say about assessment in particular, the majority spoke about their experience of assessment, hospital staff and wards in detail. One notable feature of the data was the interconnected nature of these three areas: the hospital environment was seen to have an impact on some participants' willingness and ability to participate in assessment, and the experience of positive staff encounters was seen to ameliorate the effects of an assessment perceived as antagonistic. Psychosocial assessment itself had the potential to be both a negative and positive experience, and the nature of the interaction between staff member and the participant was a key determining feature of the patient's appraisal of assessment.

Three super-ordinate themes about assessment emerged from the inductive analysis of the first interviews. These were:

- Function of assessment
- Value of assessment
- Negative aspects of assessment

An additional super-ordinate theme emerged relating to the participants’ experiences of the hospital and the treatment of staff. This theme was labeled:

- “Like I was a human being” - Spectrum of care to control

This theme encapsulates the experiences of participants in the emergency department and on the wards as a spectrum ranging from being valued and cared for through being neglected and ignored to the extremes of being devalued and dehumanised by their treatment. Central to this spectrum was the participants’ concern with gaining and maintaining a sense of their own worth and value through the care of the psychiatric and medical staff.
6.1 Super-ordinate Theme 1: “Function of assessment”
Not all participants were aware of assessment or had a good recollection of it – participants 1, 8 and 9 did not explicitly talk about assessment, although they did recount experiences talking to staff members. As it plays such a central role in the guidance for managing self-harm at hospital, this in itself is a significant finding. For those who felt able to comment on assessment and its role in their experience of services, the sub-themes of “gateway to care”, “protecting the staff” and “has to be done/routine” emerged from the participants’ accounts. Box 6.1 illustrates the sub-themes of “function of assessment”, as derived from the participants’ accounts.

Box 6.1: Sub-themes of “Function of Assessment”

<table>
<thead>
<tr>
<th>Super-Ordinate Theme</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| Function of Assessment | Gateway to Care  
Assessment perceived to serve some function as an aspect of hospital treatment | Purpose of assessment is to determine further care |
|                      | Protecting the Staff (focus on risk)  
Purpose of assessment is to protect the staff from adverse consequences |
|                      | Has to be done/routine  
Purpose of assessment is to meet an organisational requirement |

6.1.1 Sub-theme 1.1: “Gateway to care”
Four participants strongly felt that assessment was there as a gateway to further services and support. This impression seemed to follow from the attitude and approach of the assessor in question. With participant 3, the assessment was “to see what was going on, and to see who I was, and then to ask me if I wanted to be referred, and that’s it”. The assessment only lasted 15 minutes, which she deemed adequate because she thought that the sole purpose of the assessment was to “see whether I needed to stay, get kept in, or let out, go home”. She made no mention of any therapeutic benefit from talking to either of the assessors she spoke to, as she attended hospital twice in quick succession.
Participant 5 also mentioned having only a brief assessment ("about twenty minutes") and she also identified one of the main functions of assessment as that of ensuring appropriate support and care is arranged. However, her experience was much more positive: she mentioned that the assessment was "all about me" and that the assessor, a psychiatric nurse, was "trying to get to the root of why you’re feeling this at this particular moment in time". She was pleased and relieved when the assessor quickly and confidently identified what she needed:

It was just like, she knew exactly what it was that could help me and she was just like, right, this will definitely help you with this, and it was just things that I wouldn’t have even thought about

Participant 6, like participant 3, had more than one experience of assessment in a short period of time, and only once does she identify the main purpose of assessment to be focused on arranging appropriate care. In this case, the assessment was with an emergency department doctor, who she described as "very concerned" with ensuring she received appropriate (psychiatric) attention. Worryingly, this contrasted sharply with her experience of assessment with psychiatrists, where she often felt undermined and disbelieved (see 6.4.3).

Participant 10 had a very positive experience of assessment, which he identified as instrumental in leading to “all the agencies… pulling together”. Whilst he acknowledged, “It’s sad that it took the overdose (to get support)”, the response of the staff and the assurance that help was there when needed, made a difference to his outlook in life after attendance.

It was perhaps surprising that this theme of assessment as a gateway to care is not more prevalent within the sample, though it does seem within these four participants’ accounts that it was not put forward as an explicit purpose by the staff members. Participants seemed to glean the purpose from the questions and the focus of the assessor during assessment, rather than from any statement of purpose.

6.1.2 Sub-theme 1.2: “Protecting the staff”
This theme was poorly represented, but it seemed a significant feature of their understanding of assessment for the two participants who mentioned it. Participant 4 recounted his experience of being assessed by a psychiatrist as follows:

When I saw a psychiatrist, one of the questions was do you ever feel violent or, no I don’t feel violent, or attacking anybody, no, and what was the other one, he said could you murder somebody? No (laughs)

The perceived strange nature of the questions was given the dual interpretation of protecting the psychiatrist from adverse events (“if he didn’t ask them and I’d have gone out and just gone on a mass axe-murdering thing, you know, whose blame would it be”) and probing into his mind in a way that only a mental health professional could do. The strange content was taken as evidence that psychiatrists have a particular type of expertise that others do not:

The way I look at it, he came, he, he’s qualified in this sort of thing and the questions he was asking were, get it out of my system basically

This ability to probe and the responsibility implied by the concern about risk both stemmed from his perception of the status of psychiatrists as unique, “special”. He accepted their need to ask questions that he cannot see the relevance of because he expected that psychiatrists have expertise that others do not.

For participant 6, the focus on risk and risk assessment frustratingly failed to consider her perceived needs, as she was deemed not to be at risk by the psychiatrists (“apparently I was too lucid to be suicidal”). She became increasingly desperate and frustrated as the psychiatrist tried to convince her that she did not need to be admitted into hospital:

It seemed that, what he wanted to know, and the reason that he was actually there was erm, because if I couldn’t justify to him that things weren’t sufficiently serious, they just, they were just gonna discharge me. I had to justify to him why he would need to bother to get me a place in hospital

She reported that the psychiatrist was trying to coerce her into agreeing that she was not suicidal even though she felt strongly that she was, so that he could be absolved from the responsibility of finding her a hospital bed. As she stated:
It went on a long time, you know, him trying to say, you know, are you sure you’re not going to be ok in the community? No, well, you know, well it’s going to be very difficult for us to get a bed for you, we’re gonna have to ring round the entire world to do this that and the other

She was left with the impression that she was on trial and had to justify herself and her need before the psychiatrist would help her: “You don’t need to have somebody put through their paces in order to justify a hospital bed”. She felt the onus for using resources and creating work for the psychiatrist was being placed on her, at a time when she was least capable of defending herself.

6.1.3 Sub-theme 1.3: “Has to be done/routine”

Several participants brought up the concept of assessment as a routine procedure, a stepping stone to being discharged back into the community.

They wouldn’t let me out of the hospital [yeah] obviously, until they had assessed me (P10)

For participant 5, who had never attended hospital with self-harm before, this impression was formed because the psychiatric nurse seemed to be using a proforma to aid the discussion:

She had a piece of paper on her leg, and she just, I think there’s like routine questions for this thing [yeah] how you felt whilst you did the cutting, erm, what brought the cutting on [yeah] what do you feel after you cut yourself, what do you feel in the ambulance on the way, and how do you feel, erm, talking to her personally, about the actual situation [right] that I was in

The proforma was not perceived negatively – it was actually taken as a sign that the psychiatric nurse was focused on the participant and her needs: “she assessed everything I said”; “she was writing down what I was saying, my answers… and she was assessing what my answers were”.

I: How do you feel about answering those kinds of questions?
P7: Well, it’s usual to me, I’m used to, I am used to it. I am pretty medically trained over the years

Participant 7 had a very different experience of the hospital, in part due to her familiarity with the staff and the procedures. She could be described as having a service user “career”, and in fact at several points she made reference to her experience and expertise during her interview: “I am pretty medically trained” “I
have been since [1970s] experienced”. For her, the routine of assessment and the hospital visit seemed to be what helped allay her anxiety. Knowing the staff and having them know her made a significant difference to her:

I: How do you think they helped? I mean, what was it about it?
P7: I think there was more trust in them
I: More trust? On your side? You mean you felt more trust?
P7: I felt more at ease

If knowing the staff and the process can make a difference in terms of the participant’s response to assessment, it seems equally true that being treated impersonally and like “a specimen”, as participant 11 reported, can have a negative impact. Participant 11 also felt that the assessment is routine, something that has to be done, but the manner in which the psychiatrist conducted the assessment made her angry and defensive:

You don’t just walk up to somebody and say your name [no], you’re Mrs [participant’s surname, name], aged [60s], [yeah], tried to commit suicide [no] you didn’t come out with that, like that erm psychiatrist did, and then bring your grandchildren and your daughters into it [yeah, it sounds like he was a bit erm] he was very very abrupt

The participant’s comments suggested that without an establishment of the ‘therapeutic alliance’, the psychiatrist’s line of questioning left her feeling like a “specimen, that they just have to probe at”.

Both participants 10 and 12 talked about assessment as something which had to be done to enable their discharge, but it is of note that when probed further, participant 12 answered as follows:

I: Did they explain to you the reasons for the assessment, beforehand?
P12: Well, I’m not sure they explained it, they just said, we’re going to have you assessed before we can release you from the hospital [yeah] sort of thing. They probably did give me reasons, but I think you know, probably hospital jargon erm, because he’s self-harmed and whatever [yeah], and I didn’t really take it all in, I just knew I had to be assessed before I could go home

Likewise, participant 10 stated: “the assessment didn’t sort of like this, (tackle the issue) face on”. For both participants, the purpose of assessment was not fully explained or understood, but they both had the impression that it was necessary.

6.1.4 Summary
The perceptions and expectations participant had of assessment were influential in forming their evaluation of assessment as an experience. Where there was a lack of information about the purposes of assessment, participants attempted to glean from their own experiences what assessment was for. Some saw it as an exercise in risk management, which could have the detrimental effect of leaving the participant feel devalued. Others saw it as a routine aspect of care, which may have affected their engagement with assessment and the salience of it as a feature of their experience. Some participants saw assessment as a gateway to future care. As a gateway, it can serve both the positive purpose of offering access to care and the negative purpose of closing off avenues of care. As a gateway, it necessarily had gatekeepers, assessors, whose job it was to decide what care was offered.

6.2 Super-ordinate Theme 2: “Value of assessment”
This theme covers four sub-themes highlighting ways in which the experience of assessment was perceived as valuable by the participants. These sub-themes are as follows:

- Someone to talk to
- Legitimating patient’s distress
- Trying to understand & feel understood
- Hope for change

Box 6.2 on the following page illustrates these sub-themes in brief.
6.2.1 Sub-theme 2.1: “Someone to talk to”

Having the opportunity to talk to someone was a key theme in the majority of accounts, although not all participants felt they were given this opportunity. For participants who experienced loneliness, this was an especially valued feature of the hospital experience, as it was less likely that they had this opportunity elsewhere. Participant 4 even valued the chance he had to speak to the ambulance team, as he found that:

When you’re living on your own, you can’t really talk to anyone

On one level, having this opportunity to talk to someone functioned to alleviate briefly the experience of loneliness and social isolation. However, the perceived value of this opportunity in the context of assessment went further than the alleviation of loneliness. The opportunity to talk was also seen as a chance to unburden oneself, and to come to terms with what had happened. As participant 3 remarked, talking allowed her to get things off her chest “instead of
just keeping everything built up inside me”, and this function of assessment as an unburdening, a lightening of the “weight” people were carrying around emotionally is echoed in several accounts. People felt better when they shared their experiences, and so when the assessment provided this opportunity, it could improve their emotional state: “I felt a lot better, just a lot better… offloading stuff what, you know, what’s in your head” (P2).

On another level, there was a tendency for participants to differentiate between talking to family or friends and talking to someone “professional”. As participant 2 shared:

You know that feeling inside, where some people you can talk to and some people you can’t talk to about stuff

A healthcare professional, in particular psychiatrists or psychologists, were seen to offer a different experience as a confidante than a friend or family member would. Participant 5 put it down to the idea that a mental health professional would know what it is like through their experience of others with mental health problems, and would maintain confidentiality whilst offering the patient options:

You know you can sort of trust them in confidence because you know, they won’t judge you, because they’ve been through it and they’ve seen loads and heard loads of people’s stories… it’s a lot more comfortable

Both participants 4 and 3 agreed with this, stating alternately that “they’re professionals… they know what to do” and “I’d rather speak to someone that knows, that understands what I’m going through”. There was a general belief that mental health professionals had the expertise to understand and suggest solutions.

Talking to someone was not seen as an easy or universally positive experience. Several participants admitted that talking about certain issues could be painful (“Sometimes I don’t like talking about it, because it just makes me think about things that I’d rather forget” (P3); “I feel a bit, yeah, quite a bit uncomfortable, it just brings memories flooding back” (P7)). Despite the pitfalls, most participants expressed the desire to speak to someone about their problems, and there was an assumption that mental health professionals, by virtue of their status, were specifically suited to the task.
6.2.2 Sub-theme 2.2: “Legitimating patient’s distress”

The theme of "legitimating distress" was significant for four patients, all of which had difficulty accepting their behaviour or had experience of being invalidated by others owing to the nature of their illnesses.

For participant 5, the visual aspect of her self-harm was important, as she visualized the pain leaving her body:

Whilst you’re seeing, it just look like you’re getting all the frustration out of yourself, releasing out of your body

Upon further discussion, it emerged that she had often struggled with family members to convey the seriousness of her mental distress. She described difficulties with her mother in particular:

…because it’s a mental thing, she can’t see it but, when she sees it when I self-harm, she can see it in the physical and then she can finally see how sort of bad an, it is (second interview)

In a sense, the self-harm expressed what she was suffering in a way that could be understood and responded to by herself and others, whereas when it was just mental pain, she was unable to express or deal with it. She also felt unable to ask for help, because she feared being disbelieved:

And it’s like oh my god, I can’t take time off work because it’s a mental illness, you know, no-one’s gonna believe me (second interview)

It seemed clear that participant 5 had difficulty accepting the legitimacy of her claim for help, as she held the belief that if something could not be seen and was not physical, it was less valid. This idea seemed to have root in her family experiences. She explained the difficulty her mother had in responding to her emotional needs:

(Her sibling’s illness) was something she could get involved with, something physical, but with mine, there’s nothing she can do, because it’s one of those conditions that you know, your mum can’t hug it better or anything like that… she can’t physically see me having a fit or anything like that, you know, it’s all sort of, it’s it’s just kind of dismissed as it not being there [right] in a way (second interview)

When she saw a psychiatric nurse who accepted and acknowledged her as someone in need of care, she described it as “a big relief”:
(Psychiatric nurse) was like, whatever’s on the sick note, that’s what (her boss) has to accept, and she has to accept the sick note, she can’t fire you [right] because you know, genuinely you are ill, in the mind, you are ill

The psychiatric nurse in effect gave her permission to take time off work, which at the time of the episode was the main source of distress. She made a powerful statement to the participant about the legitimacy of mental illness, and offered the participant options that she was unaware of before assessment.

The authority of the mental health professional was an important factor in the legitimation of needs and distress. Some of the participants felt better for having the opportunity to talk to “someone special” (P4), as they believed that psychiatric staff had the knowledge and the experience to help them.

Participant 4 felt that his need was legitimated by the psychiatrist because “He’s the first person that said it, cos he said you are totally depressed, I can see it in your eyes”. With this statement, the psychiatrist justified the participant’s help-seeking, which at some level the participant struggled to justify:

I was sort of going lo- my mind thinking oh it was just a cry for help, but it wasn’t, he knew that a, it was a relief yeah, basically

This made a difference to the participant, particularly in light of his isolation in the community:

All I know is I’ve got peace of mind at the end of the day that somebody’s got my name down, and knows I’ve been seen and everything so [yeah] and it’s just that makes me feel they know what they’re doing, somebody’s looking into it, that’s what the main thing

He came away from the assessment feeling less alone in his suffering, feeling that “at least someone knows me”.

Both participants 13 and 2 had had previous experiences of hospital where they had not been taken seriously, so on this occasion, the experience of being taken seriously and asked what was going on in their lives was important:

I’m grateful that, you know to go in there and someone’s come up, they’re not just going me in there and slinging me out, someone actually come to me and said why are you doing this?, do you know what I mean, why, what’s the reason behind this (P2)
It offered them an opportunity to start thinking about why they did what they did, and in participant 13’s case, to challenge the thought processes that led her to self-harm:

I: Can you pinpoint any ways that (assessment) might have impacted on you?
P13: Just being able to cope better

She went on to describe a recent incident where some young people had been calling her names in the street, which previously would have led to rumination and self-doubt, but on this occasion she felt capable of re-evaluating the situation:

I saw them for what they really were, pathetic, rather than erm, letting them get to me, and me feel myself as you know something that should be, that’s basically there’s something wrong with myself, and my, erm, you know that the problem was with them rather than with me (P13)

Being taken seriously, and having the opportunity to “evaluate” herself with the assessor had given her enough of a step forward that she was able to start challenging her negative thought patterns.

6.2.3 Sub-theme 2.3: “Trying to understand & feeling understood”

One common outcome of the experience of ending up in hospital was that the participant was left trying to figure out why they had done what they had done, and what they could do to prevent it happening again. Several participants expressed disbelief or uncertainty as to how they got to the point of self-harm:

I can’t bring it into my own mind, why it’s all happened, why it could’ve happened at that time… why did it come about at this time? Is it a midlife crisis, or, I really don’t know what in my mind triggered it (P12)

Assessment was an opportunity for some to try and figure out why they ended up in hospital:

I just thought it’d, it might give me a bit of erm, a bit more information, a bit more, a bit more clarity on why, you know, why I’m doing these things, do you know what I mean, just, just curious you know, just to think well, you know, they might be able to benefit me in some way, and might be able to help in some way, you know like to, to erm, just might be able to benefit me, you know like give me a few answers type of thing (P2)
A positive aspect of assessment seemed to be when the participants felt that the assessor was also interested and genuinely engaged in trying to understand what had happened and how to help them:

I had a doctor come to speak to me the next evening, erm, to try and understand why I’d done what I’d done, and erm, he seemed pretty understanding (P13)

Likewise, a negative aspect of assessment seemed to be the experience of not being understood, or when the staff did not try to find out what had happened:

(Doctor)’s told me, I don’t need you to tell me about your story in <home country>, I don’t need you to tell me about your story here [ok] I need you to tell me what is new, because all this I have in my file, I tell him no, all my problem is in <home country> and this country, and if you have that, and you don’t need me to tell you about it, why did you call me to speak with you? [yeah, ok] this told me I don’t have to answer his questions (P9)

Participant 9 became angry when the assessor he was speaking to seemed to invalidate an entire portion of his life – how he became an asylum seeker – by saying “I don’t need you to tell me about your story in <home country>“. He felt that the assessment was a waste of time if the assessor was not interested in this part of his story. Whilst the assessor’s intentions may have been different, he unfortunately conveyed a dismissive attitude to the participant with this approach. This account highlights the importance of creating space to listen and hear the patient (even when this information is already on file).

The experience of feeling understood by the staff seemed to be something that went beyond the idea of knowledge and introduces the idea of lived experience as central to understanding, as participant 1 conveyed:

They don’t really understand what we’re going through, all they do is look at books really

Feeling understood instead seemed to be linked to the effort on the staff member’s part to connect and engage with the participant’s story. Participant 7, when asked what she thought made one nurse more understanding than the others she had encountered, stated:

Because she listened to you more, and did more with you than them Her idea of being understood involved an active interaction with the staff member, both doing things with and talking to them.
6.2.4 Sub-theme 2.4: “Hope for change”

She got the whole ball rolling, she got it all started, gave me my first steps (P5)

From the services perspective, the idea of assessment is inextricably linked to the idea of promoting change in the participant’s behaviour, in the sense that the goal is to prevent further self-harm or attempted suicide. Likewise, the participants were positive about assessment where it led to some change in their lives, although this change may not be a reduction in self-harm. Participant 5 explicitly acknowledged that the psychiatric nurse she was assessed by was pivotal in bringing about change in her life:

I: How much of that would you put down to the fact that you had that assessment with the psychologist nurse?
P5: Erm, I’d probably put like half of it [yeah] or maybe a bit over half because erm, obviously I had her, and she got the whole ball rolling

This experience was positive for the participant, as she legitimised the patient’s claim for help and offered her an option the participant did not know she had. It also gave her confidence, as she explained:

[Psychiatric nurse] was dead confident, so that made me feel better in myself, as soon as I left, I was like wow, so nice [yeah] and then she sort of gave me the confidence to get that sick note for work [yeah] and get the ball rolling to get me out of there, and obviously to get myself a counsellor so I could speak to them myself (P5, second interview)

The change the psychiatric nurse enabled was not just a physical change in the participant’s circumstances. By her sympathetic treatment, she managed to enable a change in the participant’s self-confidence, allowing her to feel capable of seeking further help. It would therefore seem that being ‘heard’ and understood is a key element of an effective assessment, as this process values and affirms the patient’s being, allowing for a more positive self-regard and facilitating a more lasting hoped for change in self-concept.

For participants 4 and 10, the assessment made a difference because the assessors seemed to put a lot of effort into ensuring that support was available when they left the hospital. As participant 4 explained:
He has done quite a bit, and he’s… referred, well, he’s on to my GP… and he’s doing something else, he’s going to write to me… and he absolutely does look, seems like he does care

Both participants felt reassured that in the future, they would get the help they need, and felt less alone in their struggles:

[I’m] hugely grateful that I’ve got the help, it’s made a whole world of difference [yeah], I’m getting regular phonecalls, people are phoning me, keeping me informed, my care people are coming, I know that within the next couple of weeks, I will have the support I need (P10).

They were both much more hopeful about their situations, now that they knew people were trying to help them, and that they could expect some form of follow-up care. Knowing that the help was there can change a person’s outlook on the future:

I know there’s somewhere to turn now, they’re not all dark clouds, you know (P12)

This account suggested that the isolation the participants experienced was now more manageable and had been disrupted through this positive contact with mental health professionals. In place of the isolation, hope can begin to emerge.

For participant 13, it was the specific content of the assessment that gave her hope for the future. The assessor was able to use herself as an example for the participant, in her early twenties, to draw hope from:

P13: (She) helped me by opening up a bit how, erm how erm she was at my age [yeah] and erm, comparing herself to how she was then and erm giving me hope for the future…
I: Could you describe the impact its had or
P13: Erm, just that I’ve got a lot more to learn in life [right] and what has been now isn’t everything

In this example, the assessor was able to give the participant a different perspective on her problems, which made them seem more manageable.

Similarly, the value of assessment for participant 12 lay in the way it gave him confidence to face the future and seek help if needed:

The fact is, I think I’ve got more confidence to get in touch with somebody now, before trying to something like that… I probably didn’t have the confidence on that day to say right, I’ll walk into the hospital, I’ll
Within this theme, a number of different things are happening during assessment that promotes hope for change. First, we have assessors working to provide options and aftercare for the participants. This has the benefits of making participants feel less isolated in their distress and feel hopeful that something can be done to change their circumstances. It makes them feel cared for and valued as human beings. Secondly, we have the assessors inspiring confidence in the participants, making them feel more capable of seeking help and helping themselves.

6.2.5 Summary
The ways in which an assessment can be positively experienced reinforce the importance of assessment as a feature of hospital management. The value of assessment for the participants seemed to be both relational and psychological, in that they experienced assessment positively when it involved a beneficial, hopeful engagement with the staff member and when it involved the restoration of hope or the possibility of change in the individual’s circumstances. A positive assessment was one where the participant felt understood and valued, and where a sense of possibility, and agency, was restored.

6.3 Super-ordinate Theme 3: “Negative aspects of assessment”
This theme covers 3 sub-themes highlighting ways in which the experience of assessment had a negative impact on participants. These sub-themes were:

- Feeling judged
- Referral circle – no change
- Struggle to be heard & believed

Box 6.3 below outlines the three sub-themes, which are then discussed in further detail.
Box 6.3: Sub-themes of “Negative Aspects of Assessment”

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<thead>
<tr>
<th>Super-ordinate Theme</th>
<th>Sub-themes</th>
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<tr>
<td></td>
<td>Assessment experienced negatively when it was a vehicle for judging the patient</td>
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<td>Referral Circle – No Change</td>
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<tr>
<td></td>
<td>Assessment experienced negatively when it led to no change</td>
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<td></td>
<td>Struggle to be heard &amp; believed</td>
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<tr>
<td></td>
<td>Assessment experienced negatively when patients felt ignored/unheard/disbelieved</td>
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6.3.1 Sub-theme 3.1: “Feeling judged”

Several participants had previous experiences of being judged or devalued as a result of physical, psychological or social differences in their lives (see 5.7.3). In addition, it was common for participants to feel guilt, shame and embarrassment about their self-harm, or in participant 2’s case, his continued alcohol and drug abuse:

There I was again, back there again, do you know what I mean, so I was really embarrassed that time (P2)

I know how stupid I am (P11)

I know that I’d been stupid, and that’s exactly how I was feeling... I felt so stupid [yeah] and so embarrassed about what I’d done, ashamed even (p12)

People are in hospital and suffering terribly because they have a terminal illness and you know, they’re clinging to life and trying to prolong it, and here’s me, you know, sitting and taking all these tablets (P10)

You feel really stupid afterwards... I didn’t need to do that (P5)

Most participants came to the hospital with a fear of being judged or blamed for what they had done. Participants were often sensitive to the possibility of being judged (P12: “they didn’t stick me to one side, and say oh well, he’s done it, let him bleed to death”), and those who were treated with respect and kindness
were immensely grateful for it. It was common for those participants (P2, P4, P8 and P10) who had alcohol or drug problems to report experiencing prejudice, negative staff attitudes and poor treatment in hospital as a result of these issues:

They judge you if you’re an addict, it’s on your notes, you get terribly judged (P10)

[Psychiatrist said] you’re playing a stupid game, with how much drugs you’re taking, how much drink you’re taking (P2)

For a few participants, the experience of assessment only served to add to their feelings of guilt and shame:

A psychiatrist or psychologist, who said you know about erm, you know, you’re playing a bit of a stupid game, with how much drugs you’re taking, and how much tablets you’re taking (P2)

For participant 2, struggling with addiction and the implications of his behaviour, this conversation with “a psychiatrist or psychologist” added to his sense of hopelessness. He disengaged with the idea of assessment, as he stated “what’s it worth sitting down with a psychiatrist when I’ve done it before?” If all an assessment could do was re-state the problem (“I know what they’ll tell, they’ll tell me not to, to first cut out drink, first cut drugs, and stop erm, going and fucking round my friends”), he could not see a reason to take part in one.

I’ve been crying, crying, crying, I said, I’ve stopped crying, and it was going through my mind what I’d done, and what the psychiatrist had said (P11)

The experience of participant 11 was an example of how an assessment could compound the participant’s feelings of guilt and shame, and lead to disengagement with the process. She saw a psychiatrist who asked her “how do you think your children and grandchildren would’ve felt if you’d’ve died”. This was probably the worst topic he could have brought up in assessment, as it increased her guilt and self-blame, to the extent that when she got home the next day, she cried for hours. It seems that she felt judged by the psychiatrist’s way of asking this question: “I don’t need a bit of a kid telling me I’ve done wrong, or this that and the other, haven’t I got any thought about my children, all
this sort of thing⁴, whilst it is likely that the psychiatrist was attempting to draw on her reasons to live as protective factors against future attempts.

He didn’t sit and talk to you, ask you any questions… he went straight to the point (P11)

As a result of the psychiatrist’s manner in assessment, she adamantly refused to see another psychiatrist: “I still keep harping back to that psychiatrist, and that’s why I don’t want to see another one”. The memory was still hurtful enough that she grew agitated talking about it during the research interview.

Several participants experienced negative staff attitudes towards them owing to their self-harm or their mental illness. These attitudes positioned the individual in a category that devalued their personal experience. Participant 8 stated that from his experience: “a lot of people don’t, health workers don’t treat mental health issues, overdoses, self-harming, like you know, cutting yourself and that, they think it is oh it’s a waste of time, waste of space”. In combination with the stigma patients already perceived in the community, these attitudes discouraged engagement:

Some of [the nurses] were ignorant in their views, they don’t realise that people do have mental problems and they don’t know why they’ve got them [yeah], and I wouldn’t tell them why I’ve got them (P8)

6.3.2 Sub-theme 3.2: “Referral circle – no change”

People’s motives for seeking help varied, but what became clear in the majority was that they had reached a crisis point when they self-harmed, and something had to be done:

I thought I needed some help (P1)

I thought you can’t keep doing this (P2)

I needed some way forward, at that, the stage I was at I was nowhere (P4)

A significant negative aspect of assessment was when participants got the impression that nothing could be done to help them. In participant 3’s case, this
impression was the result of a referral circle which arose as she repeatedly tried

to get help. Each time she self-harmed, she was referred back to the same
organisation, which had been unable to help her in the past:

I: And what if anything would you suggest could be changed to make it
better, if somebody else had to go?
P3: Someone who could refer me to someone else, that I could talk to
you, not to refer me to the [self-harm service]

When she spoke to her GP or the hospital staff, the outcome was always the
same: a referral back to the service which she had disengaged from previously,
because “they make me feel uncomfortable”. In this case, there seemed to be a
mismatch between the participant’s willingness and ability to communicate and
the service’s form of therapy:

They just sit there and wait for you to say something else instead of ask
– they can ask me anything, but they don’t

A non-directive approach to therapy led her to disengage due to her discomfort,
and she expressed increasing frustration with the cycle of referral.

Participant 9’s frustration with services was compounded by the experiences he
had as an asylum seeker, who could not get the Home Office to confirm or deny
his status or any other organisation to change his circumstances. As he
expressed it:

I can’t go back to my country, I can’t go anywhere, ok, if they give me
document to say I’m refused, I can contact people, like the human rights,
something like this, to send me to other country [yes] many people, they
do this, because they have document they are refused [yeah] but the
Home office say no, ok, no refused, or no here, what do they need?

He felt trapped, and became suicidal as a result of feelings of powerlessness
and defeat. When he sought help from the crisis service, this pattern of
powerlessness was repeated:

They told me, we can’t do anything of this thing, all that we can do, just if
you feel low, we send you to hospital, I told them ok, I am agreeing with
this, but I don’t need to see anybody anymore, that’s enough

The absurdity of the situation, as he saw it, was that all he was offered was a
hospital bed or medication, when it was clear to him that:
They give you medication just to finish with you... this does not sort out your problem, if you sort out all your problems, you will not have depression or thinking about suicide

He disengaged from the hospital and the crisis service as he felt “they give me no choice, like they’ve got my hands in cuffs, no choice”. This account in particular highlights the importance of social and environmental factors in generating distress and poses challenging questions of how to respond to the social dimension of distress.

I was thinking is it worth it?... Is it worth this chat again? (P2)

Repeated experiences of services and little change in one’s circumstances are likely to be responsible for the increasing hopelessness about help-seeking that some participants expressed. For participant 2, it was the combination of being told the same thing repeatedly (to stop drinking) and yet continuing to end up in hospital with overdoses that led him to feel hopeless about the possibility of change: “I’ve had chats before and it’s, it’s not done, you know, I’ve done, I’ve gone back to the same thing”. In his second interview, he discussed his struggle to maintain hope and engage in therapy when he cycles through relapse and recovery:

If you keep relapsing, it’s like, yeah, how long this time, and it’s like getting bad and good again and in the end you get sick of relapse, sick of coming back... it gets that monotonous

[Help-seeking] gets repetitive to yourself and...it becomes a negative thing, and you start to think oh fucking hell, and that becomes a chore seeing you counselor or therapist

Participant 6 attended hospital three times in quick succession, with her suicidal ideation increasing each time as she was met with the same response: “People were desperately trying to keep me in the community when I was desperately trying to tell them I was in crisis”. On the last time she attended, she stated:

I just decided that no-one had care-, no-one actually cared whether I’d erm, whether I was killing myself or not, so I just thought why not? I was actually frustrated with not being able to kill myself [yeah] I’d gone into a really numb place

Being met with the same response each time led her to “completely giving up hope, not just in my future, but in the fact that anybody else cared”. In this way, the response that a participant is given during assessment could have a huge
impact on their hopefulness and engagement with services, especially in light of the responses given during previous assessments.

6.3.3 Sub-theme 3.3: “Struggle to be heard and believed”

Some participants experienced difficulties communicating the severity of their emotional distress to staff. For participant 1, the difficulty of communicating with staff was complicated by the nature of his mental illness. He often experienced voices and visual disturbances which made it difficult for him to talk to staff:

He [one of the voices] talks over me [ok] so I find it difficult to talk to psychiatrist. If I’m talking to somebody normal they understand and that’s alright, but if I go into the doctor, then my uncle’s got something to say

His uncle, whose voice was the most disturbing one he heard, seemed to interfere specifically with his communication with psychiatrists or doctors. Hearing this voice was a significant barrier during assessment, as he indicated that he tried to explain himself but “can’t explain everything” because of the upsetting nature of the mental phenomena.

Given this interference, it was unsurprising that participant 1 had a difficult time getting across to staff how he felt, but he also suggested that staff don’t “listen hard enough”. To him, his distress was evident even when he couldn't fully express it, but he found himself repeatedly sent home with zopiclone, instead of being admitted. As he expressed in his second interview:

P1: (Psychiatrist) said you don’t need to keep coming here
I: Right, and how do you feel about?
P1: Well, I don’t really understand why not, because I’m in crisis

When pressed to explain what a crisis was like, he struggled to find the words, saying “it’s like, just like disturbs me”. At the root of his distress was his struggle with the overwhelming voices and visual disturbances he experienced, and which also interfered with his ability to ask for help:

That’s what I hear, that’s what I see… and I’m terrified, and when I talk about it nobody listens to me

His struggle to be heard was partly a feature of his mental illness, which he felt healthcare professionals did not understand and did not respond to appropriately “I was telling them and that was, they just said well, you’re alright
to go back home”, and this barrier created by his illness played a pivotal role in his engagement and satisfaction with services.

For participant 6, the struggle was of a different nature. As mentioned earlier, she had to fight with staff to be heard and accepted as someone in need of help, because they seemed to think she was “too lucid” to be suicidal. On several occasions, she experienced staff disbelieving her because she had a mental illness (“I felt like they were constantly telling me that I didn’t know my own mind because I was depressed”), or paradoxically, because she was too articulate to be in need. In her second interview, she expanded upon her experience of being invalidated:

P6: I think when you go in, you go in to the hospital and you tell actually I know what I have, I have severe depressive disorder, they think, yeah, right, I’ll do the diagnosis thank you
I: Ok, so I mean, I mean, that last statement, it does sound like, there’s almost a lack of trust there
P6: Well, in my experience they don’t trust anyone with mental health problems whatsoever [right] down to medication, they won’t believe you

This experience of being disbelieved and mistrusted could have consequences beyond the emotional, as she related an incident where she was denied medication because her notes had the wrong dosage recorded. She went on to state the impact of this experience:

You get a total, total loss of dignity because people just constantly underestimate you, underestimating you as a person, yes, I might be hideously depressed but you know, there’s still a brain in here, and I’m still a person

Participant 3 had a negative experience of a non-directive assessment, where she was expected to lead the conversation. She felt the lack of response indicated a lack of engagement with her: “if they talked to you, I’d talk to them, but what’s the point of having a one-way conversation?” For her, this approach had the unfortunate consequence of leaving her feeling alone, frustrated and disengaged with the service: “They’re supposed to be there to help you, they don’t give nothing, they don’t do nothing for you”.

6.3.4 Summary
Assessment was not universally experienced as a positive aspect of the participants’ help-seeking. When participants experienced assessment as
invalidating, and when assessment seemed to lead nowhere and offer no hope for change, it was experienced negatively, and could compound the participants’ initial feelings of hopelessness, powerlessness and low self-worth. Assessors had considerable power within the assessment to devalue and invalidate the participant’s experiences, a power which held emotional and physical consequences for participants.

6.4 Super-ordinate Theme 4: “Like I was a human being” – Spectrum of care to control

Whilst the experience of assessment forms a part of the hospital experience, it was notable that many participants had extensive knowledge and experience of hospitals, in particular the emergency department and psychiatric wards. One theme that resonated across both positive and negative accounts was that of being treated “like I was a human being”, as participant 11 put it, instead of like “a specimen” (P11) or “sub-human” (P6). The spectrum of care experienced can be broadly categorized into three themes:

- Feeling cared for/valued
- Feeling ignored/neglected
- Feeling imprisoned/dehumanised

These three sub-themes are discussed below (see also, box 6.4 for short descriptions).

Box 6.4: Sub-themes of “Like I was a human being”

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<thead>
<tr>
<th>Super-Ordinate Theme</th>
<th>Sub-themes</th>
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<tr>
<td>Spectrum of care from being valued to being</td>
<td>Experiences which valued participants as human beings</td>
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<td>devalued – how participant’s essential humanity</td>
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<td>is positioned through care given</td>
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<td></td>
<td>Feeling Ignored/Neglected</td>
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<td></td>
<td>Experiences which contributed to participants feeling invisible/unheard</td>
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<tr>
<td></td>
<td>Feeling Imprisoned/Dehumanised</td>
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<td></td>
<td>Experiences which actively devalued the participants in some way</td>
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6.4.1 Sub-theme 4.1: “Feeling cared for/valued”

Overwhelmingly, the majority of participants spoke of the importance of feeling cared for or valued by the staff. Two participants (P1 and P3) are not included in this theme because they did not recount any caring encounters with hospital staff, although both indicated being heard by staff was a desired experience at various points in their interviews (P1: “I would suggest any of them listening to what people’s got to say”). Participant 3 shared a valued relationship with her GP, where she felt heard and cared for (see 7.2.1).

In light of the invalidating experiences highlighted in the previous chapter, this emphasis on feeling cared for or valued is not surprising, as the majority of participants felt “less than” in some way. Being cared for by staff became important as a way to restore self-worth:

- It was a feeling that you were wanted (P11)
- Someone was… looking into it and looking out for me (P4)
- It was all about me (P5)

Examples of being cared for spanned the range of staff and settings encountered in the hospital. Being offered the opportunity to talk as discussed in 6.2.1 was a major way in which participants felt cared for and valued by staff. In addition, when participants were taken seriously and given time to recover in the hospital, this helped them to feel more valued in themselves:

- She said… if you ever feel the way you do now, you can always come back and sit here (P2)
- The impression I got, if I had gone back to the ward… he would have been quite happy for me to stay in… that sort of said something (P4)
- I was grateful, I just wanted them to listen to me (P13)

This issue of time and space to recover was an important one – several participants mentioned feeling safe as a motivator for help-seeking or as a positive outcome of hospital attendance:

- I thought I’d be safe there (P2)
While I was there, I felt comforted in the notion that if things got really awful... I couldn't kill myself (P6)

I knew where I was and I knew that I was secure (P12)

When the staff gave the impression that the participant was a priority to them, participants felt valued as individuals (e.g., P5: “it was all about me”; P4: “he really wanted to help me”). Participant 9 explained:

When he speak with me... I have feeling from inside of me... these words come from the bottom of his heart [ok] he need to help, not because he is doctor, and that is his work, no, because he need to help (second interview)

In various ways, some of the staff conveyed a genuine interest and commitment to helping participants. For participant 5, this was conveyed in the psychiatric nurse’s manner: she was attentive to everything the participant said, and she was warm and friendly. For participant 8, nurses on the ward showed genuine care by recognising his symptoms of withdrawal and offering small kindnesses such as iced water and medication to ease his pain. Participant 9 explained his positive experience was the result of the doctor “looking at me in a personal way, not like in medical way” (second interview). This was in contrast to the psychiatrist who prevented him from telling his story, which for the participant was the same as saying he was not interested in the participant.

Feeling cared for and valued seemed to depend on the personal manner of the staff. As participant 10 demonstrated:

I’d say 90% of [the nurses] were exceptional, they were wonderful, there were a couple of nurses that were, didn’t get involved in conversation, I remember saying to the ward sister at night... “there’s a young nurse comes in today, she takes my obs, and I speak to her and say oh it’s raining outside, or how are you today, and she doesn’t respond”... (the ward sister) said “she’s like that with everyone... don’t take it personally”

Terms like “warm”, “friendly”, “welcoming”, “caring”, “kind”, “supportive”, “lovely”, and “genuine” abounded in descriptions of positive experiences. For some participants, care went beyond the patient-staff relationship to something more personal, with the staff offering hugs and smiles (P10), calling them their “favourite patient” (P7), sharing a cigarette and a joke outside (P4), and extracting promises from the patient to refrain from self-harm (P10 and P11).
Participants valued the brief moments when a nurse sat with them and talked (P11: “they are really caring and they sit and talk to you properly”), when they remembered the patient’s name and asked how they are (P4: “Coming out and up and down (the ward) and “are you alright”… it was all very personal”) and when they made an effort to help them (P8: “I said I can’t really pick the glass up… she actually held the glass up”; P10: “the good nurses were the ones that made a wee bit of an effort”).

It is difficult to pinpoint specific features of hospital care that were perceived as caring and validating, as the participants talked about feeling cared for in relational terms. Two staff members could express the same sentiment and be perceived in opposing ways. For example, participant 11 saw the psychiatrist as judgemental when he asked her not to self-harm again: “I don’t need a bit of a kid telling me I’ve done wrong”, but saw the nurse as caring: “Promise me you won’t come back again, and the poor girl, she was nearly in tears… I promised her, and I know I won’t do it [ok] but she was just so caring”. What this suggests is that for the participant, the relationship with staff was a pivotal aspect of their experience at hospital. A nurse who has said hello and been seen by the participant over time can ask a question that offends the participant when a psychiatrist asks it:

I: Was it the questions themselves, or was it the way that he said them? P11: It was the way that he said them, he wasn’t very nice at all, like the nurses sat down and explained to you, he sat down and said erm, my name’s such and such a body, you’re <her initial and surname>, tried to commit suicide, why?

When you really need someone to be there (P6)

Another important aspect of being cared for was the expectations, fears and hopes of the participant at the time. For some participants, the prospect of attending hospital provoked anxiety, shame and embarrassment (P12: “I felt disgraced with myself… why am I putting these people so much trouble”; P5: “you’re embarrassed you’ve done it and you’ve humiliated yourself”). Often the participant expected to be judged for their actions – they judged themselves as “stupid” (P5, P10, P11, and P12) or had experienced negative staff attitudes in the past (P8: “why should we have to deal with these”; P11: “one nurse (said) you stupid, stupid woman”). The participants who sought help willingly did so because they felt a need for help (P3: “If I didn’t want help, I wouldn’t have gone
to the hospital”; P4: “I needed some way forward”; P7: “I felt I needed it at the time”). The service users were in a vulnerable place: they had recently hurt or tried to kill themselves, and had not necessarily emerged from the emotional states which led to self-harm when they get to hospital. The way staff responded could affect how the participant went on to feel about themselves and future help-seeking. When participant 12 attended hospital, he stated “I was a bit sort of concerned that I’d put myself in that situation”. He explained:

They looked after me completely, they didn’t stick me to one side, and say oh well, he’s done it, let him bleed to death, no, there was no recriminations whatsoever

He had felt unsure about whether he wanted to survive, but after seeking help, he was relieved to live, and said “I know now that there is help everywhere”. Being cared for and supported at this vulnerable time “when you really need someone to be there” (P6) was greatly appreciated by the participants:

Just to have a chat with someone… it helps a lot and I did feel a lot better after it (P2)

He made me feel a lot better (P4)

I was relieved that there was someone there to talk to me (P5)

[On the mental health ward] they were always ready to talk (P6)

The way they care for you, you feel as if you’re the only one in the ward (P11)

It may be that the participants did not have adequate social support elsewhere to get them through crises, or that they felt completely hopeless and powerless over their lives. Having someone there at the hospital, available and willing to listen, allowed participants to feel valued and valuable as a human being.

6.4.2 Sub-theme 4.2: “Feeling ignored/neglected”

Participants were not always able to report examples of staff who were ready and willing to talk. Hospital wards and emergency departments could be very isolating and frightening places for the participants, where they felt invisible to staff.
You’re sat there and you’re silent, and you’re not talking to anyone, and it just pushes you a bit, it would make you a bit worse than you were (P5)

I was completely alone, and I didn’t know the place, and it was, it was really surreal… I was just frightened (P6)

For me, it was a lonely place (P10)

The majority acknowledged that hospital was a busy place, and expected to wait when they attended the emergency department. Often, they expressed sympathy for staff whom they perceived to be over-worked and under-resourced. This did not prevent them from finding the atmospheres of the waiting room and inpatient ward difficult to cope with. Participant 5, though she acknowledged the burden on staff (“it gets busy in there, it really does”), stated that “when you’re going through that amount, you know, all that in your head… and then you’re stuck there in the waiting room for a long time…it can send you a bit loopy”. The presence of someone to talk to was essential to prevent her mental state from deteriorating. Similarly, participant 6 was left waiting for several hours to see a psychiatrist in the morning, and the absence of any contact or comfort was distressing: “I was just frightened”. Both participants suffered physical discomfort whilst they waited, as did participant 3, who stated: “I know they were busy the last… time I went, but you shouldn’t leave someone like that, sat there waiting, covered in blood”. The experience of seeking help was already traumatic and anxiety-provoking for the participants, and being left with physical injuries in emergency departments that were often noisy and chaotic had a negative impact on their emotional states.

Some participants interpreted this treatment as a sign that staff did not care what happened to them, or disrespected them:

They just left me there for a few hours, no interest in what was going on whatsoever. I just got fed up and tried [to kill herself] again (P6)

They had me sat there, didn’t even bother telling me, so I didn’t bother waiting for hours, I just went home (P3)

I’m waiting for the doctor for three or four hours, and that was why I was angry, why, why have to wait… I don’t have to wait for him, and I will not speak with him (P9)
For these participants, being left in emotional and physical pain with no information or contact with staff, evokes hopelessness, frustration and anger. Participant 6 gave up trying to access help as she felt repeatedly ignored by staff; participant 3 went home when staff gave her no information about her care; and participant 9 disengaged because the psychiatrist kept him waiting for three hours when all he wanted was to be allowed to go home.

The hospital ward could be an equally negative place for participants. Seven participants spent the night in hospital (P2, P4, and P9-P13), whilst participant 6 was eventually admitted into a psychiatric ward after three attempts to kill herself in a short period of time. Participants 1, 7 and 10 had had previous experience of mental health wards at various points. Several of those who spent the night at hospital commented on the lack of contact with people and the boredom: “you just twiddle your thumbs and you just try to sleep” (P4); “they don’t make sure you’re ok… stay in your room” (P9, second interview); “I just stayed there all day on the bed” (P12). Both participants 6 and 10 found that longer stays on hospital wards were also characterized by a lack of contact. Participant 6 described: “staff kind of sitting around doing nothing... there was no interaction really, unless something happened”. Participant 10 experienced a mixture of good and bad on inpatient wards, but after his overdose recalled a lack of contact: “there was none of that sort of you know, even just short five minutes of intimate chat”. He admitted to feeling lonely on the ward, and also talked about witnessing physical neglect of other patients: “I’ve seen the way some of the elderly people, people that are sick are treated”. His loneliness on the ward led him to worry about future help-seeking when his disabilities worsened. He already felt vulnerable because he felt “you’ve got no voice at all” in hospital, especially when there is no family or friends available to be advocates.

Participant 6 experienced a psychiatric ward where patients were given the freedom to cater for their own needs, such as cooking, getting tea and washing. She found that her physical disabilities were neglected by staff, who she reported: “said outright ‘we don’t have any way of catering for your problems here’” (second interview). Worryingly, she also experienced a lack of “voice” on the ward such as participant 10 mentioned. She found that staff were unwilling
to listen to her when she told them about her medication: “If you tell them what your medication is, they won’t believe you, at all… they’ll only believe official doctor’s lists, and if the doctor’s got it wrong, and you know about it - tough” (second interview). She repeatedly experienced being ignored because she had a mental health problem: “I would imagine there are lots of other people like me who think why are they (the staff) doing this? I’m quite normal, generally, I just happen to have a mental health problem”.

She just said I don’t think there’s any need for you to go there (P1)

Participant 1 experienced repeated invalidation of his claim for help at hospital, as the psychiatric staff perceived his support needs to be adequately met in the community. As he lived in supportive housing and had a care team, they sent him home when he attended hospital. To the participant, this made no sense: “I don’t really understand why [I shouldn’t attend] because I’m in crisis” (second interview). As he saw it, he was in serious distress but “when I talk about it, nobody listens to me” (second interview). The psychiatric staff’s attempts to encourage him to use services according to their perception of his needs left him feeling confused, ignored and misunderstood.

Discrepancies between a staff member’s risk assessment and the participant’s own perception of need could lead to a participant feeling ignored or neglected. Both participants 3 and 6 reported repeated attendances with self-harm where they felt dismissed by the hospital staff. Participant 6 attended hospital three times with worsening self-harm and suicidal feelings, but the psychiatric staff she encountered placed her back in the community: “I wasn’t going to be able to cope with this for much longer but they just wouldn’t do anything about it”. Her struggles to get staff to respond to her deepening distress left her “very worried” that she wouldn’t be able to get help in the event of a further episode.

Sometimes, there were physical barriers between staff and patients that reinforced the service users’ feelings of loneliness and neglect on the wards. For participant 11, the tendency for doctors to come to the bedside in pairs shut down communication: “there always tended to be two of them, and they did more talking to each other than they talk to you”. The jargon they used (“all the
big words”) and the speed at which they assessed her case left her feeling intimidated and confused (“I couldn’t understand them really”). Participant 10 also commented on this “team” approach: “there would be the consultant and his team and they would literally ask me one question and then walk away… I always wanted to have more of a conversation”. Neither participant felt that they could easily discuss their anxieties with their consultants.

Another physical barrier between staff and patient communication was the “bay” (P10), or the staff area on the ward. Whilst she was on an inpatient ward, participant 7 noted that the staff “were more in the office all day literally, and never came out or did anything with you”. The office effectively separated staff from patients, creating a barrier between them. Likewise, participant 10 commented that “I’ve seen nurses do a 9 hour shift and sat in a bay, tucked on a computer. For christsakes, where’s the care? Where’s the someone to talk to?” Patients hoped for and sometimes expected that part of the hospital experience would be about being cared for: “they’re there to help you, aren’t they?” (P2). The disappointment, frustration, confusion, anger, and hopelessness that arose as a result of being ignored by staff impacted on their readiness to seek help in the future (e.g. P6: “it does frighten me”) and their experiences of hospital wards as “lonely”, “voice”-less places could affect their honesty in risk assessments: “I thought oh gosh, what if I’m sectioned?... and then you’re in hospital and you’re totally powerless when you’re in there” (P10).

6.4.3 Sub-theme 4.3: “Feeling imprisoned/dehumanised”

The spectrum of care extended from being cared for and valued as a human being to being controlled and devalued by staff. There were three ways in which services conveyed to patients that they were “sub-human” (P6). The first way, discussed in 6.3.1 as a negative aspect of assessment, was by judging or devaluing patients due to a feature of their history or social background. Some assessors seemed to view self-harmers or alcohol and drug users as to blame for their hospital admittance. Participants could be left feeling like a “specimen”, a “waste of time” and hopeless:

They make you feel you’re just not worth saving... because you’ve done it to yourself (P11, second interview)
Staff attitudes could also dehumanise patients through the process of labeling. Participant 4 was left feeling hurt and rejected when he overheard a nurse saying “what's that doctor sending all these reformed alcoholics up here for?”. His discharge immediately after the nurse said “get rid of him!” devalued his distress. He came away feeling that as a “reformed alcoholic”, he was less worthy of care.

I had one [healthcare professional] turn round and say to me once… if you’re going to do it again, do it proper will you, stop mithering us (P11, second interview)

The impact of staff prioritising hospital time and resources over the participant’s distress was also dehumanising for participants to experience. One notable feature of participant 6’s account was the anger she felt at staff insisting she stay in the community due to a lack of beds. As her suicidality increased, she stated:

I just felt like it didn’t matter, how much I, didn’t matter how eloquent I was or what I said, what I did, basically all they were going to do was like patch me up and ship me out, and it was like they were giving me the green light, go off and kill yourself, as long as you do it tidily, we don’t care

The terminology participant 6 used is interesting in how it positions her as a product the staff process: “patch me up and ship me out”. The participant felt as if she was simply a problem to dispose of, rather than a person.

The second way in which patients are dehumanised by services related to the psychiatric ward environment. Two participants (P9 and P7) spoke of the ward as akin to a “prison”:

They [the crisis service] send me to the mental health unit… not normal hospital like what they promised, send me there, put me there, like a prison (P9)

For participant 9, his admittance onto the psychiatric ward was accompanied by a sense of betrayal. After speaking to the crisis service, who told him he should go into hospital for the night, he got there to discover he was being kept until a psychiatrist discharged him. He felt trapped and treated like “a man to crime”, as if he had done something wrong. His requests, his reiteration of what he was told by the crisis service about his stay were ignored by the staff:
When they are speaking with us like this, and they don’t give us any trust, how can they inform us to be fine?

In the second interview, he made the above point that the treatment he received curtailed what could be achieved in terms of recovery and relationship. When he is treated like a prisoner, prevented from smoking outside without guards and not allowed to return home, expecting him to engage with assessment and trust staff is absurd:

I think to understand different person, I think you need to be nice… start like looking for his eyes, getting face in, start have good communication with them (second interview)

If patients are to regain a sense of themselves as worthwhile human beings, staff need to approach them as human beings, not prisoners or criminals to be watched and distrusted.

The third way in which patients could feel dehumanized related to only one participant within the sample. Participant 7 experienced a psychiatric ward which had locked doors to keep patients in. The dominating aspect of her stay was the use of restraint:

Anything else, but not that… because that is what they did to everyone… you can name it, how many times they did it in one day, 24/7… that was nearly every day, all day, literally 24/7

In her interview, she kept returning to this issue, growing more animated when she spoke of it:

I: It seems to me that [restraining] still quite upsets you
P7: It did and it still does

As she described it, the staff on the ward became a nameless “them”: “they got the whole of some team involved every time, they just had to press their personal alarms like that and then they came running and burst through activated doors”. “Everyone” was restrained, and to her it seemed random and repetitive: “it’s more like restraining you every 5 minutes, every 5 seconds even”. The atmosphere, created by this use of restraint and the team of staff working as one body, left the participant feeling under prison guard rather than under hospital care.

I: Was this being on the psychiatric ward?
P7: I wouldn’t even call it that, where I was
6.4.4 Summary

The participants’ experiences of hospital care had an impact on them in several ways: they formed the basis of the expectations participants had of what sort of treatment they would receive at hospital; they influenced the participants’ readiness and willingness to participate in assessment by impacting on their mood at the time; and they influenced how participants felt about seeking help in the future.

This super-ordinate theme focused on the personal meaning of the experiences participants recount, rather than on the physical and material conditions they experienced. For example, how people experienced the waiting room in the emergency department is discussed in terms of what it meant to them, and how it impacted on their perception of self and services.

The themes around hospital care resonate with the positive and negative aspects of assessment, and with themes in the broader circumstances of the participants’ lives, as recounted in the previous chapter and above. One way to conceptualize of this analysis is to see it as nested, with the hospital experience taking place within the broader context of a participant’s life in the community, and the experience of assessment being a sub-set of the hospital experience with a pivotal role in promoting or stifling hope. The spectrum of care presented demonstrates the various ways in which specific attitudes, settings and treatments can be interpreted as statements about the personal value of the participant and the legitimacy of their claim for help.
CHAPTER 7: FINDINGS
Outcomes from assessment and further engagement with services

“It’s swings and roundabouts, because you’re not going to die or owt like that [yeah] unless you do it yourself" (P4)

7 Introduction
This chapter primarily relies on the second interviews conducted with seven participants three months after their initial interview. The focus of the second interview was on the outcomes from assessment as perceived by the participant, their experiences with services, and their lives in general since the initial episode which constituted their entry into the study.

The themes in this chapter were mostly drawn from the second interviews, but are also supported by supplementary data from the first interviews where themes which arose at the initial meeting were reinforced and reiterated at the second meeting. In addition, where the first interview took place a few weeks after the hospital visit, participants often offered insight into the outcomes of their experience. These insights are included when they seemed significant to the participant’s meaning-making about the index episode. One feature of the follow-up interviews which is of phenomenological and practical import is that the meanings created by participants at this stage often stayed close to the meanings created in the first interview.

Seven participants took part in a second interview. All participants initially agreed to a further contact three months after the first interview, but for various reasons, a follow-up interview was not possible. These reasons are summarised in table 7.1.
Table 7.1: Summary of Follow-up Contacts & Reasons for Study Departure

<table>
<thead>
<tr>
<th>Participant</th>
<th>Attempts at Contact</th>
<th>Reasons for Study Departure</th>
</tr>
</thead>
<tbody>
<tr>
<td>P3</td>
<td>Mobile phone &amp; Letter</td>
<td>Participant unreachable by phone, and did not answer letter invitation for second interview</td>
</tr>
<tr>
<td>P4</td>
<td>Home phone &amp; Letter</td>
<td>Participant having significant health problems – in hospital at time of 3 month follow-up</td>
</tr>
<tr>
<td>P7</td>
<td>Home phone, Letter, Contact with key worker</td>
<td>No contact was made: participant had left previous address and no forwarding information could be provided</td>
</tr>
<tr>
<td>P8</td>
<td>Mobile Phone &amp; Letter</td>
<td>Participant having legal difficulties – requested time to resolve but situation did not change</td>
</tr>
<tr>
<td>P12</td>
<td>Mobile Phone</td>
<td>Contacted, but refused to take part as he felt he had moved on</td>
</tr>
<tr>
<td>P13</td>
<td>Mobile Phone &amp; Letter</td>
<td>Participant unreachable by phone, and did not answer letter invitation for second interview</td>
</tr>
</tbody>
</table>

Two super-ordinate themes are discussed below. The first super-ordinate theme is entitled “Outcomes from hospital experience” and relates to features of the aftermath of hospital attendance that were significant for the participants. The second super-ordinate theme is more descriptive, and focuses on participants’ impressions of services beyond the hospital. This theme is called “Values and limitations of other services”. Reflecting the substantive focus on hospital experiences, these themes are limited in scope, i.e., the entire range of possible services was not covered. Two services were discussed with sufficient detail and emphasis by participants to warrant attention. These were: primary care and voluntary services.

7.1 Super-ordinate theme 1: “Outcomes from hospital attendance”

This theme summarises the ways in which the participants’ experiences of hospital impacted on their lives beyond the episode.

In order to contextualise these themes, it is useful to recount what follow-up the participants expected after the hospital visit. Table 7.2 summarises each participant’s expectations for their future care.
Table 7.2: Expectations for aftercare

<table>
<thead>
<tr>
<th>Participant</th>
<th>Took part in follow-up interview?</th>
<th>GP to be informed?</th>
<th>Referrals?</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Referred back to care team</td>
</tr>
<tr>
<td>P2</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Referral to self-harm service</td>
</tr>
<tr>
<td>P3</td>
<td>No</td>
<td>Yes</td>
<td>Referral to GP – to be referred to self-harm service</td>
</tr>
<tr>
<td>P4</td>
<td>No</td>
<td>Yes</td>
<td>Referral to GP for new prescription and crisis service</td>
</tr>
<tr>
<td>P5</td>
<td>Yes</td>
<td>Yes</td>
<td>Referral to GP for new prescription and asked to consider counselling</td>
</tr>
<tr>
<td>P6</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Discharged into care of family and current psychiatrist</td>
</tr>
<tr>
<td>P7</td>
<td>No</td>
<td>Yes</td>
<td>No details mentioned</td>
</tr>
<tr>
<td>P8</td>
<td>No</td>
<td>Not mentioned</td>
<td>Referred to crisis service in community and alcohol/drugs team</td>
</tr>
<tr>
<td>P9</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Referred to crisis service in community</td>
</tr>
<tr>
<td>P10</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Referred to social services</td>
</tr>
<tr>
<td>P11</td>
<td>Yes</td>
<td>Not mentioned</td>
<td>Told psychiatrist would be in touch</td>
</tr>
<tr>
<td>P12</td>
<td>No</td>
<td>Yes</td>
<td>Referral to GP – unclear about further details</td>
</tr>
<tr>
<td>P13</td>
<td>No</td>
<td>Not mentioned</td>
<td>Referred to crisis service in community</td>
</tr>
</tbody>
</table>
Most participants were unclear about the timing and procedure for follow-up care. For instance, participant 12 exhibited confusion when asked about whether his GP was informed of his attendance: “they said well we’ll contact them, and they will refer you to somebody else, but they never contacted, or else, perhaps I misunderstood, I thought they were going to contact my doctor”. Often, participants assumed that something would be done. As participant 6 stated: “I would have thought that they’d… be mildly worried about someone dropping the kind of mental health care plan” (second interview). Likewise, participant 11 assumed some care will be provided: “they say when you try to commit suicide you get these people to help you” (second interview).

As the experience of hospital attendance with self-harm was significant to the participants, it may be that they naturally assumed help would be offered, that staff would be concerned about their welfare. For example, participant 10 assumed the psychiatrist saw him as low risk because he was not kept in hospital: “if he was assessing me as a high risk for example of self-harm… he would have probably intervened” (second interview). Participant 4 expected that the psychiatrist would continue working on his behalf once he left: “someone’s got my name, they’ve seen me, they’ll look at it every so often”. For the participants, the experience did not end when they left hospital. They had expectations that something further would be done by the staff they had seen. With this in mind, three salient sub-themes emerged:

- Stagnation
- Impact on help-seeking attitudes
- Emotional & personal resonance

These sub-themes are briefly described in box 7.3 below, and then discussed in further detail.
Box 7.3: Sub-themes of “Outcomes from hospital experience”

<table>
<thead>
<tr>
<th>Super-Ordinate theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcomes from hospital experience</td>
</tr>
<tr>
<td>Hospital experience impacted on participants’ attitudes, expectations and beliefs regarding their actions &amp; future care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stagnation</td>
</tr>
<tr>
<td>Sense of little or no change following visit to hospital, contributing to frustration &amp; hopelessness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact on help-seeking attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of hospital affects attitudes to future care-seeking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional &amp; personal resonance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experience of hospital has emotional/personal impact on patient</td>
</tr>
</tbody>
</table>

### 7.1.1 Sub-theme 1.1: “Stagnation”

For several participants, the main outcome of hospital attendance was disappointment with the lack of follow-up or change in their circumstances. Participants 1 and 6, who both had multiple experiences of the emergency department, exhibited frustration with staff and the process. Neither felt that their needs were met or recognised by staff. In his first interview, participant 1 stated: “It were a waste of time”. What he was seeking from the hospital was a cessation of mental symptoms, but the hospital staff repeatedly sent him home: “(his assessor) says, you’ve got DI, you’re getting support, so you don’t need help” (second interview). The chronic nature of his difficulties contributed to his frustration with services, as he sought a response to acute feelings his condition triggered. The stagnation he experienced was in a cycle of unsatisfying experiences with services, where both parties were left feeling hopeless: “I went to A & E all the time and they were doing nothing” (second interview).

For participant 6, the situation was similar, in that her crisis was a result of severe chronic depression. Whilst her need was eventually recognised and responded to with inpatient admission, her return to the community saw her still struggling to get support three months later:

I: What was it like in those two months after the hospital?  
P6: Very difficult, I didn’t really have any support
She found that her need for support was still heightened after discharge as it took a considerable period of time for her to recover:

It’s such a slow process, you don’t just stop being depressed [yeah] and suddenly everything’s alright (second interview)

Her situation was complicated by the fact that she moved city after this episode to be closer to family. This may be an influential factor in her struggle to get support in the community. However, having to wait substantial periods of time for support was not unique to her account. Participant 10’s support from social services both took time to arrange and then failed to effect the desired changes in his life:

They were very slow at dragging their heels, I’ve been made endless promises, you know, I’d get aid with shopping… I’d get somebody coming in every day to make sure I was alright, and suddenly, when push comes to shove, I got this computer, which was £349, which I signed for [right] and that was it (second interview)

He perceived the offered computer as a superficial attempt to address his social support needs whilst missing the point entirely. During his first interview, he identified what he needed as:

Somebody coming in with a bright little face [yeah] and scurrying about, it’s going to be human contact

The laptop was a huge disappointment, as he saw it as counterproductive – it took away the need to go out shopping, an activity that brought him into contact with people.

Participant 9 also commented on waiting times for further help. In the period between interviews: “nothing changed for me at all”. Three months passed with his daily life unchanged and suicidality unabated. He eventually sought help at his GP surgery, where he was referred to a psychologist:

I: …you actually went and asked (to see a psychologist)?
P9: I did, I did yeah… he told me at least 6 months… I said ok, what is the maximum, if it’s at least six months? He told me it’s only one year, maybe two years

For participant 9, his whole life seemed to be a period of waiting, of existing in stasis. The service response of the crisis team after his stay in hospital (“we can’t help you with the house, we can’t help you with anything like this [yeah],
all what we can help just if you feel low we can send you to hospital”), and the
response of the GP when he asked to see a psychologist (“he told me if you like
I can give you some medication for a while… medication for what?”), both
echoed the general powerlessness that pervaded his life.

In the three months since initial interview, participant 11 received no further
contacts from the hospital: “they said they were going to send someone… but
they never did”. When asked about how this lack of follow-up affected her, she
plainly stated:

It’s, I’m used to being on my own (laughs)

Like participant 9, the service response echoed her social circumstances. The
episode of seeking help had no real effect on her social isolation or her
depression, other than to reinforce this as the way things were:

I haven’t heard from a soul, I never do [yeah] they say when you try to
commit suicide you get these people to help you, I have never had
anybody come, you’re the only person that’s ever come [right] and you’ve
got nothing to do with the hospital or my doctor (second interview)

7.1.2 Sub-theme 1.2: “Impact on help-seeking attitudes”
The impact of hospital care on people’s attitudes towards future help-seeking is
a particularly important outcome to consider, as it relates to the issues of
repeated use of services, repeat self-harm and potential suicide. For instance,
participant 12, in his first and only interview, talked of his experience with
services:

I think I’ve got more confidence to get in touch with somebody now,
before trying to do something like that… I probably didn’t have the
confidence on that day to say right, I’ll walk into the hospital, I’ll speak to
somebody

This was his only experience of suicidality, and it took him by surprise: “I never
thought I’d do this kind of thing to be honest [yeah] so perhaps that’s why I
didn’t seek any help”. His positive, non-judgemental experience of services had
altered his views on the possibility and availability of help: “I know now that
there is help everywhere”. He felt confident that help was there and that he
could ask for help without reprisal. Likewise, participant 5, who had never
attended hospital with self-harm before, felt confident after her experience. In her second interview, she said:

It’s just nice having that there, you know, that option, where you really really you don’t know where to go, you don’t know where to turn to

For both participants, their experiences had opened up the possibility of help, which enabled them to have hope and confidence in the possibility of recovery: “they’re not all black clouds you know… if I ever got that kind of feeling again [yeah], yes, I would recognise it now, and I would be able to say to somebody… look there’s something wrong” (P12).

Some participants unfortunately had less positive experiences of asking for help, which negatively affected their readiness to seek help in the future. As participant 6 put it, her difficulties getting help when she was desperate, and her struggles communicating with staff had “made it quite difficult to… ask people for things” (second interview). Participant 11’s upsetting experience with a psychiatrist left her unwilling to engage with any psychiatrists: “I still keep harping back to that psychiatrist, and that’s why I don’t want to see another one”. This experience formed a potentially significant barrier to participant 11’s engagement with mental health services in the future. In addition, when she received no further contacts with psychiatry as mooted after her index episode, she made no effort to seek this contact herself.

7.1.3 Sub-theme 1.3: “Emotional and personal resonance”

The experience at hospital could have emotional or personal resonance with the participants, affecting how they think and feel about themselves. Participant 2 experienced hospital as a “shock”: “it hits home more, you know [yeah] than if you just woke up in here” (second interview). He was aware of the problematic nature of his alcohol and drug use, but the danger of his behaviour loses its salience quickly: “I’ve had scares before… but I’ve never really, do you know, after three or four weeks it’s easy to forget them things” (second interview). The hospital experience served as a powerful motivator to change, and the experience of talking about it “keeps it fresh in your mind” (second interview). It was difficult for him to maintain this motivation, but in the period of time directly after hospital, his awareness was heightened and the importance of change was paramount.
The idea of resonance is that the experience leaves an emotional impression on the participant when they go home. With participant 5, the positive aspects about her experience followed her into the months afterwards. Even in her second interview, she enthused: “if I knew where (the assessor) was now, I’d just, I’d hug her, because she’s so amazing, she’s so lovely”. She was inspired to renew her efforts not to self-harm, knowing that she always had somewhere to turn. However, with participant 11, she went over the details of what happened repeatedly because the assessor doubted her word: “this is sending me insane… because I’ve wracked my brain to try and go back… go through (what happened)” (second interview). She was still angry when we met for her second interview – the experience of being doubted by the doctor, who felt she took less tablets than she thought, affected her personally. It stayed with her because this encounter made her doubt herself.

7.1.4 Summary
This theme highlights some of the ways in which the hospital experience affects participants beyond the individual encounter. Many participants experienced disappointment and frustration with the failure of follow-up care to occur as expected or hoped for. Their experiences with services echoed the frustration and stagnation of their everyday lives. Their experiences with services also affected their beliefs about help-seeking. For those who had never sought help for self-harm before, the experience of being treated without judgement gave them the confidence to believe that help is there for them. It inspired them to help themselves. The hospital experience also had the capacity to make the participants reflect on themselves and their actions long after the experience itself.

These sorts of outcomes – frustration, stagnation, motivation, hope, confidence, self-reflection and self-doubt – are psychological and interpersonal. They capture the ways in which participants experience outcomes as personal realities rather than objective pathways through care. The impact of no follow-up could have a significance that extends beyond the inconvenience of having to seek help elsewhere. It could reinforce a message that this is how things will always be – it could reinforce hopelessness and low self-esteem, and disrupt
future help-seeking. Similarly, the care that was offered could have an unplanned meaning for the participant, such as participant 10’s response to the offered computer, or participant 5’s response to the warm care offered by the psychiatric nurse. Participants interpreted the outcomes of hospital attendance through the framework of what has meaning for them personally. The outcomes can reflect and reinforce negative messages about self-harm and by extension, the participant.

Decisions about treatment and aftercare send messages to participants about their worth, their deservingness for help. What may seem from the service perspective to be an objective assessment of risk and needs actually forms a moral judgement of the patient, as the patient perceives it. Attending hospital for self-harm disrupts the pattern of a participant’s life; whether or not they intend to change their behaviour or attend with the intention of getting help, it is an opportunity for intervention and it encourages self-evaluation. When nothing happens, when nothing further is heard, the potential for the experience to have a transformative or positive impact is lessened. In the future, the same potential for intervention may be reduced, as the participant’s previous experience informs whether they engage with the process of assessment and aftercare.

7.2 Super-ordinate theme 2: “Value and limitations of other services”
This theme describes significant aspects of participants’ perceptions of services beyond the hospital. Specifically, it summarises the perceived value and limitations of both primary care and voluntary services.

The two sub-themes are entitled:
- Experiences of Primary Care
- Experiences of Voluntary Services

These two sub-themes are described in brief in box 7.4 below and in more detail in the text.

Those participants who talked about the value of a particular service tended to also reflect on the perceived limitations of the same service, so it is useful to consider both the good and bad holistically within a participant’s account to see what this can tell us about the perceived needs of the participant and their
reasons for using other services. Specifically, participants 2 and 10, who took part in lengthy second interviews, conversed about their experiences of voluntary services for alcohol and drug abuse and sexually transmitted infections. These services filled an important gap in their psychosocial needs, although they were not without limitations.

Box 7.4: Sub-themes of “Values & Limitations of Other Services”

<table>
<thead>
<tr>
<th>Super-Ordinate Theme</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Values &amp; Limitations of Other Services</strong></td>
<td><strong>Experiences of Primary Care</strong></td>
</tr>
<tr>
<td><strong>Aspects of services beyond the hospital which were deemed helpful or unhelpful</strong></td>
<td><strong>Value &amp; limitations of GP surgeries as perceived by participants</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Experiences of Voluntary Services</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Values &amp; limitations of voluntary services as perceived by participants</strong></td>
</tr>
</tbody>
</table>

7.2.1 Sub-theme 2.1: “Experiences of Primary Care”

Several participants identified general practitioners (GPs) as an important source of support:

She said to me if anything goes wrong, I can just go in and see her (P3)

I don’t mind really who I go to, as long as they’re supportive (P5)

I talked it over with my doctor (P11, 2nd)

They’re always supportive, they’re always willing to go that extra mile to make sure you’re ok (P10, 2nd)

When GPs made themselves available to the participants, e.g., “he’s given me his own private number” (P11, second interview), this was seen to be supportive. It showed, as participant 10 says, that the GP was “always willing to go that extra mile” (second interview). Some participants also identified GPs as supportive when they listened in a non-judgemental way:

Everybody’s treated with respect, and equally, and loved, and it means an awful lot (P10, second interview)
Participant 5 was referred to a counsellor within the GP surgery, which was particularly appreciated because of its location. She stated: “If [the counsellor] gets worried about anything, she can contact [the GP], erm, you know obviously under my consent [yeah] so there’s always that there, where we’ve got complete connection with all of us” (second interview). Participant 4 appreciated it when the GP was informed about their experience at hospital: “it seems a pointless exercise going to see the GP if they’re not telling him what to do”. Participant 4 saw the role of the GP as continuing the care recommended by the psychiatrist. For both participants, it was the creation of continuity through the GP that was experienced as beneficial.

Participants identified limitations with primary care, despite valuing the opportunity to talk and the relationship the GP provided. Some participants thought that the GP was not trained to deal with mental health problems, and was only there to refer them to other services:

She’s really good, my doctor… but she can only help me with so much… I think that’s why she refers me to all these people (P3)

I: Would you talk to your GP about self-harm?
P4: I have done in the past, but he’s not the right person really… it’s a mental thing… all he can do is prescribe antidepressants

The GP was there to provide support in the community, to connect people to other services, but was not considered to have expertise in mental health issues: “he’s a GP… he’s after flu viruses and things” (P4). This stands in contrast to the authority participants felt psychiatrists and staff in hospital had (see 6.2.2), and is a potential barrier to patients using primary care as a resource for helping with self-harm. It also has implications for how patients perceive referrals back to the GP following self-harm.

7.2.2 Sub-theme 2.2: “Experiences of Voluntary Services”
Voluntary services are an important source of support in the community. Four participants interviewed for a second time spoke about their use of and their attitude towards voluntary services.
Participant 5 expressed reluctance to engage with a self-harm support group because she believed it would be “kind of depressing… because it’s like everyone talking about self-harm, it’s just like (laughs) I know, I’ve been there! Still there”. Other participants expressed a similar reluctance about talking therapies and voluntary groups: “every week I was going back [to therapy] and saying the same thing” (P2, second interview); “you hear the same thing [at voluntary group] day in and day out” (P10, second interview); “I was talking to [the psychiatrist] for say an hour and a half… but I was coming out not feeling any better or any worse” (P10, second interview). Talking about the same issues repeatedly, and hearing others talk about it, could sometimes be disheartening and off-putting. There was a perception that talking was not enough to effect real change, that it was limited in its effectiveness:

I’ve tried to talk myself well, sometime… but I mean, if I never talked to anyone, I’d think yeah but I had, I’ve done that… I can see it’d be very helpful to some people, and it was helpful to me at the time [yeah] but now I know that it’s gotta be action (P2, second interview)

This was exemplified in participant 9’s experience of voluntary services. He attended a voluntary organisation for asylum seekers but was frustrated by a lack of action: “I feel I go there for nothing. Nothing changes with them… they speak with you for nothing, nothing important”. He saw the voluntary group as unhelpful, as the focus was on support, whilst he desperately wanted to alter his circumstances. This experience of frustration extended across all his experiences with services, which probably reflected the limited ability of services to help him change his circumstances given his legal position of an asylum seeker of undetermined status.

Both participants 2 and 10 had extensive experience of voluntary services, especially alcohol and drugs support groups like Alcoholics Anonymous, and both identified real benefits derived from attending these groups. For participant 2, the alcohol and drugs groups he attended inspired hope that he could recover: “people talking about their problems… similar problems to myself so you know it can be done” (second interview). The value of shared experience was that they understood what he had been through, and he could identify with their stories: “If you’re talking to someone who’s talking back to
you, and saying yeah, here’s how it happened to me… you get a lot more out of it” (second interview). These stories not only served as positive and concrete role models for his recovery; they also provided a social space where others accepted him without question.

For participant 2, the support was valuable because it resonated with his own experiences, and he didn’t feel like he had to explain or repeat himself. The people he met at these groups were just like him; they made recovery attainable and real for him. For participant 10, the benefit of voluntary groups lay in the social aspect. Attending a voluntary group provided him with social contact: “It’s nice to get back into that community” (second interview). Whilst he still had problems with the voluntary groups – he found that he tended to be one of the older people attending alcohol and drugs support groups, and his sexuality sometimes felt like a barrier in groups which were predominantly heterosexual – they were invaluable in alleviating his loneliness. The main barrier to accessing groups for him was his physical limitations due to illness: “I can’t do two major things in a day” (second interview). This particular limitation had caused difficulties at a drugs support group in the past, as he described:

My sponsor who was a man in his 40s would say to me you’ve got to do 90 meetings in 90 days, and I was very honest with him one day, I said [sponsor’s name] you have got absolutely no idea about illness and disability, he said what do you mean? I said, someways, it takes me ages just basically to get from the sofa to get to the kitchen, to cook a meal

This barrier extended to all his commitments, including hospital visits, psychiatric appointments, voluntary groups and social service visits. Both physical and mental illnesses had the potential to disrupt a participant’s ability to commit to support. Participant 5, who suffered bouts of agoraphobia, also found it difficult to consistently attend voluntary groups or classes. Utilising services of any kind were complicated when participants had physical health problems and when their mental health was unpredictable. Whilst voluntary services tended to be flexible with regards to attendance, this unpredictability still created a barrier for participants.

7.2.3 Summary
This chapter has examined some of the outcomes and services participants have experienced beyond the hospital. As noted earlier, these themes are not exhaustive, as only a sub-sample of participants were able to discuss outcomes in more depth. In addition, initial interviews took place not long after the index episode and typically at that point participants were still waiting to hear about arrangements with aftercare.

Out of those who did take part in the second interview, it seemed to be participants who had long-term mental health difficulties, such as participants 1, 2, 5, and 6, or physical health problems, such as participants 10 and 11. It may have been that those who took part in a second interview were more likely to have unresolved difficulties, such as participant 9, who seemed to be trying any avenue he could to be heard, or participant 6, who had yet to receive any further help. Some of the participants were very isolated, and the sense was that the interview acted as a social contact for them, especially the second time around. Whilst it is difficult to say how those who took part in a second interview differed from those who did not, it is notable that one of the participants who decided against a second interview did so because he had managed to move on and did not want to revisit what had happened (P12).

At second interview, participants were mostly still waiting for care, or had had no further contacts with services. The outcomes of hospital experience tended to revolve around the impact that the initial contact with services had had on the participants, and these impressions were fading by the time three months had passed. It is important to consider how services can work to sustain the positive outcomes of hospital – self-reflection, confidence and motivation – in the period following discharge.

Experiences with other services highlight the ways in which participants categorise the help they receive. GPs were seen as supportive but limited in their ability to provide mental health expertise. Talking therapies and voluntary groups were seen as beneficial but limited due to a common belief that talking itself is of limited value. The participants wanted to see change in their lives and in how they feel, but did not necessarily believe such change was possible. Repeated use of the same services could be disheartening and drive
participants to reconsider the utility of that service, especially when physical and mental illness created barriers to continued attendance.

Identifying what participants want from a service and how they perceive that service could offer insights into barriers for engagement with follow-up care. With counselling, for example, patients did not always see how talk could translate to change, and the sustained examination of one’s actions could be difficult to cope with, especially if little material change occurred. With the GP, patients brought the perception of a GP’s role as tending physical illness into consultations, and may be less likely as a result to actively broach mental health topics. In each of these cases, it may be that those providing the service are best placed to challenge these perceptions and pre-conceptions.
CHAPTER 8: DISCUSSION

8 Introduction
This study was an exploratory investigation into the experience of psychosocial assessment following self-harm. The aim was to develop an in-depth service user-focused understanding of this experience, with a secondary goal of exploring the outcomes and impact of psychosocial assessment for service users in the medium term. This chapter summarises the findings of the study, and discusses the implications for theory, practice and policy.

8.1 Executive Summary
The participants in this study presented to hospital with multiple, complex difficulties. Their lives were characterised by struggle against psychological, social and material problems. For most participants, these difficulties were inter-connected, impacting upon each other and the participant’s sense of control and agency in their lives. A major theme which emerged was the presence of powerlessness over their circumstances. Over half of the participants expressed feeling trapped by circumstances, and unable to effect change. Continual struggle and failure to overcome difficulties left participants feeling out of control and somehow reduced, “less than”. Feelings of hopelessness and frustration seemed to emerge from this perceived lack of control.

Internal and relational senses of self were two features of the participants’ lives which were challenged by these multiple, complex difficulties. Most participants felt stigmatized in some way, either due to socially devalued aspects of their identities, or due to stigma attached to the methods by which they tried to cope with their lives and these identities. They also devalued themselves and struggled to reconcile the circumstances of their lives with the values they perceived as preferable in the wider social milieu. They judged their own actions through their perception of the behaviours and reactions of others, and held themselves accountable to socially prescribed standards.

As a result of these struggles and pervading experiences of powerlessness and devaluation, the participants mostly saw self-harm and suicide as a natural
progression in their narratives, although some participants’ accounts were also marked by a struggle to reconcile themselves with their actions. It was evident that self-harm and attempted suicide were meaningful acts, which emerged from the conditions of their lives. Suicidal intent, as expressed in the participants’ accounts, was common and complex. It rarely reflected an absolute desire for death. Instead, it reflected a struggle between a desperate desire for change and hopelessness in the face of current circumstances. It meant escape, sometimes in both a permanent and temporary way at the same time.

The experience of attending hospital with self-harm was embedded in this wider structure of struggle, powerlessness and invalidation. Experiences of the hospital varied, but revolved around the desire to be treated like a human being. For some, the hospital conveyed safety, another form of “escape” from their lives and their actions. For others, the hospital represented a continuation of the neglect, isolation and stigmatisation experienced elsewhere. It could also be both, chosen as the lesser of two evils by a desperate participant.

The experience of assessment was only one aspect of this broader experience of the hospital environment and staff, and it did not always feature distinctly in the accounts given. Assessment was not perceived as an objective evaluation of the participants’ needs or an opportunity for them to act as an active consumer and choose their healthcare. Few participants had a clear understanding of the purpose of assessment, except as a hoop to jump through or as a means for staff to decide how to deal with the patient.

The value of assessment for participants was both relational and psychological. Having someone to talk to allowed participants to work through the experience of self-harm and start to come to terms with it. In addition, assessment was an opportunity for the participant to feel accepted and thus acceptable. When staff responded to participants in a sympathetic and understanding way, it validated the participant as a human being, as someone worthy of help and as someone able to effect change. Essentially, assessment could be a vehicle to inspire hope and a belief in self-efficacy. Conversely, assessment was experienced negatively when the participant felt devalued by the assessor, judged for their
actions, or unheard. In taking the step to seek help, participants rendered themselves vulnerable to the judgements of those they saw as more knowledgeable, more powerful. Assessors, by virtue of their professional status, had considerable power to reinforce or challenge a participant’s hopelessness and self-loathing. Psychosocial assessment as a process had power to affirm or deny the patient’s humanity and hopefulness.

Assessment was not an isolated event; the period following assessment and discharge into the community was important in maintaining and building on any benefit derived from the hospital experience. Within this study, a three month follow-up period was adopted as this was perceived to be a time of high risk for repetition. It was also a substantial length of time for any follow-up or aftercare arrangements to be put into place. However, the predominant theme around aftercare was a sense of stagnation. Little changed in the three months after the index episode, leaving participants feeling disappointed, frustrated and alone. The failure of services to follow through with promises of aftercare had unintended consequences, affecting the participants’ attitudes towards future help-seeking and towards themselves. It was emblematic of lives lived in isolation from others, feeling disconnected. This stagnation was reflected in the lack of change in the participants’ accounts three months later: the same thoughts, reflections and emotions predominated.

In the absence of further input, the positive benefits of reflection, confidence and validation derived from a caring encounter began to fade. Similarly, as time moved on, the emotional and psychological disruption of the hospital encounter, that could force personal reflection on one’s life, actions, and re-evaluation of the self, faded as well.

Little was said about other services, such as primary care and voluntary services, but participants were generally positive about the availability of help. However, they often held pre-conceptions about the utility and the role of other services in treating self-harm, perhaps related to the general public perception of self-harm as a mental health problem. GPs were valued as a bridge between the participant and aftercare such as counselling, but were not seen as a useful resource in the treatment of self-harm. Voluntary services and counselling were
valued for the social support they could offer, but the value of talking as an intervention in and of itself was frequently doubted. These perceptions of services may inhibit the use of alternatives to hospital, especially when self-harm is seen by participants to require psychiatric expertise.

This study featured a small, heterogeneous sample of those who self-harm and attended hospital. Descriptive consideration of the population attending hospital in Manchester during the time of the study seems to indicate that this sub-sample reflected the broad demographics of those who self-harm and attend hospital. Interestingly, this study included as many men as women, adding to a growing literature including men’s perspectives on self-harm (e.g., Russell et al., 2010; Taylor, 2003). The presence of alcohol abuse as a factor in self-harm was evident in five accounts, echoing the figure of 33% of individuals seen to abuse alcohol in the Manchester cohort (Dickson et al., 2009), and detailing the phenomenology of alcohol and self-harm as co-existing and interacting behaviours. Unfortunately, the interviewed sample included a disproportionate representation of ethnicities, with the majority of participants identifying as White British. This means that groups who may be at higher risk and have substantially different accounts have not been reached in this study. Previous research has shown that:

There are significant and persisting differences in and inequalities in service experience and outcome between minority groups and the majority white ethnic group (National Institute for Mental Health in England, 2003a, p16)

The cumulative factors of an indirect mode of recruitment via letter and from NHS staff, potential language barriers, the low percentage contacted to take part coupled with the majority of individuals attending hospital being White, the small sample size and the general low response rate for people who self-harm in research are likely to account for most of the variance. A further study would benefit from adopting a more flexible recruitment strategy to investigate psychosocial assessment in ethnic groups of known high risk (Cooper et al., 2010).

With regards to age, this sample was interesting as it had a higher than expected proportion of participants in their fifties and sixties. Compared to data
from 2008, the proportion of participants in their twenties and thirties was similar to what would be expected. Younger participants were more likely to have partners at the time of interview, whereas the majority of the older participants were divorced, widowed or single. Bereavement and loneliness were common features of the older participants’ accounts, which supports findings from previous qualitative (Shiner et al., 2009) and quantitative research (Harrison et al., 2010; Haw & Hawton, 2008; Hawton & Harriss, 2006). Crocker, Clare and Evans (2006) conceptualised the experiences of older adults who attempt suicide as relating to three themes: struggle, control and visibility. In this study, all of the participants in some way struggled with their lives and disconnected from others. In the cases of the older participants, this struggle often related to their experiences of getting older and becoming more isolated and less able due to poor health.

These accounts did not seem to show strong gendered discourses around self-harm. Feelings of low self-worth and experiences of invalidation were present in both women and men’s accounts. A sense of not meeting socially prescribed standards was pervasive, which sometimes reflected gendered expectations (e.g., participant 9) and sometimes not (e.g., participant 6). The male participants did tend to be more isolated socially, although this seemed to relate to age as well – the younger, female participants all had partners. Alcohol abuse was more common in the male sample, with participants 2, 4, 8 and 12 in particular mentioning it as a factor in their lives. What was of interest was the presence of alcohol (or drugs) as an issue in assessment; where these were present, the assessment and treatment focused on behavioural change rather than on the possible motivating and maintaining factors or the link between self-harm and substance use.

With participant 9, specific issues relating to the experiences of asylum seekers, in combination with the after-effects of traumatic events stemming from socio-political and interpersonal circumstances, were highlighted. This participant displayed incredible psychological resilience in the face of extreme circumstances. Suicidal thoughts acted as a fantasised escape route from a circumscribed existence, but the participant’s sense of self and morality prevented action upon these thoughts. In no other case are the structural and
social factors contributing to suicidality so vividly demonstrated, or the limitations of a generic approach to psychosocial assessment so clearly highlighted. The role of society and societal norms in creating intolerable situations for the individual are evident in this account, but also in the accounts of those suffering from chronic physical difficulties (e.g., participants 6, 10 and 11) and living with stigmatised identities (e.g., participants 1, 2, 4, 5, 6, 8, 9 and 10). This study demonstrates how participants can feel trapped and reduced by the social, psychological and material circumstances of their lives.

8.2 Contribution to Knowledge
This study was the first to qualitatively explore the experience of psychosocial assessment from the service user perspective using an in-depth idiographic qualitative methodology. It builds upon numerous existing accounts which have offered insights into the experience of psychosocial assessment and the hospital following self-harm (Hengeveld et al., 1988; Horrocks et al., 2005; Palmer et al., 2007; Pembroke, 1994; Spandler, 1996; Suominen et al., 2004; Taylor et al., 2007, 2009; Whitehead, 2002) by utilising IPA to develop rich contextualised narratives of self-harm and the experience of help-seeking (Smith et al., 2009). By focusing on the experience of psychosocial assessment, it sought to provide further insight into an important aspect of services, as identified by the National Institute for Health and Clinical Excellence (2004), and to examine the experience of both process and outcome of assessment in greater depth (Whitehead, 2002). It adds to current understandings of patients and their experiences of services, which can be utilised to inform future practice.

Conducting three month follow-up interviews provided a unique insight into the longer-term impact of psychosocial assessment and hospital care following self-harm. Few studies have assessed the impact of help-seeking on people who self-harm, although there have been retrospective studies which have examined recovery from self-harm (Sinclair & Green, 2005), and personal accounts of services by service users (e.g., Harrison, 1995; Pembroke, 1994). The emphasis on cross-sectional surveys (e.g., Palmer et al., 2007) and one-off interviews (e.g., Horrocks et al., 2005; Whitehead, 2002) in the literature restricts our understanding of the temporal aspects of experience, e.g., how the
circumstances and ways in which people self-harm or become suicidal are influenced by any number of factors interacting in a participant’s life, and how these may themselves change over time (Flowers, 2008; Lilley et al., 2008).

The meanings of self-harm and suicide expressed by the participants reflect those in the wider literature (see 1.3.2 and 1.3.3). Self-harm and attempted suicide were both ways of responding to difficult emotions and circumstances, and both were ways of effecting change. Of interest is the deep ambivalence embedded in the participants’ accounts of suicidal intent. Suicide was often presented as a logical choice, a way to escape problems which there seemed to be no way of resolving (such as participant 10’s loneliness and physical health difficulties; participant 9’s undetermined asylum status; participant 12’s financial problems and participant 13’s self-negativity). This idea of suicide as “escape” fits well with the Cry of Pain model (Williams, 2001). Participants were faced with aversive circumstances and struggled to think of alternatives or solutions. For these participants, suicide followed naturally from a cognitive appraisal of further hardship as inevitable (no escape) and help as unavailable (no rescue).

When the circumstances are examined in more depth, it was interesting how aspects of the socio-cultural and material circumstances of participants impact upon their suicidality. Participants 9 and 10, for example, had both tried to change their circumstances and to reach out to others prior to the incident in question. Both had been met with silence and rejection, contributing to and perhaps even creating a sense of hopelessness in the future. Both compared a past in which they had power and freedom to a present which seemed to stay the same or steadily grow worse despite their efforts, and this contrast was difficult to accept. Both had little control over the aspects of their lives they most wanted to change. Social isolation and perceptions of powerlessness were dominant themes in the accounts of those who expressed suicidal intent, reflecting their current reduced social resources and their experiences of prior help-seeking. Within these accounts, it seemed that the expression of a desire to die was more an expression of a desperate desire for change (Baumeister, 1990), emerging from a lifeworld dominated by powerlessness and learnt helplessness. The “social” part of “psychosocial” needs comes to the fore as people’s circumstances and experiences form potent barriers to engagement
with services and hope for the future. In circumstances where suicide can seem a logical choice, given unremitting material, physical and social constraints, a psychiatric response may reinforce the hopelessness of the patient, by targeting the individual and not the constraints (Johnstone, 1997).

Alcohol problems and self-harm often co-exist, but few studies have examined the processes by which the two interact (Boenisch et al., 2010; Hawton et al., 1997). Canetto (1991) and Babiker and Arnold (1997) suggest that alcohol can be another form of self-harm, whilst others have suggested that alcohol at the time of self-harm may contribute to impulsive behaviour and greater unintentional damage caused (Hawton et al., 2007; Hufford, 2001; Suominen et al., 1997). Alcohol use also tends to be associated with poorer outcomes, reduced uptake of aftercare and less satisfaction with care received (Hawton et al., 1997; Hume & Platt, 2007; Kolves et al., 2006). This study highlighted the expectation of and perception of stigma in those with alcohol and drug problems when they attended hospital with self-harm, even long after cessation of drug use in the case of participant 10. In addition, the cycle of relapse was instrumental in reinforcing hopelessness and a sense of powerlessness in the participants. Self-harm in one case was used as a means to punish the self for abusing alcohol; in another case, the lines between substance abuse and self-harm were blurred, as the powerlessness and hopelessness experienced by the participant transformed into reckless self-damaging behaviour. This study is one of the few which qualitatively explores alcohol and its relationship with self-harm, and it highlights how alcohol can lead to self-harm through self-blame and self-punishment; can contribute to self-harm through encouraging reckless behaviour, and can serve the same functions as self-harm, by providing an escape route from negative self-evaluation and painful affect. The role of (perceived and/or expected) stigma in participants’ disengagement with services also emerged as influential.

Assessment emerged as an important opportunity for staff to provide validation and inspire hope in the participants. It could also act as a means for the participant to reflect on the circumstances which led to self-harm, and it could help them to process the emotional and psychological consequences of what happened. On the other hand, assessment could act to reinforce the negative
self-esteem and shame felt by the patient, and it could increase their hopelessness when they felt ignored and unheard. It could mirror the invalidating experiences of patients in the wider social world and silence their pleas for help. This is despite the general sense from the interviews that patients were often unaware of assessment as a structured activity designed to perform particular tasks, such as assess risk and plan care.

Patients were aware of the Other in assessment, and themselves through the eyes of the Other: how staff perceived, reacted and engaged with them. The relational aspect of assessment was that which had the most salience for participants, supporting previous research that pinpoints the importance of therapeutic relationships in the provision of therapy and care (Collins & Cутcliffe, 2003; Cutcliffe & Barker, 2002; Hilsenroth et al., 2004; Martin & Street, 2003; McCabe & Priebe, 2004; Meier et al., 2005; Reid & Long, 1993; Schröder et al., 2006; Thomas et al., 2002; Welch, 2005). It also seemed that the assessment acted as a microcosm of the individual’s wider psychosocial world: when staff accepted patients and acknowledged their distress, this gave the patients permission to re-evaluate their lives and their attitudes towards themselves.

8.3 Implications
The following sections outline implications of this research for policy, practice and future research.

8.3.1 Policy
The National Institute for Health and Clinical Excellence (2004) placed psychosocial assessment at the centre of recommended clinical management for self-harm, with little direct empirical evidence that assessment can form part of a “therapeutic process to understand and engage the service user” (National Institute for Health and Clinical Excellence, 2004, p64). This study sought to redress the balance by exploring the service user experience of psychosocial assessment, as part of a wider social and political movement to value and utilise service user expertise in the development of healthcare services (Department of Health, 2000; Faulkner, 1998; Faulkner & Thomas, 2002).
This study, whilst exploratory in nature, has several implications for the current policy around the management of self-harm. First, on reviewing the literature around psychosocial assessment and considering the user experience, it becomes evident that the ideal of psychosocial assessment as a pivotal moment in engaging the service user is not an explicit aspect of service delivery as experienced by those who self-harm. This may reflect the current dearth of evidence about how psychosocial assessment is interpreted and implemented in practice, but it may also be an outcome of conflicting pressures on staff to accurately assess risk and provide therapeutic engagement with little time to invest in understanding the context within which the patient has attended hospital. Policy makers and service providers would benefit from greater clarity around the delivery of psychosocial assessment as an intervention in itself as well as a gateway to further care. Further consideration of how the conflicting discourses of risk governance and therapeutic practice may be impacting on effective care provision may also bring clarity to the management policy.  

Secondly, the focus on risk, and how risk is interpreted by staff during assessments, needs to be examined further. In this study, the participants’ accounts demonstrate a privileging of suicidal risk judgements in hospital, despite evident ambiguity and distress at the time. In participant 6’s account, the assessor seems to deem her “too lucid” to be suicidal, yet she re-attends three times in quick succession. Given the complex, dynamic nature of risk itself, the models of risk being utilised – perhaps, sometimes implicitly – by staff require elucidation. Given this sense of suicide and self-harm as logical progressions from intolerable circumstances which emerges from participants’ accounts, it may also be fruitful to think about how risk is being defined, by whom, and for what purpose. The individual may be weighing risk of injury to oneself against risk of continuing in an unacceptable situation – in which case, discharge back into the community may have the unintended consequence of increasing the individual’s sense of entrapment.

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6 There is a randomized control trial currently underway at the Institute of Psychiatry investigating therapeutic assessment compared with standard psychosocial assessment and management for adolescents who self-harm. The primary outcome measure is engagement with first follow-up session.
Finally, the findings of this study demonstrate the lived complexity of participants’ lives, where the hospital experience becomes interwoven and sometimes subsumed by the dominant lived experiences of isolation, rejection and powerlessness. This complexity is currently absent from the service recommendations of the Royal College of Psychiatrists (2004) and the National Institute for Health and Clinical Excellence (2004) – although it is acknowledged. Similarly, it is largely absent from a dominant service user discourse, which focuses on a particular view of self-harm as a survival mechanism, a means of coping with the structural conditions of (typically) women’s lives (Cresswell, 2005; Harrison, 1995). Whilst this study offers no solutions to the dilemma of providing general recommendations on how to manage a complex and multifarious problem, it does demonstrate that qualitative research is a useful tool to use in tackling this dilemma. In addition, the value derived from assessment by participants within this study offers a starting point in building a richer understanding of what psychosocial assessment can achieve.

8.3.2 Practice

_Interpersonal nature of care_

The themes developed within this study emphasise the importance of the interaction between staff and patient. This is a recurrent theme within the literature around the experience of services, from the perspective of both patients who self-harm and/or suffer from mental health difficulties (Horrocks et al., 2005; Lindgren et al., 2004; National Institute for Health and Clinical Excellence, 2004; Shattell et al., 2006; Shattell et al., 2007; Sun et al., 2006; Taylor et al., 2009; Thomas et al., 2002) and mental health professionals (Sun et al., 2006; Talseth et al., 1997; Welch, 2005; Wilstrand et al., 2007). Echoing Horrocks and colleagues (2005) and Cutcliffe and Barker (2002), there was a clear link in several of the participants’ accounts between the perceived nature of the interaction with staff and the participants’ judgements of self-value. This impacted on the attitudes of participants towards future help-seeking, with negative experiences of staff creating psychological barriers to engagement and positive encounters inspiring confidence in participants that “there is help” (P12) available for people who self-harm.
There were three main implications about assessment which can be derived from the study’s findings, and which extend our understanding of the interpersonal nature of this encounter. These are as follows:

- **Meaning of Assessment Constructed in Interaction**

As mentioned above, the NICE construct of psychosocial assessment does not seem to be present in the patients’ accounts. Patients are instead seen to be actively engaged in attempting to understand the interaction with staff, usually concluding that it is an institutional or vaguely legal requirement for staff to complete. The role of psychiatrists in the governance of psychiatric patients comes to the fore, likely influenced by the approach of staff, the institutional setting and previous experiences of involvement with services. Whilst patients can be accepting of this role, it has the effect of removing responsibility from patients and reinforcing the power of staff over patients. Connected to this, patients often have only vague desires to get help, not necessarily being able to pinpoint what that help might look like. Their expectations are formed by their experiences – in particular by their surroundings, and the staff attitudes they experience. Assessment was given power by the patients’ interpretations of its purpose and execution by staff.

In terms of practice, more attention should be paid to the setting and execution of assessment if it is to be experienced as therapeutic or beneficial. Otherwise, patients are likely to interpret it as primarily for the staff’s benefit – to tick boxes, and to protect the hospital and the staff from their actions – rather than for their own benefit. When staff managed to convey their desire to help the patient, and to get them further care, the process could be positive and inspirational. In the absence of an explicit understanding of assessment (managed by the staff in presenting the assessment and engaging with the patient), patients may be influenced in their perception of assessment by the institutional and custodial environment of the hospital and its psychiatric inpatient wards. Staff may find it beneficial to be explicit about the therapeutic purpose of assessment, to encourage patients to engage collaboratively with the process.

- **Assessment as Opportunity to Promote Hope & Challenge Negative Self-evaluations**
The themes developed around the value of assessment closely parallel Cutcliffe and Barker’s (2002) concept of “engagement and hope inspiration” as the central value for psychiatric nursing of suicidal patients. Cutcliffe and Barker (2002) argue that engagement and hope inspiration are two linked interpersonal processes invaluable in suicide prevention. They identify key processes of relationship formation, developing a human to human connection, conveying acceptance and tolerance to the patient and understanding the patient in the inspiration of hope. Each of these processes were represented in the descriptions of valued experiences of assessment by participants in this study.

In this study, patients valued being given the opportunity to talk, being engaged with on a human level (i.e. not as a chore to get through, or a nuisance), being heard and understood and accepted as a human being worthy of care. These valued activities are all relational, stemming from the interaction with staff. Whilst the environment and the waiting process could influence the patient’s emotional and psychological readiness to take part in assessment, it was their perception of the staff's engagement with them as individuals that was valued and encouraged openness in return. When participant 9, for instance, is left to wait for hours and then told that he does not need to tell his story by the doctor, he disengages from the process, and refuses to talk about his situation.

Ziółkowska (2009) offers insight into the doctor’s position with her analysis of positioning in psychiatric interviews. She found that trainee psychiatrists tended to position patients as assessors of their difficulties, making them construct their experiences in an objective manner through their questioning. This may be a way of managing the emotional pressures of interviewing distressed patients or a way of fulfilling their medical roles of diagnosis and assessment (Ziółkowska, 2009). From the patient’s perspective, this approach can interrupt the process of relationship formation and creates the impression that staff do not care about them.

What the findings of this study and of Cutcliffe and colleagues’ work emphasise is that patients encounter staff in assessment as individuals seeking acceptance rather than as patients seeking treatment (Collins & Cutcliffe, 2003; Cutcliffe & Barker, 2002, 2006). They value assessment when it resembles a therapeutic
encounter; when they, as individuals, are validated by staff, in line with Gunderson’s concept of validation as:

The affirmation of and respect for a patient’s individuality through interaction with staff (Vatne & Hoem, 2008, p691)

Whilst participants bestow staff with authority due to their status as psychiatrists or psychiatric nurses, it is conversely when this authority is used to reinforce the participant’s value as an individual that it is most engaging. When a psychiatrist treated the patient as acceptable and normal, this was a powerful way of challenging the patient’s perception and fear of the self as abnormal and unworthy. Self-stigmatisation and the experience and fear of stigma in general were common threads in the participant’s accounts. The staff member conducting assessment is in a powerful position to challenge these negative self-evaluations which can reinforce hopelessness, by virtue of their “expert” status.

The promotion of hope in this study was connected to two processes within the relationship between staff and patient. The first was the promotion of hope through the staff member’s expression of change as possible. This was demonstrated through a number of means: through sharing personal experience, through the provision of options and arrangement of aftercare, and through the assessor, with words, deed and attitude, reassuring patients that help will always be available. The second was the promotion of hope through acceptance of the individual and belief in the individual, restoring a sense of personal agency.

- Value of Integration of Assessment with Aftercare
A sense of stagnation over the three month follow-up period was expressed by both word and emotion at follow-up interview. For some participants, the research encounter was the only input they had from services following self-harm (e.g. participant 11 at follow-up: “they say when you try to commit suicide you get this people to help you, I have never had anybody come, you’re the only person that’s ever come”). For others, the same thoughts, feelings and reflections were recycled from the first encounter with the researcher, indicative of this lack of change, such as participant 9’s continued anger and despair over his circumstances (“I: You felt so trapped in, [are you] in the same situation

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now? P9: Same, same, still same”). Anger, disappointment and bewilderment were common, as participants endured significant emotional pain that they felt deserved an equally significant response from services, and were upset when no response was forthcoming.

The three month follow-up interviews demonstrated that assessment itself was most salient for participants when it was integrated with follow-up, and was re-evaluated by participants in light of their experiences of aftercare (or lack thereof). The follow-up interviews conducted in this study emphasise the importance of swift follow-up, and shed light on the psychological factors which may be contributing to the heightened likelihood of repetition within the first three months after self-harm (Gilbody et al., 1997; Kapur et al., 2006). Once again, participants may construe a lack of follow-up as a reflection of their value to staff and by extension to others: it is interpreted as a meaningful act, rather than a product of systemic pressure. However beneficial or inspirational the assessment was, and however connected the participant felt to the staff member, that experience of being left alone without care following the hospital attendance can negate the message of value gained from such positive encounters – especially if this message is reinforced in the participant’s social and material circumstances outside the hospital.

Communication between secondary and primary care is likely to be essential in ensuring that any therapeutic benefits derived from assessment and hospital care are maintained in the community. Aftercare is often left to primary care services, which may have little or no knowledge of what has happened at the hospital. The fragile rapport established between assessor and patient can be lost at this point. As the lack of follow-up is felt as a personal betrayal by patients, it may decrease their likelihood of seeking further help from secondary or primary care. A closer alliance between secondary and primary care may enable more patient-focused and prompt aftercare to be provided.

Psychological Consequences of the Hospital Environment
The psychological state of the patient whilst waiting and on the wards influenced their engagement with the process of assessment. As in the studies of Horrocks and colleagues in Leeds (2005) and the Royal College of
Psychiatrists’ online survey in the UK (2007), participants often cited waiting as an unpleasant aspect of their experience. Nairn’s (2004) review of patient experiences in the emergency department suggests that this experience can have a significant psychological impact on patients, and Horrocks and colleagues (2005) found that their participants were sometimes left to wait anxious and fearful about their health, and being kept waiting was experienced as a message about their priority and importance by patients. This study adds support to these findings, and provided rich examples of the impact of waiting on both participants’ psychological states and their willingness to engage with staff when finally seen. Participants talked about being kept waiting as a sign that staff did not care or that they were not worthy of helping. In addition, participants often found the ward environment to be frightening and isolating, which could lead to them absconding or lying about their health to be released.

The impact of the environment on those who self-harm is an aspect which has been understudied, and is vital to engaging patients in future care. With regards to engaging patients with assessment, an awareness of the patient’s experiences in the emergency department and on the ward could assist staff in creating an atmosphere for assessment which was conducive to open and frank disclosure of difficulties. As patients often experience the wait as a slight or judgement on the staff’s part, it is important for staff to address this barrier to communication when embarking on an assessment. Akerstrom (1997) found that staff were likely to act out their hostility towards this professional pressure on patients, who they perceived to be responsible for the problem. In Akerstrom’s (1997) study, both staff and patients vented their resentment in interactions with each other, rather than at the system which creates the waiting environment. Staff may need to address their own strategies for coping with the busy emergency department and the pressure of the waiting room.

*Emotional Work*

From the participants’ accounts, there is a distinct sense of personal involvement on the part of staff, be it in participant 6’s case where the psychiatrist is trying to persuade her to go home to alleviate his inability to get her a bed, or in participant 10’s case where the nurse hugs him and exhorts him not to come back. McKinley and colleagues (2001) found that nurses who
valued the emotional aspect of their work with self-harm patients tended to have more positive attitudes towards them, indicating that this emotional involvement can benefit patients and staff. However, for the most part, staff are likely to have conflicting priorities and responsibilities that do not cultivate these sorts of emotional connections between staff and patient. The evidence presented here suggests that assessments will be more therapeutic and ultimately resonate beyond the hospital encounter if staff are engaged on a personal level with patients’ stories; this is supported in the literature on therapeutic alliance more generally. In terms of putting this into practice, the burden cannot simply fall on staff to continue to balance conflicting requirements whilst emotionally committing to their work. The support available, at the organisational and policy level, for staff to engage in therapeutic work with distressed patients, would need to be evaluated; in particular, the organisational culture in which people work, and the training and supervision provided to staff.

8.3.3 Future Research
This study was a small-scale exploration of psychosocial assessment, which focused on one hospital in Manchester. It would be useful for further research to adopt similar methods at different sites to first, explore the transferability of the themes derived from this sample, and secondly, create a stronger evidence base for the re-evaluation of psychosocial assessment in practice.

In this study, a short period of three months was adopted for follow-up, chosen because this was a known period of increased risk for repetition. However, this period of time seems to have been too short to assess the impact of aftercare fully, as the majority had experienced no further contacts with services. Whilst the stagnant narratives of the second interviews were illustrative of the fact that the initial issues leading to attendance tended to be unresolved at 3 months (and by their nature, may persist even longer for some), a longer period of follow-up in a future study would be useful in understanding more of the recovery process. Sinclair and Green’s (2005) qualitative exploration of the resolution of self-harm provides a valuable starting point in this understanding, but is limited in its applicability by the one-off nature of the interviews, and the youth of the sample. Further research which adopted a longitudinal qualitative approach may create valuable insights into the temporal variability of self-harm
(including the phenomena of method-switching, highlighted by Lilley and colleagues, 2008), and provide data on the impact of service experiences over time. In addition, this type of research may help tease apart the reasons for re-attendance with self-harm, to enrich understandings of the meanings of repetition for service users.

Owing to the small-scale nature of this study, the experience of psychosocial assessment from the staff's perspective was not included. This is an important avenue for further research, as it would provide insights into the roles of policy, emotional labour, and organisational pressure on healthcare professionals providing assessments. Work such as Hadfield and colleagues’ (2009) IPA study of accident and emergency doctors’ responses to people who self-harm is invaluable for the insight it gives into the lived worlds and warring priorities of these doctors, and further research in this vein is recommended. The research on staff attitudes to self-harm tends to focus on psychiatric nurses and utilise questionnaire responses, which does not generate the type of rich complex data required to unpick the roles and expectations of psychosocial assessment from the perspective of the assessor. As a complement to this, discourse analysis of psychosocial assessments would be valuable in considering the discursive strategies of both staff and patients under circumstances of heightened stress, and conversation analysis may allow researchers to tease apart the use of words, concepts and phrasing in assessment. Whilst there may be ethical barriers to conducting this type of research, multi-modal qualitative research would enhance our understanding of psychosocial assessment as an interactional process.

8.4 Limitations
Initially it was hoped that more than one type of assessment could be examined – assessments by a specialist self-harm team and by psychiatric staff at the hospital – as these two assessments differed in potentially significant ways. For instance, the specialist self-harm service used their assessments to establish whether patients would benefit from interpersonal psychodynamic therapy, and often conducted them in the patients’ homes. It is possible that patients would perceive these staff members in a different way to the psychiatric team because of the different location and emphasis of assessment. However, it became
evident that it was impracticable to examine these groups separately for several reasons. First, the number of patients undergoing assessment by the specialist self-harm team was low, and whilst these patients were sent invitation packs, only two out of the thirteen who took part had identifiable experience of this service. The second reason, related to the first, was the issue of identifiable experience. Participants were often unclear about who they spoke to, and whether they had received a “psychosocial assessment”. It was an unfamiliar term to the majority, and whilst they described experiences of interacting with staff and being asked questions about what happened to lead to their attendance, they rarely described this as an assessment, and it is likely that some of the participants were guessing when they identified the person they spoke to as a “psychiatrist”. Thirdly, a number of the participants had multiple experiences of services, which complicated their narratives, especially when they struggled to remember which incident was which.

The recruitment strategy of this study may have limited the transferability of the findings, as recruitment was restricted to one hospital site and was carried out by clinical staff at the hospital. This strategy was a compromise between ethics, methodology and practicality. All the recruitment strategies considered had flaws which might bias the sample or affect the quality of the data. With the decision to recruit via the specialist self-harm service, it was hoped that patients would be contacted as soon as possible after their psychosocial assessment, so that rich phenomenological detail could be gathered. By recruiting through one hospital, it was hoped that the patients would have comparable experiences of hospital care, so that the analysis could focus on depth rather than breadth. The downside of this strategy was that the response rate was extremely low, and it was likely that those who were most dissatisfied with services would be least likely to respond to the invitation. Phenomenologically, the interviews garnered a range of accounts (sometimes from the same participant) reflecting a variety of both positive and negative experiences with staff and services.

The sizeable loss of participants at follow-up (46% were either unable to take part, unwilling to take part or unreachable) is an additional limitation of the study. Despite a short follow-up period, three participants were no longer reachable by phone or did not respond to a letter invitation, and three did not
feel able to take part. Whilst there was no obvious bias in socio-demographics or index episode characteristics in those who took part compared with those who did not take part in follow-up, it may be that the samples differed in some way that has not been accounted for. One potential way they may have differed is that those who did not take part may have moved on from the episode, as participant 12 indicated when contacted. It may also be that those who were unreachable led more chaotic lives than those who could be contacted.

Phenomenological interviews require concrete and detailed descriptions, which place extensive demands on the cognitive and linguistic abilities of the participants (Kirkevold & Bergland, 2007; Smith et al., 2009). I encountered a number of complications in interviewing the participants relating to these demands. Participant 7, as mentioned previously, had mental health difficulties which seemed to limit her linguistic and emotional range. She answered most questions factually, and recurrently emphasised the importance of “knowing” staff:

P7: I felt more at ease
I: Do you think that ease had to do with the fact that you’d been before, that you knew them, as you said? (P7 nods)
Why you wanted to go there in particular?
P7: That was only part of it. Because I know them pretty well, and all the receptionists

She listed names, locations, and information about people she knew from the hospital. This was a difficult interview to conduct, because the participant seemed unable or unwilling to express emotion or rich concrete details of her experience beyond the surface. When I asked about her self-harm, she became agitated and close-mouthed. The data seemed thin, not only due to a lack of evocative detail (Kirkevold & Bergland, 2007), but because her verbal communications did not convey her palpable distress around her self-harm or her anger at her treatment in the inpatient ward.

Similarly, though for different reasons, participant 1’s interviews were difficult to conduct and interpret. He heard voices and experienced what he called

Interestingly, participant 9, who was the only non-native speaker of English in the sample, provided rich, metaphorical descriptions of his emotional and material struggles – providing a few “gem”-like phrases that seemed to encapsulate the essence of his experiences as an asylum seeker (see Smith, 2010, for a discussion of “gems” in experiential qualitative research)
“flashbacks”, of both remembered and imagined events. During the interview, he described his experiences of current and past flashbacks, and the distress they caused was a significant motivator in his help-seeking. He sometimes felt controlled by his voices, particularly his uncle’s voice, which would attempt to disrupt his communication with psychiatrists, and felt frustrated and distressed by this inability to communicate. This frustration came through in our interviews, when we paused in our conversations twice and ended both interviews early as it became too much for him to cope with.

In both cases, I included the data despite fears that it was “thin” phenomenologically, because it was rich interactionally and emotionally, and the experiences which were communicated were significant to the participants. As a high proportion of the patients staff communicate with are likely to have similar communicative difficulties, it felt important to consider the challenges these interviews raised. Participant 1’s experience was illuminating, as our interview potentially mirrored his communications with psychiatrists, with interruptions, confusion and frustration. I felt at a loss as to how to respond to his descriptions of flashbacks, and attempted to draw on Knudson and Coyle’s (2002) recommendation to explore the meaning of these with the participant. The significance of hospital for him rested on a previous experience where he did not experience flashbacks or voices whilst admitted, and this motivated his help-seeking and potentially his self-harm (to justify help-seeking). His difficulties conveying this and explaining it to me, and the attendant emotion and stress during interview, offer an insight into a particular type of difficulty staff face in assessment – notably, how to cope with emotion and stress stemming from a struggle to communicate (and how to interpret the impact of such a disparate lifeworld). Likewise, participant 7 expressed her distress from being restrained on a ward more eloquently with her body language in interview than she did with words, presenting a challenge to both the phenomenological researcher, and the assessor at hospital.

The sample in this study was heterogeneous, which could be considered a limitation in light of IPA’s criterion of homogeneity. However, as mentioned previously, this sampling strategy seems to be mainly practical, as Smith and colleagues explain:
By making the group as uniform as possible according to obvious social factors or other theoretical factors relevant to the study, one can then examine in detail the psychological variability within the group, by analysing the pattern of convergence and divergence which arises (Smith et al., 2009, p50)

The motivation for sampling homogeneously is to enable the researcher to make stronger claims about a particular sub-group of individuals, usually determined by variables such as age, gender, ethnicity, and a shared experience, such as a particular illness or process. In this study, the participants all shared a common experience of being assessed, but were not homogeneous in terms of demographics (apart from ethnicity, for the main part). As is demonstrated in chapter 1, self-harm itself is a heterogeneous multi-layered concept, and it seemed presumptive to limit my sampling by age, gender or ethnicity to enable stronger claims about one of these groups when these divisions did not clearly translate into specific experiences in previous research. Instead, I adopted a practical and open recruitment strategy, and conducted in-depth and close analysis of each individual account to create complex narratives which considered both similarities and differences across accounts. In addition, I relied on the use of reflexivity during data collection, transcription, analysis and writing in order to consider the inter-subjective and relational aspects of the research. As with any small-scale study, the findings are limited in their generalisability, but the rich narrative detail is employed to demonstrate theoretical transferability. This detail should enable the reader to perceive the relevance of themes to other groups and situations which share aspects of their experiences, characteristics and circumstances with the interviewed participants (Smith et al., 2009).

Whilst the interviewed sample all shared the experience of assessment, it is notable that the participants were heterogeneous in terms of their previous experiences of self-harm, their previous experiences of services and their suicidal intent at the time of interview. As discussed in 1.3, people who repeatedly self-harm may be substantially different in terms of precipitants, intentions and expectations compared to people self-harming for the first time. Likewise, those with previous experiences of services are likely to have developed expectations as a result of prior attendances, which may influence their interactions with staff and their readiness to engage with assessment.
Finally, as illustrated in chapter 5, the meanings of self-harm and suicide for the participants were varied and complex – for those with significant suicidal intent, it is likely that they engaged with services in a different way to those who did not. The size of the sample did not allow for a thorough exploration of these potential differences, and therefore the findings should be extrapolated with caution.

8.5 Conclusion
Assessment in itself is not of salience to participants; what is salient about assessment is the way it functions in the context of the participant’s lived experiences and the hospital encounter more generally. The key message gained from participants’ accounts of assessment is that the interaction with staff has the power to reinforce or challenge hopelessness and negative self-evaluations. In addition, the way assessment is conducted continues to have influence beyond the hospital: as an experience which creates or reinforces expectations for future instances of help-seeking; as a deterrent or an encouragement to seek help; and as the first step along the path to change. Divorced from this context, it has little meaning – just as the risk factors identified in a participant’s account have little meaning when listed on a proforma and their absence or presence noted without concrete detail. What has meaning is the interaction between participant and staff member, and the interaction between different aspects of an individual’s life – social, psychological, interpersonal and structural. Re-conceptualising psychosocial assessment as primarily an opportunity to engage with patients therapeutically may consequently affect how they perceive and use health services, and how they perceive themselves.
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APPENDICES

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Introduction
Self-harm is a contested behaviour, and the debates, discussions and disagreements around self-harm and the terminology used are considered below. The terminology used and the definitions adopted are useful for clinicians and researchers to consider as they shed light on the historical development of knowledge, how power can be demonstrated through the use of language and how preconceptions and assumptions can lie beneath seemingly innocuous terminology. It is a truism that the act of defining an object excludes all other possibilities for being – the act creates a split between what is and what is not self-harm (and what groups of people self-harm). The social and psychological implications of common terminology and definitions form the basis of this essay.

Self-mutilation and Wrist-cutting Syndrome
“Self-mutilation” was the dominant term adopted in the early 20th century, with Emerson (1913-1914) and Menninger (1938) being notable proponents. In Menninger (1938), self-mutilation was described as a form of “partial suicide”, whereby the patient resolved a struggle between the instinct to live and the instinct to die by mimicking the suicidal act whilst averting it. This psychoanalytical approach to self-harm reflects the prominence of psychoanalytic theory at the time (Shaw, 2002). Menninger also placed self-mutilation on a continuum with other self-destructive behaviours, foreshadowing later research into direct and non-direct forms of self-harm (Babiker & Arnold, 1997; Turp, 2002).

The terms “self-mutilation”, “wrist cutting” and “wrist slashing” were often used synonymously in research during the 1960s and 1970s (Graff & Mallin, 1967; Grunebaum & Klerman, 1967; Offer & Barglow, 1960; Pao, 1969). These studies focused on a sub-group of "attractive, young" women in psychiatric hospitals (Graff & Mallin, 1967). The behaviour was described as “delicate” (i.e. superficial as opposed to deep) repetitive cutting (Pao, 1969) with little or no pain and awareness during the act, serving the primary purpose of tension relief and possible secondary purposes of receiving attention/affection or status from...
others. The ward setting (Podvoll, 1969), hospital admissions practices, and
the selection of participants for research (Clendenin & Murphy, 1971;
Weissman, 1975) influenced the patient type identified in these studies.
Brickman (2004, p. 96) criticized such studies for propagating “myths of
femininity” which pathologize women’s behaviour and women’s bodies. The
employment of explanations involving early maternal deprivation and
menstruation and/or castration anxiety positioned wrist cutting as a female
malady, in both affliction and cause.

Later researchers such as Favazza and colleagues (Favazza, 1996; Favazza &
Conterio, 1988; Favazza & Rosenthal, 1993; Favazza & Simeon, 1995) created
sub-categories of self-mutilation linking moderate forms of the behaviour to both
extreme psychotic forms, such as eye enucleation, and culturally sanctioned
forms, such as tattooing, body modification and cultural practices like Chinese
foot-binding. Favazza (1996, p. 225, p225) defined “self-mutilation” as the
“direct, deliberate destruction or alteration of one’s own body tissue without
conscious suicidal intent”. Favazza aimed to present self-mutilation as a
distinct phenomenon separate from suicide and suicidal behaviours, in the spirit
of earlier attempts to formulate a unique syndrome of self-cutting without
suicidal intent (Pao, 1969; Pattison & Kahan, 1983; Weissman, 1975). In
addition, Favazza (1996) attempted to normalize self-mutilation by placing it
within a wider socio-cultural context, but still employed terms such as “deviant”
and “pathological” to describe self-harm outside of established cultural
practices.

The term “self-mutilation” is unpopular amongst service users. Service users in
Sutton’s (2005) research described the term as “sensationalistic”, “inaccurate”,
and an “exaggeration”. Pitts (1999), drawing on media representations of self-
mutilation, argued that the negative connotations of permanent maiming or
damage both alienates people and creates an inaccurate view of those who
engage in self-harming behaviours. In addition, the term has been associated
interchangeably with ideas of mental illness and a lack of agency, which can
serve to disempower and silence service user accounts (Harrison, 1995; Pitts,
1999).
Attemped Suicide and Parasuicide

“Attempted suicide” is often used to describe self-harm as it acknowledges the association between self-harm and suicide (Sakinofsky, 2000). However, the connotation of failure implicit in the descriptor “attempted” can be experienced as punitive (Pembroke, 1994; Solomon & Farrand, 1996; Spandler, 1996). In addition, the conflation of self-harm and suicide can be especially problematic for service users, if it impacts upon the treatment decisions of staff (National Institute for Health and Clinical Excellence, 2004).

Another term, “parasuicide”, has been proposed to differentiate between “genuine” suicide attempts and behaviourally similar but intentionally distinct acts (Kreitman, 1979). “Parasuicide” is defined as a suicidal gesture or act which mimics that of someone attempting suicide but carries no suicidal intent (Kreitman, 1979; Welch, 2001). Differentiating between acts on the basis of suicidal intent often fails to account for the complexity of suicidal intent (McAllister, 2003; Salter & Platt, 1990). In addition, positioning “parasuicide” in opposition with “genuine” suicide attempts can have the effect of devaluing the experience of those seen as “parasuicidal”, despite real distress driving the behaviour (Harrison, 1995). “Parasuicide” is still used in the literature, but Welch’s (2001) review noted inconsistencies in the way it is interpreted.

Both “attempted suicide” and “parasuicide” are efforts to reconcile the different yet closely linked profiles of suicide and self-harm. “Attempted suicide” and “parasuicide” are seen as gestures, a “cry for help” (Farberow & Shneidman, 1961; Stengel, 1964). This communicative intent can be interpreted as “attention-seeking”, leading to the patient being labeled a time-waster by staff (e.g. Hadfield et al., 2009; Jeffery, 1979; Walsh & Rosen, 1988). In addition, the idea of a “cry for help” cannot account for the private nature of much self-harm (Burstow, 1992; Pembroke, 1994; Spandler, 1996; Sutton, 2005). An emphasis on the communicative nature of self-harm can also detract from the wider social and psychological difficulties a person may be experiencing, by focusing on the act’s meaning in relation to the staff-patient relationship.
Deliberate Self-harm

Morgan (1979) coined the phrase “deliberate self-harm”, defined as “a deliberate non-fatal act, whether physical, drug over-dosage or poisoning, done in the knowledge that it was potentially harmful, and in the case of drug over-dosage, that the amount taken was excessive” (p88). This definition encompasses a variety of acts which are performed by the individual knowingly and purposefully. It is often used in the medical context because it differentiates between self-harm on purpose and accidental self-harm, and includes self-inflicted injury or poisoning regardless of intent (Skegg, 2005). Its usage is common within the UK (Hawton et al., 2003).

A further use of the term “deliberate” is employed by Pattison and Kahan (1983). “Deliberate self-harm syndrome” is characterized by repetitive, low lethal direct infliction of injury to the self (Pattison & Kahan, 1983). “Deliberate self-harm syndrome” is defined as a clinical entity removed from suicidal behaviour and both this syndrome and suicide attempts are positioned on a continuum of lethality. The emphasis on lethality as a defining feature of the syndrome is problematic, owing to the complex relationship between lethality and suicidal intent (Hawton, 2001; McAllister, 2003). In addition, the “direct” aspect of injury requires immediate awareness of the damage inflicted and conscious intent to harm oneself (Favazza, 1996; Pattison & Kahan, 1983). For those who experience dissociation during or after self-harm, awareness may only occur hours later (e.g. Pembroke, 1994; Strong, 1998; Sutton, 2005), and there is often a disparity between intent to damage the self and the extent of actual damage in those without medical knowledge (Hawton, 2001; Pembroke, 2007).

Service users such as Louise Pembroke (1994) have protested against the use of “deliberate” as unnecessary and demeaning, encouraging medical staff to view self-harm as a manipulative and attention-seeking act. The terminology used by staff is seen as attitude-forming (Pembroke, 1994). Likewise, the Royal College of Psychiatrists (2004, p. 7, p7) found that “some service users fear it [the term “deliberate”] might be of itself stigmatising”. Whilst no study has expressly explored the terminology used by staff and its effect on attitudes towards self-harm, the negative effects of labelling are widely acknowledged in
mental health field (Goffman, 1963; Jeffery, 1979; Link & Phelan, 2006; Rosenfield, 1997).

Self-injury and the Survivor Discourse

The discourse of self-harm survivors is that of a subjugated knowledge. It is a knowledge forged in the patient’s experience itself (Cresswell, 2006, p. 9, original emphasis)

“Self-injury” is commonly used in the survivor literature to describe those who hurt themselves as a coping mechanism (Harrison, 1995). “Self-harm” is sometimes used interchangeably with “self-injury” (Pembroke, 1994). One definition for self-injury is “intentional and direct injury of one’s body tissue without suicidal intent” (Muehlenkamp, 2005). It firmly separates self-harm from suicidal acts and encompasses behaviours such as cutting, burning, scalding, scratching, inserting objects, picking, and head-banging, but excludes self-poisoning.

Adopting the term “self-injury” allows service users to reclaim control over the meaning of their actions (Cresswell, 2005, 2006; Pembroke, 1994). As Maggy Ross wrote:

I’ll tell you what self-injury isn’t ... It’s rarely a symptom of so-called psychiatric illness. It’s not a suicide attempt… (in Pembroke, 1994, p7)

This explicit rejection of the mental health discourse around self-harm is a way for service users to create a space for new meanings and understandings drawn from their own experiences. Pembroke (1994) in particular argues that creating her own way of talking about self-harm is liberating and empowering, which reflects other struggles for equality and fair treatment (e.g. feminism, and civil rights movements).

The service user literature attempts to foreground the distress and social reality of those who self-injure, and to reject the “pathologising” effects of other terms (Harrison, 1995; Johnstone, 1997). However, self-injury is a specific entity co-opted by service users, and as such, represents a vocal fraction of the possible experiences of self-harm (Cresswell, 2005, 2006). The service user literature
also imbues self-injury with meaning and purpose, for example the definition proposed by the charity Mind:

> Self-injury… can be seen as a symbolic way of expressing deep distress – a non-verbal form of communication in which the feelings are ‘externalised’ through the body (Harrison, 1996, p. 3, p3)

This definition presents a view that could alienate service users with ambivalent or negative feelings towards self-harm.

**Self-poisoning**

The survivor discourse around self-injury positions self-poisoning as an act closely aligned with suicide attempts and suicidal intent. The symbolic and physical aspects of self-injury are seen as distinct from suicide, attempted suicide, and self-poisoning (Harris, 2000; Harrison, 1997; Pembroke, 1994). This distinction between self-poisoning and self-injury is also made by some clinicians (Muehlenkamp, 2005; Pattison & Kahan, 1983; Stanley et al., 2001; Taylor & Cameron, 1998). Fagin argued:

> Self-injury [is] different from self-poisoning, where substances (usually drugs) are ingested, usually in order to die, cry for help or obtain temporary respite from unhappiness or unbearable distress, and I believe that people who poison themselves have different characteristics from those who injure themselves (Fagin, 2006, p196)

Taylor and Cameron (1998) identified epidemiological differences in those who self-injure and those who self-poison in an emergency department cohort. Those who self-injure were significantly younger and typically male (68% of self-injury group), with those who self-poison being predominantly female (67% of overdose group). Likewise, in a multi-centre study of hospital attendances in the UK, women were more likely to self-poison at index episode than men (Hawton et al., 2007). In a community sample of adolescents, girls self-harmed more than boys, but the differences in numbers of males compared with females was less pronounced for the self-cutting group than the self-poisoning (Rodham et al., 2004).

Self-poisoning is often the most common form of self-harm in hospital samples (Corcoran et al., 2004; Hawton et al., 2007; Hawton et al., 2003; Taylor & Cameron, 1998), whereas community-based surveys suggest that self-cutting may be more prevalent in the community (Hawton et al., 2002; Laye-Gindhu &
Schonert-Reichl, 2005; Meltzer et al., 2002). This difference may be partly an artifact of data collection: self-poisoning is more likely to require medical attention owing to the less immediate and controlled nature of the damage inflicted (Sutton, 2005). In addition, most community surveys of self-harm are completed with adolescents (e.g. Hawton et al., 2002; Laye-Gindhu & Schonert-Reichl, 2005), whom Taylor and Cameron (1998) identify as more likely to self-injure. The difference may also relate to lay understandings of self-harm: overdosing on illicit drugs or prescribed medication might not be interpreted as self-harm in community settings.

Studies exploring the reasons people self-poison have identified a number of non-suicidal motivations (Bancroft et al., 1979; Bancroft et al., 1976; Dorer et al., 1999; Rodham et al., 2004), with ambivalence around suicidal intent being a common feature (Salter & Platt, 1990). In a comparison of self-poisoning and self-cutting in adolescents, self-poisoning was more often associated with a wish to die, but also with the desire to find out if someone cared for them; both self-poisoning and self-cutting were most commonly motivated by a desire to relieve a “terrible state of mind” (Rodham et al., 2004). The boundaries between the two behaviours are therefore not clearly defined by motivation. It is notable that in a Sri Lankan study of self-poisoning with pesticides, a particularly lethal method of self-harm, motives were typically non-suicidal and the behaviour conceptualized as a response to stressful events (Konradsen et al., 2006): a profile which resonates with the survivor definition of self-injury in the UK (Harrison, 1996).

Separating self-injury from self-poisoning in the survivor literature seems to be related to positioning self-injury as anti-suicide (Burstow, 1992; Harrison, 1995; Sutton, 2005); as a repetitive, low lethal, controlled means of coping with emotions and events in one’s life (Nathan, 2006). The question remains: why is it so important for service users to create a space between self-harm and suicide? One possible reason is to define the appropriate response for services. The risk culture within the mental health system (Rose, 1998) prioritizes the prevention of suicide, which can detract from those who self-harm for other reasons (e.g. Burstow, 1992; Pembroke, 1994; Spandler, 1996). In addition, there is growing concern that the policy of close observations on those
Deemed at risk of suicide can have a negative impact (c.f. Cardell & Pitula, 1999; Cutcliffe & Barker, 2006). Enforced hospitalization and self-harm bans can mirror the powerlessness which self-harm countered in the initial instance (Harrison, 1995; Liebling et al., 1997; Pembroke, 1994).

Another possible reason for the demarcation is to define a positive relationship with self-harm for the service user. Many service users talk about a “vicious circle” of negativity following self-harm (Harrison, 1995; Johnstone, 1997), which perpetuates the behaviour and reflects societal attitudes towards self-destruction (Walsh & Rosen, 1988). By naming self-injury as a means to survive and cope, self-injury becomes a strength rather than a weakness, a symbol of the struggle the service user has endured (Harris, 2000). Scars can become “battle scars”, signs of survival (Pembroke, 1994). Suicide, by contrast, is positioned as a weakness, and so remains something to struggle against. Self-poisoning is perceived as a more ambiguous act (Sutton, 2005) and this may contribute to its absence in the survivor literature.

**Locating Self-harm**

Interests are always served by definitions: the only question is which interests (Schiappa, 1996, p227)

There is inherent contradiction and tension within the multiple terms used for self-harm. On the one hand, the service user is seen as incomprehensible, unreasoning and out of control (Harris, 2000). On the other, the service user is deliberate, directed and manipulative (e.g. Jeffery, 1979; Walsh & Rosen, 1988). The mental health discourse on self-harm, which oscillates between these two viewpoints, tends to locate self-harm within the individual. The myriad attempts at typology and categorization can create stereotype and individualize self-harm (Brickman, 2004; Johnstone, 1997; Shaw, 2002). Within institutions, people become identified with the monikers of “self-harmers”, “cutters”, and “overdoses”: terms which can encourage dismissive and punitive attitudes (Clendenin & Murphy, 1971; Cresswell & Karimova, 2010; Jeffery, 1979; Pembroke, 1994; Podvoll, 1969; Spandler, 1996; Weissman, 1975).

User-focused research has challenged the idea that an individual can be equated with a particular method of self-harm, as many people who self-harm
use multiple methods, dependent on the purpose, context and meaning of the act (Arnold, 1995; Bywaters & Rolfe, 2002; Hume & Platt, 2007; Pembroke, 1994; Solomon & Farrand, 1996). A recent prospective cohort study based on data from the multi-centre monitoring project found that a third of repeaters switched method between episodes (Lilley et al., 2008). There is therefore no straightforward differentiation of people by method of self-harm (McAllister, 2003). The meaning of self-harm is located within the individual’s life experience, not in the actions performed.

**A Continuum Approach to Self-harm**

Another way of defining self-harm is by examining gradations of self-harming behaviour. The variety of behaviours that can be thought of as self-harming includes activities like overwork, over-exercising, piercing and tattooing (Babiker & Arnold, 1997; Clarke & Whittaker, 1998). Behaviours such as eating disorders and alcohol/drug abuse can also be thought of as self-harming, as they can operate as the medium through which a person hurts themselves (Arnold, 1995; Babiker & Arnold, 1997; Harris & Barraclough, 1997; Hufford, 2001). In Laye-Gindhu and Schonert-Reichl’s (2005) school survey, a small number of the adolescents reported eating-disordered behaviours (7%), and reckless behaviour (5%) as methods of self-harm. It is possible that these behaviours may be performing the same functions as self-harm (Babiker & Arnold, 1997). One young woman in her late teens described it this way:

... I don’t think self-harm is just about cutting or hitting walls and things. I think it includes eating disorders, because they are self-harming. When I got a bit older I had some problems with alcohol and solvents, and a lot of self-harming behaviour through having multiple relationships. I think that’s very self-harming (Bywaters & Rolfe, 2002, p3).

Turp (2003) conceived of a continuum between self-harm and self-care. This continuum shows a gradation from adequate self-care to compromised self-care, through to mild, moderate and severe self-harm. Whilst the model is based on clinical experience rather than on identification of such groups within the population, it is intuitively plausible. One element not clarified by the model is the fact that more than one of these behaviours can co-exist, for instance, someone who self-injures may pay more attention to other needs because the self-harm “allows” them to do so (Harris, 2000; Harrison, 1995). The concept of inadequate self-care is discussed by Babiker and Arnold (1997). They
introduce the concepts of indirect self-harm, and self-harm by omission. These
behaviours (or inactions) may not be picked up by services, and may not be
reported as problems. Whilst these behaviours or inactions may not count as
“self-harm” from a clinical point of view, it is worth noting that they may still form
part of a service user’s experiences and may reflect different aspects of the
same difficulties.

Summary
This overview illustrates the ways in which terminology can be indicative of the
attitudes held about self-harm, and how this can in turn impact on the ways self-

harm is approached by services. The terminology used by clinicians has been
criticized for the ways in which it can stereotype clients, and service users have
been active in re-defining self-harm so that it reflects and respects their
experiences. The complexity and heterogeneity of self-harm is demonstrated in
the range of ideas and disagreements about it. In reality, no single method of
self-harm can always be defined as suicidal or as a way of coping, just as most
people seen by services may demonstrate more than one type of self-harm on
different occasions, and may express more than one motivation for self-
harming.

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Appendix 2: Manchester Self-harm Assessment Form (MASH form)
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<table>
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<tr>
<th>1. Patient Details</th>
</tr>
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<tbody>
<tr>
<td>NHS No.</td>
</tr>
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<td>DISTRICT No.</td>
</tr>
<tr>
<td>Preceded...</td>
</tr>
<tr>
<td>Date of birth</td>
</tr>
<tr>
<td>Date of presentation</td>
</tr>
<tr>
<td>Time of presentation (24hr)</td>
</tr>
<tr>
<td>If not specified please give reason.</td>
</tr>
</tbody>
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<tr>
<th>2. Self-harm Details</th>
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<tbody>
<tr>
<td>Date of harm.</td>
</tr>
<tr>
<td>Time of harm (24hr).</td>
</tr>
<tr>
<td>Was alcohol taken within 6 hours prior to this attempt?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>How many units?</td>
</tr>
<tr>
<td>Method of harm:</td>
</tr>
<tr>
<td>Self-poisoning drugs</td>
</tr>
<tr>
<td>Stabbing</td>
</tr>
<tr>
<td>Other (burning, aspiration, CO poisoning etc)</td>
</tr>
</tbody>
</table>

| Further details for drug poisoning: specify and number of tablets, for all wastewater methods give details of attempt. |

<table>
<thead>
<tr>
<th>Ticks drugs taken as part of self-harm</th>
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<tbody>
<tr>
<td>Paracetamol (not compounds)</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Paracetamol and other</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Other analgesics, aspirin, etc</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Other analgesics</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Other drugs, aspirin, etc</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Other drugs (specify)</td>
</tr>
<tr>
<td>Yes</td>
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<tr>
<th>Anti-depressants</th>
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<tr>
<td>Anti-convulsants</td>
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<td>No</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Yes</td>
<td>No</td>
</tr>
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<td>Body mass</td>
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<td>No</td>
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<td>Smokes</td>
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<td>Other treatments</td>
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</tr>
<tr>
<td>Other notes</td>
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<th>Official use only:</th>
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<th>16</th>
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<th>3. Ethical Status for Suicide</th>
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<tr>
<td>Sex. Male</td>
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<tr>
<th>Mental status:</th>
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<tbody>
<tr>
<td>4. Current Mental State</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>Symptoms of depression</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Loss of interest</td>
</tr>
<tr>
<td>Sleep disturbance</td>
</tr>
<tr>
<td>Appetite disturbance</td>
</tr>
<tr>
<td>Hopelessness</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
</tr>
<tr>
<td>Suicidal plan</td>
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<tr>
<td>Hospitalisation/education</td>
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<th>4. Current Mental State</th>
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<tbody>
<tr>
<td>Symptoms of depression</td>
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<tr>
<td>Yes</td>
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<tr>
<td>Loss of interest</td>
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<td>Sleep disturbance</td>
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<td>Hospitalisation/education</td>
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<th>5. Clinical Impression</th>
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<tbody>
<tr>
<td>How potentially lethal was this attempt?</td>
</tr>
<tr>
<td>Low</td>
</tr>
</tbody>
</table>

| What is the likelihood of further attempts? |
| Low | Moderate | High |

| What is the chance that further attempts will be lethal? |
| Low | Moderate | High |

<table>
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<tr>
<th>6. Management Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>What was the outcome? (tick appropriate box(es))</td>
</tr>
<tr>
<td>Discharged, normally referred to GP</td>
</tr>
<tr>
<td>Discharged, normally referred to hospital</td>
</tr>
<tr>
<td>Discharged, to see GP</td>
</tr>
<tr>
<td>Discharged, no referral</td>
</tr>
<tr>
<td>Self-discharge</td>
</tr>
<tr>
<td>Referred to specialist (Hosp &amp;/or Psychiatric)</td>
</tr>
<tr>
<td>Referred to GP</td>
</tr>
<tr>
<td>Referred to other services (specify)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Further details of management follow up:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation offered to patient</td>
</tr>
<tr>
<td>General hospital admission requested</td>
</tr>
<tr>
<td>General hospital admission followed up</td>
</tr>
<tr>
<td>Psychiatric referral offered but patient refused</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assessed by (BLOCK CAPITALS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Speciality:</td>
</tr>
<tr>
<td>Data of assessment:</td>
</tr>
<tr>
<td>Time of assessment (24hr):</td>
</tr>
<tr>
<td>格Consultant</td>
</tr>
<tr>
<td>Registrar</td>
</tr>
<tr>
<td>Other (specify):</td>
</tr>
</tbody>
</table>
Invitation Letter

STUDY NAME: EXPLORING THE EXPERIENCE OF ASSESSMENT AFTER SELF-HARM

Dear Participant

I work for the [specialist self-harm team] based at [the study hospital]. Part of our job is to collect information about any emergency department attendances due to self-harm. I believe that you came to the emergency department recently, and talked to a member of staff about what had happened.

I am writing to ask whether you would be interested in talking to a researcher about your experience at the emergency department. The research is designed to include people with a variety of experiences, and we hope that the feedback people give about their experiences will help us to improve services.

I enclose some more information about this study. The research is based at the University of Manchester. If you think you would like to take part or would like a researcher to contact you about the study – please fill in your details on the slip below and send back in the envelope provided. If you decide not to, this will in no way affect your medical care in the future.

Yours sincerely

[Member of Specialist Self-harm Team]

EXPLORING THE EXPERIENCE OF ASSESSMENT AFTER SELF-HARM

I AM WILLING TO BE CONTACTED BY A RESEARCHER ABOUT TAKING PART:
NAME (IN CAPITALS):............................................................DATE:........
SIGNATURE:............................................................................
ADDRESS:................................................................................
TELEPHONE NUMBER:...........................................................
If your first language is NOT English, but you want to know more about the study, please state your preferred language:......................................................
Research Study: Exploring the experience of assessment after self-harm

We would like to invite you to take part in a PhD student research study into the experience of being assessed after self-harm. Before you decide whether or not to take part, please take some time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

The purpose of this study is to ask people about their experiences of assessment at the hospital after self-harm. An assessment is an interview with a staff member about what led to the hospital visit. It is recommended by the NHS that every person receives one. There are differences in the way these interviews are carried out. We would like to find out:

1. What people think of this assessment
2. What the experience is like for them
3. How the assessment can be improved
4. How people feel after the assessment

We are interested in trying to improve services by asking people who have experienced services for their opinions. We hope to interview about 20 people. Each interview will take approximately one hour. With the results of this study, we hope to be able to plan better care for those who self-harm and go to hospital.

Why have you been contacted?

You have been contacted because you may have experienced an assessment like this. If you wish to take part, please send your contact details to the interviewer in the envelope provided.

What does the study involve?

The study involves an interview with Cheryl Hunter, a PhD student at the University of Manchester. A topic guide is enclosed with this information. You can choose which topics you want to talk about. The interview can take place
at a time and venue that suits you. If you need to travel, your travel expenses will be reimbursed.

You will be asked if you want to take part in a second interview, once the first interview is completed. You do not need to commit to the second interview at that time. The interviews are for research purposes, and the interviewer is not trained as a counsellor.

**What happens if I don’t want to take part?**
Taking part in this study is voluntary. If you do not wish to take part, or want to withdraw at a later date, you can do so without giving a reason. This study will not affect any medical care you may receive in the future.

**Will my taking part in this study be kept confidential?**
Yes. What you tell us during the interview will be kept confidential within the research team. Confidentiality will only be broken if the researcher has reason to believe that you or someone else is at serious risk of harm.

We would like to record the interview using an audio digital recorder. This allows us to keep more information from the interview for writing up. This recording will be kept confidential, and will not have your name on it. Being recorded is voluntary. If you decide that you do not want the interview recorded, you can still take part.

**What happens with my information?**
This will be kept in a locked filing cabinet for no longer than 10 years. Only the research team will have access to these. The interviewer hopes to publish the study results in academic journals and in a PhD thesis. This may include quotes from the interviews. These quotes will be anonymous, with any identifying information removed from them.

**What are the possible drawbacks to taking part?**
We are interested in hearing about your experience. The study does not involve any treatment or counselling. You may find talking about parts of your experience stressful or upsetting. If this happens, you can choose not to talk
about these parts of your experience or stop the interview at any time without giving a reason.

**What are the possible benefits of taking part?**
Your views and opinions will allow us to develop recommendations to improve assessments. This may not benefit you personally, but may help others who have assessments following self-harm in the future.

**What if there is a problem?**
We hope that taking part is a positive experience for you. However, if you have any concerns, you can contact the interviewer Cheryl Hunter, who will try to answer any questions you have. If you remain unhappy and wish to complain formally, you can do this by contacting the University Research Governance Co-ordinator on 0161 275 7583. Although it is extremely unlikely, if you are harmed during the research due to someone’s negligence you may have grounds for a legal action for compensation against the University of Manchester but you may have to pay your legal costs.

**Who is organising and funding the research?**
Staff employed by the Manchester Mental Health and Social Care Trust are sending out these letters on the behalf of the research team. Cheryl Hunter is the main researcher, and she is funded by the Medical Research Council.

This research has been reviewed and approved by the Tameside and Glossop Local Research Ethics Committee.

**If you have any questions, or would like to find out more about the project, please contact:** Cheryl Hunter on 0161 275 0734 or e-mail her on cheryl.hunter@postgrad.manchester.ac.uk
First Interview Guide (sent with invitation letter)

Interview Guide

The following questions are examples of the types of questions I might ask in the interview. If there are any questions you are uncomfortable with, these can be left out. Alternatively, if there is anything you feel is important and would like to talk about, feel free to bring these up.

Introduction
   1. Background information
   2. How long has it been since your visit to the hospital?

Circumstances leading to hospital visit
   3. Could you tell me a bit about what was going on in your life at the time you attended the emergency department?
   4. How were you feeling when you self-harmed on the day in question? What was/were your reason(s) for self-harm?
   5. How did you get to the emergency department? How did you feel about seeking medical help/attending emergency department?
   6. Did you have a choice about going to the hospital?

At the hospital
   7. How did you feel when you got to the emergency department? (depends on if they were conscious at the time) When you realised you were in hospital, how did you feel?
   8. Could you tell me what you remember about being at the hospital?
   9. How did you feel during this experience?

Assessment
   10. What (if anything) were you told about the assessment before it happened?
   11. How did you feel about having an assessment?
   12. Could you tell me in your own words what the assessment was like?
   13. How did you feel during the assessment?

Outcome of Assessment
14. What were the outcomes of the assessment?

15. What aftercare/follow-up were you offered? Was it discussed with you/explained to you? How did you feel about the course of action chosen?

16. How did you feel at the end of the assessment?

17. How did you get home after the hospital visit?

18. How would you feel about going back to the hospital if you had to?

**Improvements/Suggestions**

19. What would you change about the experience if you could?

20. Can you think of ways to improve hospital services for others?

21. Are there any outcomes you would identify as important/relevant even if not achieved? What are they?
Appendix 4: Second Interview Guide

Interview Guide: Interview 2

Since the Last Interview
1. What has your life been like since the hospital visit?
2. What were the reactions of significant others after your hospital visit?
3. What was your reaction? How did you feel afterwards?
4. Do you think the visit was helpful/unhelpful? Yes/no, explore why
5. Since that visit, what contact have you had with services? Prompts: mental health services, voluntary, psychiatrist etc
6. What has this contact been like for you? Has it been helpful/unhelpful? If so, why/why not?

Self-harm
7. Have you self-harmed since that visit? Yes/no, explore why/why not – what has changed from before? If yes, did you re-attend hospital?
8. How would you/how do you feel about going back to the hospital if you have to? Explore feelings and reasons for feelings
9. Are there any ways in which you try not to self-harm/to reduce the severity of your self-harm? Explore what these are/how effective they’re felt to be

Outcomes
10. In what ways do you feel the assessment/hospital visit has affected your life? Explore – if there have been other visits, have these had an effect? Probe – social, personal, work, family
11. At the end of the last interview, desired and actual outcomes were identified. Has the experience had an effect on these? Yes/no – explore how. Has there been any further effects of the experience that you can think of?

Improvements/Suggestions
12. What would you change about the experience if you could?
13. Can you think of ways to improve hospital services for someone like yourself?
Appendix 5: Consent Forms

CONSENT FORM

Study Title: Exploring the experience of assessment after self-harm
Researcher: Cheryl Hunter
Participant ID Number:

Consent to take part in the interview

1. I have read and understand the information sheet

2. I have had a chance to ask any questions and discuss any issues with the researcher

3. I understand that my participation is voluntary

4. I am free to withdraw at any time without giving a reason.

5. If I decide to withdraw from the study, my medical care or legal rights will not be affected

6. I agree to the publication of direct quotations from the interview that cannot be used to identify me

7. I agree to be audio-taped during the interview

8. At this time, I agree to take part in the interview.

Signature…………………………………………………………………………………………

Name (in capitals)………………………………………………………………………………………

Date…………………………………………………………………………………………

Signature of witness…………………………………………………………………………………………

Name (in capitals)………………………………………………………………………………………
INFORMATION SHEET and CONSENT FORM (AFTER THE INTERVIEW)

Study Title: Exploring the experience of assessment after self-harm
Researcher: Cheryl Hunter
Participant ID Number:

What happens next?
1. After the interview, I will type up the information you have given me. At this time, I will remove any information from the tape that might identify you. If you would like to read this document and check that you agree with it, I can post this out to you.
2. I would like to contact you in three months time to see if you have any further information to add to the research. If you are prepared to let me telephone you at this point, please tick the corresponding box below.
3. At the end of the study, I will produce a report on the experiences of everyone who has taken part. If you would like to receive a copy of this report, please tick the corresponding box below.

Consent

YES NO

1. I would like to read the interview notes
   Please tick appropriate box:

2. I am willing to be contacted in three months
   Please tick appropriate box:

3. I would like a copy of the final report
   Please tick appropriate box:

Signature………………………………………………………………………………………………………………………………………………
Name (in capitals)…………………………………………………………………………………………………………………………
Address……………………………………………………………………………………………………………………………………
Telephone……………………………………………………………………………………………………………………………………
Date…………………………………………………………………………………………………………………………………………
Signature of researcher………………………………………………………………………………………………………………
Name (in capitals)………………………………………………………………………………………………………………………

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Appendix 6: Feedback Form

Feedback Sheet

Research Study: Exploring the experience of assessment after self-harm

How did you feel about taking part in the study before the interview? Please circle the number which most closely resembles how you felt.

Very anxious  Slightly anxious  Neutral  Slightly relaxed  Very relaxed
1------------------------- 2 --------------------- 3 ----------------- 4 ------------------------- 5

Any further comment?

........................................................................................................................................
........................................................................................................................................

How do you feel after the interview? Please circle the number which most closely resembles how you felt.

Very anxious  Slightly anxious  Neutral  Slightly relaxed  Very relaxed
1------------------------- 2 --------------------- 3 ----------------- 4 ------------------------- 5

Any further comment?

........................................................................................................................................
........................................................................................................................................

Is there anything you want to add to the research that you did not feel comfortable talking about? (continue on back of sheet if necessary)

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Do you have any comments on the way the interview was conducted?

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
........................................................................................................................................
Appendix 7: Worked Example of Analysis

As Chapter 4 describes, there are five main stages to the analytic process in IPA. These are as follows:

6. Several readings of the transcript with initial notes on themes
7. Development of themes
8. Creation of higher order themes (which connect previous themes together)
9. Creation of a master list of themes, with quotations to illustrate
10. Creation of a group master list

Worked examples of each stage are presented below.

Stage 1: Initial Reading and Annotation of Transcripts

Table 1 below demonstrates the initial stage of IPA which involves a close reading of the text, in order to familiarise oneself with the participant’s lifeworld and account, and to consider the assumptions and pre-conceptions the researcher is bringing to the analysis.

In the example presented, the left hand side of the table contains a portion of the transcript of participant 5’s interview, a young woman who had a history of self-harm. The interviewer’s speech is preceded by an “I:” and is in plain text; the participant’s speech is preceded by a “P:”, in bold text. Any text in square brackets such as “[right]” indicates speech by the individual who was not currently dominant in the conversation. For instance, in this section, I occasionally say “yeah” or “right”, expressing my engagement with participant 5’s account and these are embedded within her text in square brackets. The text surrounded by the symbols “<” and “>” indicates text that has been altered or removed to reduce the likelihood of identifying the participant.
Table 1: Initial Coding of Transcripts – Participant 5

<table>
<thead>
<tr>
<th>Section of First Interview Transcript</th>
<th>Initial Annotation of Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>I: Ok, was it the first time you’ve gone to hospital for self-harm or…?</td>
<td>I’ve done it loads of times – self-harm as normal for her, normalised, something she often does/has done – what purpose does it serve for her? What use is it, for it to be maintained? Early teen when she started self-harming</td>
</tr>
<tr>
<td>P: Er, first time into hospital, yeah</td>
<td>All frustration really – frustration as the trigger or precipitating emotion – relieve stress as motive/function of SH</td>
</tr>
<tr>
<td>I: But erm, you’ve done it before, have you?</td>
<td>Too busy – work, college, people demanding. Frustration building up – frustration gets worse overtime if there’s no release for it</td>
</tr>
<tr>
<td>P: Oh yeah, yeah, I’ve done it loads of times</td>
<td>Self-harm as a release for frustration</td>
</tr>
<tr>
<td>I: Right, and erm, when would you say you started self-harming?</td>
<td>Led to SH – it just led me to do that (and she followed?) makes it sound like a natural progression – external locus of control</td>
</tr>
<tr>
<td>P: Probably when I was about &lt;early teen&gt;</td>
<td></td>
</tr>
<tr>
<td>I: &lt;Early teens&gt;? So that’s about &lt;x&gt; years ago?</td>
<td></td>
</tr>
<tr>
<td>P: Yeah</td>
<td></td>
</tr>
<tr>
<td>I: Ok, and er, on the day in question, last Monday you said, what was going on in your life to lead to the self-harm?</td>
<td></td>
</tr>
<tr>
<td>P: It was all frustration really [Right] because I was so busy with my college work [Yeah] and I was also really busy with my actual work and then I’ve got really annoying people that I work with so it was frustration. All of it just building up and building up [Right] and then it just led me to do that because it was sort of a release.</td>
<td></td>
</tr>
<tr>
<td>I: So it was to release all of the frustration out?</td>
<td></td>
</tr>
<tr>
<td>P: Yeah</td>
<td></td>
</tr>
</tbody>
</table>

The right-hand margin displays the initial comments made on this piece of transcript. The plain text expresses descriptive aspects of the transcript, i.e. noting what she says (“I’ve done it loads of times”), details (“early teen when she started self-harming”) and summaries of the descriptive content (“Self-harm as a release for frustration”). The text which is underlined indicates more interrogative, conceptual notes, which link into the literature on the topics. For instance, “relieve frustration as motive/function of SH” ties this section to a wider literature on the functions of self-harm, and “makes it sound like a natural progression – external locus of control” is a comment on the implications of her language use in terms of control over behaviour. One linguistic comment is made in this section, which relates to the last note about control: the italicised text “led to SH – it just led me to do that (and she followed?)” demonstrates how linguistic choices could be indicative of wider conceptual issues.

Stage 2: Development of themes

The second stage was carried out using QSR International NVivo7. I coded each individual transcript in-depth. The coding was initially descriptive, as I tried to capture the sense of the participant’s accounts in codes (or “nodes”, as
NVivo7 calls them). Each portion of text could be coded under more than one node. An example would be the following text from participant 12’s account:

She, she was asking similar questions to you, how I felt, [yeah], any reason why I should’ve done it, sort of thing, I tried to explain about the finance and things like that, she asked me if I’d ever done it before, I said no, she said well how do you feel? I said I felt so stupid, and embarrassed. She said how do you feel about getting home? I said I felt fine, I don’t have any problems, she said well I’ll have a word with the nurse when I go out, and then she said yes, you can go

This text was coded under several different codes, including:

- “Emotional impact of self-harm – embarrassment”
- “Emotional impact of self-harm – shame”
- “Outcome – discharge”
- “Self-conscious emotion”
- “Aftermath – negativity towards the self”
- “Assessment questions”

Some codes were organisational, rather than interpretive, for example “Outcome – discharge” was used to group together instances across accounts that revealed the outcome of assessment. This was of prior interest within the study, as policy placed assessment at a pivotal position in determining further care for people who self-harmed. Coding examples of “outcome” within the accounts allowed me to further explore the context and implications of different aftercare arrangements (see chapter 7 for findings).

Other codes were descriptive, and sometimes overlapping. This occurred partly as a result of the in-depth coding technique, and partly as a result of different accounts or passages seeming to indicate different emphases or meaning. The emotion-related codes above are examples of this, for instance, “self-conscious emotion” emerged as a code for all instances of the emotions, guilt, shame, embarrassment or pride, which imply consideration of ourselves in contrast with others. “Aftermath – negativity towards the self” was a more temporal code to capture how one direct effect of self-harm in the participants’ accounts was self-negativity, as demonstrated by shame and embarrassment, but also by expressions of self-loathing and disappointment in accounts, e.g.:
I started getting upset at myself again [yeah] why I’d been, you know why I’d done this, you know, again, a doctor that should’ve been looking after somebody else coming to assess me [right] so it was all upsetting me in that sort of frame of mind (P12)

Once an entire interview was coded in this manner, a coding report from NVivo was created, which gave me a complete list of codes including quotes coded underneath it. One example is presented in figure 1 below.

**Figure 1: Extract from coding report for participant 12**

<table>
<thead>
<tr>
<th>Node Coding</th>
<th>Free Nodes</th>
<th>Affectivity towards the self</th>
<th>References</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference 1</td>
<td>Character Range 5.716 - 5.990</td>
<td>I was quite embarrassed and I was actually [emo] more than embarrassed. I felt disgraced with myself [yeah], you know, why am I doing such a stupid thing, why am I putting these people to so much trouble [mm-hm] when all I’ve got to do is get over it and get it sorted out...</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 2</td>
<td>Character Range 12.521 - 12.752</td>
<td>I felt more sorry for those lads that had been knocked about than I did for me, I just felt as though, how stupid I was [yeah], in there, there’s somebody out there who’s willing to beat me up, and I’m doing it to myself, you know</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 3</td>
<td>Character Range 12.821 - 12.871</td>
<td>I did, felt like an idiot. I felt really</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 4</td>
<td>Character Range 12.987 - 13.071</td>
<td>I’d decided, yeah, I felt how, how silly it was for me to try it in the first place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 5</td>
<td>Character Range 16.857 - 17.102</td>
<td>totally adjusting to what I’d done to myself [yeah], [emo] bringing it into reason into my mind, knowing that I was so stupid, I wasn’t, I was very embarrassed about it [yeah] but I knew that I’d been stupid, and that’s exactly how I was feeling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 6</td>
<td>Character Range 17.140 - 17.348</td>
<td>when she came to assess me, which was late in the evening, I was able to just tell her that I felt stupid [yeah] and so embarrassed about what I’d done, ashamed even of what I’d done [right] you know,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 7</td>
<td>Character Range 21.100 - 21.671</td>
<td>She, she was asking similar questions to you, how I felt [yeah], any reason why I should’ve done it, sort of thing. I tried to explain about the finance and things like that, she asked me if I’d ever done it before, I said no, she said well how do you feel? I said I felt so stupid, and embarrassed. She said how do you feel about getting home? I said I felt fine. I don’t have any problems, she said well I’ll have a word with the nurse when I go out, and then she said yes, you can go</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reference 8</td>
<td>Character Range 23.076 - 23.334</td>
<td>That’s why, I started getting upset at myself again [yeah] why I’d been, you know why I’d done it, you know, again, a doctor that should’ve been looking after somebody else coming to assess me [right] so it was all upsetting me in that sort of frame of mind</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Stage 3: Creation of higher order themes**

The next stage in IPA analysis is to reduce and conceptually develop the coding to create higher-order themes. These themes should have interpretive and conceptual value, i.e. they should be telling us something meaningful about the participant’s experience. Table 2 below demonstrates a super-ordinate theme and the initial themes subsumed under it from participant 12’s account.
This super-ordinate theme combines several aspects of Smith and colleagues’ (2009) suggested guidelines (see also, chapter 4). The heading “Emotional aftermath of episode” is an example of contextualisation, as it groups a number of themes by the time at which they occurred (i.e. after the self-harm episode). However, the heading can also be identified as functional, as it describes the purpose of the other themes (i.e. describing the emotional content of his response to self-harm). In fact, this heading was an example of subsumption, as “Emotional aftermath of episode” was one of the more general themes developed in the initial thematic analysis. As this example demonstrates, the super-ordinate themes can develop in several different ways, and the main impetus is to capture the salient aspects of the participant’s experience with these themes. In this instance, and for other participants, a particularly salient aspect of the experience of self-harm was the emotional consequences of the action.

**Stage 4: Creation of a master list of themes, with quotations to illustrate**

The last stage for each individual account was to create a master list of themes. This master list should capture the most salient and meaningful aspects of that individual’s account, and is used in the next stage to develop cross-case themes.

<table>
<thead>
<tr>
<th>Emotional aftermath of episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>A change in emotional state after self-harm: worry about consequences</td>
</tr>
<tr>
<td>Aftermath – negativity towards self</td>
</tr>
<tr>
<td>Emotional impact of event – embarrassment</td>
</tr>
<tr>
<td>Emotional impact of self-harm – shame</td>
</tr>
<tr>
<td>I didn’t feel any different</td>
</tr>
<tr>
<td>Feeling separated from the episode</td>
</tr>
<tr>
<td>Feeling stupid</td>
</tr>
<tr>
<td>Relief to survive afterwards</td>
</tr>
<tr>
<td>Self-conscious emotion</td>
</tr>
<tr>
<td>Got something out of his system</td>
</tr>
<tr>
<td>Reflecting on consequences of actions</td>
</tr>
</tbody>
</table>
Comparing this table with Table 2, some of the initial themes under this super-ordinate theme have been removed or adapted (e.g. “relief to survive”), whilst other themes are not present (e.g. “guilt”). With continued engagement with the transcript and the themes, often themes take on different interpretations – the theme “guilt” developed as I examined the participant’s transcript and his concern about his family. Some of the negativity towards himself seemed to emerge from a sense of guilt around doing something which could negatively impact on others. In addition, some themes start to fit better into other...
categories - the theme “relief to survive” resembled themes that were eventually gathered under the super-ordinate theme of “coming to terms with the attempt”. Finally, other themes become redundant as they can be seen to express the same concept as another theme (such as “self-conscious emotion”) or because they do not seem significant enough within the participant’s account (such as “I didn’t feel any different”).

Stage 5: Creation of a group master list
The creation of a group master list involves many of the same processes as before, except that the aim at this point is to develop themes which have wider significance across participants, i.e. to relate the individual accounts to one another to derive the essential aspects of experience. As chapter 4 describes, there need not be absolute agreement from participants with regards to a theme, nor does a theme need to include every participant. The aim is to create a meaningful understanding of the experience of interest. Table 4 below shows an extract from a group theme around the experiences that led to self-harm. The theme “Life as a struggle” is a broad super-ordinate theme which captured a significant aspect of most of the participants’ experiences. The sub-theme “struggle with loss and loneliness” is more specific, and the quotes demonstrate how this one theme is present in multiple accounts in different ways, e.g., participant 4 describes the isolation of being alone, whereas participant 9 describes the impact of losing his family and his friends through leaving his home country to seek asylum in Britain. The significant shared aspect of both experiences is the impact this has on their lives in general (a sense of struggle), which creates a role for self-harm in coping with and expressing this struggle physically.
Table 4: Example of a group theme

<table>
<thead>
<tr>
<th>Theme 1: Life as a struggle</th>
<th>Sub-theme</th>
<th>Brief Description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggle with loss &amp; loneliness</td>
<td>Impact of grief and loss – loneliness, feeling rejected, feeling let down by family and friends</td>
<td>5 participants</td>
<td>When you’re living on your own, you can’t really talk to anyone (P4) It’s very difficult losing everything (P9) It’s the emptiness, the total emptiness (P10) You just get real real lonely [yeah] and you can’t go any further down so you just want to go away (P11) I’m a very isolated person (P13)</td>
<td></td>
</tr>
</tbody>
</table>

Conclusion

This appendix demonstrates the process of conducting an IPA analysis in-depth. The examples allow the reader to consider how the analysis was conducted, and thereby act as a demonstration of transparency, as Yardley (2000) recommends. However, through their transparency, they also demonstrate the complexity of conducting such an analysis, and it is likely that others would have different opinions about how to code text, name themes and interpret accounts. This is the heart of hermeneutics, whereby interpretation is always an interaction between self and other to create dynamic, situated knowledge.
Appendix 8: Master Lists

This appendix contains supplementary master lists for each super-ordinate theme described in analysis chapters 5, 6 and 7. These tables are presented in order of appearance within the main text.

Super-ordinate Theme from Chapter 5: “Life as a struggle”

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Struggle with addiction</td>
<td>Addiction as all-consuming, destroying you on a personal, psychological and social level</td>
<td>3 participants</td>
<td>[drugs] rip you apart, they destroy you (P10) Mentally, [alcohol]’s just crippled me (P2) ... wasting away basically (P4)</td>
</tr>
<tr>
<td>Struggle with loss &amp; loneliness</td>
<td>Impact of grief and loss – loneliness, feeling rejected, feeling let down by family and friends</td>
<td>5 participants</td>
<td>When you’re living on your own, you can't really talk to anyone (P4) It’s very difficult losing everything (P9) It’s the emptiness, the total emptiness (P10) You just get real real lonely [yeah] and you can't go any further down so you just want to go away (P11) I’m a very isolated person (P13)</td>
</tr>
<tr>
<td>Struggle to cope with illness</td>
<td>Unable to cope with mental illness, impact of physical illness on mental health</td>
<td>3 participants</td>
<td>I can’t handle it anymore (P1) I was very very ill, unable to work, unable to get out of the house (P6) I thought my life is just, this is hell on earth (P10)</td>
</tr>
<tr>
<td>Overwhelmed - external pressures</td>
<td>Pressures of work, money, family – things building up to a pressure point</td>
<td>5 participants</td>
<td>Things just get on top of me (P3) It was all frustration really (P5) Pressure and that, you know, like over the years (P8) It’s a struggle waiting a fortnight to get some money (P12) I was his ticket to some fantasy that he has with success in life (P13)</td>
</tr>
<tr>
<td>Conflicts with others</td>
<td>Being bullied, fighting with family/friends/others</td>
<td>3 participants</td>
<td>They take off the drugs, attack me (P9) She said we didn’t argue, but it must have stuck in my mind (P11) I wanted to express my anger at him (P13)</td>
</tr>
</tbody>
</table>
### Super-ordinate Theme from Chapter 5: “Life as less than”

#### Theme 2: Life as less than

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
</table>
| Powerlessness            | Feeling trapped by circumstances & incapable of changing things                   | 7 participants | I feel powerless where I’m going to end up (P2)  
I would’ve just thought of coping with it, and having to cope with it, and there’d be no choice (P5)  
What I need to do, I can’t do (P9)  
I don’t see a light at the end of the tunnel (P10)                                                                                             |
| Self-hatred & low self-worth | Seeing the self as less than, as somehow not worthy                              | 6 participants | I hated myself for doing it (P4)  
I totally hate what I look like, completely, just nothing’s right about me (P5, 2nd int)  
I’ve never felt whole (P10)  
(Illiteracy) always makes me feel so little (P11)  
I felt a bit unworthy… why should they like me so much (P13)                                                                                     |
| Stigmatised identities   | Living with disability, mental illness, drug addiction, as asylum seeker         | 8 participants | …racist group between the people and the asylum seeker (P9)  
I’m not a tramp… I might drink, but my hygiene comes first (P8)  
Nobody coming and approaching you, or speaking to me (P10)  
It would be like, people talking, oh what’s she doing, she’s cutting herself and, you know, trying to get attention (P5) |
### Theme 3: Meanings of self-harm and suicide

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-harm as way of coping with negative emotions</td>
<td>Self-harm is a coping mechanism, a way of relieving distress</td>
<td>3 participants</td>
<td>I can’t handle it anymore (P1) Cutting myself, and then, that would sort of release it (P5) I felt I was going to a point of despair (P7)</td>
</tr>
<tr>
<td>Self-harm to hurt the self/self-punishment</td>
<td>Self-harm in response to self-loathing – violence against the self</td>
<td>3 participants</td>
<td>If I don’t hurt me, I’d probably end up hurting someone (P3) Wanted to punish myself for being stupid (P4) It’s like a vicious circle (P5)</td>
</tr>
<tr>
<td>Suicide as way to escape or to end suffering</td>
<td>Suicide as the &quot;way out&quot; – the way they choose to end their suffering or avoid further pain</td>
<td>4 participants</td>
<td>Just get it over and done with, don’t face the music (P12) The only way to escape my state of mind (P13) Completely hopeless that I was ever going to get better (P6) It’s probably better if you just put me down, because I suffer a lot of pain (P10)</td>
</tr>
<tr>
<td>Suicide as logical response to life’s difficulties</td>
<td>Given the circumstances or their evaluation of the value of their life, suicide is logical</td>
<td>3 participants</td>
<td>If you sort out all your problems, you will not have depression or thinking about suicide (P9) I’ve had a good life, a full life (P10) I weigh that against that and mathematically, that makes life not worth living (P13)</td>
</tr>
<tr>
<td>Giving up - hopelessness</td>
<td>Believing that things cannot change for the better, there is nothing left to live for</td>
<td>5 participants</td>
<td>I thought this is it, right, I’ve had enough (P6) My life for me is finished, for me myself is finished (P9) My inner spirit’s gone, I feel like a shell (P10) Just give up on them and everything else (P13)</td>
</tr>
</tbody>
</table>
### Theme 1: Function of assessment

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
</table>
| Gateway to care                  | Assessment is there to determine what could best help the patient                | 4 participants | He just needed to see if I wanted to be referred to <self-harm service> and to give me some leaflets (P3)  
She was just like, right, this will definitely help you with this (P5)  
He was very concerned that I should see someone who was actually gonna give me some proper help (P6)  
Told me in no uncertain terms that she was only a phonecall away (P10) |
| Protecting the staff (focus on risk) | Assessment is there for risk purposes, to protect the psychiatrist in case something happens | 2 participants | It's, one of those things, isn't it, as you say, he's got to ask it, just to cover himself (P4)  
Him trying to say, you know, are you sure you're not going to be ok in the community, and so on (P6) |
| Has to be done (routine)         | Assessment as a hoop to jump through to get discharged                             | 5 participants | I think there's like routine questions for this thing (P5)  
It's usual to me ... I'm used to it (P7)  
They wouldn't let me out of the hospital [yeah] obviously, until they had assessed me (P10)  
As though you were a specimen, that they just have to probe at (P11)  
I just knew I had to be assessed before we can release you from the hospital (P12) |
**Super-ordinate Theme from Chapter 6: “Value of Assessment”**

<table>
<thead>
<tr>
<th><strong>Theme 2: Value of assessment</strong></th>
<th><strong>Sub-themes</strong></th>
<th><strong>Brief description</strong></th>
<th><strong>Representation</strong></th>
<th><strong>Key quotes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Someone to talk to</td>
<td></td>
<td>Talking as a release, sharing a problem can help one cope—benefit of talking to someone “special”</td>
<td>7 participants</td>
<td>At least I can speak to someone... instead of just everything built up inside me (P3) Just to say I really feel like this... I felt a lot better (P2) It’s just like a massive weight has been lifted (P5) It gets some of my experiences out (P7) It’s that they’re professionals and that they know what to do, that’s, they can take control of the situation (P4)</td>
</tr>
<tr>
<td>Legitimating patient’s distress</td>
<td></td>
<td>The assessor sees the person’s distress and takes it seriously—validating their need</td>
<td>4 participants</td>
<td>Genuinely you are ill, in the mind, you are ill (P5) Relieved that… my mental state was obviously been taken seriously (P13) [Psychiatrist]'s the first person that said it, cos he said you are totally depressed, I can see it in your eyes (P4)</td>
</tr>
<tr>
<td>Trying to understand &amp; feeling understood</td>
<td></td>
<td>Link between effort to understand and feeling that you were being understood</td>
<td>7 participants</td>
<td>Just trying to find out my reasons (P12) Be more understanding... talk to them more (P7) Speak with me... find out why I am here (P9)</td>
</tr>
<tr>
<td>Hope for change</td>
<td></td>
<td>Assessment sets the gears in motion for the help/support needed and promotes hope</td>
<td>5 participants</td>
<td>She got it all started, gave me my first steps (P5, 2nd int) I came out to huge support which was the hospital’s doing (P10) They know I’m here... they’re looking into it (P4) She sort of gave me the confidence (P5) It’s made a whole world of difference (P10) I’ve got a lot more to learn in life... and what has been now isn’t everything (P13) I know there’s somewhere to turn now, they’re not all dark clouds (P12)</td>
</tr>
</tbody>
</table>
## Theme 3: Negative aspects of assessment

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling judged</td>
<td>Participants experiencing moral judgement over what they have done</td>
<td>3 participants</td>
<td>You're playing a bit of a stupid game (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Do I think about my children, does it bother me that I'm leaving them (P11)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>They judge you if you're an addict (P10)</td>
</tr>
<tr>
<td>Referral circle – no change</td>
<td>Assessment defeated by lack of options for follow-up</td>
<td>5 participants</td>
<td>Someone who could refer me to someone else (P3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All they were going to go was like, patch whatever up and ship me out (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>I was thinking is it worth it?... is it worth this chat again? (P2)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>We can't do anything... all we can do, just, if you feel low, we can send you to hospital (P9)</td>
</tr>
<tr>
<td>Struggle to be heard &amp; believed</td>
<td>Staff don't seem to hear what they are saying, or believe that they need the help</td>
<td>4 participants</td>
<td>If I couldn't justify to him that things weren't sufficiently serious, they just were gonna discharge me (P6)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>When I talk about it nobody listens to me (P1)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>They just sit there staring at you (P3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>People like this are just deaf and dumb (P9)</td>
</tr>
</tbody>
</table>
Super-ordinate Theme from Chapter 6: “Like I was a human being” – Spectrum of care to control

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling cared for/valued</td>
<td>When the experience of services and staff leaves the patient feeling like a valued human being, with genuine needs</td>
<td>11 participants</td>
<td>She was very helpful, very caring, she seemed very genuine (P5) I felt a bit more positive from being listened to (P13) You’re given care, they’re caring for you (P4) She was the only one that called me her favourite patient (P7) They are really caring and they sit and talk to you properly (P11) Her warm smile lifted my spirits (P10)</td>
</tr>
<tr>
<td>Feeling ignored/ neglected</td>
<td>When the experience of services and staff leaves the patient struggling to feel recognized or dismissed</td>
<td>7 participants</td>
<td>I don’t think there’s any need for you to go there (P1) Where’s the care? Where’s the someone to talk to? (P10) I keep going there and no-one will help me (P3) They were more in the office all day literally (P7) I don’t have to wait for him (P9)</td>
</tr>
<tr>
<td>Feeling imprisoned/ dehumanised</td>
<td>When the experience of services and staff leaves the patient feeling less than, treated more like prisoners than patients</td>
<td>6 participants</td>
<td>He’s took an overdose, why should we have to deal with this? (P8) You stupid, stupid woman, taking tablets (P11) Restraining you every 5 minutes (P7) They put me there, like a prison (P9) Just shout drugs and he’ll come running (P10)</td>
</tr>
</tbody>
</table>
Super-ordinate Theme from Chapter 7: “Outcomes from hospital experience”

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stagnation</td>
<td>Participants experience little or no change since the episode</td>
<td>5 participants</td>
<td>It's been a long time since I've had any support (P6, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;I haven't heard from a soul (P11, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;Nothing changed for me at all (P9, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;We can't help you with anything (P9, 1&lt;sup&gt;st&lt;/sup&gt;)&lt;br&gt;I've been made endless promises (P10, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;It were a waste of time (P1, 1&lt;sup&gt;st&lt;/sup&gt;)</td>
</tr>
<tr>
<td>Impact on help-seeking attitudes</td>
<td>Experience affects the participant's attitudes towards future help-seeking</td>
<td>5 participants</td>
<td>It's just nice having that option (P5, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;It's made it quite difficult to ask people for things (P6, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;The experience I went through, I wouldn't go (P11, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;They can only point you in the right direction (P2, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;There's somewhere to turn to (P12, 1&lt;sup&gt;st&lt;/sup&gt;)</td>
</tr>
<tr>
<td>Emotional &amp; personal resonance</td>
<td>Experience has an emotional and/or personal impact on the participant</td>
<td>4 participants</td>
<td>It keeps it fresh in your mind (P2, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;I don't feel stressed now (P12, 1&lt;sup&gt;st&lt;/sup&gt;)&lt;br&gt;I felt amazing the next day (P5, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;It was anger with him (P11, 2&lt;sup&gt;nd&lt;/sup&gt;)&lt;br&gt;I've got something out of my system (P12, 1&lt;sup&gt;st&lt;/sup&gt;)</td>
</tr>
</tbody>
</table>
Super-ordinate theme from Chapter 7: “Value & Limitations of Other Services”

<table>
<thead>
<tr>
<th>Sub-themes</th>
<th>Brief description</th>
<th>Representation</th>
<th>Key quotes</th>
</tr>
</thead>
</table>
| Experiences of Primary Care | The value and limitations of GP surgeries including the nature of patient-doctor relationships | 5 participants | It’s nice to have that sort of circle (P5, 2nd)  
He sits and listens to you (P11, 2nd)  
I can tell her everything (P3, 1st)  
Always willing to go that extra mile (P10, 2nd)  
She can only help me with so much (P3, 1st)  
He doesn’t look at the mental picture, you see (P4, 1st) |
| Experiences of Voluntary Services | Ways in which participants have found voluntary services to be helpful or limited | 4 participants | A connection, you get more... identification (P2, 2nd)  
People a lot worse than me... they’ve got well (P2, 2nd)  
It’s nice to get back into that community (P10, 2nd)  
They seem kind of depressing (P5, 2nd)  
I feel I go there for nothing, nothing changes (P9, 1st)  
I don’t feel very safe (P10, 2nd)  
I can’t do two major things in a day (P10, 2nd)  
Here again, type of thing (P2, 2nd) |
Appendix 9: Article on Data Collection

This article has been published in the British Psychological Society’s Psychology of Women Section Review (copyright reserved by the British Psychological Society).


It stemmed from my experiences of data collection, and my engagement with ideas around reflexivity and IPA’s theoretical basis. It was presented as an oral paper at the British Psychological Society Psychology of Women Section Annual Conference, 2009.

Connecting and disconnecting: reflections on data collection with people who self-harm

Introducing the points and the project

In this article, my aim is to sketch out some thoughts on the intersection between methodology, reflexivity and emotion in research. I am currently nearing the end of data collection with people who have recently attended hospital following self-harm or attempted suicide. The substantive focus is on the lived experience of undergoing a psychosocial assessment, which the National Institute for Clinical Excellence (2004) pinpoints as an essential feature of the management of self-harm. The choice of interpretative phenomenological analysis, or IPA, as the methodological approach seemed to fit well with my commitment to value service users as “experts by experience” (Faulkner, 1998), whilst recognising the impact of the researcher on both process and product (Charmaz, 1990; Larkin et al., 2006). Its focus on personal experience and meaning making (Smith & Eatough, 2007) matched with the aim of finding out what assessment was like for those who undergo it.

The process of data collection has been fraught with emotional highs and lows – moments of connection and disconnection with my participants and the
project. In this article, it is my argument that reflection on these moments forms an essential initial point of engagement with analysis. In addition, I feel that elements of IPA’s theoretical background can give us ways of conceptualising and utilising these moments to enhance our interpretations. With the initial caveat that this article can only present a very brief and partial account of these issues, and therefore in no way represents an immutable argument, I will begin with a short overview of reflexivity.

“Reflexivities”: define and conquer

In Sue Wilkinson’s (1988, p. 493) paper on reflexivity, she writes:

The concept of reflexivity is not easy to define because it appears in the literature in a number of “guises”, each having several possible levels of analysis.

Since this seminal paper, it would be misleading to say that reflexivity has become easier to define, but it has certainly become a common term in a diverse range of disciplines. Reflexivity is cited as a gold standard for qualitative research – a tool by which the rigour, authenticity, and credibility of an account are enhanced (e.g. Koch & Harrington, 1998; Lynch, 2000). It is perhaps better thought of as “reflexivities” (Gough, 2003; Lynch, 2000), as there are a number of different “types” in the literature. These include: personal, functional and disciplinary (Wilkinson, 1988); descriptive and analytical (Stanley, 2004); epistemological (Willig, 2008); hermeneutic or intersubjective (Finlay, 2003); embodied (Burns, 2003) and mechanical, substantive, and methodological (Lynch, 2000).

In its simplest terms, reflexivity involves engaging in an ongoing practice of “critical self-reflection” (Finlay & Gough, 2003, p. xi) which renders our assumptions and processes explicit and “accountable” (Gough, 2003; Stanley, 2004). The focus of this reflection is not necessarily the self, although it is often used in this way to acknowledge the presence, and impact, of the researcher (Altheide & Johnson, 1994). Parker (2004b, p. 25) writes that reflexivity is a “way of working with subjectivity”, and this work can occur on several different levels – the inter/personal, the social/political and the institutional/cultural.
An engagement with reflexivity in qualitative research rests on the widespread identification of the research encounter as “situated, emergent and negotiated” (Finlay, 2003, p. 8), with both the researcher and the researched active participants within this encounter. These understandings of research mean that some reflexive awareness is necessary in any activity involving people, if only to acknowledge this context-dependency. It makes sense that the type of reflexive practice adopted should reflect the purposes of the research endeavour (DeVault, 1997; Parker, 2004b), both in order to avoid unnecessary “navel-gazing”, and to enhance the usefulness of the exercise. The natural question thus becomes: what level of reflexive practice is suitable when conducting an IPA research project?

Where there's a method, there's a way
As mentioned earlier, IPA focuses on experience and meaning making (Smith, 1996a; Smith & Osborn, 2008). It draws on three theoretical traditions concerned with the nature of knowledge, experience and interaction: phenomenology, hermeneutics and symbolic interactionism.

Phenomenology emerged as a systematic movement in the early twentieth century as a reaction to a perceived epistemological inadequacy of the natural sciences (Moran, 2000). Husserl felt that the natural sciences rested on an unchallenged assumption that there existed a natural world (Langdridge, 2007). His argument was that we needed to “go back to the things themselves” (Husserl, 1965, p. 102), engaging directly with objects in consciousness, whilst suspending or “bracketing” all assumptions. Whilst phenomenology is a diverse branch of thought, and has moved beyond this initial conception (Moran, 2000), this idea to “go back to the things themselves” has stayed a central tenet of the movement.

The key phenomenological aspect of IPA lies in its view of people as “experts on their own experiences” (Reid et al., 2005, p. 20). IPA aims to gain insight into someone’s lifeworld, an understanding of how they experience and interpret events and objects. People are viewed not as mental entities reflecting on objects external to them, but as embedded “persons-in-context” who are actively engaged in and inseparable from the world (Larkin et al., 2006, p. 105).
From this perspective, it makes little sense to talk of “objective” knowledge of the world, or to be concerned with the “truth” – as validated by something external – of experiential claims (Ashworth, 1996).

The IPA researcher seeks to get this insider perspective on the phenomenon they are investigating. It is acknowledged, however, that entering someone else’s lifeworld is an indirect process, requiring interpretation (Smith & Eatough, 2007; Smith & Osborn, 2008). This process is called a double hermeneutic, wherein “the researcher is trying to make sense of the participant trying to make sense of their personal and social world” (Smith, 2004, p. 40). Hermeneutics is another word for interpretation (Schmidt, 2006), and IPA researchers draw on philosophers such as Heidegger, Gadamer and Schleiermacher when discussing this activity. For Heidegger (1962, p. 192) “an interpretation is never a presuppositionless apprehending of something presented to us” – it is rather an activity undertaken as a “person-in-context” (Larkin et al., 2006, p. 106). As a “person-in-context”, we are historically and socially embedded in the world.

Gadamer (1975, p. 269) emphasises how our interpretations are formed by what he calls our “horizon”, which refers to our preconceptions, assumptions and past experience – everything which forms our particular stand-point. This horizon is constantly shifting with new information, as we attempt to understand the text or the other. Gadamer argues that we need to attend to our preconceptions, so as to allow ourselves to be open to the meanings of what we are engaging with. The aim is to achieve a “fusion of horizons” (Gadamer, 1975), a bringing together of our horizon and theirs, and by doing so, challenge our preconceptions and broaden the possibilities of our understanding.

Symbolic interactionism refers to Herbert Blumer’s theory that the way people act towards objects is based on the meaning they ascribe to those objects and that meanings arise out of, or stem from, social interaction in the first place (Smith, 1996a).

In IPA, there is an assumed link (albeit a mediated and often complicated one) between the experience and people’s accounts of it – the implication being that via social interaction (such as an interview), we can make sense of what objects
mean to participants, and also that meanings are constructed within, and are influenced by, interactions (Smith, 1996a).

From these theories, there emerges a picture of the individual as an embedded, contextual being, influenced by and influential in social interactions with others. Our aim is to understand their experience of a phenomenon, and to achieve this, we have to interpret their account - a process which in turn is influenced by our position as an embedded, contextual being. In terms of reflexive practice, accepting Gadamer’s concept of “horizons” requires that we take seriously our preconceptions and our past experience, because we inevitably bring these into all encounters. This involves personal and functional reflexivity, as described by Wilkinson (1988), as our identity and motivations as a researcher and our background, characteristics, assumptions, and experience as an (historically and socially situated) individual, all form our “horizon”. However, it is also posited by Gadamer that these preconceptions change continuously in response to experience, and our grasp of them will always be partial. In fact, it is only possible to grasp some after they have changed (Smith, 2007). This creates a need for reflection on the encounters themselves, possibly of the inter-subjective kind Finlay talks about, wherein the researcher attends to “the self-in-relation-to-others” (2002a, p. 216). In order to identify those preconceptions which pre-existed the experience, the researcher needs to reflect on the interactional aspects of the research encounter, and I would argue that this includes positioning in the encounter, and our emotional, embodied reactions to the participant’s story.

Reflections on dis/connections
To illustrate some of what I have been discussing so far, I am going to draw on examples from my research. To locate myself briefly (and partially), I came to it as someone sharing the experience I was interested in studying, although not for that reason. Having an academic background in psychology made me wary of placing myself as an “insider” to the topic, and I have avoided doing so in my approach to participants. Whilst I agree with Oakley’s (1981) argument that personal involvement with one’s participants can be a valuable tool for knowledge, I felt that I could not claim to know what things were like for people on the basis of my experience, and therefore did not want to use this
experience as a gambit. One idea I wanted to avoid reinforcing is that of a homogeneous group of “self-harmers”, which influenced my choice of IPA due to its idiographic focus (Smith, 2004), as self-harm is a complex issue, crossing boundaries of age, race, sexuality and gender. There has been much feminist debate around the issue of homogeneity and insider/outsider positions in research (see Wilkinson & Kitzinger, 1996), and it seems clear that there are dangers in any uncritical acceptance of these concepts. As Song and Parker (1995, p. 246) point out:

Many dimensions of sameness and difference can be operating at any given moment. And where two people may claim commonality on one dimension, they may fall apart on another

Hurd and McIntyre (1996, p. 79) talk of the “affective pull of sameness”, which can work to distance the researcher from the task of challenging their own assumptions. This happened to me during one interview, with an interviewee of the same gender (female), ethnicity (white), and age group, who was suffering from depression. The interview flowed conversationally, to the point where it took a moment of disconnection to disrupt my implicit assumption of “sameness”:

Me: Yeah. And erm, is it cutting that you do?
P5: Erm, it was cutting, and I also, I use needles and I just stick those in me
Me: Right, that doesn’t sound very nice!
P5: No

The lightly-made comment was the result of genuine surprise which she (thankfully!) received in good humour. As I transcribed, this moment stuck out due to its emotional nature. On reflection, I felt it revealed how much I was identifying with (and projecting onto) the participant. The idea of insertion was one I had come across before, both in research and in contact with people, and the surprise seemed to stem from this assumption of sameness, rather than a reaction to the topic. In terms of analysis, this moment seems akin to an amber light in a traffic set, saying proceed with caution. Later, I wrote about the “lie of empathy”:

…my empathising may be getting in the way of me accessing people’s true feelings or reflections on an element of experience
During analysis in IPA research, the researcher strives to enter a hermeneutic circle with the participant, which involves an iterative process of coming into the participant's account and reflecting on it from our own perspective (Smith, 2007). Bondi (2003) describes empathy within the interview as a similar process of moving between immersion and observation. A danger lies in being static in one part of the circle – as I was until my surprise shook me out of it, leading me to question the “familiarity” I felt with her story. Any moments of familiarity seem to warrant analysis – how much is an unreflective “seduction of sameness” like Hurd and McIntyre (1996, p. 86) describe? How much is unchallenged prejudices and social attitudes (Jaggar, 1989)? Does this familiarity prevent engagement with the participant’s account as they tell it (not as we hear it)? Although access is always mediated by our horizon, by being reflexive and becoming aware of this, we can potentially tease apart empathic engagement and self-projection.

It is not always possible to identify which researcher characteristics will be salient in an interaction, making it difficult to prepare for their potential effects (Bondi, 2003). An interview is a complex situation (Hoffman, 2007) to which we bring a number of acknowledged and implicit selves (Reinharz, 1997). The participant too, brings their own horizon and layers to it, and they view us in ways dependent on these (Deverell, 1998; Oakley, 1981; Richards & Emslie, 2000).

When researching those who self-harm or attempt suicide, there is naturally an ethical concern to protect them. However, this concern can sometimes implicitly position participants as uncomplicatedly vulnerable, or passive. I have found that participants can be active in taking control in the interview, and in placing me in roles that serve a function for them. For example, in an interview with an older, male participant, I found myself being placed in a position of ignorance:

P8: … you don’t know half of it [yeah] you’ll, you’ll never even know I’d say a tenth of it, you’ll never even know about a fiftieth [yeah] of what’s gone on in my life

He repeatedly emphasized his control of the situation, and I found myself colluding with this to gain his co-operation. By taking this position, I allowed him
Reflecting on this interaction led me to question the notion of being an “insider”. Here it was the gap created by the participant that seems to hold the possibility for understanding his experiences with services, in the psychological need he had to create it, and the identity he forcibly presented in interaction. My own responses to the placement as ignorant revealed somewhat of my assumptions that, despite my student status, I was an expert and knew what to expect.

Thinking of people as embodied has helped me to conceptualise my emotional reactions in interviews. Finlay argues that it is “the relational space between participant and researcher [that] is the site of disclosure of the Other” (2005, p. 287). We do not just construct meaning through a disembodied intellectualising, but do so as embodied participants (Burns, 2003). For instance, when interviewing participant 9, a suicidal asylum seeker, I felt myself taking on elements of his story emotionally:

What did this interview do to me? I felt exhausted, guilty, deeply deeply wrong. I felt that I should be able to do something

His helplessness and anger were transferred to me and became my own. In terms of Gadamer’s (1979, p. 273) “fusion of horizons”, I actively felt my own assumptions shifting in the engagement, as I became aware of the inadequacy of my understanding, and our perspectives fused. The anger seemed to be an “outlaw emotion” (Jaggar, 1989) signalling a structural inequality that I was complicit in, and brought home the moral responsibilities of research to highlight these. Bringing these emotions to the fore and dwelling in them gave me an insight into the participant’s socially circumscribed world, which brought me closer to an embodied sense of his lived experience.

Not all participants evoke strong emotional reactions, such as participant 9, or create such a marked impression of their positioning of me, such as participant 8. I am not arguing that these reactions and interactions are the only aspects worthy of attention. Rather, I am suggesting that instead of simply venting our
emotions in a diary to “[clear]… the emotional decks” (Jaggar, 1989, p. 148), we can include them in our analytical toolbox to create deeper, more nuanced insights (Bourne, 1998; Masters, 1998).

One small step…
In a review of the use of IPA, Brocki and Wearden (2006) argued that more attention should be paid to the researcher’s presence in all stages of research. Here, my aim was to share some initial thoughts on how this could be done during data collection.

When we enter the interview situation, we bring with us our preconceptions, assumptions, background and experience. These form our “‘horizon’ of intelligibility” (Martin & Sugarman, 2001, p. 196), the basis by which we come to understand others. Any “fusion of horizons” also changes our capacities to understand in the future, making any interpretation inevitably partial. Reflexivity is a necessary part of the endeavour to understand, as to remain open to others’ perspectives, we need to be aware of our own (changing) preconceptions.

Sometimes in interaction, our preconceptions reveal themselves as they are challenged and changed. Moments of emotional reaction and detachment can act as markers to this process – giving insight into when these challenges happen. By attending to these moments, we take a small step towards explicating our initial interpretive frames (Smith, 2007) which can then be accounted for in analysis. As Frank writes, “the challenge is not to eliminate ‘bias’ … but to use it as a focus for more intense insight” (1997, p. 89). The proposed reflection on emotional reactions and detachments in play during interviews is seen as an important first step towards richer insights – both into the interpretive process and into the experiential worlds of our participants.

References


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Appendix 10: Reflexive Account

Introduction

This appendix considers the personal impact of the study, and the potential impact of the personal on the study itself – its conduct and its conclusions. Following from Seale’s (1999) assertion that no researcher can exhibit “superhuman self-consciousness”, the below account is inevitably partial, a product of the particular time and place in which it was compiled. The choices made at this point – what to reveal, explicate and infer – are likely to create a different record of the project and its impact than if this was written six months ago or six months in the future. However, I echo Brocki and Wearden’s (2006) concern that few researchers prioritise reporting the use of reflexivity in IPA studies, despite this transparency of accounting being a key criteria for quality within IPA research (Smith et al., 2009; Yardley, 2000). Whilst I acknowledge that the manner in which this accounting is presented – in an appendix – continues this trend for sidelining reflexivity, I hope that the form and thoroughness of the consideration presented below allows the reader to place this thesis and its findings in the psychological and social context of its production. To quote Schleiermacher:

> As every utterance has a dual relationship, to the totality of language and to the whole thought of its originator, then all understanding also consists of the two moments, of understanding the utterance as derived from language, and as a fact in the thinker . . . Every person is on the one hand a location in which a given language forms itself in an individual manner, on the other their discourse can only be understood via the totality of language. But then the person is also a spirit which continually develops, and their discourse is only one act of this spirit of connection with the other acts (Schleiermacher, 1998, p8-9)

Personal Background & Beliefs

Self-harm is a curious topic, in that it evokes emotional and visceral responses from people, whether or not they have personal experience of the issue itself. The experience of answering the question “so what’s the topic of your thesis?” over the last three years has in itself provided a kaleidoscope of responses, ranging from personal disclosure to evident distaste and confusion. To me, there seems to be a basic human struggle with the idea of hurting oneself – even in those who understand why this response can seem inevitable and natural; even in those who engage in this behaviour. The potential for disjunction between thought, emotion and behaviour in those who self-harm
adds another layer of complexity to this topic: those who self-harm do not necessarily understand or empathise with their own need to do so. Experience does not gift the individual with insight - insight requires uncomfortable self-reflection and personal exploration. This struggle to understand invokes emotional and visceral responses in the participant as well as in the healthcare professional whose role it is to assist the individual on their journey to "recovery", whatever this term may mean.

I came to the topic academically through my interest in abnormal and clinical psychology in university. I swiftly became an advocate of the dimensional theories around abnormality: it seemed natural for each one of us to be more or less anxious, more or less depressed, more or less manic than the next person. I carried out a third year library dissertation on the concept and treatment of borderline personality disorder, attracted, as many others before and since, by the exaggerated self-destructive tendencies of those with personality disorders and the blurred lines between normal and abnormal personality. Self-harm and attempted suicide were considered aspects of borderline personality disorder’s psychopathology, and my exploration of BPD led to an increased academic interest in self-harm and suicide. After university, I moved to Belfast, where I became involved in facilitating a support group for depression (with Aware Defeat Depression), volunteering for Childline and Samaritans, and studying for an MSc in clinical applications of psychology. Within my voluntary work, I heard many stories of depression, struggle, suicidal thoughts and self-harm as a means of coping with life. I also became involved in interviewing people around Belfast for a nationwide health and stress survey and became aware of the levels of self-harm and suicide in Northern Ireland (coupled with alcohol and drug abuse, and the trauma of the Troubles). I prepared research proposals to explore self-harm in more depth, convinced of the pressing importance of understanding self-harm from the service user perspective as I became more involved in the topic in each strand of my life.

I have always been curious about the linearity of people’s life stories, as what can be represented in a logical progressive fashion (thereby creating a sense of inevitability) does not feel as directed at the time. How something is written and reported biases the way it can be understood, but the idea of representing what
“really happened” is both undesirable and impossible. Over the course of the three years that the previous paragraph represents, there was a lot of change and conversely little change in my life. I was in no way linearly working towards an intellectual and humanitarian goal of studying self-harm and representing the service user perspective. Indeed, for a brief period of time, I was a service user, in the literal sense of attending hospital following an episode of self-harm and receiving a psychosocial assessment. Did this influence me, give me greater “insider” knowledge of what it is like? I cannot say for certain, but my experiences must have influenced my current views and beliefs of self-harm and suicide to some extent, if only because they have influenced the ways in which I have developed over the intervening time, and how I have made sense of the mess of selves I am in order to use the pronoun “I” in a singular fashion. In a way, it is only by contrast with the views of others and my continuing experiences of social interactions involving the topics of self-harm and suicide that my beliefs are thrown into relief.

When I initially applied for the PhD studentship, I didn’t reflect much on my personal experience of the topic, perhaps because my personal experience is only one strand of knowledge, one aspect of a multi-faceted set of preconceptions. At that point, a couple of years had passed and I was in a different emotional place – I had been working in Childline, Samaritans and Aware Defeat Depression, and I had learnt the lessons I felt the episode could teach me. I was more focused on what I could add to the research arena with my academic and occupational history, and what a PhD could mean for my personal and professional development. As I had written drafts of research proposals pertaining to self-harm for my MSc and voluntary work, stumbling onto a prestigious MRC-funded studentship in the same field made my heart plummet. I was excited, daunted and anxious at the same time. I controlled myself very carefully as I filled in the application and attended for interview, as I was aware that my CV could look odd, littered with temping jobs, an incomplete MSc and a break in my academic career (finishing my undergraduate degree in 2005 instead of 2004 as expected), and I did not dare to hope that I would be successful. It was a “too good to be true” moment if ever there was one. When I was accepted, I was absolutely stunned and overjoyed – with an extra element of self-doubt and anxiety more related to my intellectual ability than to my
psychological history. Perhaps here lies my first object belief about self-harm: it can be incidental, symptomatic of the problem (in my case, oft-crippling and stubbornly persistent self-doubt) rather than the problem itself.

The incident itself I have reflected on a number of times, and considered utilising as an auto-ethnographic exercise within this PhD. There are several reasons why I did not expand upon it in this way: firstly, well-conducted auto-ethnography reveals the social through the account of the personal (Reed-Danahay, 1997). I lacked confidence that I could derive such wider connotations from my personal experience, and felt that this potential shift in focus towards the personal created an ethical dilemma given my aim to focus on the experiences of service users. Would my story obscure or deflect attention from the stories of participants? I felt uncomfortable emphasising the ex-service user self, above the other selves I brought into the field with me (Reinharz, 1997), and this discomfort is not only personal but extends to my political and professional beliefs and knowledge about self-harm. I saw my participants as people first and foremost, with messy, contradictory, multiple selves, one of which might be labelled “self-harmer”. The stigmatised nature of this identity rendered it problematic, and in my view placed more definitional importance on it than was justified, both for the participant and for others in their social milieu. I did not want to label myself or my participants in this way, or to create an artificial bond based on a single behaviour.

Secondly, I felt that such an account would be most useful if drawn from sources written close to the event itself, which I did not have. I ascribe to the view of several phenomenologists that our pre-conceptions and assumptions shift as we come to know them (Gadamer, 1979; Moran, 2000; Smith, 2007). A retrospective account, such as this one, says more about the present than the past – this can still be instructive, but in different ways.

Thirdly, I engaged in extensive reading around reflexivity, feminist accounts of knowledge and experience and auto-ethnography, and my belief in the utility of my experience began to shift. I still feel that the insights I developed, both from my own experience of depressive feelings, thoughts of self-harm and suicide and from knowledge of others in my circle of acquaintances with similar
experiences, have been useful in the process of interviewing and interpreting this study’s findings, but over time, I became more and more convinced that my experience did not privilege me with “insider” knowledge of other’s accounts. I started to feel that this assumption of “sameness”, as Hurd and MacIntyre (1996) argue, could be misleading and prevent full engagement with an individual’s story. My article, Hunter (2010), discusses an example of this in relation to participant 5, who was the closest in age and temperament to me, but had experiences both revealed and, I suspected, undisclosed which were removed from my own. Our points of commonality enabled my interpretation of her account – I felt I could understand the functionality of her self-harm, her self-loathing and her frustration with herself for falling back on self-harm when life became stressful – but our points of difference were significant – notable in her strained relationships with her family, in particular, her mother, and her agoraphobia. With only two hour-long interviews, we barely scratched the surface of these experiences.

Fourthly, I did not want to exploit my experience to encourage disclosure, especially as self-harm often co-occurs with abuse, violence and trauma. As my own experience was relatively untraumatic, related to “milder” difficulties in coping with an intensely stressful period of examinations and transition, a relationship breakdown and pre-existing psychological dispositions to be unhelpfully self-critical and pessimistic, I felt uncomfortable with the idea of using my experience to place myself on a par with others who self-harm. I felt an outsider in many respects – at the time, I often felt fraudulent, especially in accepting help from others (although I now suspect this to be a fairly common response in those who self-harm, due to its literal self-inflicted nature). Whilst I have since used this experience in voluntary work settings, where sharing experiences is used as a self-help strategy and I believed sharing my own experiences could be an aid in inspiring hope in others, it seemed inappropriate to use a similar strategy in my PhD. Methodologically, I did not want to bias the direction and purpose of the interview with self-disclosure and assumptions of sameness. Methodologically and ethically, I did not want to impose my experience and interpretation of it onto the interviewee’s experience (although I was aware that the presented findings were my interpretation rather than a representation of the participant’s experience). My aim was to give the participant
conversational space to formulate their own accounts of self-harm and suicide, and to reveal their views and attitudes through this accounting. Whilst I acknowledge that this itself is problematic, as silence from a researcher can communicate as loudly as a voiced opinion, my initial decision was motivated by a desire to allow the participants a voice they may not always feel they have.

There was also an additional pressure, albeit a self-imposed one, on me to succeed academically, on my own terms, without exposing this psychological “weakness”. However common self-harm and suicidal thoughts may be, I became a victim of my own desire to avoid stigma, and so stigmatised myself. I felt it was important to present to the academic environment a particular face: that of a dedicated and capable PhD student (a psychologically stable one, at that!). Eventually, I spoke up about my experience, and my supervisors were considered and supportive – and gave me the personal space to decide how much I wished to disclose. One supervisor advised me that reflexivity in research is not simply about self-disclosure, but about how you use the self to disclose the socio-cultural world – how you use reflection to gain insight into the structures which pervade our lives, and how this insight can be used to transform and empower. From then on, I felt relieved that I was not betraying my ethical and methodological commitment to reflexive practice, even if the details of my life were not revealed. The importance of reflexivity lay in its use as a tool to expose and question assumptions and to reveal what is hidden by our socio-cultural embeddedness.

I have been struck throughout this process by how closely interlinked the personal, political and professional are within the life of a researcher. As a PhD student, I have struggled with feelings of intellectual inferiority that have been partly due to my social positioning within the academic world but also due to my chosen pathway as qualitative researcher in a psychiatry department (and in the field of psychology). I realise now that struggling with questions and doubts is a valuable part of being a good qualitative researcher, but I also realise that this strength, as I perceive it, can be exploited as a weakness in the academic world, especially in medical research. Insinuations about sample size, doubts about relevance and transferability, which I have tried to address in my work, reveal subtle and not-so-subtle assumptions about the superiority of the
“scientific method”. I see this assumption of superiority as a weakness and a failing, as it shows a lack of insight into the human production of science and knowledge, and a dogmatic adherence to method over purpose. However, experiencing these doubts and the fight to be heard in itself offers insight into the experience of those who self-harm. The dogmatic adherence to diagnosis over personal meaning within the medical world is a problem every mental health patient faces once they enter that system. Yet the question remains: how useful is a diagnosis in helping a person to live in a manner acceptable to them? As McDowell and MacLean (1998) assert, quantitative and qualitative methods both can, and should, inform practice and policy in health services research. Qualitative methods in mental health research focuses on the meaning of illness, which is an essential part of creating meaningful and useful interventions.

Balancing between self and other: reflections on research

Interpretative Phenomenological Analysis is an intense methodological approach, relying on a high level of personal engagement from the researcher. Reflexivity is an essential part of this process from the initial stages of data collection to the final stages of preparing written reports. Within this section, I will reflect on my engagement with IPA and some of the dilemmas and difficulties I faced during the research endeavour.

Hunter (2010) touches upon the emotional burden of conducting an intensive study of people who self-harm. The stories of participants were often harrowing and the hopelessness and frustration participants expressed, especially when little was done to help them, could be catching. From my own experience, I felt I understood this hopelessness, but I was also aware that this sort of thinking can be rooted in a constricted and distorted view of the available options (however this view was developed). I related to the participants’ feelings of awkwardness and reluctance when it came to seeking help – even though I facilitated a self-harm self-help group, I was aware that I personally would not have used that sort of service, out of embarrassment and pessimism. On occasions, I worried about the way I found it easy to relate to pessimism in the participants’ accounts and wondered if the interview interaction conveyed an acceptance of this perspective. Whilst my position as researcher was not
designed to be therapeutic, I felt there was an ethical obligation to challenge certain parts of people’s accounts, especially erroneous beliefs about service availability or utility (e.g. P9), or destructive views about themselves (e.g. P5 and P10) – but I also did not want to disrupt their construction of meaning around the self-harm incident which led to their involvement in the study.

I tried to balance this desire to help in the immediate moment with my commitment to the research endeavour and its potential value for future patients. For instance, during participant 5’s second interview, I gently challenged her self-negativity and empathised with her fears and doubts about herself. I felt it was important to not implicitly accept through silence her assertions of looking like a “monster”. With participant 9, I stayed silent as he vented his distress and upset that he would not be allowed to work in healthcare with mental health difficulties, but used the time after the interview to talk about this in more depth, and to mention discrimination legislation around employment. He had other difficulties relating to his asylum seeking status, but it was an integral part of his coping mechanism to believe that he could have a future life – a job, a home, a family – and he had formed the belief that there was no hope for a future as a result of admitting suicidal thoughts and seeking help for them at hospital. He saw this permanent “black mark” against him, which I felt needed to be challenged, even with the caveat that sometimes people do suffer from discrimination due to their mental health.

Another dilemma I faced was how I should respond to distressing disclosures. By this, I do not mean disclosures of immediate distress, as a protocol was put in place to respond to emotional distress at the time of the interview in a tiered and contextually sensitive manner. The dilemma related to how I should react in interviews when people talked about experiences of abuse, violence or suicidality as part of their accounts of the incident which led to their hospital attendance. I was concerned with being authentic in my responses to distressing accounts, partly as a means of maintaining rapport but also partly to reflect a real involvement with their stories. Listening to participant 12’s account of slitting his throat and waiting to die, I felt it would be disingenuous to act unaffected by it. However, I was aware of a fine line between a real response of dismay and sympathy and a potentially stigma-reinforcing judgement. This
balance between engagement and judgement neutrality was difficult to maintain. When participant 5 offhandedly remarked that she inserted objects into herself to self-harm, I was naturally shocked but responded in a similarly low-key manner. When participant 9 disclosed his history of abuse (by handing me a letter, during his interview), I felt his pain had to be acknowledged, even if all I could do was wordlessly convey my emotional response.

These stories affected me beyond the interview encounter, throughout transcription and analysis, causing moments of withdrawal from the material. It was difficult to maintain a belief that this research could do sufficient to make these revisits of trauma worthwhile. The feedback forms I received and the chats with participants after interview helped me to feel that the encounter itself could be beneficial, to some extent. However, the need for close and repeated readings of the material as part of the analytic process was emotionally challenging. I utilised supervision (occasionally) and my research journal (more often) partly as a way to “[clear]… the emotional decks” as Jaggar (1989, p148) suggests, and to question where my responses were coming from – were they judgemental? Did they reflect a personal belief or expose a sensitivity pertaining to my own experience? Even with this support, analysis was slow and occasionally tortured, as I tried to engage hermeneutically but protect myself personally from the effects of the stories I heard. A PhD in itself is an incredible psychological investment, and being responsible for every aspect of the work – design, execution and dissemination – is no doubt challenging even when the subject matter is less harrowing.

Finally, another challenge arose in coding the data. As the first time I had conducted this type of project, I initially coded the data exhaustively, and it was difficult to move beyond description to interpretation. As a novice, and a student, it is common to lack confidence in one’s analysis, and I was no exception. The nature of qualitative research is such that the most effective learning is with practice, as accounts of “how to” analyse or interpret describe a process which is inherently fluid and dynamic. IPA appeals to many students, partly because it provides a clear and coherent analytic procedure, but once this process is in motion, it swiftly becomes apparent that a huge gap exists between procedural rules and practical application. I was also concerned that I
would reinforce stereotypical views of self-harm if I used the language of psychology, which IPA, stemming from psychological research, seems to encourage. My preconceptions and knowledge base inevitably have an impact on the types of concepts employed to code data, and whilst the researcher’s “horizon of intelligibility” (Martin & Sugarman, 2001, p. 196, p196) is valued in IPA, I worried that I would simply re-affirm ideas of self-harm as a symptom of mental illness. This complicated my navigation of the balance between interpretation and description, as I tried to employ Finlay’s (2008) concept of a reflexive dance to move between engaging with the participant’s account on its own terms and identifying what resources I used to understand that account. As is probably true with all qualitative research, the methodology provided a structure and a rationale for the employment of such a structure, but beyond that, the work required a great deal of personal investment, engagement and development.

**Concluding Thoughts**

I have learnt a lot in the process of conducting this study, personally, academically and practically. Engaging with feminist literature and methodology debates has admittedly been destabilising at times but has also enriched and expanded my appreciation of research and its challenges. Personally, I perhaps entered this process with something to prove to myself, and I have learnt from my participants to perceive this pressure in a different way, and to consider the role of social attitudes in the formation of my own prejudices. Whilst I have not focused on the rewards of the work above, I want to mention in conclusion the real pleasure I derived from meeting my interviewees, who inspired me to reflect on and re-consider some of my ideas about self-harm, struggle and survival. Whilst a minority of the interviews were difficult, and the conversation stilted, the majority were rewarding both intellectually and personally. Even the difficult ones offered new insights and perspectives on self-harm and services, which have influenced the conclusions of the study.

I feel that there is no simple conclusion to this piece, and no easy way to capture the impact of this study on my life and my perspectives. Perhaps, as Carol Smart and Rachel Shaw have pointed out, this reflection is only the tip of the iceberg, and the years to follow will offer different perspectives and revisions.
(Shaw, 2008; Smart, 2009a). Gadamer believed that our preconceptions were constantly shifting and it was only as they changed that we became aware of their meaning (Gadamer, 1979; Smith, 2007). If that is the case, then any conclusion I draw is likely to have shifted by the time of your reading!

References


