Parental and professional beliefs about the function of self-harm in young people

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Thesis submitted in partial fulfilment of the requirements of Staffordshire University for the degree of Doctorate in Clinical Psychology

April 2019

Total word count: 16,510

THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
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Registration number	**08020349**
Initial date of registration	**19th September 2016**

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: Date:

Acknowledgements

I would like to thank my research supervisor Dr Helen Combes for her support throughout the completion of this project.

I would also like to thank my clinical supervisor Dr Ross Mackenzie who provided me with guidance during my first year of training and invaluable support during recruitment for this research.

I am very grateful to each of the participants that took time out of their busy schedules to take part in the research.

I would also like to say thank you to my parents for their ongoing unconditional support and guidance throughout my education and career.

Finally, I thank my wife, Sana, for her constant encouragement and bringing out the best in me.

Preface

This thesis comprises of three chapters, each prepared with the intent of submitting to a selected journal or audience. The relevant guidelines for journal submission can be found in the appendices of Chapters 1 and 2. Supplementary materials are included for each paper for the purposes of this portfolio, some of which will be removed prior to submission for publication. The word count for Chapter 2 will be reduced prior to journal submission to ensure compliance with author guidelines.

Chapter 1 - The literature review has been prepared for submission to *Parenting: Science and Practice.* This journal is an international peer-reviewed journal that publishes articles relevant to parenting. The journal aims to advance theory, research and practice in relation to parenting and caregiving.

Chapter 2 – The empirical paper has been prepared for submission to *Journal of Adolescence*. This journal is an international peer-reviewed journal that addresses issues of professional and academic importance relating to development between puberty and adulthood. The journal aims to foster good practice through publishing research on adolescent development.

Chapter 3 – The executive summary has been prepared as an accessible version of the empirical paper for distribution amongst relevant staff groups.

Word Counts

Thesis Abstract: 300

Chapter 1: 7,675

Chapter 2: 6,532

Chapter 3: 2,003

Total Word Count: 16,510

Contents

Thesis Abstract

This thesis was completed as part of the academic requirements for the degree of Doctorate in Clinical Psychology. The research was based on the author's prior clinical experience of supporting people who self-harmed. Self-harm is seemingly on the rise among young people, and support is often provided by parents or professionals. Chapter 1 of this thesis is a review of the literature exploring parental beliefs about the functions of self-harm. Using a systematic search, 8 papers were found and evaluated using a structured appraisal tool, the Critical Appraisal Skills Programme (CASP). Most papers were of good quality. Synthesis of the findings indicated that parents hold a range of views about self-harm, with some misconceptions identified. Parents should be provided with accurate information on self-harm to ensure they are in the best position to support their children. Parents would also benefit from being provided with support for the feelings evoked by discovery of their child's self-harm. Chapter 2 is an empirical study using Q-methodology to explore Child and Adolescent Mental Health Service (CAMHS) staff beliefs about why young people self-harm. Twenty-five staff members from a range of professions completed Q-sorts, where they ranked 65 statements about self-harm in terms of relative agreement and disagreement. A large overlap in beliefs was found between all staff. Beyond this, two distinct accounts were identified; 'self-harm is a private experience used for coping' and 'self-harm seeks connection with others'. Overall, CAMHS staff appear knowledgeable about self-harm. Future studies could aim to use Q-methodology with other populations such as alternative staff groups or young people who self-harm to explore their beliefs. Chapter 3 is an executive summary of the empirical paper, written in a more accessible style. This paper is aimed to be disseminated amongst CAMHS staff in the NHS Trusts where the research was undertaken.

CHAPTER 1: Literature Review

Parental understanding of the functions of adolescent self-harm: A review of the literature

Word Count: 7,675

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Figures & Tables

Abstract

The aim of this narrative review was to identify and synthesise the findings from the literature on parents' understanding of the function of adolescent self-harm. This is important, as previous research has found that parental understanding can affect how they respond to the young person and the timeliness of seeking professional support. A literature search was conducted using Healthcare Databases Advanced Search (HDAS). Papers were obtained from PsycINFO, PubMed, Medline, EMBASE and CINAHL databases, in addition to grey literature sources. Eight studies met the inclusion criteria and were critically evaluated using the Critical Appraisal Skills Programme tool (CASP, 2018). Most studies were of good quality, meeting the majority of the CASP criteria. Parental understanding of the functions of self-harm were divided into functions relating to the self and functions relating to others. Possible intrapersonal functions of self-harm identified by parents were that of emotion regulation and self-harm as a coping strategy for mental health problems. Parents identified interpersonal functions of self-harm, such as self-harm being for attention, manipulation or control. In sum, parents have a wide range of beliefs about the function of self-harm. Some understanding is accurate, however possible misconceptions were identified such as self-harm being a method of manipulation or a failed attempt at suicide. Parents would benefit from accurate information and specific training which may help them to feel better equipped to support their children. Clinicians working with parents of children who self-harm should be aware of the range of feelings that self-harm may evoke in parents.

Keywords

self-harm; adolescent; parents; understanding

Introduction

Definition of Self-harm

Self-harm can be defined as the act of engaging in a behaviour or ingesting a substance with the intention of causing harm to oneself, irrespective of the motive or extent of suicidal intent (National Collaborating Centre for Mental Health, 2011; Owens, Hansford, Sharkey & Ford, 2016). Over the years, self-harm has become synonymous with terms such as deliberate self-harm, self-injurious behaviour, para-suicidal behaviour, or non-suicidal self-injury. Importantly, a key distinction made is the intent behind the behaviour. Although there is an increased risk of suicide in individuals who engage in self-harm (Hawton, Saunders & O'Connor, 2012), not all people who engage in self-harm are suicidal (Curtis, Thorn, McRoberts, Hetrick, Rice & Robinson, 2018).

Types of Self-harm

Self-harm can take many forms, however commonly used methods include cutting, burning, hitting, biting or poisoning oneself (Lloyd-Richardson, Perrine, Dierker & Kelley, 2007). Placing oneself in vulnerable situations or engaging in non-recreational risk-taking behaviour can also be considered as self-harming behaviours (Patton, Harris, Carlin & Hibbert, 1997). Self-poisoning, intoxication and self-cutting are often the most typical forms of self-harm people present with in hospitals (Hawton, Saunders & O'Connor, 2012; Rissanen, Kylma & Laukkanen, 2011).

Prevalence of Self-harm

Prevalence estimates of self-harm vary greatly, which may be in part due to the lack of standardised nomenclature and the variability of research methods used, which can result in cross-study comparison challenges (Laye-Gindhu & Schonert-Reichl, 2005). Further convoluting reported figures are the variability in populations selected for study and the secretive nature of the behaviour, leading to an underrepresentation of the statistics. Historically, research on self-harm has been conducted with 'psychiatric' samples (Laye-Gindhu & Schonert-Reichl, 2005), which renders it difficult to

generalise findings to non-clinical samples such as the general population or people who have not presented to mental health services.

The World Health Organisation (WHO, 2018) defines adolescence as a transitional phase of growth between childhood and adulthood, which usually encompasses any person between 10 and 19 years old. Self-harm is reported to be relatively common among adolescents, and more common in females than males (Hawton, Rodham, Evans & Weatherall, 2002). A meta-analysis on the prevalence of suicidal-phenomena in adolescents found that 13% of adolescents will have engaged in deliberate self-harm at some point in their lives (Evans, Hawton, Rodman & Deeks, 2005). Another meta-analysis conducted on international prevalence research published between 2005 and 2011 found a 16.1% lifetime prevalence of adolescent deliberate self-harm (Muehlenkamp, Claes, Havertape & Plener, 2012). Moreover, a review by Rissanen and colleagues summarised the prevalence of adolescent self-harm among several countries which highlighted that prevalence rates varied between 4.1% and 17% (Rissanen, Kylma & Laukkanen, 2011).

Causes of Self-harm

Self-harm research focussing on adolescent populations is important for several reasons. It has been suggested that self-harming behaviours typically originate in adolescence (van der Kolk, Perry & Herman, 1991). Furthermore, adolescence can be viewed as a critical period of development during which substantial biological changes occur, in addition to the rise of novel challenges such as studies, work and relationships (Curtis et al., 2018). It is also a period of increased transitions, such as an increase in responsibilities and independence (Bista, Thapa, Sapkota, Singh & Pokharel, 2016). Due to the interplay between biological, psychological and social factors, coupled with peer and cultural influences, self-harm often begins during adolescence, and is commonly associated with the start of puberty (Curtis et al., 2018).

The origin and causes of the development of suicidal behaviour, including self-harm, has been the subject of extensive research over the years. Many factors which contribute to the occurrence of self-harming behaviours have been identified, such as interpersonal difficulties, parental death or separation, problems at work or school, bullying, low self-esteem, impulsivity, perfectionism, physical ill health, mental health

difficulties, or even knowing others who self-harm (Hawton, Saunders & O'Connor, 2012). Adverse childhood experiences, particularly a history of physical or sexual abuse may also be risk factors for the development of self-harm behaviours (Gratz, 2003; Hawton & James, 2005). The impact of social media on influencing young people's self-harm has also been well documented in the literature. Dyson and colleagues (2016) conducted a systematic review and found that social media use can exert both a positive and negative impact on young people at risk of self-harming.

A diathesis-stress model has been proposed to make sense of the plethora of factors contributing to the development of suicidal behaviours (Evans, Hawton & Rodham, 2004). This model suggests that the interaction between predisposing biological factors, personality factors and cognitive vulnerabilities, coupled with exposure to adverse life events, increases the risk of developing and engaging in self-harming behaviours (Mann, Waternaux, Haas, & Malone, 1999).

Functions of Self-harm

A review by Klonsky (2007) found that self-harm was often preceded by acute negative affect, followed by decreased negative affect and relief following an act of self-harm. The author concluded that the converging evidence suggests that self-harm primarily serves an affect-regulation function (Klonsky, 2007). Other studies have reported that self-harm is often used as a strategy to alleviate intense and overwhelming negative emotions. Anger, anxiety and frustration tended to be most present prior to self-harm, followed by feelings of relief and calmness after self-harming (Klonsky & Muehlenkamp, 2007; Rasmussen, Hawton, Philpott-Morgan & O'Connor, 2016).

Other reported functions of self-harm include self-punishment, sensation seeking and 'anti-suicide' (Klonsky, 2007; Klonsky & Muehlenkamp, 2007). Self-punishing, such as expressing anger at oneself through self-harming, is in-line with previous research which highlights the presence of low self-esteem and self-derogation in some people who self-harm (Lundh, Karim & Quilisch, 2007). Sensation seeking may occur when self-harm is used to generate a feeling of excitement or to 'feel something' in response to blunted affect, or to distract oneself (Brown, Comtois & Linehan, 2002). Self-harm may also be a protective behaviour preventing individuals from acting on suicidal feelings (Suyemoto, 1998).

In addition to intrapersonal purposes of self-harm, interpersonal functions have also been identified as being important. Self-harm may serve the function of eliciting care or attention from a significant other or elicit reinforcing responses in clinical or school settings (Klonsky & Muehlenkamp, 2007). Self-harm may also be a way of bonding with others such as friends who also self-harm (Klonsky, 2007). Self-harm has also been conceptualised as a means of keeping people close, avoiding abandonment, or to be taken more seriously by others (Allen, 1995).

The interpersonal functions of self-harm have historically contributed to the belief that individuals who engage in self-harm are manipulative and attention seeking (Tantam & Whittaker, 1992). However, this belief is most likely a misconception and is in contrast with the fact that self-harm is often a private and secretive act, with many adolescents concealing their behaviour from others (Gratz, 2003). Furthermore, influencing others may not have been the intent of the self-harm, but rather a by-product of the behaviour (Linehan, 1993).

Generally, research supports that self-harm often occurs for intrapersonal reasons over interpersonal reasons, however it highlights that self-harm rarely serves only one function (Gardner, Dodsworth & Klonsky, 2016) and likely serves multiple functions simultaneously (Suyemoto, 1998).

Understanding Self-harm

Self-harm is often misunderstood. There exists a plethora of research investigating the views and understandings of staff in hospital settings (Saunders, Hawton, Fortune & Farrell, 2012). Findings from such studies often report that accident and emergency staff attitudes are particularly negative towards individuals who repeatedly self-harm. A lack of understanding of the behaviour is often attributed to this attitude, and research consistently finds that staff would benefit from further training on self-harm (Gibb, Beautrais & Surgenor, 2010; Timpson, Priest & Clark-Carter, 2012).

Parents of Self-harming Adolescents

Whilst much of the research has focused on staff knowledge, attitudes and training needs, understanding self-harm from the perspective of parents is less understood, but is of paramount importance. Research examining adolescent views indicates that parents are identified as a valuable source of support and can be key facilitators in the help-seeking process (Fortune, Sinclair & Hawton, 2008). This has found to be true particularly when parents are supported and understand the behaviour (Rissanen, Kylma & Laukkanen, 2009). A recent review concluded that providing parents with accurate information about self-harm, parenting skills and social support may benefit parents in supporting their children (Arbuthnott & Lewis, 2015).

Interpersonal difficulties, such as conflict with parents has been identified as a possible risk factor for the development of self-harming behaviour, however this could be due to the erroneous belief that people who self-harm often come from 'dysfunctional' or abusive families (McDonald, O'Brien & Jackson, 2007). Because of such stigma, parents may avoid seeking professional help due to shame, embarrassment, or concerns around being labelled as a poor parent (Sayal, Tischler, Coope, Robotham, Ashworth, Day, Tylee & Simonoff, 2010).

The parental discovery of self-harm can be traumatic for parents and commonly leads to feelings of confusion, guilt, shame and helplessness (Raphael, Clarke & Kumar, 2006). Self-harm can also negatively impact parents' well-being, which in-turn affects their ability to support the young person. A study by Ferry and colleagues found that self-harm can have an extensive impact on not only parents' emotional states, but on their mental health, relationships with partners and other family members, and their work and finances (Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell & Hawton, 2016).

How parents understand and make sense of self-harm also affects how they respond to the behaviour. For instance, one response was to exert control in response to feelings of powerlessness (Ferrey, Simkin, Hughes, Stewart & Locock, 2015). Another recent study by Ferrey and colleagues described how parental strategies changed upon discovery of a child's self-harm. These included changes such as increased or decreased support offered, changes in the level of control and changes in the monitoring of the child (Ferrey, Hughes, Simkin, Locock, Stewart, Kapur, Gunnell &

Hawton, 2016). Of note, these changes in parental responses were moderated by how parents conceptualised their child's self-harm. Moreover, a study in Hong Kong found that parents who are overwhelmed with feelings of guilt, frustration, incapability and anxiety regarding their child's self-harm may 'overreact' and provoke further self-harm (Yip, Ngan & Lam, 2003). Additionally, parents commonly detect their child's self-harm prior to any disclosure or contact with services, however misconceptions about the behaviour may lead to delays in help-seeking (Oldershaw, Richards, Simic & Schmidt, 2008). Clearly, then, it is important to consider the existing research on parental understanding of their children's self-harm.

Review Rationale and Aim

Whilst there is existing research on parental experiences of discovering self-harm, the impact this can have on parents and families, and the role of parents, there is currently no review that has consolidated the findings on what parents believe to be the function of self-harm. This is important, as previous research has found that parental understanding can affect how parents respond to the young person and the timeliness of seeking professional support. Echoing this, research has found that when clinical staff understand self-harm behaviour, they are more compassionate and deal with self-harm more effectively. Parents' understanding of the function of self-harm is vital to consider and may highlight areas of misconception leading to more relevant strategies and support.

The aim of this review is to identify, critique, and synthesise the findings from the literature on parents' understanding of the function of their adolescent children's self-harm.

In this review, self-harm is defined as intentional injury to oneself, without suicidal intent. Additionally, the term 'parents' is not limited to biological parents but also includes carers, guardians or the main care-givers of the child.

Method

Search Strategy

Prior to commencing this review, an initial scoping search was undertaken on the Cochrane Library and ProQuest databases to assess whether a literature review on this topic had been conducted previously. These searches revealed that no existing review had been conducted that specifically examined parental understanding of the function of adolescent self-harm.

Following this, a systematic search of the existing literature was conducted using the National Institute of Health and Care Excellence (NICE) Healthcare Databases Advanced Search (HDAS) system. The databases used in the search were selected from a range of relevant disciplines to ensure the breadth of existing literature was covered. The databases used in the search were PsycINFO, PubMed, Medline, EMBASE and CINAHL. Grey literature was also sought for this review and relevant articles were searched for on Ethos, ProQuest and OpenGrey databases.

To generate the search terms, the research question was divided into four key areas; ‘parents’, ‘understanding’, ‘adolescent’ and ‘self-harm’. Alternative search terms were developed using the thesaurus function on HDAS to search for similar words.

The search terms were entered systematically into each database and combined to retrieve articles featuring the terms in their title, abstract or key words. Additional search terms were also obtained from relevant articles’ key words and added to the final set of search terms (see Figure 1).

parent* OR guardian* OR carer* OR mother* OR mum OR mom OR father* OR dad OR "loved one" OR "care giver" OR care-give* OR "parent-child relationship"

AND

view* OR attitude* OR perception* OR explanation* OR justification* OR justify* OR understand* OR thought* OR perspective* OR reason* OR function* OR experience*

AND

child* OR adolescen* OR teen* OR teenager* OR youth OR young

AND

"self harm" OR self-harm* OR "self injurious" OR self-injurious OR "self destructive" OR self-destructive OR "self injury" OR self-injury OR "self mutilation" OR self-mutilation OR "self inflicted" OR self-inflicted

Figure 1. Final Search Terms

Search Criteria

No minimum date range was employed for this search and articles published up until the end of April 2018 were included. The selection criteria for the studies were generated based on the aims of this review and after an initial scoping search of the existing literature. The final inclusion and exclusion criteria can be seen in Figure 2.

Inclusion Criteria:

- English language studies
- Empirical studies (both peer-reviewed and unpublished)
- Study related to parents or carers of self-harming adolescents or young adults (<25 years old)
- Research exploring parents or carers understanding of the function of self-harm behaviour
- Research is from parent or carer perspectives

Exclusion Criteria:

- Non-research article (e.g. books, clinical guidelines, editorials, letters)
- Review papers
- Studies looking at perspectives of staff, teachers, peers or other non-parental family members
- Studies focusing on self-harm with exclusively suicidal intent
- Studies focusing on self-harm exclusively in the context of developmental disorders (e.g. Autism or learning disabilities) or eating disorders
- Studies that do not examine parental or carer views on the function of self-harm

Figure 2. Study Inclusion and Exclusion Criteria

Rationale for Search Criteria

English language studies were included in the review, and papers written in other languages were excluded; this was because the researcher is unable to read other languages and it was not possible to employ an interpreter for this review. Additionally, although the parents of adolescents are primarily the focus of this review, the initial scoping search for literature indicated that some relevant research included young adults, classed under the age of 25 years. It may be likely that adults older than 25 years are subject to different life stressors and may be more autonomous and subject

to less parental influence than an under 25-year-old adult, therefore parental views on adult children who self-harm may be different. Finally, with regards to the inclusion criteria, there is existing literature on the impact of parental discovery of self-harm and the focus of this review was specifically to examine parents' or carers' understanding of the function of self-harming behaviour.

To overcome publication bias, relevant grey literature such as unpublished research and theses were included in this review. Publications such as books, letters and editorials were excluded as they are not empirical studies. Review papers were also excluded as these summarise existing literature and are not standalone empirical studies. Studies focusing on self-harm in the context of suicide were excluded, as the reasons for non-suicidal self-harm may differ from self-harm with suicidal intent. Further to this, studies where the young person self-harmed in the context of developmental disorders or other comorbid difficulties such as eating disorders were excluded as there are likely to be confounding factors which relate to self-harm in these contexts.

Screening Process

Following the search on HDAS, a total of 3,484 articles were found across the included databases. A total of 691 duplicate articles were initially removed, leaving 2,793 articles to be screened against the inclusion and exclusion criteria.

Studies were screened based on their title and abstract to assess for relevance. If there was uncertainty on the relevance of the study, then the articles were included for full-text eligibility screening, along with other potentially suitable articles. A total of 2,758 articles were removed following the title and abstract screening process. The remaining 35 full-text articles were screened, and seven studies were deemed to meet the inclusion criteria. An additional unpublished thesis was added after hand-searching relevant articles reference lists and searching grey literature sources.

Figure 3 illustrates a summary of this process.

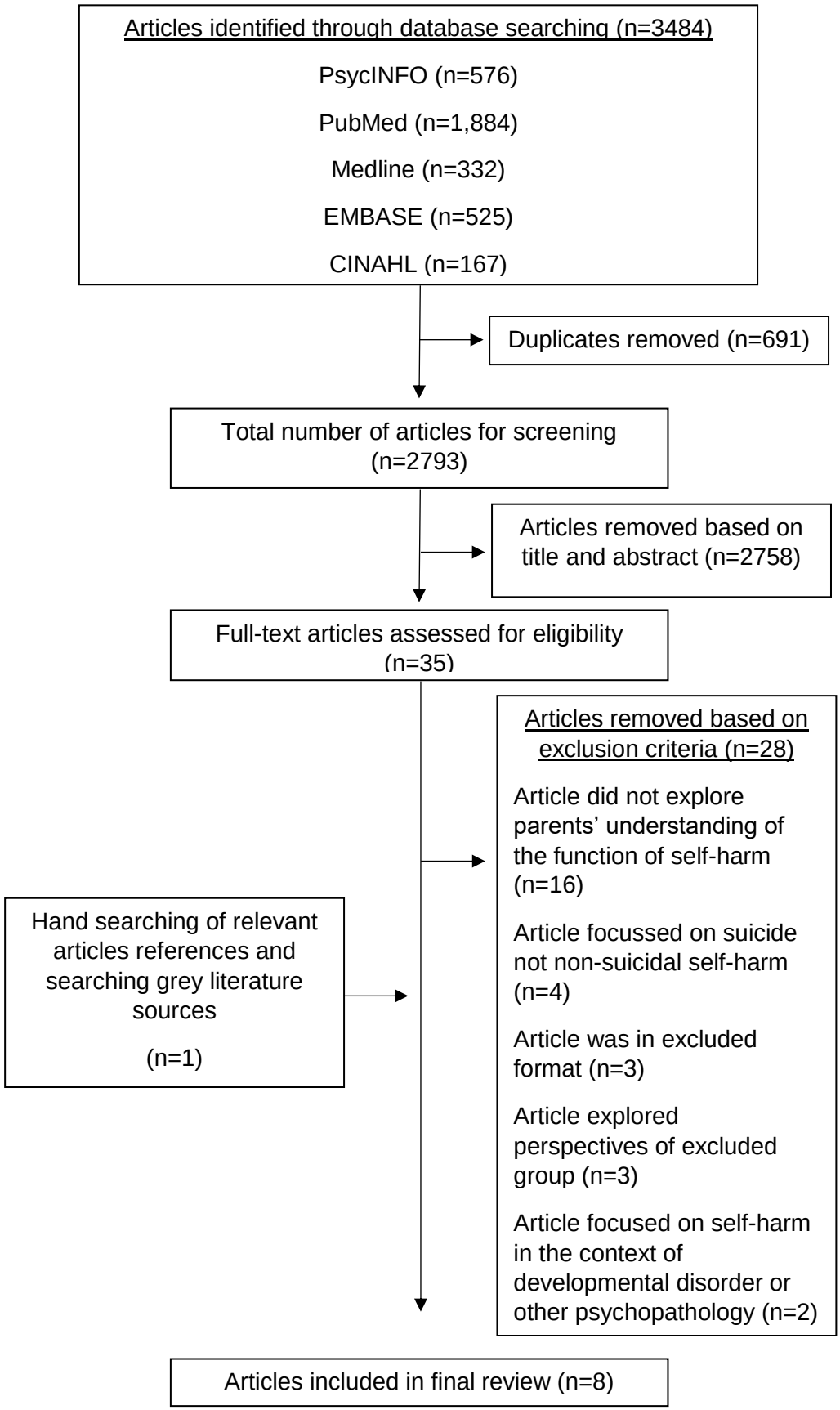

Figure 3. Screening Process Flowchart

Search Results

Eight papers were selected for detailed review. Of these papers, seven were peer-reviewed articles obtained through the systematic search and one was an unpublished thesis obtained through grey literature resources. All eight papers were qualitative in design using mostly interview data, with one study using a focus group and another including an open-ended questionnaire which was analysed qualitatively. All papers explored the views of parents or carers of children who self-harmed, however no paper exclusively focused on exploring parental understanding of the function of self-harm. Instead, the functions of self-harm were mentioned in each of these papers either in the context of an identified theme or in response to a specific interview question.

Critical Appraisal

The Critical Appraisal Skills Programme tool (CASP, 2018) was chosen to develop a systematic approach to the evaluation of the studies. Due to the designs of the shortlisted studies, criteria from the qualitative variant of the CASP were selected (see Appendix A).

The qualitative variant of the CASP consists of a 10-item checklist which covers three broad areas when appraising the quality of research; the validity, content and implications of the results (CASP, 2018). Alternative tests of rigour more suited to qualitative research, such as credibility and trustworthiness were also considered when evaluating the studies (Cypress, 2017). Each of the eight included studies were entered into a spreadsheet and evaluated against the 10 checklist items to assess whether each study satisfied the item's criteria (see Appendix B). These were rated as either 'Yes', 'No' or 'Can't Tell'. An additional rating 'Yes – Partially' was added, whereby a definitive 'Yes' could not be scored. Whilst addition of this rating lead to an adaptation of the standalone CASP tool, it was deemed necessary to include this to account for instances where studies met some, but not most, aspects of the criteria.

For comparison across studies and to make judgements about the quality of the findings, a scoring system was implemented. Ratings of 'Yes', 'Yes – Partially' and 'No' were scored as 3, 2, and 0, respectively. A rating of 'Can't Tell' was scored as 0, as this rating would only be given if insufficient information was provided by the

authors, therefore it was assumed that this was more likely to be rated closer to ‘No’ than ‘Yes – Partially’. Additionally, scoring ‘Can’t Tell’ as 1 may inflate the quality scores. Once complete, each study was given an overall quality score, ranging from a minimum score of 0 to a maximum score of 30.

Whilst the adoption of a scoring system can be helpful, it is important to recognise the intrinsic issues that are synonymous with this approach. For instance, the use of a single score can mask problems in some areas of the study if other areas scored highly (Valentine & Cooper, 2008). Furthermore, a total score with an arbitrary minimum and maximum makes it difficult to justify why research falls into one category over another (Valentine & Cooper, 2008). Consequently, the scores were not classified into traditional categories such as ‘Good’, ‘Average’ and ‘Poor’. Additionally, the use of numerical scores increases the risk of inconsistent ratings across studies (Greenland & O’Rourke, 2001), however this was addressed by use of a second independent rater with a background in research who also rated the quality of the included studies. Any discrepancies in ratings were resolved through discussion between the raters and a final score was given.

Data Synthesis

Synthesis has been described as an activity in which individual parts are brought together to form a whole which is characterised by some degree of innovation, so that the end result is greater than the sum of its parts (Barnett-Page & Thomas, 2009). In the context of research, findings of individual studies are considered critically and then amalgamated, to identify what is currently known about the topic of interest.

In this review, only qualitative studies were obtained, therefore statistical methods of synthesis were not conducted. Relevant data from each study was extracted and summarised in a table, along with quality scores. Following this, a methodological critique was presented for each study to consider the research’s quality and usefulness in addressing the aims of the review. A synthesis of common findings across the literature was then conducted.

Results

Summary of Studies

A descriptive overview of the studies included in the review and a summary of the characteristics and quality scores can be seen in the table below.

Reference & Country	Aims	Study Sample	Data Collection & Analysis	Findings (specific to the functions of self-harm)	Strengths (+) Limitations (-)	Quality Score (Max 30)
Byrne et al., 2008 ***Deliberate self-harm in children and adolescents: A qualitative study exploring the needs of parents and carers*** ***(Ireland)***	To uncover the views of parents and carers of young people who self-harm to identify their support needs, in relation to developing a support programme	Parents (n=15) and carers (n=10) of adolescents aged up to 16 who had self-harmed	Participants attended a focus group. Facilitators' post-group discussion recorded verbatim to develop a transcript along with field notes, flip chart records debriefing notes and feedback forms Conceptual Analysis	A variety of views on why young people self-harm were discussed Self-harm is: addictive; a ritual; for emotional release; attention seeking behaviour	+ Focus group allowed for direct service user involvement in service development - Recruited from services therefore findings may not generalise to parents whose children have not attended services - Individual interviews may have provided richer information	23

Ferrey et al., 2016 ***Changes in parenting strategies after a young person's self-harm: A qualitative study*** ***(UK)***	To explore how the discovery of a child's self-harm affected parenting behaviour	Parents (n=37) of young people aged under 25 who had self-harmed	Semi-structured narrative interviews were conducted and transcribed for analysis Thematic Analysis	Parents' conceptions of self-harm affected the type of parenting strategy adopted Self-harm is: normal for the developmental stage; part of mental health problems; deliberate; bad; naughty; attention seeking; manipulative; an attempt at gaining control	+ Large sample of parents with rich qualitative data + Not limited to parents whose children were in services - Most participants were mothers, with few fathers who took part - Limited ethnic diversity with only one participant from a minority ethnic background - Finished themes not checked with parents	27
Hughes et al., 2017 ***Making sense of an unknown terrain: How parents understand self-harm in young people*** ***(UK)***	To explore parents' experiences of adolescent self-harm and how they make sense of the behaviour, in relation to creating a web-based resource for parents	Parents and other family members* (n=41) of young people under 25 who had self-harmed *Article only reports findings based on interviews with parents (n=37)	Narrative interviews conducted and transcribed for analysis Thematic analysis	Sense-making following discovery of self-harm was described as a process of: (1) initial reactions of confusion, (2) search for information, (3) attempts to build a new way of seeing Self-harm is: part of puberty and teenage-culture; a way of expressing painful feelings; a response to relationship	+ Large sample of parents in different stages of coming to terms with self-harm + Included mothers and fathers + Included parents of children who had not been seen by mental health services - Limited ethnic diversity of sample	27

				difficulties or mental health problems		
Kelada et al., 2016 ***Parents' experiences of nonsuicidal self-injury among adolescents and young adults*** ***(Australia & USA)***	To examine the impact of adolescent self-harm on parent health, parental responses and interactions with professionals	Study 1: Australian parents (n=16) of adolescents who had self-harmed Study 2: American parents (n=22) of children (aged 15-24) who had self-harmed	Study 1: Participants completed open-ended questionnaires Study 2: Participants participated in semi-structured interviews Thematic analysis used in both studies	Study 1: Many themes identified including 'searching for reasons for self-harm' Study 2: Parents had a lack of knowledge about self-harm and were uncertain of how to deal with the situation Self-harm is: attention seeking behaviour; for emotion regulation	+ Both studies included mothers and fathers - Some parents knew about self-harm for years, retrospective recall and time to adjust may have affected responses - Large portion of children had mental health difficulties therefore parental responses may have been influenced by other aspects of their diagnosed condition	22
McDonald et al., 2007 ***Guilt and shame: Experiences of parents of self-harming adolescents*** ***(Australia)***	To examine the experiences of mothers of adolescents who self-harm and gain insight on how this affects their and the families' well-being	Mothers (n=6) of children (aged 12-21) who had self-harmed	Conversational interviews focused on mothers' experiences were conducted and transcribed for analysis Hermeneutic phenomenology	Mothers felt overwhelmed and inadequate, feeling they lacked knowledge and understanding of their child's experience. All mothers felt guilt which was exacerbated by feelings that their own circumstances contributed to the self-harm	+ Rich interview data - Limited sample size with only mother's perspectives - Limited ethnic diversity in sample - Sample group overwhelmingly from a medium-high socioeconomic background	28

				Self-harm is: a response to negative feelings such as rejection and self-loathing		
Oldershaw et al., 2008 ***Parents' perspectives on adolescent self-harm: Qualitative study*** ***(UK)***	To gain the perspectives of parents of adolescents who self-harm in relation to service provision, making sense of self-harm and its personal and emotional impacts	Parents (n=12) of adolescents (aged 13-18) referred to child and adolescent mental health services (CAMHS) for self-harm	Semi-structured interviews conducted and transcribed for analysis Interpretative Phenomenological Analysis (IPA)	Upon discovering self-harm, parents speculated on the reasons for the behaviour. Causal factors fell into three categories; emotional, situational and personality. Self-harm is: to cope with negative emotions; for emotional expression; to provide control; a phase	+ Participant consulted when validating themes + Rich data provided for IPA - Sample limited to recruitment from two CAMHS teams. - Only half of the parents approached agreed to participate – possible sampling or response bias	28
Rissanen et al., 2008 ***Parental conceptions of self-mutilation among Finnish adolescents*** ***(Finland)***	To describe self-harm from the view point of parents of Finnish adolescents	Parents (n=4) of female adolescents who self-harmed	Open-ended interviews conducted and transcribed Inductive content analysis	Participants described self-harm as a confusing phenomenon. Functions were divided into two categories: relating to the adolescent and relating to others	+ Rich interview data - Small sample size - Parents recruited through children engaged in self-harm study – possible response bias - No explicit statement of implications or areas of future research	21

				Self-harm is: to relieve bad feelings, anxiety and internal pain; a cry for help; melodramatic; an act of protest; a form of protecting the parent; an attempt to commit suicide		
Tuls, 2011 ***Parent response to adolescent self-injurious behavior: A collective case study*** ***(USA)***	To gain a qualitative understanding of the parents' perspective and comprehension of self-harm behaviour	Parents (n=4) of adolescents (13-17 years) admitted to inpatient psychiatric residential facility with self-harm as a presenting issue	Semi-structured interviews conducted and transcribed Within- and cross-case analysis from interviews, notes, medical records and member checking Inductive content analysis	During the interview participants were asked about their thoughts on the reasons for self-harm behaviours Self-harm is: an emotional release; socially influenced; about being in control	+ Post-interview transcripts checked with participants for validity + Explicit consideration of biases and subjectivity - Recruited from inpatient facilities where self-harm was only part of the reason for admission - Small sample of white single mothers	29

Table 1 - Summary of Study Characteristics and Quality Scores

Quality of Studies

The quality scores of studies ranged from 21 to 29, with only three studies scoring below 27. The maximum possible score obtainable was 30, therefore this indicated that the majority of studies included in this review met most of the criteria in the CASP.

Byrne and colleagues aimed to identify the needs of parents and carers of young people who self-harmed to aid the development of a support programme (Byrne, Morgan, Fitzpatrick, Boylan, Crowley, Gahan, Howley, Staunton & Guerin, 2008). Using a qualitative focus group with 15 parents and 10 carers, the study included a rigorous and detailed data analysis, a clear statement of the findings and the development of a support programme following the study. However, although the participants were appropriate to the needs of the study, the authors only recruited parents and carers of children who attended services and did not justify some decisions made around time-frames, which limited the overall transferability of the findings. Additionally, there was no explicit consideration of ethical issues addressed in this study.

Ferrey and colleagues explored how parenting strategies were affected following the discovery of a child's self-harm (Ferrey et al., 2016). The researchers used narrative interviews with 37 parents who were recruited from a wide variety of sources. The interview data gathered was transcribed by a professional transcriber and checked by the researchers, which boosted the commitment to the data (Yardley, 2000). Two researchers also analysed the data which improved the credibility of the findings, however the final themes were not checked with participants. Furthermore, purposive sampling was used, which would have improved transferability of the findings, however diversity within the sample was limited.

Hughes and colleagues aimed to develop a web-based resource through exploring how parents of adolescents who self-harm made sense of the behaviour (Hughes, Locock, Simkin, Stewart, Ferrey, Gunnell, Kapur & Hawton, 2017). The researchers used narrative interviews with 37 parents. The data analysis was rigorous and conducted independently by two researchers, improving its credibility. The researchers also invited participants to a meeting in which the findings were discussed, however they did not state who attended this. Similarly to Ferrey and

colleagues (2016), purposive sampling was sought, however diversity in the sample remained limited.

Kelada and colleagues assessed the impact of adolescent self-harm on parents in two studies (Kelada, Whitlock, Hasking & Melvin, 2016). A strength of the research was that it recruited both mothers and fathers, which improved the potential of gathering more diverse viewpoints. Although there was a clear aim stated by the authors, the use of two studies using different methodologies was a limitation of the study. It was unclear why a questionnaire was chosen to gather experiential and sensitive information from the 16 parents in Study 1 and this decision was not justified by the authors. Use of interviews with 22 parents in Study 2 were appropriate for the aims of the research, however more explicit details on the nature of the interview would have improved transparency and trustworthiness of the findings. Furthermore, despite a third researcher who was uninvolved in the interviews conducting the thematic analysis in Study 2, it is not clear who was involved in the analysis of the data in Study 1. The lack of transparency reduced the trustworthiness of the findings, as the authors did not indicate the steps taken to reduce bias or researcher influence in the development of the themes. Overall the results were deemed to be helpful, however the use of two different methodologies limited the ability to form a coherent and clear conclusion about parental understanding of adolescent self-harm.

McDonald, O'Brien and Jackson (2007) aimed to describe the experiences of six mothers of self-harming adolescents using conversational interviews. A strength of the research was the collection of detailed data using interviews with mothers of self-harming children. Data analysis was rigorous, with all three researchers immersing themselves in the data through reading and re-reading the transcripts and reflecting on the data through discussion and questioning the emerging meanings. The researchers were also mindful and open about their assumptions about mothers of self-harming children. Ideally more information on the structure of the interviews would have been beneficial to improve the transparency and trustworthiness of the findings. Furthermore, it was unclear who conducted the interviews, which also would have improved the transparency of the study. The use of a small sample of six volunteers recruited through local news media limited the transferability of the findings.

Oldershaw and colleagues conducted a study to gain the perspectives of 12 parents of self-harming adolescents in relation to their role in seeking or maintaining help (Oldershaw, Richards, Dimic & Schmidt, 2008). Strengths of this study included the use of interviews which were reviewed by independent colleagues with experience of qualitative research and a parent of an adolescent who self-harmed. Data analysis was also conducted independently by two researchers to achieve triangulation and minimise researcher bias. The findings were also reported clearly, with excerpts from the interviews to support identified themes. Participants were consulted when validating themes which improved the credibility of the findings. Limitations of the study included the recruitment of participants from only two Child and Adolescent Mental Health Service (CAMHS) teams, which reduced the transferability of the findings.

Rissanen, Kylma and Laukkanen (2008) aimed to describe self-harm from the perspective of parents of self-harming children in Finland. Whilst interviews with parents provided rich data, there were several methodological weaknesses in this study. The study used four parents who were recruited through their children who were involved in a separate self-harm study conducted by the same researchers, which raised issues around researcher and sample bias. Details on the contents of the interview were also deemed vague which limited the transparency and trustworthiness of the findings. Analysis was also conducted by the main researcher with no triangulation or member checks, which reduced the trustworthiness of the findings. Additionally, there was no mention by the authors of the contribution of the research to current knowledge and potential areas for future research. The latter, in addition to a very limited consideration of the strengths and weakness of the study, reduced the overall usefulness of the research.

Tuls (2011) conducted a study to gain an understanding of parental perspectives and understanding of self-harm. Overall this study was of high quality and was rated highly on all of the CASP criteria. This may have been due to the doctoral-thesis nature of the study, which allowed for the author to describe many aspects of the research in-depth. For example, the author described his relationship with the participants explicitly and his previous role on the ward where participants were recruited, improving the trustworthiness of the findings. Rigour was also demonstrated through checking post-interview transcripts with participants. A major limitation of this study was the recruitment of only four parents of children admitted to a ward where self-

harm was not the sole presenting issue. Furthermore, the study was not published and therefore not subject to the peer review process.

Synthesis of Studies

The studies in this review were qualitative in design, with seven of the eight studies using interviews to collect information. One study utilised both questionnaires and interviews (Kelada et al., 2016) and one used a focus group (Byrne et al., 2008). Studies varied in the age of the young person who self-harmed, with some studies focusing on parents of children as young as 12 (McDonald et al., 2007) and some up to 25-years old (Ferrey et al., 2016; Hughes et al., 2017). None of the selected studies exclusively examined parental understanding of the function of self-harm, however this was explored in each study.

Following the discovery of self-harm, parents attempt to understand self-harm and try to make sense of why their child engaged in this behaviour (Byrne et al., 2008; Hughes et al., 2017; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008). Common feelings parents had when trying to understand their children's self-harm was that of shock, devastation, guilt, shame, fear and isolation (Byrne et al., 2008; Hughes et al., 2017; McDonald et al., 2007). One study noted that parents found self-harm to be a confusing phenomenon that evoked negative emotions (Rissanen et al., 2008), whilst another described how parents were unsure of what self-harm was until they discovered it (Kelada et al., 2016). Shock of discovering self-harm was not always the case however, with some studies reporting that parents suspected their child was self-harming and were suspicious prior to discovering the self-harm (Ferrey et al., 2016; Oldershaw et al., 2008).

Most parents were aware that self-harm served a function in their child's life. Moreover, some parents understanding of the function of self-harm was dependent on what they believed to be the cause of the behaviour (Oldershaw et al., 2008). Some parents viewed self-harm as a normal behaviour for the developmental stage of their child and a part of teenage culture (Ferrey et al., 2016; Hughes et al., 2017; Rissanen et al., 2008; Tuls, 2011). Hughes and colleagues describe how parents were later fearful upon discovering that adults also self-harm (Hughes et al., 2017). This destabilised the belief that self-harm was a phase and part of the normal turmoil of adolescence

(Ferrey et al., 2016; Oldershaw et al., 2008). Some parents also expressed the belief that self-harm was a 'typical' behaviour in adolescence, particularly among females (Rissanen et al., 2008). Echoing this, Oldershaw and colleagues described how some parents saw self-harm as a typical teenage behaviour akin to taking alcohol or drugs, with some parents expressing regret that their child 'opted' for self-harm (Oldershaw et al., 2008).

Functions of self-harm were mostly divided into two main categories; functions relating to the self and functions relating to others. In many of the studies, parents understood self-harm to serve the purpose of emotion regulation or for emotional release from feelings such as anger (Byrne et al., 2008), rage (Tuls, 2011), self-hatred (Hughes et al., 2017) and self-loathing (McDonald et al., 2007). Furthermore, self-harm was conceptualised as a coping strategy to relieve negative feelings such as anxiety (Rissanen et al., 2008) and to ease internal pain (Hughes, et al., 2017; Oldershaw et al., 2008). Other intrapersonal reasons identified by parents were that self-harm can be an addictive or ritualistic behaviour that provides a 'buzz' (Byrne et al., 2008). In addition to this, two of the studies reported that parents believed self-harm was a way of providing the adolescent with a sense of control over their own body (Oldershaw et al., 2008; Tuls, 2011). Rissanen and colleagues also described how some parents believed that self-harm was a failed attempt at suicide (Rissanen et al., 2008). Other parental conceptualisations of self-harm were that self-harm was part of mental health difficulties and was a way of dealing with depression, anxiety, post-traumatic stress, personality difficulties, or hallucinations (Ferrey et al., 2016; Hughes et al., 2017).

Interpersonal functions of self-harm were also identified by parents. As noted above, some parents felt that self-harm was part of mental health difficulties, however some parents were uncertain about how much of the self-harm was related to mental health, or how much was 'naughty' behaviour (Ferrey et al., 2016). When parents viewed self-harm as a deliberate, naughty or bad behaviour, this increased parents' levels of monitoring and control of the child (Ferrey et al., 2016). Moreover, some parents viewed self-harm as a manipulative act used to gain control of the parent or situation (Ferrey et al., 2016; Hughes et al., 2017). Furthermore, parents identified self-harm as an attention seeking behaviour (Byrne et al., 2008; Ferrey et al., 2016; Kelada et al., 2016) or a 'cry for help' (Rissanen et al., 2008).

Whilst many of the aforementioned interpersonal reasons for self-harm were viewed negatively, some parents described self-harm as a way of protecting the parent (Rissanen et al., 2008). Self-harm was also considered as a form of emotional expression (Oldershaw et al., 2008), which served the function of communicating distress. Despite awareness of the possible functions of self-harm, Oldershaw and colleagues noted that many parents did not go beyond intellectual understanding of the behaviour (Oldershaw et al., 2008).

Discussion

The aim of this review was to identify and synthesis the findings from the current research on parental understanding of the function of their adolescent children's self-harm. In total, eight articles were critically appraised and synthesised.

Parental Beliefs

Parents' views on the function of adolescent self-harm were divided into functions relating to the self and functions relating to others. Broadly, parents cited more intrapersonal reasons for the function of self-harm, which is reflected in the literature that suggests that self-harm is often for intrapersonal reasons over interpersonal reasons (Gardner, Dodsworth & Klonsky, 2016).

Parents identified emotion regulation as a key function of self-harming, which is in-line with previous findings (Klonsky, 2007; Klonsky & Muehlenkamp, 2007; Rasmussen, Hawton, Philpott-Morgan & O'Connor, 2016). Some parents viewed self-harm as an addictive behaviour which provided a 'buzz' (Byrne et al., 2008). This, too, is consistent with findings that self-harm is used to generate feelings of excitement (Brown, Comtois & Linehan, 2002). Interestingly, some parents viewed self-harm as a failed attempt at suicide (Rissanen et al., 2008), which is in contrast with research that suggests that self-harm acts as a protective behaviour that may prevent individuals from acting on suicidal feelings (Suyemoto, 1998).

Similarly to research with hospital staff (Saunders, Hawton, Fortune & Farrell, 2012), attitudes towards self-harm were negative, with some parents believing that self-harm

was a manipulative act used to gain attention, manipulate others or to control a situation. Although not necessarily the case, previous research indicates that self-harm may serve the function of eliciting attention from others (Klonsky & Muehlenkamp, 2007).

Overall, synthesis of the studies highlighted that parental understanding of the functions of self-harm can be both accurate and misconceived. Clinicians would benefit from being aware of the different perspectives parents may have when discussing their children's self-harm. Being able to provide parents with accurate information on self-harm would potentially alleviate misconceptions about the behaviour which can sometimes lead to stricter parenting practices and less supportive relationships (Ferrey et al., 2015; Ferrey et al., 2016). For parents who may accurately believe the functions of self-harm to be for emotion regulation purposes, advice could be given on alternative ways in which to help their child cope with difficult emotions or for parents to be provided with information on how they may positively impact on their children's emotion regulation ability (Morris, Criss, Silk & Houltberg, 2017), whilst being mindful of possible existing feelings of guilt.

In addition to parents' understanding, their feelings in response to self-harm should be considered. Upon discovery of self-harm, parents attempt to understand and make sense of why their child engaged in the behaviour (Byrne et al., 2008; Hughes et al., 2017; McDonald et al., 2007; Oldershaw et al., 2008; Rissanen et al., 2008). This process of sense-making is commonly preceded by feelings of shock, devastation, confusion and sadness (Hughes et al., 2017; Oldershaw et al., 2008). Some parents reported feeling overwhelmed with emotion to the extent of being in denial about the self-harm and avoiding intervention (Oldershaw et al., 2008). This feeling of avoidance may be related to the prominent feelings of guilt and shame experienced by some parents (Byrne et al., 2008; Hughes et al., 2017; McDonald et al., 2007). Parents reported feeling blamed for their child's self-harm and experienced a sense failure for being unable to recognise and prevent it (Byrne et al., 2008; Raphael et al., 2006). Consequently, parents may hesitate to initiate contact with services due to the stigmatising nature of self-harm and fear of being judged (Raphael et al., 2006; Sayal, et al., 2010; Yip et al., 2003).

How services respond to and support parents is of key importance. Some parents reported that CAMHS were a powerful force in either reducing or heightening their distress (Oldershaw et al., 2008). Furthermore, advice or input from other agencies such as schools or general practitioners may also impact on the timeliness of accessing help, with their input either encouraging or curbing parents' help seeking (Oldershaw et al., 2008).

The individual variability between parents should be held in mind by clinicians. For some, self-harm is perceived as a normal behaviour and a phase during adolescence (Ferrey et al., 2016; Hughes et al., 2017; Rissanen et al., 2008; Tuls, 2011). Parents with this outlook may later experience worries and fears upon discovering that self-harm can often continue into adulthood (Hughes et al., 2017). Clinicians should be aware of the possible misconceptions and anxieties parents may hold about self-harm and offer support and accurate information. Other parents may present with feelings of guilt or shame. Parents with these feelings may also benefit from accurate information on the origins of self-harm and empathic responses from staff. Furthermore, parents may feel disempowered by their child's self-harm which can reduce their confidence in their perceived parenting capacity (Raphael et al., 2006; Byrne et al., 2008; McDonald et al., 2007; Oldershaw et al., 2008). Therefore, empowering parents who seek support could be an area of focus for clinicians. For example, guiding parents on how to implement effective parenting strategies and avoiding a reflexive response to exert control over their child (Ferrey et al., 2015).

Limitations of Included Studies

Prior to drawing any conclusions, it is important to note the methodological critique of the studies used in this review. Many of the studies had issues relating to the sample of participants used which limited the transferability of the findings. For example, the use of only mothers in many of the studies, the small sample size, and the recruitment of parents from mental health services. Therefore, findings from the review should be cautiously generalised to fathers and parents of children who have not been involved with mental health services.

The critical appraisal process highlighted that most of the studies were of good quality, with most fulfilling almost all of the CASP criteria for qualitative studies. Despite the

methodological flaws, the findings relating to the functions of self-harm were similar between studies of lower and higher quality. For instance, Byrne and colleagues (2008), Kelada and colleagues (2016) and Rissanen and colleagues (2008) found that parents had similar beliefs about the function of self-harm as those parents in the higher quality studies.

Limitations of Review

There are several limitations of this review that warrant attention. For instance, the search and selection of papers for review was conducted by only one researcher, which may have been influenced by subjectivity. This was attempted to be minimised through the transparent and explicit documentation of the search and selection process. Moreover, the use of a scoring system when critically appraising the articles may have led to possible biases when rating the articles. This was addressed through the use of an independent researcher who was involved in the critical appraisal process; although this researcher was not involved in the search and selection of the papers. Furthermore, the addition of a 'Yes – Partially' rating was an adaptation of the existing CASP tool, which may have impacted on the original intended use of the tool. An additional limitation was the use of articles only published in English, which may have led to the exclusion of relevant articles.

Implications

The results from this review demonstrated that some parents have a good understanding of the functions of self-harm, but also highlighted possible misconceptions about the behaviour. For instance, some parents may believe that self-harm is a failed attempt at suicide or is a manipulative act used to gain attention or control. Negative attitudes and beliefs about self-harm have also been demonstrated in the literature investigating staff beliefs, and it is often concluded that staff would benefit from further training (Gibb, Beautrais & Surgenor, 2010; Timpson, Priest & Clark-Carter, 2012). The same may hold true for parents of children who self-harm, who would likely benefit from education or training to help them feel better

equipped on how to help their children. Moreover, providing parents with accurate information would help them in supporting their children (Arbuthnott & Lewis, 2015).

For parents who understood the function of self-harm to be for intrapersonal reasons, such as dealing with difficult emotions, they appear to respond in a more concerned and compassionate way. Contrastingly, parents who believe the behaviour to be manipulative and used for control may feel more frustrated and respond by exercising more control over the child. Parents would likely benefit from clinicians exploring their understanding and beliefs about self-harm and being provided with accurate information and alternative strategies.

Regardless of parents' views on the function of self-harm, parents often report feeling shock, devastation, guilt and shame. Parents may be hesitant to disclose information to services and seek support due to embarrassment and anticipation of being judged. These feelings should be considered by clinicians who may be in the position of needing to sensitively and empathically support parents during the help-seeking process.

Future Research

This review highlighted several possible areas for future research. Firstly, research focused exclusively on parental understanding of the function of self-harm is currently non-existent. Parents' views about the function of self-harm was dependent on their beliefs about the cause (Oldershaw et al., 2008), therefore an exploration of parental understanding of the causes and origins of self-harm may provide valuable information. Differentiating between research focused on parental beliefs on the causes and functions of self-harm would also be beneficial. Further areas of potential research could be an increase in quantitative research. Prospective studies could perhaps compare the functions of self-harm described by parents and their children. More research investigating the views of fathers would also provide greater insight into any possible parental differences in conceptualising and responding to children's self-harm.

Conclusion

In sum, parents have a wide range of beliefs about the functions of self-harm. Some understanding of the functions of self-harm is accurate, such as self-harm serving an emotion regulation purpose, whilst other views may be misconceptions, such as self-harm being a method of manipulation or a failed attempt at suicide. How parents understand and make sense of self-harm may also affect how they respond to the behaviour. As parents can be a valuable source of support for their children and key facilitators in the help-seeking process, clinicians should be aware of and explore parents' current understanding of their child's self-harm. The individual purpose of self-harm varies between individuals and parents would benefit from accurate information about self-harm through tailored training or supportive contact with mental health services.

Declaration of Interest

None.

Funding

The research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

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Appendices

Appendix A - Critical Appraisal Skills Programme (CASP) Tool

www.casp-uk.net
info@casp-uk.net
Summertown Pavilion, Middle Way Oxford OX2 7LG

CASP Checklist: 10 questions to help you make sense of a **Qualitative** research

How to use this appraisal tool: Three broad issues need to be considered when appraising a qualitative study:

- Are the results of the study valid? (Section A)
- What are the results? (Section B)
- Will the results help locally? (Section C)

The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions. There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.

About: These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.

For each new checklist, a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.

Referencing: we recommend using the Harvard style citation, i.e.: *Critical Appraisal Skills Programme (2018). CASP (insert name of checklist i.e. Qualitative) Checklist. [online] Available at: URL. Accessed: Date Accessed.*

CASP
Critical Appraisal Skills Programme

Section A: Are the results valid?

1. Was there a clear statement of the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- what was the goal of the research
- why it was thought important
- its relevance

Comments:	

2. Is a qualitative methodology appropriate?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- Is qualitative research the tight methodology for addressing the research goal

Comments:	

Is it worth continuing?

3. Was the research design appropriate to address the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)

Comments:	

CASP
Critical Appraisal Skills Programme

4. Was the recruitment strategy appropriate to the aims of the research?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher has explained how the participants were selected
- If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- If there are any discussions around recruitment (e.g. why some people chose not to take part)

Comments:

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

Comments:

CASP
Critical Appraisal Skills Programme

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Comments:

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- If approval has been sought from the ethics committee

Comments:

CASP
Critical Appraisal Skills Programme

8. Was the data analysis sufficiently rigorous?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

Comments:

9. Is there a clear statement of findings?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider whether
- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Comments:

CASP
Critical Appraisal Skills Programme

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Comments:	

Appendix B – Critical Appraisal Skills Programme (CASP) Ratings

CASP Criteria	Byrne et al. (2008)	Ferry et al. (2016)	Hughes et al. (2017)	Kelada et al. (2016)	McDonald et al. (2007)	Oldershaw et al. (2008)	Rissanen et al. (2008)	Tuls, (2011)
Clear statement of aims	Y	Y	Y	Y	Y	Y	Y	Y
Qualitative methodology appropriate	Y	Y	Y	Y	Y	Y	Y	Y
Design appropriate to aims	Y	Y	Y	YP	Y	Y	Y	Y
Recruitment appropriate to aims	YP	Y	Y	YP	YP	YP	YP	YP
Data collection addressed research issue	Y	Y	Y	YP	Y	Y	YP	Y
Relationship of researcher and participants	CT	CT	CT	CT	YP	YP	CT	Y
Ethical issues considered	N	Y	Y	Y	Y	Y	Y	Y
Data analysis rigorous	Y	Y	Y	YP	Y	Y	YP	Y
Clear statement of findings	Y	Y	Y	YP	Y	Y	Y	Y
Value of research – will results help locally	Y	Y	Y	Y	Y	Y	N	Y
Quality Score (Max 30)	**23**	**27**	**27**	**22**	**28**	**28**	**21**	**29**

Key:

Y – Yes (3 points) P – Yes Partially (2 Points) CT – Can't Tell (0 Points) N – No (0 Points)

Appendix C – Target Journal Instructions for Authors

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Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our Author Services website.

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Contents

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CHAPTER 2: Empirical Paper

Why do young people self-harm?
A Q-methodology study exploring staff beliefs

Word Count: 6,532

Contents

Figures & Tables

Abstract

Introduction

Staff knowledge and understanding about self-harm can influence their attitudes towards people who self-harm. Negative attitudes and a need for training have frequently been highlighted in research conducted with emergency department staff. Less explored are the beliefs held about self-harm within specialist mental health services. Q-methodology is a research method that can be used to explore subjective beliefs about self-harm.

Method

Twenty-five staff members from a range of professions were recruited from Child and Adolescent Mental Health Services (CAMHS) across two NHS Trusts in the UK. The staff were tasked with completing a Q-sort, which involved ranking 65 statements about self-harm in terms of relative agreement and disagreement to explore the range of subjective beliefs about self-harm. The data was then subject to factor analysis and varimax rotation. Extracted factors were interpreted based on existing theories and participants' accounts.

Results

There was a large overlap in staff beliefs within CAMHS. Most staff believed that self-harm was used for coping with intense emotions and rejected negative connotations, such as self-harm is an act of manipulation. Beyond this, two distinct accounts were found; 'self-harm is a private experience used for coping' and 'self-harm seeks connection with others'.

Conclusion

CAMHS staff appear to hold accurate knowledge about self-harm. The beliefs expressed in this study are a useful indicator of how staff may understand the function of self-harm in young people. Future studies could use Q-methodology with other

populations such as alternative staff groups or young people who self-harm to explore their beliefs.

Keywords

Q-methodology, self-harm, young people, adolescents, staff beliefs, CAMHS

Funding

The research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Introduction

Self-harm is defined as causing deliberate injury to oneself, with or without suicidal intent (National Collaborating Centre for Mental Health, 2011). In addition to physically injuring oneself, causing deliberate emotional harm, such as placing oneself in vulnerable situations, or engaging in non-recreational risk-taking behaviour, can also be considered self-harming behaviour (Patton, Harris, Carlin & Hibbert, 1997).

There is a plethora of research exploring the reasons why individual's self-harm from the perspectives of people who self-harm. Dominant theories propose that self-harm primarily serves an affect-regulation function (Klonsky, 2007). Self-harm may protect against suicidal feelings through attempting to cope with distress rather than escaping it permanently, in addition to a means of self-punishment or sensation seeking (Klonsky & Muehlenkamp, 2007). Self-harm also serves interpersonal functions by eliciting care or attention from others, avoiding abandonment, communicating distress, bonding with others, or keeping people close (Allen, 1995; Klonsky & Muehlenkamp, 2007). According to the National Institute of Health and Care Excellence (NICE, 2004), the nature and meaning of self-harm varies greatly between individuals and is contextually determined.

Prevalence

Globally, self-harm is a significant challenge, and within England is at the forefront of the Department of Health's (DOH) initiative for suicide prevention (DOH, 2017). Previous self-harm is a strong predictor of suicide, as more than half of adolescents who commit suicide have a history of self-harm (Rodway et al., 2016).

Self-harm can occur at any age but is most common in young people. Between 4.6% and 6.6% of people in Britain have self-harmed (Meltzer, Lader, Corbin, Singleton, Jenkins & Brugha, 2002) and 13% of young people aged 15 or 16 have self-harmed at some point during their lives (Hawton, Rodham, Evans & Weatherall, 2002). These figures are likely to be higher because many young people are reluctant to disclose self-harm (Klineberg, Kelly, Stansfeld & Bhui, 2013).

A recent study examining health records from 674 general practices across the UK reported a 68% increase in self-harm incidents among girls aged 13-16 between 2011-

2014 (Morgan et al., 2017). Further to this, a report by the National Society for the Prevention of Cruelty to Children (NSPCC) indicated that self-harm among young people rose by as much as 14% over a three-year period (NSPCC, 2016). In a recent report, the NSPCC stated that 5% of total counselling sessions over the year were related exclusively to self-harm. There was also a 5% increase overall in the number of counselling sessions with young people regarding mental health issues including suicidal thoughts and feelings and self-harm (NSPCC, 2018).

Staff Attitudes and Understanding

Research with staff often explores the attitudes, perceptions and training needs of people who are in contact with individuals who self-harm. Much of this research is focused on staff who work in Accident and Emergency (A&E) services and suggests that A&E staff hold negative attitudes towards people who self-harm. Saunders, Hawton, Fortune and Farrell (2012) conducted a systematic review of 74 studies and found that general hospital staff held negative attitudes and perceptions towards individuals who self-harmed. Artis and Smith (2013) used interviews with 10 staff members from one emergency department and found that when staff perceived people who self-harmed to have no 'story' about why they self-harmed, they felt frustrated and thought attending to these patients took time away from 'genuine' patients. Heyward-Chaplin, Sheperd, Arya and O'Boyle (2018) conducted a recent study in a UK burns and plastic surgery department and used a questionnaire to examine professionals' attitudes towards people who presented with self-harm and staff adherence to NICE guidance. Results from 59 completed questionnaires indicated that most staff held positive attitudes and compassion towards people who self-harmed, however a small but significant minority of staff reported negative attitudes and said that they found it difficult to be compassionate. The researchers also found that patients who self-harmed were less likely to be offered surgery than patients with similar but accidental injuries.

The negative attitudes expressed by staff are also experienced by individuals who attend A&E. Taylor, Hawton, Fortune and Kapur (2009) conducted a review on the attitudes towards services among people who self-harmed and found that poor communication and a perceived lack of knowledge about self-harm were common

themes. Arnold (1995) conducted surveys with women who attended A&E for self-harm, who reported negative experiences with staff and said they would be reluctant to seek support following their experiences. When also forced to attend A&E services, some people reported feeling ashamed and unworthy, which was reinforced by punitive care (Owens, Hansford, Sharkey & Ford, 2016). Interactions such as these may likely lead to a cycle of shame, avoidance and further self-harm.

Despite much of the research highlighting negative staff attitudes, positive attitudes towards people who self-harm have also been reported. Koning, McNaught and Tuffin (2017) used semi-structured interviews with 15 emergency department staff and reported that staff held mostly positive attitudes towards patients that self-harmed, however frustrations were related to the perception that the system was failing those patients who sought help, and the staff did not feel that they had sufficient knowledge or skills about how to help people who self-harmed. Cleaver (2014) conducted a review of studies exploring emergency care staff attitudes towards young people who self-harmed and concluded that the service setting, patient characteristics and educational training all influenced staff attitudes. O'Connor and Glover (2017) conducted a meta-synthesis of nine qualitative studies exploring inpatient staff experiences of people who self-harmed and found that systemic factors were influential in inhibiting or facilitating the relational process of staff working with people who self-harmed.

It appears that several factors influence staff attitudes towards young people who self-harm. Other factors which have been found to be associated with positive staff attitudes and greater knowledge towards people who self-harm are perceived effectiveness of care, previous training experience, higher academic qualifications and decreased age of staff (Carter, Latif, Callaghan & Manning, 2018).

Staff Training and Service Context

Staff understanding and levels of knowledge about self-harm are important factors in determining how they perceive and respond to self-harm (McHale & Felton, 2010). Crawford, Geraghty, Street and Simonoff (2003) used questionnaire surveys with 126 health professionals and found that if staff felt clinically effective, they felt less negative towards young people who self-harmed. Accordingly, staff training is often

recommended as an outcome from studies exploring staff attitudes and is requested by staff who report feeling unprepared for treating self-harm. In a recent study, Thomas (2017) interviewed nurses with experience of working with young people who self-harmed and found that the nurses felt their current mental health training was inadequate and they would benefit from empathy and attitudes-based training. Moreover, Kumar and colleagues (2016) surveyed 773 general hospital staff in India and found great statistical variation in staff attitudes and knowledge about self-harm and indicated an urgent need for staff training.

Mental health staff have more specialised education and training on mental health issues and may hold more favourable opinions towards people who self-harm compared with medical staff (Patterson, Whittington & Bogg, 2007). Timson, Priest and Clark-Carter (2012) used two self-report questionnaires to measure perceived knowledge and attitudes towards self-harm with staff from Child and Adolescent Mental Health Services (CAMHS), A&E and school. The researchers found a significant negative relationship between staff knowledge and staff negativity among all three groups of professionals, and concluded that as staff knowledge increased, negative attitudes decreased**.** Furthermore, the researchers found significant differences between A&E staff, CAMHS staff and teachers, with CAMHS staff demonstrating a more positive attitude overall and more knowledge than the other two groups. Moreover, Saunders, Hawton, Fortune and Farrell (2012) found that mental health staff in community and hospital settings displayed greater positive attitudes than general hospital staff towards people who self-harmed. The researchers found that frustration, anger and a sense of helplessness were more common among doctors than nursing staff, however this was only true of general hospital staff.

Despite the varied levels of understanding between staff within different contexts, there is less research exploring community mental health staff attitudes and beliefs about self-harm in comparison to emergency department staff (Saunders, Hawton, Fortune & Farrell, 2012).

Q-Methodology

Q-methodology has been recommended by NICE (2004) as an appropriate method to explore perspectives on self-harm. To date, there have been no published studies exploring CAMHS staff beliefs about self-harm using Q-methodology. One study used Q-methodology to explore the perceptions of the general public on self-harm and related this to clinical practice (Rayner & Warner, 2003). The study showed that Q-methodology was a helpful method to generate accounts about self-harm in a less threatening manner. A second Q-study was conducted in a secure unit and explored the beliefs held by staff towards women with learning disabilities (James & Warner, 2005). The researchers developed six distinct accounts of why self-harm occurs. Finally, one Q-study has explored community staff beliefs about why people with learning disabilities self-harm (Dick, Gleeson, Johnstone & Weston, 2010). The researchers identified five viewpoints on why staff believe people with learning disabilities self-harm, which highlights the complexity of the issue.

Study Aims and Rationale

Staff beliefs about self-harm can influence their attitudes towards the people who self-harm and possibly their response to the behaviour. To promote better care and engagement, it is vital to explore the knowledge and understanding of self-harm held by staff working with young people.

This study aims to use Q-methodology to explore staff beliefs about self-harm in young people engaged with CAMHS. CAMHS was chosen for this study as the variety of professionals working within this setting, all of whom may be in contact with people who self-harm, will provide a range of viewpoints ideal for Q-methodological studies. Moreover, staff beliefs have been explored in previous literature, however this has often been conducted in emergency departments. Research investigating community mental health staff beliefs will also be beneficial to explore the views about self-harm in these settings.

Method

Approvals

The study has received ethical approval from the Staffordshire University Ethics Committee (see Appendix A), in addition to NHS ethical approval from the Health Research Authority (see Appendix B). Local approval was also sought from two NHS Trusts in the UK (see Appendix C and D).

Q-Methodology: The Inverted Factor Technique

Developed by Stephenson (1935), Q-methodology was originally established as an adaptation of traditional factor analysis. In Q-methodology, an 'inverted' factor technique is used, whereby the participants become the test variables and the test items become the sample population (Stephenson, 1935; Watts & Stenner, 2005). The test items used in Q-methodology often take the form of statements which are derived from a wide range of sources and are selected to represent the existing views on a topic (Stainton Rogers 1995). The aim of Q-methodology is to search for patterns in the data, based on how participants have ranked statements, that reflect different understandings of the topic being investigated (Stephenson, 1953).

Materials

The set of statements selected in Q-methodology is known as the Q-set. The number of statements in a Q-set can vary, however should contain items that provide good coverage in relation to the research area and be broadly representative of the existing opinions on the topic under investigation (Watts & Stenner, 2012). The size of the final set of statements to an extent is dictated by the subject matter, however a Q-set of 40 to 80 items is often recommended (Curt, 1994; Stainton Rogers, 1995).

Statements about self-harm were generated from searching the existing research literature, news articles, blogs, magazines, television programmes and informal discussions with mental health staff. Statements were compiled until saturation. Following this, the statements were checked for duplication or paraphrased statements; these statements were subsequently removed. The remaining statements

were then examined to ensure balance across themes was met. For example, there was an approximately equal number of statements on interpersonal and intrapersonal reasons why young people may self-harm. The list of statements was randomised then re-reviewed by the researcher and piloted by two Clinical Psychologists with experience of working with young people who self-harm. This was to ensure balance, coverage, readability and clarity. The final Q-set contained 65 statements (see Appendix I).

Participants

In Q-methodology, it is the statements rather than the participants that make up a representative sample (Watts & Stenner, 2005). A large number of participants is therefore not required in Q-methodology studies (McKeown & Thomas, 1988). Furthermore, participants are not randomly sampled but instead are selected to be representative of the target population (Kitzinger, 1995).

Inclusion criteria for the study was any CAMHS staff member over 18 years old with clinical contact with young people. A combination of strategic and snowball sampling was employed, whereby a broad range of professionals representative of the diverse CAMHS workforce were sought. The study was advertised via an email sent to managers of all CAMHS teams across two NHS Trusts (see Appendix E), along with an information sheet providing more details about the study (see Appendix G). Managers were asked to disseminate the email to their respective teams and participants who were interested in taking part were able to contact the researcher via email. The researcher also arranged to visit some teams to discuss the study and provided the team with contact information if they wished to take part. Informed consent was obtained from all participants prior to taking part in the study (see Appendix F).

In total, 25 staff members were recruited. The study sample consisted of a range of healthcare professions, including nurses, social workers, support workers, psychiatrists, psychologists, play and parenting practitioners and systemic family therapists.

Condition of Instruction

Q-methodology involves participants sorting statements by placing them onto a response matrix known as a 'Q-grid', which contains a pre-determined number of rows and columns such that it resembles the shape of a quasi-normal distribution. Participants place the statements onto this grid under a particular 'condition of instruction'; for example, ordering statements based on how much they agree or disagree with them. The condition of instruction, paired with the shape of the grid, renders the task of sorting the statements more manageable whilst also tasking participants to consider each statement in relation to another (McKeown & Thomas 1988). The completed grid with all statements placed is known as a participants' Q-sort (Stainton Rogers, 1995).

For studies containing over 60 items, a Q-grid using a 13-point scale, that is, 13 columns, is recommended (Brown, 1980). The Q-grid used in this study therefore contained 13 columns, ranging from most disagree (-6) to most agree (+6) (see Appendix J). Each column was given a selected number of rows to reflect a quasi-normal distribution (see Table 1). The number of rows was determined based on the assumption that CAMHS staff would have some pre-existing knowledge on why young people self-harm, however still allowed for less experienced staff, or staff who were more uncertain about self-harm to be able to complete the Q-sort.

Rank	-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
Number of statements	2	3	4	5	6	8	9	8	6	5	4	3	2

Table 1. Rank ordering of statements

Each statement was printed onto a 5cm x 3cm card and the deck was shuffled before being given to each participant. A standard set of instructions was provided to each participant (see Appendix H). Participants were asked to read each statement and broadly divide them into three separate piles; statements they agree, disagree or were neutral with. Participants were then asked to begin with the 'agree' pile and place these cards onto the Q-grid, with the statements they agree most with on the right-most side the grid. This was then repeated for the statements in the 'disagree' pile, with the

statements they disagree most with on the left-most side. The remaining 'neutral' cards were then sorted into the remaining spaces. Following this, participants were invited to talk about their completed Q-sorts and comment on their experience of completing it. The information gathered was used to supplement the analysis when interpreting factors from the data. The time taken to complete the Q-sort ranged between 30 and 45 minutes.

Analysis

In Q-methodology, the Q-sorts are factor analysed for interpretation and Q-sorts which are highly correlated will cluster and emerge as factors. These factors are extracted and then subject to varimax rotation. Participants with similar accounts or Q-sorts will 'load' onto the same factors, whilst Q-sorts with low correlations will usually load onto different factors (James & Warner, 2005). From the factors identified, high loading Q-sorts are merged to form composite Q-sorts or factor arrays. These factor arrays are then subject to interpretation, in terms of existing accounts, theories and information gathered during the Q-sorting process.

The 25 completed Q-sorts were factor analysed using Ken-Q, a statistical software package developed for Q-methodology studies (Banasick, 2016). The data was then interpreted following guidelines from Brown (1980) and Watts and Stenner (2012).

Reflexivity

The main author is a 27-year-old British-Pakistani male. Prior to Clinical Psychology training the main author worked in a Personality Disorder Service, supporting young people and adults who self-harmed. This led to an interest in researching staff beliefs about self-harm. The main author believes that a constructivist position is important to hold, particularly when studying a subjective concept such as the function of self-harm. The main author completed the Q-sort prior to data collection to bring an awareness of their own biases when analysing and interpreting the data.

Results

Correlations

Pairwise correlations were used to examine the relationships between the 25 Q-sorts (see Appendix K). A significant correlation was calculated to be $r \geq .24$ ($p<.05$) using the formula 2.58 x [1/√n statements] (Brown, 1980).

The majority of participants' Q-sorts strongly intercorrelated, indicating similarities in their viewpoints. One participant's Q-sort did not significantly correlate with three other Q-sorts, suggesting that one individual held different views about self-harm compared with three others. This was explored further when interpreting factors.

Data Analysis

Centroid factor analysis was used to explore the potential number of factors within the data set. Seven factors were initially produced following guidelines from Brown (1980).

Only one factor produced an eigen value above 1, suggesting a one-factor model using the Kaiser-Guttman criterion (Guttman, 1954; Kaiser, 1960; 1970). However, minority views risk being overlooked through application of an arbitrary cut-off, therefore an alternative check was applied to determine the final number of factors to ensure minority views were not missed. Brown (1980) suggests that factors that contain two or more significantly loading Q-sorts should be extracted. The formula from Brown (1980) was used to determine significant loading at the $p<.01$ level (2.58 x [1/√n statements] = ±.32). This suggested that a two-factor model was supported.

Varimax rotation was then applied to factors 1 and 2 to maximise the differences between the factors This two-factor solution explained 64% of the variance and can be considered a successful model, which should explain at least 35-40% of variance (Watts & Stenner, 2012). All significantly loading Q-sorts within each factor were then used to create each factor array (see Appendix M). Factors were then interpreted using a crib sheet to explore items consistently within each factor and ensure a holistic inspection of patterns within each account (see Appendix L for all data outputs).

Consensus Statements

Many statements were homogenous throughout both factors, with no statistically significant difference between rankings ($p>.05$). A summarised account of this consensus is presented below, with the statement number appearing first in parentheses, followed by the rank within each factor, where +6 indicates most agreement and -6 indicates most disagreement. All statements can be seen in Appendix I.

Participants believed that self-harm was used by young people as a means of coping with difficult emotions (1. F1: +5, F2: +6) and to provide a sense of relief (23. F1: +5, F2: +4). Participants also believed that young people who self-harm experience their emotions as intense (53. F1: +4, F2: +4) and may find it easier to deal with physical pain instead of emotional pain (40. F1: +4, F2: +3). In addition to coping with difficult emotions, participants believed self-harm was used to block out painful memories (11. F1: +3, F2: +4). Participants also identified that young people may self-harm because they feel powerless (5. F1: +2, F2: +2) and viewed self-harm as a means of providing a sense of control (30. F1: +4, F2: +5). Self-harm was also considered a method of communication or expression (64. F1: +4, F2: +5).

Participants did not believe that young people self-harm out of boredom (39. F1: -5, F2: -3) or as a means of recreation (17. F1: -6, F2: -5) or enjoyment (12. F1: -3, F2: -4). Participants also did not believe that self-harm was used as a way of challenging mental health professionals (6. F1: -4, F2: -3). Participants also disagreed that self-harm occurred because young people had not been punished enough for it (48. F1: -3, F2: -4). Despite the reported increase in rates of self-harm, participants did not believe that self-harm occurred due to its prominence or ‘popularity’ (29. F1: -3, F2: -3). Participants also did not agree that self-harm was caused by young people being part of an ‘emo’ or ‘goth’ sub-culture (36. F1: -4, F2: -4), or as a method to fit in with friends (57. F1: -2, F2: -1).

Beyond this consensus, two distinct viewpoints were identified by participants and are presented below. Statements which were placed significantly differently ($p<.01$) and discriminate each factor are identified with an asterisk next to their rank number.

Factor 1: Self-harm is a private experience used for coping

This factor explained 35% of the variance and represented the viewpoint of 14 diverse participants. Within this group there were assistant, trainee, clinical and counselling psychologists, a systemic family therapist, a play therapist, a support worker and a social worker.

In addition to the consensus statements, this viewpoint represented participants who believed that young people self-harm to cope with distressing thoughts (54. +6) and release emotional tension (49. +6). Many participants drew on clinical experience when completing the Q-sort, with one participant stating, “I’ve heard emotional pain a lot, that seems to always be a reason.” Self-harm was considered a method of gaining immediate relief (61. +5*) and helping young people feel better (60. +3*).

Participants within this viewpoint believed that self-harm served the function of protecting young people from acting on suicidal feelings (44. +3*) and did not occur because young people want to end their life (26. -4*). In response to statement 26, one participant stated, “people say it’s the complete opposite of that, it’s to stay alive.”

In comparison to Factor 2, participants within this account believed more so that self-harm made young people feel alive (20. +1*). One participant remarked that self-harm “brings a connection to the body” whilst another stated that “cutting reminds them that they are real, when they feel the pain.”

Participants within this viewpoint most disagreed with the suggestion that young people self-harm because they are manipulative (21. -6*) and wanted to make other people upset (63. -5) or keep others close (18. -1*). One participant stated that young people self-harm to “take the pain away from others and onto themselves”, suggesting that self-harm was an act of protecting others. Participants were also more neutral towards self-harm occurring because young people are ignored (59. 0*). Participants also did not believe young people self-harm to gain attention (10. -3*) or be rebellious (4. -4). One participant stated, “they often don’t tell anyone they’ve done it, it’s a solitary thing, a private experience.”

Factor 2: Self-harm seeks connection with others

This factor explained 29% of the variance and represented the viewpoint of 11 diverse participants. Within this group there were psychiatrists, clinical psychologists, nurses, parenting practitioners and a social worker.

In addition to the consensus statements, this viewpoint represented participants who believed young people self-harm as a distraction (25. +3*) and because they do not know alternative coping strategies (34. +3) and are impulsive (50. +1*). They also believed that young people self-harm because of social pressures (65. +2*). One participant stated, “they want to feel emotionally connected with friends, sharing their feelings and stress”, whilst another stated, “you do get some copy-catting.”

Participants within this account disagreed that young people self-harm because they have a mental illness (27. -2*). One participant stated, “there’s a rationale behind what they do, it can’t be explained away by a diagnosis or label.” Participants also did not believe that self-harm was addictive (47. -4*). One participant instead stated that self-harm was “perhaps habitual.” Participants also did not believe that self-harm occurred because young people have a raised pain threshold and cannot feel the pain (19. -6*). They also rejected biological reasons such as self-harm resulting from hormonal changes or puberty (13. -3*), or a chemical imbalance in the brain (31. -5*). During the post-sort interview, some participants expressed uncertainty about this and wondered about the existing evidence base for biological theories of self-harm. One participant stated, “I don’t know about the research, is there any?” whilst another stated, “I don’t know about hormonal changes, I’ll look that up.”

In comparison to Factor 1, participants were neutral about whether the function of self-harm was to elicit attention from others (10. 0*), however believed more so that self-harm helps young people get their needs met from others (7. +1*) and keeps other people close (18. 0*). One participant stated, “I think they’re trying to elicit some help, but don’t know how.” Despite this, participants rejected the idea that self-harm was done to make others run around after them (51. -6). One participant stated, “young people may feel so neglected or ignored, they may begin to notice that it brings people to them, maybe after doing it secretly for a while first.”

Discussion

The aim of this study was to use Q-methodology to explore CAMHS staff beliefs about self-harm in young people. Two distinct viewpoints were identified from 25 Q-sorts, completed by staff from a range of diverse professions. Many staff related back to their clinical experience when completing the Q-sort, suggesting that their beliefs were shaped by their experiences of working with young people.

Account 1: Self-harm is a private experience used for coping

Overall, staff within this account tended to identify intrapersonal motives as the function of self-harm. Staff within this account viewed self-harm primarily as a method used by young people to cope with distressing thoughts and feelings. Staff believed that self-harm was used to help young people feel better and gain relief from their experiences. These viewpoints are consistent with existing literature that proposes that self-harm is used primarily for affect regulation (Klonsky, 2007). Staff also strongly believed that self-harm was a protective factor against suicide, and young people did not self-harm with suicidal intent. These views again are in-line with research that indicates that self-harm may protect against suicidal feelings (Klonsky & Muehlenkamp, 2007).

Staff within this account rejected the suggestion that young people self-harm because they are manipulative or rebellious. Staff believed that self-harm was a private act often conducted in secret. This belief is supported by research that suggests that young people are reluctant to disclose their self-harm (Klineberg, Kelly, Stansfeld & Bhui, 2013).

Account 2: Self-harm seeks connection with others

Staff within this account tended to view interpersonal motives as the function of self-harm, for example getting needs met from others or keeping people close. Some staff believed that self-harm was a method of feeling connected to others and sharing their emotional experience. These findings are in-line with research which suggests that

self-harm is used to elicit care or to bond with others (Allen, 1995; Klonsky & Muehlenkamp, 2007).

Staff disagreed with the negative connotations commonly associated with these interpersonal motives, for example, disagreeing that self-harm was 'to make other people run around after them'. Notably, however, staff within this account were neutral towards the concept of self-harm as an attention seeking act.

Staff from this perspective believed that self-harm was used by young people as a distraction but was not addictive, but rather habitual, as they may not know other coping strategies. Staff also did not believe that any diagnosis was a suitable explanation for self-harm. Staff rejected the suggestion that self-harm occurred because young people cannot feel pain or had chemical imbalances in the brain. Other biological explanations for self-harm such as hormonal changes were also rejected by staff within this group. This may reflect the medical knowledge of some of the staff within this group, or the uncertainty of some staff who were unsure about any biological theories or evidence around self-harm.

Participant Consensus

There was agreement across all staff that self-harm was used to gain relief from intense emotions and painful memories. Staff believed that young people may find it easier to cope with the physical pain than to experience emotional pain. Staff also believed that young people may feel powerless and self-harm may provide them with a means of control in their lives. Overall, staff believed that there was no single explanation for a young person's self-harm. Staff believed that the function of self-harm varied from person to person and was greatly affected by an individual's circumstances, which is in-line with NICE guidance (2004).

Most staff did not believe that young people self-harm because they enjoyed it. Self-harm was also not viewed as a method of challenging mental health professionals. Although research suggests that rates of self-harm are rising (Morgan et al., 2017), staff did not belief that young people self-harmed because it was 'popular' or to fit in with friends.

Participant Experience of the Q-Sort Process

Q-methodology allowed for staff to examine and explain their views on why young people self-harm. After completing the Q-sort process, one participant stated, “that was really interesting, a great way to do it”, whilst another participant stated, “it really does make you think, like where to put statements relative to each other.” Most staff reported finding it easier to identify statements they agreed with, however found it more difficult to rank statements they disagreed with. Some staff reported that this difficulty was due them disagreeing strongly with several statements, though needing to adhere to the Q-grid arrangement. Some staff also reported that they found it easier to sort statements that were specific such as ‘young people self-harm as a distraction’ and found it more difficult to sort general statements such as ‘young people self-harm to cope with difficulties at home.’

Clinical Implications

This study used Q-methodology with CAMHS staff to explore their beliefs about self-harm. The findings indicated that staff within CAMHS appear to hold accurate and evidence-based knowledge about self-harm.

In comparison to previous Q-studies which found five (Dick, Gleeson, Johnstone & Weston, 2010) and six (James & Warner, 2005) accounts held by staff about self-harm in people with learning disabilities, this study found two distinct viewpoints held by staff. This may reflect less complexity in the beliefs about self-harm in young people compared to people with learning disabilities. Additionally it may demonstrate the shared commonality in beliefs about self-harm held by the different professions working within CAMHS.

The consensus viewpoints held by staff highlighted that most staff did not believe self-harm was an act to challenge mental health professionals, but rather was related to having some form of control. This identified need for control may be related to the belief that young people may feel powerless. This might suggest that interventions for self-harm could implement methods to strengthen young people’s autonomy and provide them with more control within their lives. For instance, working collaboratively with the young person and involving them in decisions about their care.

Staff within one account exhibited some uncertainty around biological theories for self-harm. Future training could provide staff with the existing evidence base for such explanations. Clinical Psychologists within teams would be in a position to offer training to staff regarding existing theories for self-harm and address any misconceptions or uncertainty held by staff.

Some staff also believed that self-harm was a habitual process and young people were not necessarily addicted to self-harming. This may also relate to the belief held by staff that young people need alternative strategies to cope with their emotions. Accordingly, it would be beneficial for staff to be equipped with knowledge regarding alternative strategies for self-harm. For example, those highlighted in interventions such as Dialectical Behaviour Therapy (DBT; Linehan, 1993).

Staff trained in DBT could utilise relevant modules of this approach such as emotion regulation and distress tolerance to support young people with self-harm. Clinical Psychologists within services could play a key role in disseminating this knowledge to staff groups through tailored training or 'DBT skills' workshops. Clinical Psychologists within CAMHS could also provide support and consultation to staff members within teams and alternative staff groups such as school and social care.

Both viewpoints held by staff are supported by the existing research on the functions of self-harm. Staff within CAMHS appear aware that the reasons for self-harm are unique and personal for each individual. This may indicate that the knowledge from tailored training about self-harm is successfully retained by staff within CAMHS. Future training should also ensure that staff explore the functions of self-harm for each young person they work with and not assume a particular function for their self-harm. CAMHS staff who are aware of the variety of possible functions of self-harm are also in a position to support parents of young people who self-harm who may often present to services with misconceptions about the behaviour.

Limitations

Despite the rigorous process of generating the Q-set, this study is unlikely to have identified all of the reasons why young people self-harm. For instance, the influence of social media was not included in the statements and may not have been sufficiently

covered by broader statements such as ‘young people self-harm to fit in with their friends’ or ‘young people self-harm because they are copying others’. Furthermore, when generating the statements, service users or experts by experience were not consulted which may have led to some viewpoints being overlooked. After completing the study, staff were asked whether they felt their viewpoints were sufficiently covered by their Q-sort. Whilst most staff agreed, some reported that they would have liked to have seen statements regarding the effect of television and music in influencing young people’s self-harm, in addition to parental mental health and cultural reasons for self-harming, such as embracing one’s heritage.

A broader limitation of Q-studies is that participants may only rank the predetermined statements, therefore novel viewpoints are unlikely to arise without further exploration with participants. Moreover, some staff reported difficulties in ranking statements they disagreed with when adhering to the Q-grid arrangement. The forced-choice nature of Q-sorts can also be a limitation of Q-studies, as not all views may be accurately portrayed.

Staff also completed the Q-sort in the researcher’s presence to allow for further discussion around particular statements and their placement. Although participants were reassured that their responses were anonymous, the researcher’s presence may have led to some biased responding, whereby participants may have felt less open to agree with pejorative statements around self-harm. Moreover, CAMHS staff will have likely received training on self-harm and therefore some may have felt obliged to state views consistent with their training rather than their actual beliefs.

Other limitations that warrant consideration are that the emerging themes were not checked with participants, and the Q-sorts were not repeated to check for reliability of viewpoints. Demographic information was also not collected from participants which would have been useful when interpreting the factors. Information such as age, gender and length of time in CAMHS would have helped provide further context when interpreting the factors.

Future Research

Future studies could aim to mitigate the effects of the limitations of this study, for instance by using focus groups with service users or experts in the area to ensure all views around self-harm are sufficiently covered. Furthermore, Q-sorts could be completed online to further anonymise participants' viewpoints and compare these findings to those obtained when a researcher is present. It would also be useful to seek feedback on the viewpoints described in this study from young people who self-harm.

Further research could utilise Q-methodology with other populations such as parents, young people, or alternative groups such as teachers. The inherent limitations of Q-studies could also be minimised, such as using a less restrictive Q-grid and ensuring all viewpoints are captured using a structured post-sort interview.

An interesting use of Q-methodology would also be to implement the Q-sorting process in staff training (Rayner & Warner, 2003). Staff could complete their own Q-sorts to explore their current understanding of self-harm and how this may change over time.

Beyond Q-methodology, interviews or focus groups could be used to explore how staff respond to self-harm, and whether this is moderated by their beliefs. For instance, exploring whether different approaches are taken by staff if they believe a young person's self-harm is for intrapersonal or interpersonal reasons.

Conclusion

To date, this is the first study to use Q-methodology to explore beliefs about self-harm with CAMHS staff. This was important to investigate, as previous research indicated that staff beliefs about self-harm can influence their attitudes towards individuals who self-harm. These implicitly or explicitly expressed attitudes may be recognised by young people, which may subsequently lead to feelings of shame and further self-harm.

Overall, this study demonstrated that CAMHS staff beliefs about self-harm are consistent with the existing literature regarding the functions of self-harm. Although these findings are not generalisable to all CAMHS staff, the beliefs expressed by staff in this study are a useful indicator of how staff understand self-harm in young people.

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Appendices

Appendix A – University Ethical Approval

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Arsal Rana
Title of Study	Why do young people self-harm? A Q Methodology Study exploring staff beliefs
Award Pathway	DClinPsy
Status of approval:	**Approved**

Action now needed:

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is Professor Nachi Chockalingam, N.Chockalingam@staffs.ac.uk .

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the IPR coordinator (Dr Peter Kevern) an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

One reviewer made the following recommendations:

1. This is an interesting and relevant project. I wonder why the researcher has not considered doing an online study however. There is some consideration given in the proposal to the possible influence of social desirability effects on participant's responses or discomfort in admitting to negative beliefs but then an assumption that reassurance of participants will be sufficient to mitigate against this effect. How readily (even if they believe this) will participants admit to more pejorative belief systems around self-harm? I would have also liked more consideration given to how you capture what people truly believe versus what they think is the correct thing to say. This seems particularly relevant to CAMHS professionals who often deliver training on self-harm, will have had positions shared about why people self-harm (often with an emphasis that this is *not* about attention-seeking), so even if they believe such things how do you capture views that are less easy to consciously acknowledge or may depart from dominant narratives within that organisational culture? The researcher may wish to consider possibly using an

online and face-to-face sample to compare the influence of methodology on the findings.

2. A difficulty with the theoretical aspect of the study for me is that there is reference made to particular beliefs having implications for responses to self-harm but how will the researcher be able to establish what are helpful/less helpful attitudes that may lead to pejorative practice (which I presume is the concern)? For instance, a belief that a young person self-harms for attention could actually be an accurate one depending on how attention is defined. It will depend on the valence given to this. Would it be possible to broaden out the study to consider beliefs about how to respond to self-harm too?

3. No reference is made in the information sheet to the findings being written up in a thesis. Will there also be further planned dissemination in terms of conferences, training or feedback to teams? This should be added to the information sheet if that is the case.

4. The consent form should typically contain a prompt above the tick boxes for participants to initial their consent for each item (not just tick the box)

I have approved the project but would recommend the researcher considers points 1 and 2 in particular, even if this is to have a robust defence and consideration of the limitations of their design when this is evaluated later at viva.

Signed: Dr Peter Kevern
University IPR coordinator

Date: 6.7.18

Appendix B – NHS Health Research Authority Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Mr Arsal Rana
Trainee Clinical Psychologist
Midlands Partnership NHS Foundation Trust
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DE

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

15 October 2018

Dear Mr Rana

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Why do young people self-harm? A Q-methodology study exploring staff beliefs**
IRAS project ID:	**236749**
Sponsor	**Staffordshire University**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?

You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light'

email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

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

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

IRAS project ID	236749

The sponsor contact for this application is as follows:

Name: Dr Helen Combes
Tel: 01782 295803
Email: h.a.combes@staffs.ac.uk

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **236749**. Please quote this on all correspondence.

Yours sincerely

Juliana Araujo
Assessor
Email: hra.approval@nhs.net

Copy to: *Sponsor Representative: Dr Helen Combes, Staffordshire University*
Lead NHS R&D Office Representative: Mrs Audrey Bright, Midlands Partnership NHS Foundation Trust

IRAS project ID	236749

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity insurance letter]	1	14 July 2017
HRA Schedule of Events [Schedule of Events Validated]	1	04 September 2018
HRA Statement of Activities [Statement of Activites Validated]	4.4	04 September 2018
Interview schedules or topic guides for participants [Q sort statments]	1	31 August 2018
IRAS Application Form [IRAS_Form_03092018]		03 September 2018
Letters of invitation to participant [Letter of invitation]	1	14 July 2018
Participant consent form [Consent form]	3	31 August 2018
Participant information sheet (PIS) [Participant information sheet (PIS)]	5.0	13 October 2018
Referee's report or other scientific critique report [IPR report 1]	1	05 July 2018
Referee's report or other scientific critique report [IPR report 2]	1	29 June 2018
Referee's report or other scientific critique report [University Ethical Approval Letter]	1	06 July 2018
Research protocol or project proposal [IPR form with Trust Signitures]	2. Please note date on top document (erroneously)	21 June 2018
Research protocol or project proposal [IPR form with Trust Signitures]	2. Please note date on top document (erroneously)	21 June 2018
Summary CV for Chief Investigator (CI) [Researcher CV]	1	14 July 2018
Summary CV for supervisor (student research) [Supervisor CV]	1	25 November 2016

IRAS project ID	236749

Summary of assessment

The following information provides assurance to you, the sponsor and the NHS in England and Wales that the study, as assessed for HRA and HCRW Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England and Wales to assist in assessing, arranging and confirming capacity and capability.

Assessment criteria

Section	Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will form the agreement between the sponsor and the participating NHS organisations. The Schedule of Events was submitted.
4.2	Insurance/indemnity arrangements assessed	Yes	No comments
4.3	Financial arrangements assessed	Yes	No application for external funding will be made for this study.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the	Not Applicable	No comments

Section	Assessment Criteria	Compliant with Standards	Comments
	Clinical Trials Regulations assessed		
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Not Applicable	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England and Wales

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.
This is a multi-site study undertaking the same research activities; there is therefore one site type. The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England and Wales in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. Where applicable, the local LCRN contact should also be copied into this correspondence. If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England and Wales which are not provided in IRAS, the HRA or HCRW websites, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net or HCRW at Research-permissions@wales.nhs.uk. We will work with these organisations to achieve a consistent

approach to information provision.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and Wales, and the minimum expectations for education, training and experience that PIs should meet (where applicable).
As per the Statement of Activities a Local Collaborators will be in place at each participating NHS organisation. No assistance to identify potential Local Collaborators will be required from the participating NHS organisations. GCP training is not a generic training expectation, in line with the HRA/HCRW/MHRA statement on training expectations.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken
HR Good Practice Resource Pack requirements are not applicable. No research activities will be undertaken in areas where healthcare is delivered.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales to aid study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix C – NSCHT Letter of Access

North Staffordshire Combined Healthcare NHS
NHS Trust

RESEARCH AND DEVELOPMENT DEPARTMENT
Management Suite, Harplands Hospital
Hilton Road, Harpfields, Stoke-on-Trent, ST4 6TH
Telephone 0300 123 1535 ext 4687
Fax 01782 441637
Email r&d@combined.nhs.uk
Follow us on twitter @nschtresearch

11 January 2019

Researcher:
Mr Arsal Rana
c/o St George's Hospital
Corporation Street
Stafford
ST16 3SR

Dear Mr Rana

Letter of Access for non-NHS Researchers

This *Letter of Access for Non-NHS Researchers* has been issued by North Staffordshire Combined Healthcare NHS Trust, Research and Development Department, and we can confirm that we have undertaken the relevant pre-engagement checks in accordance with the NIHR *"Research Passport and Streamlined Human Resources Arrangements" (September 2012)*[1] enabling you to undertake research related activity at this organisation.

Research Reference Numbers:	R&D Ref.:	CHC0173/RS
	IRAS ID.:	236749
	UKCRN ID.:	N/A
	REC Ref.:	N/A
	Protocol Version.:	1.0, 21/06/2018
Research Title:	Why do young people self-harm? A Q-methodology study exploring staff beliefs	
Date Research Ends:	30/04/2019	
Date Letter of Access Expires:	30/04/2019	
Local Research Manager:	Kerri Mason	
Research Activity:	Taking informed consent and conducting study interview with staff participants	

This letter should be presented before you commence your research at this organisation.

[1] www.nihr.ac.uk/policy-and-standards/research-passports.htm
[2] **Arsal Rana's current NHS Proforma will expire on 19/09/2019.** The issue of this Letter of Access is therefore conditional on the validation of a new NHS Proforma undertaken on or before this date.
[3] HRA Approval (15/10/2018) / NHS Confirmation of Capacity and Capability (11/01/2019)
[4] www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

In accepting this letter, this confirms your right of access to conduct research through our organisation for the purpose and on the terms and conditions set out below. This right of access commences from the date of this letter and ends on **30/04/2019**[2] unless terminated earlier in accordance with the clauses below:

1. You have a right of access to conduct such research as confirmed by North Staffordshire Combined Healthcare NHS Trust, Research and Development Department.

   Please note that you cannot start the research until the Chief Investigator has received a letter of HRA Approval from the Health Research Authority and the Principal Investigator has received NHS Confirmation of Capacity and Capability from North Staffordshire Combined Healthcare NHS Trust, Research and Development Department confirming the conduct[3] of the research study identified above.

2. The information supplied about your role in research at this organisation has been reviewed and you do not require an honorary research contract. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.

3. You are considered to be a legal visitor to the organisations premises. You are not entitled to any form of payment or access to other benefits provided by this organisation or this organisation to employees and this letter does not give rise to any other relationship between you and this organisation, in particular that of an employee.

4. While undertaking research through this organisation you will remain accountable to your substantive employer, but you are required to follow the reasonable instructions of this organisation or those instructions given on their behalf in relation to the terms of this right of access.

   4.1. To clarify any specific governance requirements at this organisation you must contact the Local Research Manager named above directly.

5. Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

6. You must act in accordance with this organisations policies and procedures, which are available to you upon request, and the UK Policy Framework for Research[4].

7. You are required to co-operate with this organisation in discharging its duties under the Health and Safety at Work Act 1974, and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on this organisations premises. You

[1] www.nihr.ac.uk/policy-and-standards/research-passports.htm
[2] **Arsal Rana's current NHS Proforma will expire on 19/09/2019.** The issue of this Letter of Access is therefore conditional on the validation of a new NHS Proforma undertaken on or before this date.
[3] HRA Approval (15/10/2018) / NHS Confirmation of Capacity and Capability (11/01/2019)
[4] www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

8. If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer, and this organisation prior to commencing your research role.

9. You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

   Please note researchers are not permitted any access to personal identifiable information without the prior informed consent of patients/research participants.

10. You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on this organisations premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this organisation does not accept responsibility for damage to or loss of personal property.

11. This organisation may revoke this letter and/or terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

12. Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

13. No organisation will indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

14. If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal

[1] www.nihr.ac.uk/policy-and-standards/research-passports.htm
[2] Arsal Rana's current NHS Proforma will expire on 19/09/2019. The issue of this Letter of Access is therefore conditional on the validation of a new NHS Proforma undertaken on or before this date.
[3] HRA Approval (15/10/2018) / NHS Confirmation of Capacity and Capability (11/01/2019)
[4] www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

procedures. You must also inform your nominated manager/ Local Research Manager as named above directly.

Yours sincerely

Dr Chris Link
R&D Director

Copies:

North Staffordshire Combined Healthcare NHS Trust, HR Directorate:
Alexa Lloyd, HR Advisor, Trust HQ, Bellringer Road, Trentham, Stoke-on-Trent, ST4 8HH

HR Department of Substantive Employer:
Audrey Bright, R&D Office, Midlands Partnership NHS Foundation Trust

[1] www.nihr.ac.uk/policy-and-standards/research-passports.htm
[2] **Arsal Rana's current NHS Proforma will expire on 19/09/2019.** The issue of this Letter of Access is therefore conditional on the validation of a new NHS Proforma undertaken on or before this date.
[3] HRA Approval (15/10/2018) / NHS Confirmation of Capacity and Capability (11/01/2019)
[4] www.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research/

Appendix D – MPFT Confirmation of Capacity and Capability

NHS
Midlands Partnership
NHS Foundation Trust
A Keele University Teaching Trust

NHS
Health Research Authority

From: Midlands Partnership NHS Foundation Trust

To: Arsal Rana. Rv020349@student.staffs.ac.uk

Cc:

Subject: Confirmation of Capacity and Capability at **Midlands Partnership NHS Foundation Trust**

Attachment: Agreed statement of activities.

Date: 29 November 2018

Dear Arsal

RE: IRAS No: 236749

Confirmation of Capacity and Capability at Midlands Partnership NHS

Foundation Trust

Full Study Title: Why do young people self-harm? A Q methodology study

This email confirms that **Midlands Partnership NHS Foundation Trust** has the capacity and capability to deliver the above referenced study. Please find attached our agreed Statement of Activities as confirmation.

We agree to start this study on **29 November 2018**, If you wish to discuss further, please do not hesitate to contact me.

Kind regards

Ruth Lambley Burke,

Head of Research and Innovation

Block 7, St George's Hospital, Corporation Street, Stafford ST16 3AG

Cc

Appendix E – Email to Managers

Subject: Research participants required for CAMHS study

Dear [Name]

I am a Trainee Clinical Psychologist completing my doctorate at Staffordshire University. I am currently starting a research project investigating the beliefs held by staff working in CAMHS about why young people self-harm.

I am hoping to recruit a range of participants from various CAMHS teams across the North and South Staffordshire regions and would greatly appreciate if you were able to disseminate this email and information sheet to the [Team Name]. Inclusion criteria for the study is any staff member over 18 years old working with young people in CAMHS (regardless of whether or not the young people they work with self-harm).

I have attached a participant information sheet providing more detail on the rationale for this study, what participation would involve and the possible risks that may arise (and how these have been minimised).

If you or any members of staff have any questions or are interested in taking part in the research, please feel free to email me on [researcher email address].

Many thanks,

Arsal Rana

Trainee Clinical Psychologist

[Contact details]

Appendix F – Consent Form

CONSENT FORM

Title of Project: Why do young people self-harm? A Q-methodology study exploring staff beliefs

Please initial box

1. I confirm that I have read the information sheet for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
4. I understand that notes will be taking during my participation and am aware of how this data will be managed. ☐
5. I understand that I can request to have my data removed from the study up to two weeks after my participation date. ☐
6. I understand that this research is being conducted in partial fulfilment of the requirements of Staffordshire University for the award of Doctorate in Clinical Psychology. ☐
7. I consent that data collected could be used for publication in scientific journals or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes and understand that all data will be presented anonymously. ☐
8. I agree to take part in the above study. ☐

Participant Name (print)	Date	Signature
Researcher Name (print)	Date	Signature

Appendix G – Participant Information Sheet

Participant Information Sheet

Researcher: Arsal Rana (Trainee Clinical Psychologist) | rv020349@student.staffs.ac.uk

Research Supervisor: Dr Helen Combes (Clinical Psychologist) | H.A.Combes@staffs.ac.uk | 01782 295803

Study title

Why do young people self-harm? A Q-methodology study exploring staff beliefs

Brief summary

The aim of this study is to investigate the beliefs held by staff working in Child and Adolescent Mental Health Services (CAMHS) about why young people engage in self-harming behaviours. Exploring why staff think young people self-harm is important, as staff beliefs about self-harm may influence how they respond to it. Q-methodology is a type of research method that is used to explore a variety of viewpoints and subjective understandings on a particular topic.

This research is being conducted in partial fulfilment of the requirements of Staffordshire University for the award of Doctorate in Clinical Psychology. Participants need to be working age adults (over 18 years old), employed in a CAMHS setting.

What is involved

Taking part in the study will involve meeting with the researcher for approximately 30 minutes and completing a "Q-sort". Participants will be given a pile of cards, each containing a statement detailing a different reason why a young person might self-harm (for example, "Young people self-harm to distract themselves from emotional pain"). Participants will then be asked to order these statements by placing the cards on to a grid, which will require making decisions about which statements they agree, disagree or are neutral about in relation to the other statements. Whilst completing this activity, participants will have the opportunity to discuss their choices during the Q-sort with the researcher (although this is not mandatory).

What are the possible benefits of taking part?

The statements generated for the Q-sort will be obtained from the existing research literature and therefore aim to be representative of the variety of existing views on self-harm reasons in young people. Through taking part in the study, some participants may learn about other reasons why young people self-harm that they may not have considered before.

It is hoped that through this research, there will be a greater understanding of the views held by different professionals working in CAMHS on why young people self-harm. This will provide valuable insight into their views on this complex behaviour, whilst also offering recommendations on how best to respond to and manage self-harm in this population.

What are the possible disadvantages and risks of taking part?

1. Participants will be provided with a range of statements on why young people may self-harm. Reading through these statements may cause emotional distress and anxiety in some individuals.
2. Some participants may feel pressured to answer a certain way or may not feel comfortable disclosing their feelings on responses that may be perceived negatively by others (for example, may be uncomfortable agreeing with the statement "young people self-harm because they're manipulative").
3. Participants will have to take time during their work day to complete the study, which may impact on their workload.

How will these risks be managed or reduced?

1. CAMHS staff are likely to be aware of some of the reasons why young people may self-harm. If a participant becomes distressed by the research it will be stopped immediately and they will be offered support. Details of available support is also provided at the bottom of this document.
2. Participants will not be judged based on their responses and should be aware that their responses are anonymous. The researcher being present also allows for participants to elaborate on responses if they wish to do so.
3. A time best suited to participants will be arranged to complete the study. Team managers will also be informed of the time-frame of the study and be made aware that some staff may be participating in the research for this period of time during working hours.

How will my information be kept confidential?

All data will be anonymised and made unidentifiable through the use of randomly generated codes. Participant names and their codes will be kept separate from the data and kept within an encrypted file only accessible by the researcher. Along with the arrangement of statements during the Q-sort, any qualitative feedback offered will be noted down manually by the researcher. These notes will be transferred on to a secure Microsoft Word document and the hand-written notes taken will be destroyed within 24 hours. The encrypted data files will be stored on a dedicated and password protected memory stick and also be saved on the University Cloud Storage system. Electronic data will be kept securely for 10 years, in accordance with university policy, before being deleted.

How will my data be used?

The results will be written up as part of a doctoral thesis project and submitted to a research journal. All data, including any quotes taken from the qualitative data will be anonymous. The final research report will state that the research was conducted in CAMHS teams across NHS Trusts in the West Midlands, however will not go into any further detail. It will also state the different professions that took part in the research but not state specific numbers of each profession. If published, it is aimed that the paper will be disseminated amongst teams in the Children and Young Persons Directorate of North and South Staffordshire Trusts.

What if I don't want to continue with this study?

All participants have the right to withdraw from the study at any time without having to provide a reason. Participants also have the right to request that their data is removed from the study without giving a reason. Please note that this can only be done up to two weeks after the date of participation. Please see General Data Protection Regulation (GDPR) section below for more information.

Further information and contact details

This study has been reviewed and approved by the Faculty of Health Sciences Ethics Committee at Staffordshire University. If you have any further questions or concerns about this study please feel free to contact the researcher or the researchers' supervisor whose contact details are provided at the top of this document.

If you feel distressed by the research or require more general support around self-harm, support is available from the following services. Alternatively, support can also be sought from your GP.

- Samaritans – Call:116 123 or visit https://www.samaritans.org
- SANE – Call: 0300 304 7000 or visit http://www.sane.org.uk/home
- Mind Infoline – Call: 0300 123 3393 or visit https://www.mind.org.uk/information-support/helplines/

General Data Protection Regulation (GDPR)

Staffordshire University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Staffordshire University will keep identifiable information about you for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information http://www.staffs.ac.uk/data-protection/

Midlands Partnership NHS Foundation Trust (MPFT) will collect information from you for this research study in accordance with our instructions.

MPFT will keep your name and contact details confidential and will not pass this information to Staffordshire University. MPFT will use this information as needed, to contact you about the research study, and make sure that relevant information about the study is recorded for your care, and to oversee the quality of the study. Certain individuals from Staffordshire University and regulatory organisations may look at your research records to check the accuracy of the research study. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

Appendix H – Q-sort Instructions

Why Do Young People Self-Harm? A Q-methodology Study

Definitions

For this study the following definitions should be used when completing the Q-sort:

- *Young people:* An individual aged between 13-17 years old
- *Self-harm:* Deliberate injury to oneself, with or without suicidal intent

Q-sort Instructions

You will be given a set of statements (a "Q-Set"), each with a different reason why a young person might self-harm. Your task will be to read through these statements and place them on a grid (the "Q-grid") which reflects how much you agree or disagree with each of these statements.

At any time during the study you are able to discuss the placement of statements (i.e. your "Q-sort") with the researcher - This is entirely optional.

1. Read through each statement in turn and separate them intro three piles; one pile for statements you *generally agree* with, one pile for statements you *generally disagree* with, and a third pile for statements you feel *neutral* about.

2. When you have three separate piles, select the pile which contains statements you generally agree with and begin to place these statements onto the Q-grid; with those statements you agree most with on the rightmost side of the Q-grid. Note that statements in the same *column* of the Q-grid are equally 'weighted'.

3. Repeat this process for the pile of statements you generally disagree with, this time placing those statements you disagree most with on the leftmost side of the Q-grid.

4. Sort through the final pile of statements and place them in the remain spaces of the Q-grid.

5. Once you have filled all of the spaces on the Q-grid you are able to rearrange the statements until you are satisfied with the placement of all statements.

6. When you are finished, the researcher may ask you some questions about how you found the process of sorting the statements or ask about any statements you found particularly meaningful or if you felt any statements were missing. If you would like to, you can discuss the completed Q-sort with the researcher.

Thank you for taking part in the study

Appendix I – Q-set (Statements)

Q-set

1. Young people self-harm to cope with difficult emotions
2. Young people self-harm because they like to experience pain
3. Young people self-harm because it helps them identify with others who self-harm
4. Young people self-harm because they want to be rebellious
5. Young people self-harm because they feel powerless
6. Young people self-harm to challenge mental health professionals
7. Young people self-harm because it gets their needs met from others
8. Young people self-harm because they have learning difficulties
9. Young people self-harm to numb their feelings
10. Young people self-harm for attention
11. Young people self-harm to block out painful memories
12. Young people self-harm because they enjoy it
13. Young people self-harm because of hormonal changes/puberty
14. Young people self-harm to get admitted to hospital
15. Young people self-harm to punish themselves
16. Young people self-harm because they are immature
17. Young people self-harm for fun or recreation
18. Young people self-harm because it keeps people close
19. Young people self-harm because they have a raised pain threshold and cannot feel the pain
20. Young people self-harm because it makes them feel alive
21. Young people self-harm because they are being manipulative
22. Young people self-harm because they use drugs
23. Young people self-harm because it gives them a sense of relief
24. Young people self-harm to cope with difficulties at home
25. Young people self-harm as a distraction
26. Young people self-harm because they want to end their life
27. Young people self-harm because they have a mental illness
28. Young people self-harm because they feel unsafe
29. Young people self-harm because it is popular at their age
30. Young people self-harm because it gives them a sense of control
31. Young people self-harm because they have a chemical imbalance in their brain
32. Young people self-harm because they are trying new experiences
33. Young people self-harm because they don't get on with their parents
34. Young people self-harm because they don't know alternative coping strategies
35. Young people self-harm because they dislike themselves
36. Young people self-harm because they are part of the 'emo' or 'goth' subculture
37. Young people self-harm because they can't control their emotions
38. Young people self-harm because of transitions in their life
39. Young people self-harm because they are bored
40. Young people self-harm because they find it easier to deal with physical pain than emotional pain

41. Young people self-harm because they are copying others
42. Young people self-harm because they have been abused
43. Young people self-harm because they have a personality disorder
44. Young people self-harm because it protects them from acting on suicidal feelings
45. Young people self-harm because they think they don't fit in with society
46. Young people self-harm because they are being bullied
47. Young people self-harm because it is addictive
48. Young people self-harm because they have not been punished enough for the behaviour
49. Young people self-harm to release emotional tension
50. Young people self-harm because they are impulsive
51. Young people self-harm to make others run around after them
52. Young people self-harm because they have poor body image
53. Young people self-harm because they feel intense emotions
54. Young people self-harm to cope with distressing thoughts
55. Young people self-harm to cope with academic stress
56. Young people self-harm because they have low self-esteem
57. Young people self-harm to fit in with their friends
58. Young people self-harm because it makes people take them seriously
59. Young people self-harm because they are ignored
60. Young people self-harm because it makes them feel better
61. Young people self-harm to gain immediate relief
62. Young people self-harm because they feel rejected
63. Young people self-harm to make other people upset
64. Young people self-harm because they are trying to communicate or express something
65. Young people self-harm because of social pressures

Appendix J – Q-grid

Q-grid

Most Disagree **Most Agree**

-6	**-5**	**-4**	**-3**	**-2**	**-1**	**0**	**+1**	**+2**	**+3**	**+4**	**+5**	**+6**
(2)												(2)
	(3)										(3)	
		(4)								(4)		
			(5)						(5)			
				(6)				(6)				
					(8)		(8)					
						(9)						

Appendix K – Correlation Matrix

	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10	P11	P12	P13	P14	P15	P16	P17	P18	P19	P20	P21	P22	P23	P24	P25
P1	**1**	0.35	**0.74**	**0.56**	**0.75**	**0.79**	**0.56**	**0.63**	**0.78**	**0.76**	**0.73**	0.46	**0.59**	**0.67**	0.48	**0.69**	**0.69**	**0.66**	**0.71**	**0.73**	**0.69**	**0.69**	**0.63**	**0.73**	**0.58**
P2		**1**	0.42	0.28	0.45	0.3	0.34	0.26	0.32	0.39	0.36	0.21	0.48	0.28	0.39	0.22	0.46	0.28	0.44	0.2	0.35	0.28	0.44	0.37	0.34
P3			**1**	**0.62**	**0.76**	**0.74**	**0.59**	**0.61**	**0.7**	**0.78**	**0.66**	**0.66**	**0.64**	**0.63**	**0.67**	**0.73**	**0.67**	**0.69**	**0.72**	**0.68**	**0.68**	**0.64**	**0.63**	**0.68**	**0.57**
P4				**1**	**0.53**	**0.6**	**0.59**	**0.65**	**0.51**	**0.59**	**0.53**	**0.6**	0.46	**0.68**	0.44	**0.56**	**0.53**	**0.65**	**0.72**	**0.63**	**0.5**	**0.58**	0.48	**0.61**	0.3
P5					**1**	**0.76**	**0.59**	**0.65**	**0.66**	**0.84**	**0.75**	**0.6**	**0.62**	**0.63**	0.4	**0.64**	**0.75**	**0.68**	**0.73**	**0.63**	**0.58**	**0.71**	**0.6**	**0.69**	**0.64**
P6						**1**	**0.55**	**0.68**	**0.71**	**0.79**	**0.67**	**0.58**	**0.63**	**0.63**	**0.52**	**0.63**	**0.62**	**0.66**	**0.75**	**0.74**	**0.56**	**0.68**	**0.61**	**0.72**	**0.6**
P7							**1**	0.48	**0.57**	**0.67**	**0.51**	**0.58**	0.41	**0.58**	0.35	**0.55**	**0.65**	**0.55**	**0.57**	**0.55**	0.43	0.44	0.42	**0.54**	0.4
P8								**1**	**0.61**	**0.63**	**0.63**	0.48	**0.59**	**0.65**	**0.53**	**0.6**	**0.64**	**0.68**	**0.7**	**0.73**	**0.6**	**0.66**	**0.59**	**0.75**	**0.54**
P9									**1**	**0.7**	**0.67**	**0.52**	**0.53**	**0.71**	0.49	**0.71**	**0.69**	**0.69**	**0.77**	**0.79**	**0.68**	**0.69**	**0.71**	**0.75**	**0.61**
P10										**1**	**0.71**	**0.67**	**0.58**	**0.74**	**0.52**	**0.66**	**0.69**	**0.71**	**0.78**	**0.7**	**0.57**	**0.73**	**0.7**	**0.72**	**0.66**
P11											**1**	0.38	**0.68**	**0.59**	0.41	**0.6**	**0.63**	**0.61**	**0.63**	**0.71**	**0.53**	**0.7**	**0.62**	**0.76**	**0.57**
P12												**1**	0.34	**0.64**	0.44	**0.57**	**0.66**	**0.66**	**0.63**	**0.56**	**0.54**	0.45	**0.58**	**0.54**	0.4
P13													**1**	0.46	**0.57**	**0.5**	**0.54**	**0.54**	**0.57**	**0.53**	**0.54**	**0.62**	**0.54**	**0.68**	0.49
P14														**1**	**0.51**	**0.67**	**0.66**	**0.7**	**0.75**	**0.77**	**0.65**	**0.71**	**0.68**	**0.71**	**0.58**
P15															**1**	0.44	**0.5**	0.48	**0.51**	**0.59**	**0.52**	0.48	**0.51**	**0.56**	0.38
P16																**1**	**0.59**	**0.7**	**0.7**	**0.7**	**0.74**	**0.59**	**0.59**	**0.66**	**0.52**
P17																	**1**	**0.69**	**0.73**	**0.64**	**0.64**	**0.63**	**0.7**	**0.72**	**0.63**
P18																		**1**	**0.8**	**0.74**	**0.68**	**0.66**	**0.62**	**0.73**	**0.59**
P19																			**1**	**0.76**	**0.66**	**0.76**	**0.72**	**0.77**	**0.58**
P20																				**1**	**0.65**	**0.73**	**0.63**	**0.8**	**0.57**
P21																					**1**	**0.61**	**0.71**	**0.69**	0.46
P22																						**1**	**0.7**	**0.79**	**0.65**
P23																							**1**	**0.71**	**0.6**
P24																								**1**	**0.63**
P25																									**1**

Note: A significant value is highlighted in shaded grey and was calculated as r≥ .24 using the Brown (1980) formula at significance level p<.05: 1.96 x (1 / √no. of statements in the Q-set). Strong correlations (r= ≥ .50, Cohen, 1988) are boldened and underlined.

Appendix L - Ken-Q Outputs

Unrotated Factor Matrix

Participant	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
P1	0.8437	-0.0772	0.0075	0.0039	0.0002	-0.0756	0.0078
P2	0.4326	-0.3789	0.1965	-0.1714	0.0307	0.076	0.0074
P3	0.8573	-0.0209	0.0008	-0.1098	0.0107	-0.0527	0.0038
P4	0.7047	0.4047	0.2133	0.0909	0.0141	-0.0958	0.0124
P5	0.8426	-0.0356	0.0019	-0.3063	0.1172	-0.1252	0.0226
P6	0.8354	0.0159	0.0001	-0.03	0	-0.2517	0.095
P7	0.665	0.1951	0.0387	-0.2622	0.0808	0.0051	0.0001
P8	0.7827	0.0434	0.0014	0.1779	0.0471	-0.1254	0.0215
P9	0.8384	-0.0147	0.0005	0.0932	0.014	0.1123	0.0167
P10	0.8792	0.0246	0.0004	-0.256	0.0764	-0.0674	0.0062
P11	0.7862	-0.1682	0.0333	0.0393	0.0033	-0.2581	0.1005
P12	0.6806	0.3213	0.1186	-0.247	0.0702	0.1813	0.0455
P13	0.7015	-0.3288	0.1385	0.0436	0.0038	-0.2548	0.0977
P14	0.8208	0.1952	0.0388	0.0946	0.0144	0.1194	0.0189
P15	0.6226	-0.0705	0.0062	0.0084	0.0004	-0.0478	0.0031
P16	0.7812	0.0874	0.0068	0.0869	0.0124	0.1015	0.0135
P17	0.8257	-0.0629	0.0051	-0.1726	0.0308	0.2185	0.0681
P18	0.8315	0.1759	0.031	0.0394	0.0033	0.0881	0.0101
P19	0.8881	0.119	0.0135	0.0128	0.0007	0.0837	0.0091
P20	0.8495	0.1244	0.0147	0.2827	0.123	-0.0483	0.0044
P21	0.7645	-0.0489	0.0032	0.2164	0.0697	0.2558	0.097
P22	0.8177	-0.077	0.0074	0.1836	0.0501	-0.0776	0.0081
P23	0.7897	-0.1751	0.0361	0.0263	0.0018	0.2496	0.0918
P24	0.8795	-0.0729	0.0068	0.1936	0.0557	-0.0273	0.001
P25	0.6887	-0.1614	0.0306	-0.068	0.0031	0.018	0.0004
Eigenvalues	15.3221	0.7812	0.1254	0.6349	0.0617	0.5262	0.0556
% Explained Variance	61	3	1	3	0	2	0

Cumulative Communalities Matrix

Participant	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5	Factor 6	Factor 7
P1	0.7118	0.7178	0.7179	0.7179	0.7179	0.7236	0.7237
P2	0.1871	0.3307	0.3693	0.3987	0.3996	0.4054	0.4055
P3	0.735	0.7354	0.7354	0.7475	0.7476	0.7504	0.7504
P4	0.4966	0.6604	0.7059	0.7142	0.7144	0.7236	0.7238
P5	0.71	0.7113	0.7113	0.8051	0.8188	0.8345	0.835
P6	0.6979	0.6982	0.6982	0.6991	0.6991	0.7625	0.7715
P7	0.4422	0.4803	0.4818	0.5505	0.557	0.557	0.557
P8	0.6126	0.6145	0.6145	0.6461	0.6483	0.664	0.6645
P9	0.7029	0.7031	0.7031	0.7118	0.712	0.7246	0.7249
P10	0.773	0.7736	0.7736	0.8391	0.8449	0.8494	0.8494
P11	0.6181	0.6464	0.6475	0.649	0.649	0.7156	0.7257
P12	0.4632	0.5664	0.5805	0.6415	0.6464	0.6793	0.6814
P13	0.4921	0.6002	0.6194	0.6213	0.6213	0.6862	0.6957
P14	0.6737	0.7118	0.7133	0.7222	0.7224	0.7367	0.7371
P15	0.3876	0.3926	0.3926	0.3927	0.3927	0.395	0.395
P16	0.6103	0.6179	0.6179	0.6255	0.6257	0.636	0.6362
P17	0.6818	0.6858	0.6858	0.7156	0.7165	0.7642	0.7688
P18	0.6914	0.7223	0.7233	0.7249	0.7249	0.7327	0.7328
P19	0.7887	0.8029	0.8031	0.8033	0.8033	0.8103	0.8104
P20	0.7217	0.7372	0.7374	0.8173	0.8324	0.8347	0.8347
P21	0.5845	0.5869	0.5869	0.6337	0.6386	0.704	0.7134
P22	0.6686	0.6745	0.6746	0.7083	0.7108	0.7168	0.7169
P23	0.6236	0.6543	0.6556	0.6563	0.6563	0.7186	0.727
P24	0.7735	0.7788	0.7788	0.8163	0.8194	0.8201	0.8201
P25	0.4743	0.5003	0.5012	0.5058	0.5058	0.5061	0.5061
Cumulative % Expln Var	61	64	65	68	68	70	70

Factor Matrix with Defining Sorts Flagged

Q sort	Factor 1		Factor 2	
P1	0.5726		0.6244	flagged
P2	0.0655		0.5714	flagged
P3	0.6205	flagged	0.5919	
P4	0.7937	flagged	0.1743	
P5	0.5998	flagged	0.5929	
P6	0.6291	flagged	0.55	
P7	0.6234	flagged	0.3028	
P8	0.6086	flagged	0.4942	
P9	0.6107	flagged	0.5746	
P10	0.6673	flagged	0.573	
P11	0.4689		0.6532	flagged
P12	0.7198	flagged	0.2198	
P13	0.2982		0.7151	flagged
P14	0.7388	flagged	0.4074	
P15	0.4135		0.4708	flagged
P16	0.637	flagged	0.4606	
P17	0.5689		0.6017	flagged
P18	0.7338	flagged	0.4289	
P19	0.7374	flagged	0.509	
P20	0.7125	flagged	0.4792	
P21	0.533		0.5502	flagged
P22	0.5535		0.6068	flagged
P23	0.4668		0.6606	flagged
P24	0.602		0.6453	flagged
P25	0.4013		0.5825	flagged
%Explained Variance	35		29	

Free Distribution Data Results

Q sort	Mean	St.Dev.
P1	0	3
P2	0	3
P3	0	3
P4	0	3
P5	0	3
P6	0	3
P7	0	3
P8	0	3
P9	0	3
P10	0	3
P11	0	3
P12	0	3
P13	0	3
P14	0	3
P15	0	3
P16	0	3
P17	0	3
P18	0	3
P19	0	3
P20	0	3
P21	0	3
P22	0	3
P23	0	3
P24	0	3
P25	0	3

Factor Scores with Corresponding Ranks

Statement Number	Statement	Statement Number	factor 1	factor 1	factor 2	factor 2
			Z-score	Rank	Z-score	Rank
1	Young people self-harm to cope with difficult emotions	1	1.79	3	1.83	2
2	Young people self-harm because they like to experience pain	2	-0.37	41	-0.63	44
3	Young people self-harm because it helps them identify with others who self-harm	3	-0.36	40	-0.19	34
4	Young people self-harm because they want to be rebellious	4	-1.32	60	-0.84	51
5	Young people self-harm because they feel powerless	5	0.75	16	0.72	18
6	Young people self-harm to challenge mental health professionals	6	-1.25	58	-1.07	54
7	Young people self-harm because it gets their needs met from others	7	-0.23	37	0.58	24
8	Young people self-harm because they have learning difficulties	8	-0.78	49	-0.83	50
9	Young people self-harm to numb their feelings	9	1.03	12	0.95	13
10	Young people self-harm for attention	10	-0.9	52	0.04	32
11	Young people self-harm to block out painful memories	11	1.1	11	1.37	7
12	Young people self-harm because they enjoy it	12	-1.05	53	-1.29	60
13	Young people self-harm because of hormonal changes/puberty	13	-0.41	43	-0.93	52
14	Young people self-harm to get admitted to hospital	14	-0.35	39	-0.57	40
15	Young people self-harm to punish themselves	15	0.89	14	0.89	14
16	Young people self-harm because they are immature	16	-1.39	62	-1.41	62
17	Young people self-harm for fun or recreation	17	-1.81	65	-1.55	63
18	Young people self-harm because it keeps people close	18	-0.39	42	0.25	30
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	19	-0.71	46	-1.79	65
20	Young people self-harm because it makes them feel alive	20	0.41	24	-0.47	37
21	Young people self-harm because they are being manipulative	21	-1.75	64	-0.67	45
22	Young people self-harm because they use drugs	22	-0.84	50	-0.82	49

23	Young people self-harm because it gives them a sense of relief	23	1.68	4	1.39	6
24	Young people self-harm to cope with difficulties at home	24	0.57	19	0.74	16
25	Young people self-harm as a distraction	25	0.41	23	1.09	11
26	Young people self-harm because they want to end their life	26	-1.29	59	-0.75	48
27	Young people self-harm because they have a mental illness	27	-0.16	35	-0.74	46
28	Young people self-harm because they feel unsafe	28	0.51	20	0.62	22
29	Young people self-harm because it is popular at their age	29	-1.15	55	-1.09	55
30	Young people self-harm because it gives them a sense of control	30	1.25	9	1.46	5
31	Young people self-harm because they have a chemical imbalance in their brain	31	-0.62	44	-1.34	61
32	Young people self-harm because they are trying new experiences	32	-0.7	45	-0.57	41
33	Young people self-harm because they don’t get on with their parents	33	-0.35	38	-0.48	39
34	Young people self-harm because they don’t know alternative coping strategies	34	0.67	18	1.06	12
35	Young people self-harm because they dislike themselves	35	0.67	17	0.69	19
36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	36	-1.22	57	-1.28	59
37	Young people self-harm because they can’t control their emotions	37	0.28	28	0.38	28
38	Young people self-harm because of transitions in their life	38	-0.01	32	-0.03	33
39	Young people self-harm because they are bored	39	-1.37	61	-1.11	56
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	40	1.38	8	1.09	10
41	Young people self-harm because they are copying others	41	-0.89	51	-0.47	38
42	Young people self-harm because they have been abused	42	0.48	21	0.59	23
43	Young people self-harm because they have a personality disorder	43	-0.73	47	-1	53
44	Young people self-harm because it protects them from acting on suicidal feelings	44	1.03	13	0.23	31
45	Young people self-harm because they think they don’t fit in with society	45	0.15	29	-0.34	36
46	Young people self-harm because they are being bullied	46	0.39	25	0.48	26

47	Young people self-harm because it is addictive	47	-0.02	33	-1.16	57
48	Young people self-harm because they have not been punished enough for the behaviour	48	-1.12	54	-1.26	58
49	Young people self-harm to release emotional tension	49	1.98	1	1.47	4
50	Young people self-harm because they are impulsive	50	-0.18	36	0.52	25
51	Young people self-harm to make others run around after them	51	-1.22	56	-1.62	64
52	Young people self-harm because they have poor body image	52	0.46	22	0.38	29
53	Young people self-harm because they feel intense emotions	53	1.55	6	1.36	8
54	Young people self-harm to cope with distressing thoughts	54	1.86	2	2.27	1
55	Young people self-harm to cope with academic stress	55	0.33	27	0.47	27
56	Young people self-harm because they have low self-esteem	56	0.84	15	0.74	15
57	Young people self-harm to fit in with their friends	57	-0.77	48	-0.61	43
58	Young people self-harm because it makes people take them seriously	58	0.07	30	-0.28	35
59	Young people self-harm because they are ignored	59	0.01	31	-0.75	47
60	Young people self-harm because it makes them feel better	60	1.19	10	0.64	20
61	Young people self-harm to gain immediate relief	61	1.62	5	1.1	9
62	Young people self-harm because they feel rejected	62	0.35	26	0.64	21
63	Young people self-harm to make other people upset	63	-1.49	63	-0.57	42
64	Young people self-harm because they are trying to communicate or express something	64	1.49	7	1.75	3
65	Young people self-harm because of social pressures	65	-0.03	34	0.72	17

Factor score correlations

	factor 1	factor 2
factor 1	1	0.8864
factor 2	0.8864	1

Factor 1 Sort Weights

Q Sort	Weight
P4	10
P14	7.58404
P19	7.53532
P18	7.41242
P12	6.96396
P20	6.74703
P10	5.60851
P16	4.99781
P6	4.85412
P7	4.75397
P3	4.70409
P9	4.54068
P8	4.50664
P5	4.36776

Factor 1 Sort Correlations

Q Sort	P4	P14	P19	P18	P12	P20	P10	P16	P6	P7	P3	P9	P8	P5
P4	100	68	72	65	60	63	59	56	60	59	62	51	65	53
P14	68	100	75	70	64	77	74	67	63	58	63	71	65	63
P19	72	75	100	80	63	76	78	70	75	57	72	77	70	73
P18	65	70	80	100	66	74	71	70	66	55	69	69	68	68
P12	60	64	63	66	100	56	67	57	58	58	66	52	48	60
P20	63	77	76	74	56	100	70	70	74	55	68	79	73	63
P10	59	74	78	71	67	70	100	66	79	67	78	70	63	84
P16	56	67	70	70	57	70	66	100	63	55	73	71	60	64
P6	60	63	75	66	58	74	79	63	100	55	74	71	68	76
P7	59	58	57	55	58	55	67	55	55	100	59	57	48	59
P3	62	63	72	69	66	68	78	73	74	59	100	70	61	76
P9	51	71	77	69	52	79	70	71	71	57	70	100	61	66
P8	65	65	70	68	48	73	63	60	68	48	61	61	100	65
P5	53	63	73	68	60	63	84	64	76	59	76	66	65	100

Factor Scores for Factor 1

Statement No.	Statement	Z-score	Sort Values	Raw Sort P4	Raw Sort P14	Raw Sort P19	Raw Sort P18	Raw Sort P12	Raw Sort P20	Raw Sort P10	Raw Sort P16	Raw Sort P6	Raw Sort P7	Raw Sort P3	Raw Sort P9	Raw Sort P8	Raw Sort P5
49	Young people self-harm to release emotional tension	1.978	6	6	4	6	5	2	5	4	5	6	6	4	6	5	5
54	Young people self-harm to cope with distressing thoughts	1.855	6	5	6	6	6	3	5	5	5	2	4	5	3	4	3
1	Young people self-harm to cope with difficult emotions	1.788	5	4	5	3	3	3	6	5	6	4	4	6	3	6	6
23	Young people self-harm because it gives them a sense of relief	1.684	5	4	3	4	5	3	4	4	3	4	5	6	6	5	4
61	Young people self-harm to gain immediate relief	1.617	5	4	4	5	3	5	4	3	2	6	4	5	5	3	3
53	Young people self-harm because they feel intense emotions	1.553	4	5	4	3	4	4	4	0	5	1	5	2	5	6	6
64	Young people self-harm because they are trying to communicate or express something	1.491	4	4	6	2	5	2	6	5	3	1	6	1	2	4	3
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	1.384	4	5	2	5	3	6	1	6	-1	5	5	3	1	1	4
30	Young people self-harm because it gives them a sense of control	1.25	4	6	-1	4	2	3	3	3	1	5	4	4	1	5	3
60	Young people self-harm because it makes them feel better	1.194	3	2	5	2	3	5	2	4	4	1	3	5	3	-1	3
11	Young people self-harm to block out painful memories	1.096	3	2	4	5	1	3	5	1	3	3	-2	3	4	4	1
9	Young people self-harm to numb their feelings	1.031	3	3	5	3	2	5	4	4	-1	0	0	3	2	1	1

44	Young people self-harm because it protects them from acting on suicidal feelings	1.027	3	3	3	3	4	6	0	2	6	1	0	2	5	-2	0
15	Young people self-harm to punish themselves	0.894	3	1	-1	3	4	4	2	2	4	3	2	4	2	0	2
56	Young people self-harm because they have low self-esteem	0.842	2	0	2	4	3	-1	1	2	4	2	3	3	3	4	2
5	Young people self-harm because they feel powerless	0.747	2	3	2	2	2	1	1	3	2	3	1	1	0	0	4
35	Young people self-harm because they dislike themselves	0.674	2	-1	1	1	6	1	2	3	0	2	-1	4	1	2	4
34	Young people self-harm because they don't know alternative coping strategies	0.671	2	-1	3	2	1	1	0	6	1	4	3	1	1	-1	5
24	Young people self-harm to cope with difficulties at home	0.573	2	0	1	4	2	0	3	0	2	1	2	2	4	0	-1
28	Young people self-harm because they feel unsafe	0.514	2	3	1	0	2	1	1	1	-1	4	-2	1	1	3	2
42	Young people self-harm because they have been abused	0.479	1	0	3	1	0	1	3	0	2	1	3	1	4	-1	-1
52	Young people self-harm because they have poor body image	0.456	1	1	1	1	4	1	1	-1	3	0	0	0	1	3	0
25	Young people self-harm as a distraction	0.408	1	3	3	2	1	0	1	-1	1	0	-1	1	0	0	1
20	Young people self-harm because it makes them feel alive	0.406	1	2	-3	0	0	1	2	0	4	5	2	2	0	1	0
46	Young people self-harm because they are being bullied	0.386	1	0	1	1	1	-2	3	1	2	0	1	1	4	3	-1
62	Young people self-harm because they feel rejected	0.354	1	-1	2	1	0	1	3	2	1	1	1	-1	1	1	1
55	Young people self-harm to cope with academic stress	0.333	1	0	1	1	2	-1	2	1	0	2	1	-1	3	1	0

37	Young people self-harm because they can't control their emotions	0.283	1	-6	0	0	0	4	0	3	3	3	2	2	0	1	5
45	Young people self-harm because they think they don't fit in with society	0.153	0	-1	2	0	1	0	2	2	0	0	-2	-1	0	2	0
58	Young people self-harm because it makes people take them seriously	0.065	0	2	2	1	-5	0	-1	1	-1	2	0	0	0	0	1
59	Young people self-harm because they are ignored	0.009	0	2	0	-1	0	-1	1	0	-2	0	1	-2	-1	1	1
38	Young people self-harm because of transitions in their life	-0.005	0	0	1	2	1	-3	0	-1	1	0	-2	-1	0	1	0
47	Young people self-harm because it is addictive	-0.018	0	1	-1	-1	-3	-1	0	2	2	-1	2	2	-2	-1	2
65	Young people self-harm because of social pressures	-0.03	0	-3	1	1	1	-2	1	0	-1	3	-3	-2	2	2	1
27	Young people self-harm because they have a mental illness	-0.157	0	0	-1	0	1	4	-4	0	-3	-3	2	0	-1	-2	0
50	Young people self-harm because they are impulsive	-0.182	0	-2	-2	-3	0	0	0	1	1	1	-3	3	-1	0	2
7	Young people self-harm because it gets their needs met from others	-0.233	0	-1	0	-1	-2	-1	-2	1	-3	2	-2	-1	0	2	2
33	Young people self-harm because they don't get on with their parents	-0.349	-1	-2	0	0	0	-3	0	1	-1	-1	-4	-2	1	0	-1
14	Young people self-harm to get admitted to hospital	-0.35	-1	2	0	-2	0	-3	-3	-1	0	-1	-1	0	-1	-1	-3
3	Young people self-harm because it helps them identify with others who self-harm	-0.359	-1	-2	-1	-2	-1	0	-1	0	0	-2	1	-1	2	-4	0
2	Young people self-harm because they like to experience pain	-0.371	-1	0	0	-4	-2	2	-3	-1	1	-1	3	1	-3	-2	-4

18	Young people self-harm because it keeps people close	-0.387	-1	-3	-3	0	0	-2	-2	0	-1	0	-2	0	0	2	1
13	Young people self-harm because of hormonal changes/puberty	-0.412	-1	1	0	-1	-1	2	-1	-4	-2	-2	-6	-1	-5	3	-1
31	Young people self-harm because they have a chemical imbalance in their brain	-0.619	-1	1	-2	0	-1	2	-4	-2	-2	-4	0	-5	-6	0	-3
32	Young people self-harm because they are trying new experiences	-0.697	-1	1	-2	-1	-3	-2	-1	-3	0	-3	-3	-2	-2	-3	-3
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	-0.705	-2	-1	-1	-4	-1	2	-1	-2	-6	-1	1	-3	-4	-4	-2
43	Young people self-harm because they have a personality disorder	-0.725	-2	-1	-2	0	-1	0	-5	-2	1	-5	-4	-3	-3	-1	-1
57	Young people self-harm to fit in with their friends	-0.767	-2	-2	-4	-2	-2	-1	-1	-1	-2	-3	-4	-2	2	-2	-2
8	Young people self-harm because they have learning difficulties	-0.778	-2	-1	0	-5	-4	0	-1	-2	0	-1	-3	-1	-3	-1	-6
22	Young people self-harm because they use drugs	-0.839	-2	1	-3	-2	-2	-4	-3	-2	-2	-2	-1	-4	-5	2	-4
41	Young people self-harm because they are copying others	-0.886	-2	-5	-5	-2	-1	-4	0	-2	0	-1	-1	-2	-1	-1	-2
10	Young people self-harm for attention	-0.896	-3	0	-4	-1	-6	-5	-4	-1	-5	0	0	0	-1	-2	0
12	Young people self-harm because they enjoy it	-1.047	-3	-2	0	-1	-2	-4	-1	-5	0	-2	-5	-5	-3	-6	-4
48	Young people self-harm because they have not been punished enough for the behaviour	-1.121	-3	-2	-1	-6	-3	0	-2	-6	-4	-4	1	-5	-2	0	-6

29	Young people self-harm because it is popular at their age	-1.149	-3	-3	-3	-2	-4	-4	0	-4	-4	-3	-5	0	-1	-2	-5
51	Young people self-harm to make others run around after them	-1.217	-3	1	-2	-3	-1	-6	-5	-5	-5	-4	-1	-3	-4	-4	-4
36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	-1.224	-4	-4	-5	-4	-4	-2	-2	-4	-1	-2	-1	-4	-1	-5	-1
6	Young people self-harm to challenge mental health professionals	-1.252	-4	-4	-4	-1	-2	-2	-4	-3	-4	-6	0	-4	-4	-3	-3
26	Young people self-harm because they want to end their life	-1.293	-4	-6	-1	-3	-5	-3	-5	-1	-3	-1	-3	-4	-2	-3	-2
4	Young people self-harm because they want to be rebellious	-1.32	-4	-3	-6	-3	-1	-1	-3	-4	-5	-2	-6	-3	-3	-5	-2
39	Young people self-harm because they are bored	-1.369	-5	-3	-2	-4	-5	-6	-2	-3	-3	-5	0	-6	-2	-3	-3
16	Young people self-harm because they are immature	-1.388	-5	-4	-5	-3	-3	-1	-3	-3	-4	-3	-1	-3	-5	-6	-5
63	Young people self-harm to make other people upset	-1.49	-5	-5	-3	-5	-6	-3	-6	-3	-3	-6	0	0	-2	-5	-1
21	Young people self-harm because they are being manipulative	-1.753	-6	-4	-6	-6	-3	-5	-6	-5	-2	-5	-5	0	-6	-4	-2
17	Young people self-harm for fun or recreation	-1.807	-6	-5	-4	-5	-4	-5	-2	-6	-6	-4	-4	-6	-4	-3	-5

Factor 2 Sort Weights

Q Sort	Weight
P13	6.82307
P23	5.46454
P11	5.31172
P24	5.15521
P1	4.77136
P22	4.47783
P17	4.39722
P25	4.11045
P2	3.95543
P21	3.67882
P15	2.82004

Factor 2 Sort Correlations

Q Sort	P13	P23	P11	P24	P1	P22	P17	P25	P2	P21	P15
P13	100	54	68	68	59	62	54	49	48	54	57
P23	54	100	62	71	63	70	70	60	44	71	51
P11	68	62	100	76	73	70	63	57	36	53	41
P24	68	71	76	100	73	79	72	63	37	69	56
P1	59	63	73	73	100	69	69	58	35	69	48
P22	62	70	70	79	69	100	63	65	28	61	48
P17	54	70	63	72	69	63	100	63	46	64	50
P25	49	60	57	63	58	65	63	100	34	46	38
P2	48	44	36	37	35	28	46	34	100	35	39
P21	54	71	53	69	69	61	64	46	35	100	52
P15	57	51	41	56	48	48	50	38	39	52	100

Factor Scores for Factor 2

Statement No.	Statement	Z-score	Sort Values	Raw Sort P13	Raw Sort P23	Raw Sort P11	Raw Sort P24	Raw Sort P1	Raw Sort P22	Raw Sort P17	Raw Sort P25	Raw Sort P2	Raw Sort P21	Raw Sort P15
54	Young people self-harm to cope with distressing thoughts	2.268	6	5	6	5	6	6	5	6	4	5	6	5
1	Young people self-harm to cope with difficult emotions	1.83	6	5	4	5	6	4	5	5	5	2	2	3
64	Young people self-harm because they are trying to communicate or express something	1.754	5	6	5	6	4	3	6	2	4	0	6	1
49	Young people self-harm to release emotional tension	1.469	5	3	2	5	5	5	2	5	0	4	4	3
30	Young people self-harm because it gives them a sense of control	1.463	5	2	5	6	4	4	1	4	1	4	3	4
23	Young people self-harm because it gives them a sense of relief	1.386	4	4	1	4	3	5	4	5	1	3	5	0
11	Young people self-harm to block out painful memories	1.372	4	4	6	1	3	1	3	4	4	1	4	5
53	Young people self-harm because they feel intense emotions	1.358	4	3	2	4	5	5	5	6	-1	-1	5	1
61	Young people self-harm to gain immediate relief	1.096	4	2	3	2	2	4	1	4	0	5	1	6
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	1.093	3	6	5	3	2	-1	4	1	2	2	-2	4
25	Young people self-harm as a distraction	1.087	3	1	3	4	4	3	4	2	1	0	5	1
34	Young people self-harm because they don’t know alternative coping strategies	1.064	3	1	4	3	1	4	6	3	3	4	0	-3
9	Young people self-harm to numb their feelings	0.945	3	-1	4	4	3	0	4	3	2	3	0	4

15	Young people self-harm to punish themselves	0.887	3	4	2	-1	1	2	1	4	5	1	2	2
56	Young people self-harm because they have low self-esteem	0.741	2	3	0	3	4	-1	0	1	3	1	3	2
24	Young people self-harm to cope with difficulties at home	0.74	2	0	1	0	3	2	3	3	3	2	1	3
65	Young people self-harm because of social pressures	0.723	2	2	3	0	2	2	3	1	3	0	2	0
5	Young people self-harm because they feel powerless	0.72	2	1	1	3	5	0	3	2	2	3	-1	-2
35	Young people self-harm because they dislike themselves	0.685	2	3	0	1	2	2	1	1	6	0	1	0
60	Young people self-harm because it makes them feel better	0.643	2	0	1	1	2	6	-1	3	-1	1	3	3
62	Young people self-harm because they feel rejected	0.635	1	-1	0	0	3	0	2	2	6	2	1	5
28	Young people self-harm because they feel unsafe	0.624	1	5	-1	3	0	3	2	1	4	-1	-1	-2
42	Young people self-harm because they have been abused	0.586	1	2	3	-2	0	1	0	2	0	3	4	4
7	Young people self-harm because it gets their needs met from others	0.577	1	3	0	2	1	2	-1	0	1	5	2	-1
50	Young people self-harm because they are impulsive	0.519	1	2	1	2	-1	3	0	0	-1	0	3	6
46	Young people self-harm because they are being bullied	0.482	1	-1	4	2	0	1	3	0	2	-1	2	1
55	Young people self-harm to cope with academic stress	0.468	1	-2	1	2	1	2	2	2	3	0	1	2
37	Young people self-harm because they can’t control their emotions	0.38	1	-1	1	1	1	3	-1	3	5	-1	0	-1
52	Young people self-harm because they have poor body image	0.376	0	1	2	1	2	0	1	1	-1	0	2	0

18	Young people self-harm because it keeps people close	0.252	0	4	0	2	1	0	1	-4	0	2	-2	0
44	Young people self-harm because it protects them from acting on suicidal feelings	0.227	0	0	3	0	1	1	2	0	0	-5	4	-1
10	Young people self-harm for attention	0.035	0	1	-1	-3	0	1	1	-1	1	6	-3	-1
38	Young people self-harm because of transitions in their life	-0.031	0	-1	0	1	-1	0	2	0	1	0	-2	-1
3	Young people self-harm because it helps them identify with others who self-harm	-0.185	0	-1	0	1	1	-1	-3	-1	0	2	0	-4
58	Young people self-harm because it makes people take them seriously	-0.281	0	1	-1	-2	-2	0	0	-2	-3	1	0	1
45	Young people self-harm because they think they don't fit in with society	-0.335	0	0	-1	-1	-1	-2	0	-3	1	-2	-1	2
20	Young people self-harm because it makes them feel alive	-0.465	0	0	-4	0	0	1	-1	-2	-1	-5	1	-2
41	Young people self-harm because they are copying others	-0.469	-1	0	-1	-2	0	-1	-2	-4	-4	-1	3	0
33	Young people self-harm because they don't get on with their parents	-0.477	-1	-4	0	-1	0	1	0	-1	2	-5	-3	-1
14	Young people self-harm to get admitted to hospital	-0.566	-1	-1	-2	-5	-2	1	-1	-5	-2	1	1	3
32	Young people self-harm because they are trying new experiences	-0.566	-1	0	-2	0	0	-2	-1	-4	-1	-1	-1	-5
63	Young people self-harm to make other people upset	-0.572	-1	2	-3	0	-4	-4	-4	0	-2	1	-2	1
57	Young people self-harm to fit in with their friends	-0.613	-1	-2	0	-1	0	-2	0	-1	-3	-4	-2	-2
2	Young people self-harm because they like to experience pain	-0.632	-1	-3	-1	-4	-2	-1	-2	0	1	-4	1	1

21	Young people self-harm because they are being manipulative	-0.671	-1	1	-4	-1	-5	-5	-3	-1	-2	4	-1	1
27	Young people self-harm because they have a mental illness	-0.739	-2	-5	2	-6	-3	-3	-4	1	0	3	0	-1
59	Young people self-harm because they are ignored	-0.752	-2	-2	-6	-1	-1	0	0	1	0	-6	-4	0
26	Young people self-harm because they want to end their life	-0.754	-2	-3	2	-2	-3	-2	-1	0	0	-6	-1	-5
22	Young people self-harm because they use drugs	-0.816	-2	1	-3	0	-2	-1	-6	-1	-4	-2	-5	0
8	Young people self-harm because they have learning difficulties	-0.827	-2	0	-1	-2	-1	-2	-2	-6	-5	-2	-3	2
4	Young people self-harm because they want to be rebellious	-0.843	-2	-2	-2	-1	-1	-3	-2	-3	-3	-2	-2	-1
13	Young people self-harm because of hormonal changes/puberty	-0.929	-3	-2	-2	-5	-1	-6	0	-2	-3	-3	0	2
43	Young people self-harm because they have a personality disorder	-1.002	-3	-5	1	-4	-6	-4	-5	-1	-1	6	0	-5
6	Young people self-harm to challenge mental health professionals	-1.069	-3	-1	-6	-4	-4	-3	-1	-1	-2	1	-4	-2
29	Young people self-harm because it is popular at their age	-1.087	-3	-4	-1	-2	-3	0	-3	-4	-4	-4	-1	-2
39	Young people self-harm because they are bored	-1.112	-3	-2	-3	-1	-2	-3	-4	-3	-4	0	-5	-3
47	Young people self-harm because it is addictive	-1.156	-4	-6	-4	1	-4	-1	1	-5	-1	-4	-3	-3
48	Young people self-harm because they have not been punished enough for the behaviour	-1.26	-4	-5	-3	-3	-1	-5	-5	-2	2	-2	-4	-4
36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	-1.278	-4	-3	-2	0	-6	-2	-5	-2	-2	-2	-5	-6
12	Young people self-harm because they enjoy it	-1.291	-4	-3	-5	-3	-4	-1	-3	-6	-2	-1	-1	-4

31	Young people self-harm because they have a chemical imbalance in their brain	-1.339	-5	-4	-2	-6	-2	-4	-2	0	-6	-3	0	-6
16	Young people self-harm because they are immature	-1.409	-5	0	-5	-4	-3	-6	-4	-3	-5	-1	-6	0
17	Young people self-harm for fun or recreation	-1.549	-5	-4	-3	-5	-3	-5	-2	-3	-5	-3	-4	-3
51	Young people self-harm to make others run around after them	-1.622	-6	-3	-4	-3	-5	-4	-3	-5	-3	-3	-6	-4
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	-1.787	-6	-6	-5	-3	-5	-3	-6	-2	-6	-3	-3	-3

Descending Array of Differences Between Factor 1 and Factor 2

Statement No.	Statement	Factor 1	Factor 2	Difference
47	Young people self-harm because it is addictive	-0.018	-1.156	1.138
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	-0.705	-1.787	1.082
20	Young people self-harm because it makes them feel alive	0.406	-0.465	0.871
44	Young people self-harm because it protects them from acting on suicidal feelings	1.027	0.227	0.8
59	Young people self-harm because they are ignored	0.009	-0.752	0.761
31	Young people self-harm because they have a chemical imbalance in their brain	-0.619	-1.339	0.72
27	Young people self-harm because they have a mental illness	-0.157	-0.739	0.582
60	Young people self-harm because it makes them feel better	1.194	0.643	0.551
61	Young people self-harm to gain immediate relief	1.617	1.096	0.521
13	Young people self-harm because of hormonal changes/puberty	-0.412	-0.929	0.517
49	Young people self-harm to release emotional tension	1.978	1.469	0.509
45	Young people self-harm because they think they don’t fit in with society	0.153	-0.335	0.488
51	Young people self-harm to make others run around after them	-1.217	-1.622	0.405
58	Young people self-harm because it makes people take them seriously	0.065	-0.281	0.346
23	Young people self-harm because it gives them a sense of relief	1.684	1.386	0.298
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	1.384	1.093	0.291
43	Young people self-harm because they have a personality disorder	-0.725	-1.002	0.277
2	Young people self-harm because they like to experience pain	-0.371	-0.632	0.261
12	Young people self-harm because they enjoy it	-1.047	-1.291	0.244
14	Young people self-harm to get admitted to hospital	-0.35	-0.566	0.216
53	Young people self-harm because they feel intense emotions	1.553	1.358	0.195

48	Young people self-harm because they have not been punished enough for the behaviour	-1.121	-1.26	0.139
33	Young people self-harm because they don’t get on with their parents	-0.349	-0.477	0.128
56	Young people self-harm because they have low self-esteem	0.842	0.741	0.101
9	Young people self-harm to numb their feelings	1.031	0.945	0.086
52	Young people self-harm because they have poor body image	0.456	0.376	0.08
36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	-1.224	-1.278	0.054
8	Young people self-harm because they have learning difficulties	-0.778	-0.827	0.049
5	Young people self-harm because they feel powerless	0.747	0.72	0.027
38	Young people self-harm because of transitions in their life	-0.005	-0.031	0.026
16	Young people self-harm because they are immature	-1.388	-1.409	0.021
15	Young people self-harm to punish themselves	0.894	0.887	0.007
35	Young people self-harm because they dislike themselves	0.674	0.685	-0.011
22	Young people self-harm because they use drugs	-0.839	-0.816	-0.023
1	Young people self-harm to cope with difficult emotions	1.788	1.83	-0.042
29	Young people self-harm because it is popular at their age	-1.149	-1.087	-0.062
46	Young people self-harm because they are being bullied	0.386	0.482	-0.096
37	Young people self-harm because they can’t control their emotions	0.283	0.38	-0.097
42	Young people self-harm because they have been abused	0.479	0.586	-0.107
28	Young people self-harm because they feel unsafe	0.514	0.624	-0.11
32	Young people self-harm because they are trying new experiences	-0.697	-0.566	-0.131
55	Young people self-harm to cope with academic stress	0.333	0.468	-0.135
57	Young people self-harm to fit in with their friends	-0.767	-0.613	-0.154
24	Young people self-harm to cope with difficulties at home	0.573	0.74	-0.167
3	Young people self-harm because it helps them identify with others who self-harm	-0.359	-0.185	-0.174
6	Young people self-harm to challenge mental health professionals	-1.252	-1.069	-0.183
30	Young people self-harm because it gives them a sense of control	1.25	1.463	-0.213
39	Young people self-harm because they are bored	-1.369	-1.112	-0.257

17	Young people self-harm for fun or recreation	-1.807	-1.549	-0.258
64	Young people self-harm because they are trying to communicate or express something	1.491	1.754	-0.263
11	Young people self-harm to block out painful memories	1.096	1.372	-0.276
62	Young people self-harm because they feel rejected	0.354	0.635	-0.281
34	Young people self-harm because they don’t know alternative coping strategies	0.671	1.064	-0.393
54	Young people self-harm to cope with distressing thoughts	1.855	2.268	-0.413
41	Young people self-harm because they are copying others	-0.886	-0.469	-0.417
4	Young people self-harm because they want to be rebellious	-1.32	-0.843	-0.477
26	Young people self-harm because they want to end their life	-1.293	-0.754	-0.539
18	Young people self-harm because it keeps people close	-0.387	0.252	-0.639
25	Young people self-harm as a distraction	0.408	1.087	-0.679
50	Young people self-harm because they are impulsive	-0.182	0.519	-0.701
65	Young people self-harm because of social pressures	-0.03	0.723	-0.753
7	Young people self-harm because it gets their needs met from others	-0.233	0.577	-0.81
63	Young people self-harm to make other people upset	-1.49	-0.572	-0.918
10	Young people self-harm for attention	-0.896	0.035	-0.931
21	Young people self-harm because they are being manipulative	-1.753	-0.671	-1.082

Factor Q-sort Values for Statements sorted by Consensus vs. Disagreement

Statement No.	Statement	factor 1	factor 2	Z-Score variance
1	Young people self-harm to cope with difficult emotions	5	6	0
5	Young people self-harm because they feel powerless	2	2	0
15	Young people self-harm to punish themselves	3	3	0
16	Young people self-harm because they are immature	-5	-5	0
22	Young people self-harm because they use drugs	-2	-2	0
35	Young people self-harm because they dislike themselves	2	2	0
38	Young people self-harm because of transitions in their life	0	0	0
8	Young people self-harm because they have learning difficulties	-2	-2	0.001
29	Young people self-harm because it is popular at their age	-3	-3	0.001
36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	-4	-4	0.001
9	Young people self-harm to numb their feelings	3	3	0.002
37	Young people self-harm because they can’t control their emotions	1	1	0.002
46	Young people self-harm because they are being bullied	1	1	0.002
52	Young people self-harm because they have poor body image	1	0	0.002
28	Young people self-harm because they feel unsafe	2	1	0.003
42	Young people self-harm because they have been abused	1	1	0.003
56	Young people self-harm because they have low self-esteem	2	2	0.003
32	Young people self-harm because they are trying new experiences	-1	-1	0.004
33	Young people self-harm because they don’t get on with their parents	-1	-1	0.004
48	Young people self-harm because they have not been punished enough for the behaviour	-3	-4	0.005
55	Young people self-harm to cope with academic stress	1	1	0.005
57	Young people self-harm to fit in with their friends	-2	-1	0.006
24	Young people self-harm to cope with difficulties at home	2	2	0.007
3	Young people self-harm because it helps them identify with others who self-harm	-1	0	0.008

6	Young people self-harm to challenge mental health professionals	-4	-3	0.008
53	Young people self-harm because they feel intense emotions	4	4	0.01
30	Young people self-harm because it gives them a sense of control	4	5	0.011
14	Young people self-harm to get admitted to hospital	-1	-1	0.012
12	Young people self-harm because they enjoy it	-3	-4	0.015
2	Young people self-harm because they like to experience pain	-1	-1	0.017
17	Young people self-harm for fun or recreation	-6	-5	0.017
39	Young people self-harm because they are bored	-5	-3	0.017
64	Young people self-harm because they are trying to communicate or express something	4	5	0.017
11	Young people self-harm to block out painful memories	3	4	0.019
43	Young people self-harm because they have a personality disorder	-2	-3	0.019
62	Young people self-harm because they feel rejected	1	1	0.02
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	4	3	0.021
23	Young people self-harm because it gives them a sense of relief	5	4	0.022
58	Young people self-harm because it makes people take them seriously	0	0	0.03
34	Young people self-harm because they don’t know alternative coping strategies	2	3	0.039
51	Young people self-harm to make others run around after them	-3	-6	0.041
41	Young people self-harm because they are copying others	-2	-1	0.043
54	Young people self-harm to cope with distressing thoughts	6	6	0.043
4	Young people self-harm because they want to be rebellious	-4	-2	0.057
45	Young people self-harm because they think they don’t fit in with society	0	0	0.06
49	Young people self-harm to release emotional tension	6	5	0.065
13	Young people self-harm because of hormonal changes/puberty	-1	-3	0.067
61	Young people self-harm to gain immediate relief	5	4	0.068
26	Young people self-harm because they want to end their life	-4	-2	0.073
60	Young people self-harm because it makes them feel better	3	2	0.076

27	Young people self-harm because they have a mental illness	0	-2	0.085
18	Young people self-harm because it keeps people close	-1	0	0.102
25	Young people self-harm as a distraction	1	3	0.115
50	Young people self-harm because they are impulsive	0	1	0.123
31	Young people self-harm because they have a chemical imbalance in their brain	-1	-5	0.13
65	Young people self-harm because of social pressures	0	2	0.142
59	Young people self-harm because they are ignored	0	-2	0.145
44	Young people self-harm because it protects them from acting on suicidal feelings	3	0	0.16
7	Young people self-harm because it gets their needs met from others	0	1	0.164
20	Young people self-harm because it makes them feel alive	1	0	0.19
63	Young people self-harm to make other people upset	-5	-1	0.211
10	Young people self-harm for attention	-3	0	0.217
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	-2	-6	0.293
21	Young people self-harm because they are being manipulative	-6	-1	0.293
47	Young people self-harm because it is addictive	0	-4	0.324

Factor Characteristics

	factor 1	factor 2
No. of Defining Variables	14	11
Avg. Rel. Coef.	0.8	0.8
Composite Reliability	0.982	0.978
S.E. of Factor Z-scores	0.134	0.148

Standard Errors for Differences in Factor Z-scores

	factor 1	factor 2
factor1	0.19	0.2
factor2	0.2	0.209

Distinguishing Statements for Factor 1

(P < .05 : Asterisk (*) Indicates Significance at P < .01)

Both the Factor Q-Sort Value and the Z-Score (Z-SCR) are Shown

Statement No.	Statement	Statement Number	factor1 Q-SV	factor1 Z-score	Significance	factor2 Q-SV	factor2 Z-score	Significance
49	Young people self-harm to release emotional tension	49	6	1.98		5	1.469	
54	Young people self-harm to cope with distressing thoughts	54	6	1.86		6	2.268	
61	Young people self-harm to gain immediate relief	61	5	1.62	*	4	1.096	
60	Young people self-harm because it makes them feel better	60	3	1.19	*	2	0.643	
44	Young people self-harm because it protects them from acting on suicidal feelings	44	3	1.03	*	0	0.227	
34	Young people self-harm because they don't know alternative coping strategies	34	2	0.67		3	1.064	
20	Young people self-harm because it makes them feel alive	20	1	0.41	*	0	-0.465	
25	Young people self-harm as a distraction	25	1	0.41	*	3	1.087	
45	Young people self-harm because they think they don't fit in with society	45	0	0.15		0	-0.335	
59	Young people self-harm because they are ignored	59	0	0.01	*	-2	-0.752	
47	Young people self-harm because it is addictive	47	0	-0.02	*	-4	-1.156	
65	Young people self-harm because of social pressures	65	0	-0.03	*	2	0.723	
27	Young people self-harm because they have a mental illness	27	0	-0.16	*	-2	-0.739	
50	Young people self-harm because they are impulsive	50	0	-0.18	*	1	0.519	
7	Young people self-harm because it gets their needs met from others	7	0	-0.23	*	1	0.577	
18	Young people self-harm because it keeps people close	18	-1	-0.39	*	0	0.252	

13	Young people self-harm because of hormonal changes/puberty	13	-1	-0.41	*	-3	-0.929	
31	Young people self-harm because they have a chemical imbalance in their brain	31	-1	-0.62	*	-5	-1.339	
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	19	-2	-0.71	*	-6	-1.787	
41	Young people self-harm because they are copying others	41	-2	-0.89		-1	-0.469	
10	Young people self-harm for attention	10	-3	-0.9	*	0	0.035	
51	Young people self-harm to make others run around after them	51	-3	-1.22		-6	-1.622	
26	Young people self-harm because they want to end their life	26	-4	-1.29	*	-2	-0.754	
4	Young people self-harm because they want to be rebellious	4	-4	-1.32		-2	-0.843	
63	Young people self-harm to make other people upset	63	-5	-1.49	*	-1	-0.572	
21	Young people self-harm because they are being manipulative	21	-6	-1.75	*	-1	-0.671	

Distinguishing Statements for Factor 2

(P < .05 : Asterisk (*) Indicates Significance at P < .01)

Both the Factor Q-Sort Value and the Z-Score (Z-SCR) are Shown

Statement No.	Statement	Statement Number	factor1 Q-SV	factor1 Z-score	Significance	factor2 Q-SV	factor2 Z-score	Significance
54	Young people self-harm to cope with distressing thoughts	54	6	1.86		6	2.27	
49	Young people self-harm to release emotional tension	49	6	1.98		5	1.47	
61	Young people self-harm to gain immediate relief	61	5	1.62		4	1.1	*
25	Young people self-harm as a distraction	25	1	0.41		3	1.09	*
34	Young people self-harm because they don't know alternative coping strategies	34	2	0.67		3	1.06	
65	Young people self-harm because of social pressures	65	0	-0.03		2	0.72	*
60	Young people self-harm because it makes them feel better	60	3	1.19		2	0.64	*
7	Young people self-harm because it gets their needs met from others	7	0	-0.23		1	0.58	*
50	Young people self-harm because they are impulsive	50	0	-0.18		1	0.52	*
18	Young people self-harm because it keeps people close	18	-1	-0.39		0	0.25	*
44	Young people self-harm because it protects them from acting on suicidal feelings	44	3	1.03		0	0.23	*
10	Young people self-harm for attention	10	-3	-0.9		0	0.04	*
45	Young people self-harm because they think they don't fit in with society	45	0	0.15		0	-0.34	
41	Young people self-harm because they are copying others	41	-2	-0.89		-1	-0.47	
20	Young people self-harm because it makes them feel alive	20	1	0.41		0	-0.47	*
63	Young people self-harm to make other people upset	63	-5	-1.49		-1	-0.57	*

21	Young people self-harm because they are being manipulative	21	-6	-1.75		-1	-0.67	*
27	Young people self-harm because they have a mental illness	27	0	-0.16		-2	-0.74	*
26	Young people self-harm because they want to end their life	26	-4	-1.29		-2	-0.75	*
59	Young people self-harm because they are ignored	59	0	0.01		-2	-0.75	*
4	Young people self-harm because they want to be rebellious	4	-4	-1.32		-2	-0.84	
13	Young people self-harm because of hormonal changes/puberty	13	-1	-0.41		-3	-0.93	*
47	Young people self-harm because it is addictive	47	0	-0.02		-4	-1.16	*
31	Young people self-harm because they have a chemical imbalance in their brain	31	-1	-0.62		-5	-1.34	*
51	Young people self-harm to make others run around after them	51	-3	-1.22		-6	-1.62	
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	19	-2	-0.71		-6	-1.79	*

Consensus Statements -- Those That Do Not Distinguish Between ANY Pair of Factors

All Listed Statements are Non-Significant at P > 0.01, and Those Flagged with an * are also Non-Significant at P > 0.05)

Statement Number	Significance	Statement	Statement Number	factor1 Q-SV	factor1 Z-score	factor2 Q-SV	factor2 Z-score
1	*	Young people self-harm to cope with difficult emotions	1	5	1.788	6	1.83
2	*	Young people self-harm because they like to experience pain	2	-1	-0.371	-1	-0.632
3	*	Young people self-harm because it helps them identify with others who self-harm	3	-1	-0.359	0	-0.185
4		Young people self-harm because they want to be rebellious	4	-4	-1.32	-2	-0.84
5	*	Young people self-harm because they feel powerless	5	2	0.747	2	0.72
6	*	Young people self-harm to challenge mental health professionals	6	-4	-1.252	-3	-1.069
8	*	Young people self-harm because they have learning difficulties	8	-2	-0.778	-2	-0.827
9	*	Young people self-harm to numb their feelings	9	3	1.031	3	0.945
11	*	Young people self-harm to block out painful memories	11	3	1.096	4	1.372
12	*	Young people self-harm because they enjoy it	12	-3	-1.047	-4	-1.291
14	*	Young people self-harm to get admitted to hospital	14	-1	-0.35	-1	-0.566
15	*	Young people self-harm to punish themselves	15	3	0.894	3	0.887
16	*	Young people self-harm because they are immature	16	-5	-1.388	-5	-1.409
17	*	Young people self-harm for fun or recreation	17	-6	-1.807	-5	-1.549
22	*	Young people self-harm because they use drugs	22	-2	-0.839	-2	-0.816
23	*	Young people self-harm because it gives them a sense of relief	23	5	1.684	4	1.386
24	*	Young people self-harm to cope with difficulties at home	24	2	0.573	2	0.74
28	*	Young people self-harm because they feel unsafe	28	2	0.514	1	0.624

29	*	Young people self-harm because it is popular at their age	29	-3	-1.149	-3	-1.087
30	*	Young people self-harm because it gives them a sense of control	30	4	1.25	5	1.463
32	*	Young people self-harm because they are trying new experiences	32	-1	-0.697	-1	-0.566
33	*	Young people self-harm because they don't get on with their parents	33	-1	-0.349	-1	-0.477
34		Young people self-harm because they don't know alternative coping strategies	34	2	0.67	3	1.06
35	*	Young people self-harm because they dislike themselves	35	2	0.674	2	0.685
36	*	Young people self-harm because they are part of the 'emo' or 'goth' subculture	36	-4	-1.224	-4	-1.278
37	*	Young people self-harm because they can't control their emotions	37	1	0.283	1	0.38
38	*	Young people self-harm because of transitions in their life	38	0	-0.005	0	-0.031
39	*	Young people self-harm because they are bored	39	-5	-1.369	-3	-1.112
40	*	Young people self-harm because they find it easier to deal with physical pain than emotional pain	40	4	1.384	3	1.093
41		Young people self-harm because they are copying others	41	-2	-0.89	-1	-0.47
42	*	Young people self-harm because they have been abused	42	1	0.479	1	0.586
43	*	Young people self-harm because they have a personality disorder	43	-2	-0.725	-3	-1.002
45		Young people self-harm because they think they don't fit in with society	45	0	0.15	0	-0.34
46	*	Young people self-harm because they are being bullied	46	1	0.386	1	0.482

48	*	Young people self-harm because they have not been punished enough for the behaviour	48	-3	-1.121	-4	-1.26
49		Young people self-harm to release emotional tension	49	6	1.98	5	1.47
51		Young people self-harm to make others run around after them	51	-3	-1.22	-6	-1.62
52	*	Young people self-harm because they have poor body image	52	1	0.456	0	0.376
53	*	Young people self-harm because they feel intense emotions	53	4	1.553	4	1.358
54		Young people self-harm to cope with distressing thoughts	54	6	1.86	6	2.27
55	*	Young people self-harm to cope with academic stress	55	1	0.333	1	0.468
56	*	Young people self-harm because they have low self-esteem	56	2	0.842	2	0.741
57	*	Young people self-harm to fit in with their friends	57	-2	-0.767	-1	-0.613
58	*	Young people self-harm because it makes people take them seriously	58	0	0.065	0	-0.281
62	*	Young people self-harm because they feel rejected	62	1	0.354	1	0.635
64	*	Young people self-harm because they are trying to communicate or express something	64	4	1.491	5	1.754

Relative Ranking of Statements in Factor 1

			Consensus	
	Highest Ranked Statements	factor 1	Distinguishing	factor 2
49	Young people self-harm to release emotional tension	6	D	5
54	Young people self-harm to cope with distressing thoughts	6	D	6
	Positive Statements Ranked Higher in factor 1 Array than in Other Factor Arrays			
23	Young people self-harm because it gives them a sense of relief	5	C*	4
61	Young people self-harm to gain immediate relief	5	D*	4
53	Young people self-harm because they feel intense emotions	4	C*	4
40	Young people self-harm because they find it easier to deal with physical pain than emotional pain	4	C*	3
60	Young people self-harm because it makes them feel better	3	D*	2
9	Young people self-harm to numb their feelings	3	C*	3
44	Young people self-harm because it protects them from acting on suicidal feelings	3	D*	0
15	Young people self-harm to punish themselves	3	C*	3
56	Young people self-harm because they have low self-esteem	2	C*	2
5	Young people self-harm because they feel powerless	2	C*	2
35	Young people self-harm because they dislike themselves	2	C*	2
24	Young people self-harm to cope with difficulties at home	2	C*	2
28	Young people self-harm because they feel unsafe	2	C*	1
42	Young people self-harm because they have been abused	1	C*	1
52	Young people self-harm because they have poor body image	1	C*	0
20	Young people self-harm because it makes them feel alive	1	D*	0
46	Young people self-harm because they are being bullied	1	C*	1
62	Young people self-harm because they feel rejected	1	C*	1
55	Young people self-harm to cope with academic stress	1	C*	1
37	Young people self-harm because they can’t control their emotions	1	C*	1

45	Young people self-harm because they think they don't fit in with society	0	D	0
58	Young people self-harm because it makes people take them seriously	0	C*	0
59	Young people self-harm because they are ignored	0	D*	-2
38	Young people self-harm because of transitions in their life	0	C*	0
47	Young people self-harm because it is addictive	0	D*	-4
27	Young people self-harm because they have a mental illness	0	D*	-2
	Negative Statements Ranked Lower in factor 1 Array than in Other Factor Arrays			
45	Young people self-harm because they think they don't fit in with society	0	D	0
58	Young people self-harm because it makes people take them seriously	0	C*	0
38	Young people self-harm because of transitions in their life	0	C*	0
65	Young people self-harm because of social pressures	0	D*	2
50	Young people self-harm because they are impulsive	0	D*	1
7	Young people self-harm because it gets their needs met from others	0	D*	1
33	Young people self-harm because they don't get on with their parents	-1	C*	-1
14	Young people self-harm to get admitted to hospital	-1	C*	-1
3	Young people self-harm because it helps them identify with others who self-harm	-1	C*	0
2	Young people self-harm because they like to experience pain	-1	C*	-1
18	Young people self-harm because it keeps people close	-1	D*	0
32	Young people self-harm because they are trying new experiences	-1	C*	-1
57	Young people self-harm to fit in with their friends	-2	C*	-1
8	Young people self-harm because they have learning difficulties	-2	C*	-2
22	Young people self-harm because they use drugs	-2	C*	-2
41	Young people self-harm because they are copying others	-2	D	-1
10	Young people self-harm for attention	-3	D*	0
29	Young people self-harm because it is popular at their age	-3	C*	-3
36	Young people self-harm because they are part of the 'emo' or 'goth' subculture	-4	C*	-4

6	Young people self-harm to challenge mental health professionals	-4	C*	-3
26	Young people self-harm because they want to end their life	-4	D*	-2
4	Young people self-harm because they want to be rebellious	-4	D	-2
39	Young people self-harm because they are bored	-5	C*	-3
16	Young people self-harm because they are immature	-5	C*	-5
63	Young people self-harm to make other people upset	-5	D*	-1
	Lowest Ranked Statements			
21	Young people self-harm because they are being manipulative	-6	D*	-1
17	Young people self-harm for fun or recreation	-6	C*	-5

Relative Ranking of Statements in Factor 2

			Consensus	
	Highest Ranked Statements	factor 2	Distinguishing	factor 1
54	Young people self-harm to cope with distressing thoughts	6	D	6
1	Young people self-harm to cope with difficult emotions	6	C*	5
	Positive Statements Ranked Higher in factor 2 Array than in Other Factor Arrays			
64	Young people self-harm because they are trying to communicate or express something	5	C*	4
30	Young people self-harm because it gives them a sense of control	5	C*	4
11	Young people self-harm to block out painful memories	4	C*	3
53	Young people self-harm because they feel intense emotions	4	C*	4
25	Young people self-harm as a distraction	3	D*	1
34	Young people self-harm because they don't know alternative coping strategies	3	D	2
9	Young people self-harm to numb their feelings	3	C*	3
15	Young people self-harm to punish themselves	3	C*	3
56	Young people self-harm because they have low self-esteem	2	C*	2
24	Young people self-harm to cope with difficulties at home	2	C*	2
65	Young people self-harm because of social pressures	2	D*	0
5	Young people self-harm because they feel powerless	2	C*	2
35	Young people self-harm because they dislike themselves	2	C*	2
62	Young people self-harm because they feel rejected	1	C*	1
42	Young people self-harm because they have been abused	1	C*	1
7	Young people self-harm because it gets their needs met from others	1	D*	0
50	Young people self-harm because they are impulsive	1	D*	0
46	Young people self-harm because they are being bullied	1	C*	1
55	Young people self-harm to cope with academic stress	1	C*	1
37	Young people self-harm because they can't control their emotions	1	C*	1

18	Young people self-harm because it keeps people close	0	D*	-1
10	Young people self-harm for attention	0	D*	-3
38	Young people self-harm because of transitions in their life	0	C*	0
3	Young people self-harm because it helps them identify with others who self-harm	0	C*	-1
58	Young people self-harm because it makes people take them seriously	0	C*	0
45	Young people self-harm because they think they don't fit in with society	0	D	0
	Negative Statements Ranked Lower in factor 2 Array than in Other Factor Arrays			
52	Young people self-harm because they have poor body image	0	C*	1
44	Young people self-harm because it protects them from acting on suicidal feelings	0	D*	3
38	Young people self-harm because of transitions in their life	0	C*	0
58	Young people self-harm because it makes people take them seriously	0	C*	0
45	Young people self-harm because they think they don't fit in with society	0	D	0
20	Young people self-harm because it makes them feel alive	0	D*	1
33	Young people self-harm because they don't get on with their parents	-1	C*	-1
14	Young people self-harm to get admitted to hospital	-1	C*	-1
32	Young people self-harm because they are trying new experiences	-1	C*	-1
2	Young people self-harm because they like to experience pain	-1	C*	-1
27	Young people self-harm because they have a mental illness	-2	D*	0
59	Young people self-harm because they are ignored	-2	D*	0
22	Young people self-harm because they use drugs	-2	C*	-2
8	Young people self-harm because they have learning difficulties	-2	C*	-2
13	Young people self-harm because of hormonal changes/puberty	-3	D*	-1
43	Young people self-harm because they have a personality disorder	-3	C*	-2
29	Young people self-harm because it is popular at their age	-3	C*	-3
47	Young people self-harm because it is addictive	-4	D*	0
48	Young people self-harm because they have not been punished enough for the behaviour	-4	C*	-3

36	Young people self-harm because they are part of the ‘emo’ or ‘goth’ subculture	-4	C*	-4
12	Young people self-harm because they enjoy it	-4	C*	-3
31	Young people self-harm because they have a chemical imbalance in their brain	-5	D*	-1
16	Young people self-harm because they are immature	-5	C*	-5
	Lowest Ranked Statements			
51	Young people self-harm to make others run around after them	-6	D	-3
19	Young people self-harm because they have a raised pain threshold and cannot feel the pain	-6	D*	-2

Appendix M – Factor Arrays

Composite Q sort for Factor 1

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
✳✳◀ Young people self-harm because they are being manipulative	Young people self-harm because they are bored	Young people self-harm because they are part of the 'emo' or 'goth' subculture	✳✳◀ Young people self-harm for attention	✳✳▶ Young people self-harm because they have a raised pain threshold and cannot feel the pain	Young people self-harm because they don't get on with their parents	✳▶ Young people self-harm because they think they don't fit in with society	Young people self-harm because they have been abused	Young people self-harm because they have low self-esteem	✳✳▶ Young people self-harm because it makes them feel better	Young people self-harm because they feel intense emotions	Young people self-harm to cope with difficult emotions	✳▶ Young people self-harm to release emotional tension
Young people self-harm for fun or recreation	Young people self-harm because they are immature	Young people self-harm to challenge mental health professionals	Young people self-harm because they enjoy it	Young people self-harm because they have a personality disorder	Young people self-harm to get admitted to hospital	Young people self-harm because it makes people take them seriously	Young people self-harm because they have poor body image	Young people self-harm because they feel powerless	Young people self-harm to block out painful memories	Young people self-harm because they are trying to communicate or express something	Young people self-harm because it gives them a sense of relief	✳◀ Young people self-harm to cope with distressing thoughts
	✳✳◀ Young people self-harm to make other people upset	✳✳◀ Young people self-harm because they want to end their life	Young people self-harm because they have not been punished enough for the behaviour	Young people self-harm to fit in with their friends	Young people self-harm because it helps them identify with others who self-harm	✳✳▶ Young people self-harm because they are ignored	✳✳▶ Young people self-harm because it makes them feel alive	Young people self-harm because they dislike themselves	Young people self-harm to numb their feelings	Young people self-harm because they find it easier to deal with physical pain than emotional pain	✳✳▶ Young people self-harm to gain immediate relief	
		✳◀ Young people self-harm because they want to be rebellious	Young people self-harm because it is popular at their age	Young people self-harm because they have learning difficulties	Young people self-harm because they like to experience pain	Young people self-harm because of transitions in their life	✳✳◀ Young people self-harm as a distraction	✳◀ Young people self-harm because they don't know alternative coping strategies	✳✳▶ Young people self-harm because it protects them from acting on suicidal feelings	Young people self-harm because it gives them a sense of control		
			✳▶ Young people self-harm to make others run around after them	Young people self-harm because they use drugs	✳✳◀ Young people self-harm because it keeps people close	✳✳▶ Young people self-harm because it is addictive	Young people self-harm because they are being bullied	Young people self-harm to cope with difficulties at home	Young people self-harm to punish themselves			
				✳◀ Young people self-harm because they are copying others	✳✳▶ Young people self-harm because of hormonal changes/puberty	✳✳◀ Young people self-harm because of social pressures	Young people self-harm because they feel rejected	Young people self-harm because they feel unsafe				
					✳✳▶ Young people self-harm because they have a chemical imbalance in their brain	✳✳▶ Young people self-harm because they have a mental illness	Young people self-harm to cope with academic stress					
					Young people self-harm because they are trying new experiences	✳✳◀ Young people self-harm because they are impulsive	Young people self-harm because they can't control their emotions					
						✳✳◀ Young people self-harm because it gets their needs met from others						

Legend

✳ Distinguishing statement at P< 0.05

✳✳ Distinguishing statement at P< 0.01

▶ z-Score for the statement is higher than in all the other factors

◀ z-Score for the statement is lower than in all the other factors

Composite Q sort for Factor 2

-6	-5	-4	-3	-2	-1	0	1	2	3	4	5	6
✳◀ Young people self-harm to make others run around after them	✳✳◀ Young people self-harm because they have a chemical imbalance in their brain	✳✳◀ Young people self-harm because it is addictive	✳✳◀ Young people self-harm because of hormonal changes/puberty	✳✳◀ Young people self-harm because they have a mental illness	✳▶ Young people self-harm because they are copying others	Young people self-harm because they have poor body image	Young people self-harm because they feel rejected	Young people self-harm because they have low self-esteem	Young people self-harm because they find it easier to deal with physical pain than emotional	Young people self-harm because it gives them a sense of relief	Young people self-harm because they are trying to communicate or express something	✳▶ Young people self-harm to cope with distressing thoughts
✳✳◀ Young people self-harm because they have a raised pain threshold and cannot feel the pain	Young people self-harm because they are immature	Young people self-harm because they have not been punished enough for the behaviour	Young people self-harm because they have a personality disorder	✳✳▶ Young people self-harm because they want to end their life	Young people self-harm because they don't get on with their parents	✳✳▶ Young people self-harm because it keeps people close	Young people self-harm because they feel unsafe	Young people self-harm to cope with difficulties at home	✳✳▶ pain Young people self-harm as a distraction	Young people self-harm to block out painful memories	✳◀ Young people self-harm to release emotional tension	Young people self-harm to cope with difficult emotions
	Young people self-harm for fun or recreation	Young people self-harm because they are part of the 'emo' or 'goth' subculture	Young people self-harm to challenge mental health professionals	✳✳◀ Young people self-harm because they are ignored	Young people self-harm to get admitted to hospital	✳✳◀ Young people self-harm because it protects them from acting on suicidal feelings	Young people self-harm because they have been abused	Young people self-harm because they feel powerless	✳▶ Young people self-harm because they don't know alternative coping strategies	Young people self-harm because they feel intense emotions	Young people self-harm because it gives them a sense of control	
		Young people self-harm because they enjoy it	Young people self-harm because it is popular at their age	Young people self-harm because they use drugs	Young people self-harm because they are trying new experiences	✳✳▶ Young people self-harm for attention	✳✳▶ Young people self-harm because it gets their needs met from others	✳✳▶ Young people self-harm because of social pressures	Young people self-harm to numb their feelings	✳✳◀ Young people self-harm to gain immediate relief		
			Young people self-harm because they are bored	Young people self-harm because they have learning difficulties	✳✳▶ Young people self-harm to make other people upset	Young people self-harm because of transitions in their life	✳✳▶ Young people self-harm because they are impulsive	Young people self-harm because they dislike themselves	Young people self-harm to punish themselves			
				✳▶ Young people self-harm because they want to be rebellious	Young people self-harm to fit in with their friends	Young people self-harm because it helps them identify with others who self-harm	Young people self-harm because they are being bullied	✳✳◀ Young people self-harm because it makes them feel better				
					Young people self-harm because they like to experience pain	Young people self-harm because it makes people take them seriously	Young people self-harm to cope with academic stress					
					✳✳▶ Young people self-harm because they are being manipulative	✳◀ Young people self-harm because they think they don't fit in with society	Young people self-harm because they can't control their emotions					
						✳✳◀ Young people self-harm because it makes them feel alive						

Legend

✳ Distinguishing statement at P< 0.05

✳✳ Distinguishing statement at P< 0.01

▶ z-Score for the statement is higher than in all the other factors

◀ z-Score for the statement is lower than in all the other factors

Appendix N – Journal of Adolescence Guide for Authors

JOURNAL OF ADOLESCENCE

The Journal of the Foundation for Professionals in Services to Adolescents (FPSA)

AUTHOR INFORMATION PACK

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ISSN: 0140-1971

DESCRIPTION

The *Journal of Adolescence* is an international, broad based, cross-disciplinary journal that addresses issues of professional and academic importance concerning development between **puberty** and the attainment of **adult status** within society. Our focus is specifically on **adolescent *development***: change over time or negotiating age specific issues and life transitions. The aim of the journal is to encourage research and foster good practice through publishing empirical studies, integrative reviews and theoretical and methodological advances. The *Journal of Adolescence* is essential reading for adolescent researchers, social workers, psychiatrists, psychologists, and youth workers in practice, and for university and college faculty in the fields of psychology, sociology, education, criminal justice, and social work.

Research Areas Encompassed:
- Adolescent development with particular emphasis on social, cognitive, and emotional functioning
- Resilience, positive development, and effective coping
- Disturbances and disorders of adolescence
- Public health approaches and interventions designed to reduce risk or support positive development

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Introduction

The Journal of Adolescence is an international, broad based, cross-disciplinary journal that addresses issues of professional and academic importance concerning development between puberty and the attainment of adult status within society. Our focus is specifically on adolescent development: change over time or negotiating age specific issues and life transitions. The aim of the journal is to encourage research and foster good practice through publishing empirical studies, integrative reviews and theoretical and methodological advances. The Journal of Adolescence is essential reading for adolescent researchers, social workers, psychiatrists, psychologists, and youth workers in practice, and for university and college faculty in the fields of psychology, sociology, education, criminal justice, and social work.

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- Resilience, positive development, and effective coping
- Disturbances and disorders of adolescence
- Public health approaches and interventions designed to reduce risk or support positive development

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CHAPTER 3: Executive Summary

Why do young people self-harm? An exploration of staff beliefs

Word Count: 2,003

Contents

Why do young people self-harm? An exploration of staff beliefs

Executive Summary

Arsal Rana

Trainee Clinical Psychologist

Introduction

- Self-harm can be defined as deliberately causing injury to oneself, with or without the intent of committing suicide (National Collaborating Centre for Mental Health, 2011).

- The National Institute of Health and Care Excellence (NICE, 2004) states that the meaning of self-harm varies between each individual and is determined by personal circumstances.

- Research suggests that one of the most common functions of self-harm is emotion regulation (Klonsky, 2007; Klonsky & Muehlenkamp, 2007).

- Self-harm can occur at any age but is most common in young people. Some studies estimate that 13% of people aged 15 or 16 have self-harmed during their lives (Hawton, Rodham, Evans & Weatherall, 2002).

- Recent research suggests that rates of self-harm are rising. A study in the UK found a 68% increase in self-harm incidents reported among girls aged 13-16 between 2011 and 2014 (Morgan, Webb, Carr, Kontopantelis, Green, Chew-Graham, Kapur & Ashcroft, 2017).

- Research with staff members who are in contact with people who self-harm is often conducted with emergency department staff. Findings from many of these studies highlight that staff can hold negative attitudes towards people who self-harm (Saunders, Hawton, Fortune & Farrell, 2012).

- The negative attitudes expressed by some staff are experienced by individuals who self-harm, which may further lead to cycles of shame, avoidance and further self-harm.

- Research finds that as staff knowledge about self-harm increases, negative attitudes towards individuals who self-harm decreases (Timson, Priest & Clark-Carter, 2012).

- Staff training is often recommended as an outcome from studies exploring staff attitudes and is usually requested by staff who report feeling unprepared for treating self-harm.

- There are likely to be differences in the levels of understanding about self-harm between staff working in different service settings.

- Overall there is less research exploring community mental health staff attitudes and beliefs about self-harm in comparison to emergency department staff.

What was the aim?

The aim of this study was to investigate the beliefs held by staff working in Child and Adolescent Mental Health Services (CAMHS) about why young people self-harm.

Q-methodology was used to investigate this.

What is Q-methodology?

Q-methodology is a type of research method developed by William Stephenson (1935), used to explore personal opinions on a topic. Q-methodology is useful to explore topics such as self-harm, as it involves asking people to sort statements about a topic in order to find out what is least and most important to them. In this way, people do not need to come up with new ideas, but instead are able to rate the options presented to them.

This sorting is usually done by placing statements (printed on cards) onto a grid.

The number of spaces on the grid is designed to make people to think carefully about what they agree and disagree with. An example of this grid can be seen further below (see Figure 1).

These completed grids are known as Q-sorts. Once all of the participants have completed their Q-sort, they are analysed using a technique called factor analysis to look for similarities and differences in the placement of statements.

A number of distinct factors (viewpoints) are then generated and interpreted to explore the topic under investigation.

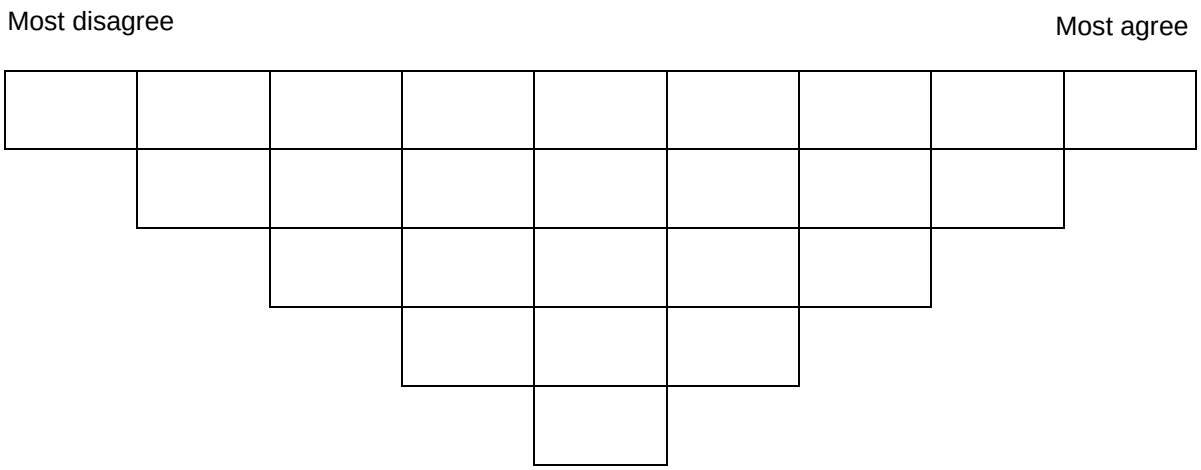

Figure 1. An example of a grid used in Q-methodology

What was done?

Prior to the study commencing, it was approved by the Staffordshire University Ethics Committee and the NHS Health Research Authority.

Sixty-five statements about why young people might self-harm were generated from the existing literature. This included research articles, magazines, news, online blogs, television programmes and informal discussions with mental health staff.

Examples of these statements can be seen below (see Figure 2).

Young people self-harm to cope with difficult emotions	Young people self-harm for attention	Young people self-harm because of social pressures
Young people self-harm because they want to end their life	Young people self-harm because it gives them a sense of control	Young people self-harm to punish themselves

Figure 2. Example statements

Any CAMHS staff member over the age of 18 who had some form of clinical contact with young people was able to take part in the study. A broad range of professions were sought so that the results would be more representative of the diverse CAMHS workforce.

The study was advertised via an email sent to CAMHS managers and the researcher also visited teams to discuss the study and recruit participants.

In total, 25 staff members took part from a range of healthcare professions. The study sample included nurses, social workers, support workers, psychiatrists, psychologists, play and parenting practitioners and systemic family therapists.

All 25 participants completed a Q-sort, which took between 30-45 minutes. Afterwards, participants were asked to comment on their Q-sort and answer some questions to help interpret the results.

The results were then analysed using a computer programme known as Ken-Q. This software highlighted Q-sorts that were similar to each other and grouped these into clusters. These clusters then formed the study factors (i.e. the different viewpoints).

These viewpoints were then explored further to examine staff beliefs about self-harm.

What was found?

Data analysis revealed that some statements were shared (ranked similarly) by all participants.

These shared viewpoints were:

- Participants agreed that young people self-harm for a variety of reasons which are different for everyone. Most participants believed that young people self-harm to cope with difficult emotions, block out painful memories and to gain a sense of relief. Participants also agreed that young people self-harm because they feel intense emotions and may find it easier to deal with physical pain than emotional pain. Most participants also felt that self-harm may occur if young people feel powerless, and it provides them with a sense of control.

- Most participants did not view self-harm as a method of challenging mental health professionals. Participants also did not believe that young people self-harm because they enjoyed it, or because it was 'popular', or to fit in with friends.

Beyond this consensus, two distinct viewpoints were found to be held by participants.

Viewpoint 1: Self-harm is a private experience used for coping

This factor represented the viewpoint of 14 participants.

Participants who held this viewpoint tended to identify personal functions of self-harm:

- Self-harm is used to cope with distressing thoughts and feelings
- Self-harm is used to help young people feel better
- Self-harm provides a relief for young people
- Self-harm protects against suicide
- Self-harm is a private act, conducted in secret

Participants within this viewpoint did not believe that young people self-harm because they are manipulative or rebellious. These participants also did not agree that self-harm was used to gain attention, make other people upset or to keep other people close.

Viewpoint 2: Self-harm seeks connection with others

This factor represented the viewpoint of 11 participants.

Participants who held this viewpoint tended to identify inter-personal functions of self-harm:

- Self-harm gets young people's needs met from others
- Self-harm keeps people close
- Self-harm helps young people feel connected to others
- Young people self-harm because of social pressures

Participants within this viewpoint rejected negative stereotypes such as self-harm as an act 'to make others run around after them'. Participants also did not believe that any diagnosis or 'label' was a suitable explanation for self-harm.

Further distinguishing this viewpoint were the beliefs held by participants that biological theories could not account for self-harm; such as young people self-harming because they had a chemical imbalance in their brains or they could not physically feel the pain.

What does this mean?

- The findings suggest that staff within CAMHS are knowledgeable about the functions of self-harm.

- Two distinct viewpoints were found which were characterised by the function of self-harm either serving personal reasons (for the self) or inter-personal reasons (relating to others).

- This is in-line with current understandings and research about the functions of self-harm (Klonsky, 2007; Klonsky & Muehlenkamp, 2007).

- The shared viewpoints held by staff highlighted that most staff rejected the negative connotations about self-harm, such as self-harm being used to challenge others.

Recommendations

- Many staff believed that self-harm was a result of young people feeling powerless. This may highlight that interventions for addressing self-harm could involve providing young people with a greater sense of control within their lives, such as working collaboratively with them or involving them in decisions where possible.

- Some staff believed that self-harm was not addictive, but rather done out of habit, and possibly as a result of young people not knowing other coping strategies. It may therefore be beneficial for staff to be trained about alternative strategies to provide to young people.

- Staff could be trained in components of Dialectical Behaviour Therapy (DBT) such as emotion regulation and distress tolerance techniques, which would support them in providing young people with alternative strategies for self-harm.

- Post-sort interviews with staff (i.e. discussion after completing the Q-sort) revealed that some staff would like to know more about the biological theories for self-harm. For example, whether there is a link between hormonal changes and self-harm, or self-harm resulting from changes within the brain. Staff training could address this.

- Staff should continue to explore the individual reasons for self-harm with each young person they work with.

Now what?

It is important to consider some of the limitations of the study before suggesting further research.

Some of the identified issues with this study were:

- It is unlikely that the set of statements generated for this study represent every belief about self-harm.

- Post-sort interviews with staff highlighted some potentially missing statements. For example, some staff said that they would have liked to have seen some statements about the influence of television and media, parental mental health and cultural reasons for self-harming.

- Staff completed the Q-sort in the researchers presence, which may have influenced how they ranked certain statements.

- The viewpoints that were found in this study were not checked with participants after completing the study, which would have helped improve their validity.

- Q-sorts were only completed once by participants. Some Q-studies repeat the sort after some time with a small number of participants to check the reliability of the Q-sorts (i.e. the stableness of views).

Future research may wish to first address the limitations of the study. For instance, using a focus group when generating statements to ensure that participant viewpoints are considered when generating the study materials. Q-sorts may also be completed online to further anonymise participants' responses, which may help them respond more openly. It would also be useful to seek participant feedback on the themes identified from the study to ensure that they accurately represent participant views.

Beyond this, some areas future studies may wish to consider:

- Using Q-methodology with young people or their parents.

- Using Q-methodology with staff from different service settings and comparing the findings. For example, recruiting from inpatient wards, general hospitals and schools.

- Using Q-methodology in staff training, such as asking staff to complete their own Q-sorts to explore their current understanding of self-harm and how this may change.

- Exploring whether staff beliefs about self-harm affect how they respond to the behaviour. Interviews or focus groups could be used for this.

The full research article is intended to be submitted for publication to a peer-reviewed journal, under the title: 'Why do young people self-harm? A Q-methodology study exploring staff beliefs'. This executive summary is aimed to be distributed amongst CAMHS services within Midlands Partnership Foundation Trust (MPFT) and North Staffordshire Combined Healthcare NHS Trust (NSCHT).

Conclusion

This is the first study to use Q-methodology to explore CAMHS staff beliefs about self-harm. This was vital to explore, as previous research suggested that beliefs about self-harm can influence staff attitudes towards those who self-harm. Negative attitudes are likely experienced by individuals who self-harm which may lead to further self-harm and a reluctance to seek help in the future.

This study demonstrated that CAMHS staff are knowledgeable about self-harm and hold beliefs that are consistent with the literature around self-harm in young people. The findings from this study are a useful indicator of how staff within CAMHS may understand self-harm in young people.

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