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Help-Seeking for and Responding to Adolescent Self-Harm: Exploring the Experiences of Young People and Educational Professionals

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This thesis is submitted in partial fulfilment of the requirements for the degree of Doctorate in Clinical Psychology

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List of Abbreviations

ACEs	Adverse Childhood Events
BPS	British Psychological Society
CAMHS	Child and Adolescent Mental Health Services
CASE	Child and Adolescent Self-Harm Research Group
CASP	Critical Appraisal Skills Programme
CFT	Compassion Focused Therapy
DoH	Department of Health
GDPR	General Data Protection Regulations
RTA	Reflexive Thematic Analysis
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-analyses
NICE	National Institute of Healthcare Excellence
NHS	National Health Service
SPIDER	Sample, phenomenon of interest, design, evaluation, research type
TIC	Trauma-Informed Care
ToL	Tree of Life
TS	Thematic Synthesis
WHO	World Health Organisation
UK	United Kingdom

Acknowledgements

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Declaration

This thesis has been submitted for the Clinical Psychology Doctorate at the Universities of Coventry and Warwick. It has not been submitted for any other degree or to any other institution. This thesis is an original piece of work, conceptualised, developed, and conducted under the supervision of Jacqueline Knibbs (Coventry University) and Dr Claudie Fox (University of Warwick).

The literature review will be submitted to the *Adolescent and Child Mental Health* Journal (please see Appendix A for submission guidelines). The empirical paper will be submitted to the *School Mental Health* journal (please see Appendix B for submission guidelines). The central findings from the empirical paper will be submitted as a poster presentation at the University of Warwick Postgraduate Research conference.

Summary

This thesis explores the experiences of both education staff and young people during the help-seeking process for self-harm.

Chapter One is a systematic literature review exploring young people's perceived barriers and facilitators to disclosing or help-seeking for self-harm. It critically appraises and synthesises the recent qualitative literature that has been contributed to the field, with the aim to appreciate new collective insights. Fifteen papers were identified and analysed through Thematic Synthesis. Subsequently, three analytic themes were identified which provide novel insights into a young individual's turbulent journey to help-seeking for self-harm; youths experience *inner conflict* and develop a sense of *learned apathy* as they *navigate services* which are often unfamiliar or inaccessible. The findings have several implications for both policy and practices, which if implemented comprehensively, will support an open discourse around self-harm and encourage help-seeking in these vulnerable individuals

Chapter Two is a qualitative research paper that contributes to the largely incomplete body of literature on how staff are impacted by identifying and responding to self-harm in schools. Following interviews with fourteen school and college staff, a Reflexive Thematic Analysis identified three key themes: *A Way of Being*; *Complex and Evolving Internal Processes*; and *A Rock and a Hard Place*. These themes highlighted school staff's compassionate approach to self-harm, the psychological impact of managing a disclosure or incident, and their way of coping in the face of internal conflicts and external pressures. In light of these findings, several practical considerations are proposed to improve support for school staff working with students who self-harm.

Chapter Three is a reflective piece outlining the internal processes and dilemmas faced by the researcher throughout their research journey. The author acknowledges the importance of 'reflexivity', and with reference to key psychological literature and theory, considers their influence on the research process and the research's influence on them.

Overall Word Count: 19723 (excluding Abstracts, Titles, Tables, Figures, and References)

Chapter One

Systematic Literature Review

The Barriers and Facilitators to Formal and Informal Help-Seeking in Young People who
Self-Harm: A Thematic Synthesis

Overall Chapter Word Count:7984
(Excluding Abstract, Titles, Tables, Figures, and References)

This chapter is written in preparation for submission to the *Adolescent and Child Mental Health* Journal

1.0. Abstract

Background: Self-harm is becoming an increasingly common phenomenon in adolescents and young adults, yet only a small minority of individuals disclose their behaviour or seek help from others to manage this. In recent years a wealth of qualitative research has sought to establish some of the key barriers and facilitators to disclosure and help-seeking in this population; a review is thus required to understand these new insights.

Aims: The current systematic literature review aims to synthesise the qualitative literature relating to facilitators and barriers to young people's disclosure of self-harm and their help-seeking, from both formal, informal, and online sources.

Methods: A comprehensive literature search was conducted across several databases including PsychINFO, CINHAL, MedLine, PubMed, Proquest, SCOPUS, and Web of Science. Of the 1420 studies initially identified, 15 studies were determined to satisfy requirements for inclusion and were assessed for their quality.

Results: Three themes were identified from the thematic synthesis of the included studies' findings: (1) *Inner Conflict*, reflecting how internal psychological processes create a barrier to seeking help; (2) *Learned Apathy*, describing how negative experiences of services and disclosure deter young people help-seeking; (3) *Navigating Services*, highlighting how mental health literacy and accessibility to support can influence a young person's decision to seek and engage in treatment.

Conclusions: This review presents a novel insight into a young individual's decision to seek help for self-harm. The multifaceted journey of disclosure and help-seeking relies on the individual to overcome several internal dilemmas, external stigmatising attitudes and negative responses, and navigate inaccessible services. Nevertheless, compassionate and individualised approaches can instil hope and promote the instigation or continuation of professional help. These accounts have several implications for both policy and practices across healthcare, education and wider society, which are discussed alongside this review's limitations and recommendations for future research.

Key Words: *adolescent, young adult, barriers, facilitators, help-seeking, disclosure, self-harm*

Word Count: 293

1.1. Introduction

Self-harm is a long-standing and significant social and healthcare concern (Hawton et al., 2006). Adolescents and young adults (13–25-year-olds) account for the highest incidence of self-harm within the population (Rodham & Hawton, 2009), with 18% of adolescents and 38% of young adults reporting to have self-harmed on at least one occasion (Muehlenkamp et al., 2012; Whitlock et al., 2011). Whilst self-harm can be a short-term coping mechanism without long-term implications (Moran et al., 2012), several negative clinical and social outcomes have been linked to self-harm and its concealment including increased suicidal behaviour (Mars et al., 2014). However, fewer than half of those who engage in this behaviour choose to disclose or seek help (Doyle et al., 2015).

1.1.1. The Terminology and Definition of Self-Harm

Despite an increased research focus, the conceptualisation of self-harm is a contentious issue. Inconsistencies in terminology exist globally. The term 'non suicidal self-injury' (NSSI) is favoured in the USA and refers to the direct, purposeful destruction of body tissue without suicidal intent (Nock, 2009). Contrastingly, 'self-harm', the preferred term in Europe, refers to both self-injurious behaviour and self-poisoning (Hawton et al., 2007). The term 'deliberate self-harm' (DSH) is also used, however this term has been criticised as being insensitive and accusatory (Kapur et al., 2013). Furthermore, there is a dispute regarding the degree to which self-harm alongside attempted suicide is distinct from self-harm without suicidal intent, with some viewing the motivations for self-harm as being fluid or on a continuum (Wilson & Ougrin, 2021).

Such inconsistencies have exacerbated difficulties in the comparison of international prevalence rates. The large-scale Child and Adolescent Self-harm in Europe (CASE) study attempted to rectify this and coined a comprehensive definition of self-harm to promote reliable, comparative data on its magnitude (Madge *et al*. 2008). CASE defined self-harm as an intentional act with a non-fatal outcome encompassing a range of methods including cutting, overdosing and self-battery (Madge et al., 2008). Subsequently, this is the operational definition employed throughout this review.

1.1.2. Help-Seeking for Self-Harm

Rickwood and Thomas (2012) proposed a general definition of help-seeking suggesting this is "an adaptive coping process that is the attempt to obtain external

assistance to deal with a mental health concern" (pg.6). Therefore, within this review 'help-seeking behaviour' refers to any action carried out by an individual which attempts to seek support for self-harm. This includes seeking support from formal and informal sources (Barker et al., 2005).

For the minority who do seek help for self-harm, individuals are more likely to initially seek informal support rather than approaching health services (Ystgaard et al., 2009). For some, online help-seeking is preferred over face-to-face support (Jones et al., 2011) perhaps due to the anonymity and social connection online platforms afford (Sutherland et al., 2014). This is concerning given the wealth of evidence suggesting that accessing appropriate psychological interventions can decrease the severity of injuries sustained from self-harm and reduce the risk of future suicide attempts (Aseltine et al., 2007), thus making it vital that vulnerable youth are linked with timely and appropriate support (Hom et al., 2015).

1.1.3. Evaluation of Previous Reviews

Many have endeavoured to understand young people's perceptions of seeking support for self-harm. Michelmore and Hindley (2012) were among the first to review the literature relating to self-harm, suicidality, and help-seeking behaviours in young people (aged 26 and under). They examined twenty-three epidemiological studies that reported on the sources of support, and confirmed that the majority of young people seek neither medical or psychological help for self-harm. Moreover, conclusions from three studies highlighted that young people hold beliefs around self-reliance and assume that support will be unsuccessful, acting as a barrier to help-seeking. Nevertheless, this review is limited by its predominant use of prevalence studies where information on help-seeking was secondary. Furthermore, significant differences in the literature's methodologies hindered the drawing of robust comparisons. Consequently, conclusions relating to barriers to help-seeking were somewhat incomplete.

To address these limitations, Rowe and colleagues (2014) considered the literature relating to self-harm and help-seeking behaviours in 11-19-year-olds. Further to identifying the sources of support accessed by adolescents, the authors determined factors that influenced their help-seeking. Several correlates of help-seeking emerged in literature published between 2005 and 2013, where age, gender, and frequency and method of self-harm influenced the likelihood of help-seeking. Furthermore, perceived stigma was presented as significant obstacle to help-seeking. Comparably fewer studies reported on

the facilitators to help-seeking. However, these highlighted key themes including assurances surrounding confidentiality, and feeling respected. The approach to this review was limited by the lack of transparency around the quality assessment of the selected papers: a practice that is considered pivotal to the systematic review procedure (Burls, 2014). Readers therefore cannot be assured that conclusions were drawn from studies with sound methodological design (Carroll & Booth, 2015).

Finally, a systematic review synthesised the findings from forty-one studies relating to the disclosure of self-harm (Simone & Hamza, 2020). The authors argued that the motivation behind disclosure is not always for the purpose of help-seeking, thus 'disclosure' was considered a separate entity, and studies that explicitly measured help-seeking without reference to disclosure were excluded. Results highlighted that approximately 50% of adolescents and adults disclosed self-harm, with these disclosures being more likely to be made to friends and partners than formal sources. Furthermore, fears of rejection, being a burden and upsetting a loved one, were identified to deter disclosures of self-harm. Negative disclosure experiences were commonly reported among disclosers, however, those with more positive experiences were more likely to seek formal help.

1.1.4. Rationale for the Current Review

The range of reviews of the literature centring on self-harm and help-seeking have revealed some pertinent insights, although these are limited. Each review has seemingly overlooked an important aspect and has therefore not explicitly focused on barriers and facilitators to help-seeking in young people. For example, Rowe and colleagues (2014) did not study the experiences of young adults, yet this group make up a large proportion of the population who self-harm (McManus et al, 2019). Furthermore, others have not considered the barriers and facilitators to help-seeking for self-harm exclusively (Michelmore & Hindley, 2012), including research on help-seeking for suicidality and general mental health concerns. Given the rising prevalence of self-harm (Borschmann & Kinner, 2019), exclusive consideration of this phenomenon across the 'young' population is important to yield more comprehensive insights.

Disclosure may serve as an initial step in the help-seeking process (Hasking et al., 2015) and therefore could be deemed a help-seeking behaviour, making it critical that this act is examined and promoted. Nevertheless, previous reviews may have overlooked

important papers relating to the factors that facilitate or inhibit the disclosure of self-harm (Michelmore & Hindley, 2012). Whilst this has been rectified by Simone and Hamza (2020), it is conceivable that the exclusion of papers examining help-seeking limited their findings. An understanding of the inhibiters and facilitators that individuals consider important and specific to both self-harm disclosure and help-seeking is crucial in promoting access to timely professional support. Thus, given the commonly overlapping nature of help-seeking and disclosure (Wu et al., 2012), it is important that findings relating to all help-seeking behaviours are integrated.

Furthermore, the aims of Simone and Hamza's (2020) review were relatively broad, where the authors aimed to consolidate the wide range of existing literature relating to the disclosure non-suicidal self-injury across the adolescent and adult lifespan. Of the forty-one studies included, thirty consisted of quantitative studies that reported on the demographics of the disclosure recipients, and rates or likelihood of disclosures. The included qualitative studies also varied, with many including perspectives from those who had been disclosed to and few considering accounts from adolescents. Consequently, the authors were able to provide an overview of the area, but further analytic interpretation of themes was not achieved. The current review will therefore differ from Simone and Hamza's (2020) work in several key ways. Firstly, the current review will focus solely on the experiences of adolescents and young adults who both disclose and actively help-seek for self-harm, rather than include the views of others. Secondly, the review will aim to delineate the key barriers and facilitators rather than consider this topic more generally. As a result, there will be limited overlap between the studies included within the two reviews.

The primary focus on quantitative studies is not unique to Simone and Hamza (2020), as the majority of studies included in all of the aforementioned reviews were epidemiological or correlational in nature. This approach fails to integrate the qualitative narratives from young people that may provide exploration of individual contexts and situations (Dixon-Woods et al., 2006). Although a wealth of qualitative research has recently been contributed to this field, to date, no review has synthesised the themes identified from these studies. Insight into individuals' experiences of help-seeking can inform best-practice and equip an individual's network to effectively respond to self-harm (Simone & Hamza, 2020); it is important that these new understandings are appraised.

1.1.5. Aims and Objectives

This systematic literature review aims to provide an update of the qualitative literature relating to facilitators and barriers to young people's disclosure of self-harm and their help-seeking, from both formal and informal sources. Therefore, the following research question will be addressed:

What are the perceived barriers and facilitators to formal and informal help-seeking behaviours in young people who self-harm?

The SPIDER model was employed to formulate and operationalise this question (Cooke et al., 2012; Appendix C)

1.2. Methods

1.2.1. Systematic Literature Search

Ethical approval for the review was granted through Coventry University in 2021 (Appendix D) and a review protocol was registered on PROSPERO (CRD42021287567; Appendix E) prior to the searches commencing.

An electronic search was conducted between January and March 2022, including published papers through to March 3rd 2022. Databases relevant to the field of Clinical Psychology were employed for the searches. Three databases were searched separately via EBSCOhost (PsychINFO, CINHAL and MedLine); additional searches were made through PubMed, Proquest, SCOPUS, and Web of Science. Google Scholar was also searched, as the combination of this search engine with databases is considered optimal for literature searches (Bramer et al., 2017). The reference lists of the identified papers were also scanned for prospective articles.

To identify articles that included a focus on both self-harm and help-seeking, key search terms were developed alongside the SPIDER structure (Table 1.1.). Expertise from a subject librarian was sought to formulate and refine terms which were subsequently combined using Boolean operators. The full search for each database is outlined in Appendix F.

Table 1.1.

Key Search Terms and Search Locations

Main Concept	Synonyms	Location in Text
Young people	*"young person*" or "teen*" or "child*" or "adolescen*" or "youth" or "young adult"*	Title Abstract
Self-Harm	"self-harm*' *or* 'self harm*' *or* "non-suicidal self-injur*" *or* "non suicidal self injur*" *or* "non suicidal self-injur*" *or* "non-suicidal self injur*" *or* 'NSSI' *or* "DSH" *or* "self-injury" *or* "self injury" *or* "self-injurious behav*" *or* "self-mutilation" *or* "deliberate self-harm" *or* "cutting" *or* "self-cutting" *or* "self-burning" *or* "self-poisoning" *or* "parasuicide"	Title Abstract
Help-seeking	"disclos*" *or* "self-disclosure" *or* "help-seek*" *or* "help seek*" *or* "support seek*"	Title Abstract
Barriers/Facilitators	*"barrier" or "hurdle" or "obstruct*" or "block*" or "promot*" or "facilitat*" or "support*" or "encourage*" or "inhibit" or "stigma" or "shame'*	Title Abstract Main Body

1.2.2. Inclusion/Exclusion Criteria

To ensure that only studies pertinent to the review question were selected, several inclusion and exclusion criteria were determined prior to the literature search (Table 1.2.). These criteria were established by the main author but were reviewed and agreed upon by the research team.

To avoid omitting research of value to the synthesis, a broad definition of 'qualitative methodology' was applied (Bernard & Ryan, 2010). Therefore, studies were included if the authors presented some conceptual development around participant responses. Papers that employed a mixed-methods design were also included if part of their results section met this criterion. As the review aims to reach an up-to-date understanding of barriers and facilitators, studies published before 2011 were excluded.

Table 1.2.

Inclusion and Exclusion Criteria

Criteria	Inclusion	Exclusion
Variables/Concepts	Considers the barriers and facilitators of help-seeking in self-harm and/or disclosure of self-harm	No reference to potential barriers or facilitators to help-seeking
	Self-harm is the main focus of the study, papers can include reference to suicidal behaviour.	Self-harm is not the main focus of the research (i.e studies focus primarily on suicidal behaviour, suicidal ideation, or other mental health difficulties).
	Help-seeking can be informal, formal, in person, or online.	
	Help-seeking and disclosure could have already happened or be intentional.	Definition of Self-Harm not in line with CASE
	The definition of Self-Harm in line with CASE	
Participants	Participants aged between 10 to 25 years	Participants are not aged between 10 to 25 years of age.
	Participants have engaged in self-harm as defined by CASE	Age ranges are not reported
	Participants are all genders & sexualities	Youth's perspectives are not reported separately
Timeframe	Published within the last 10 years	Published before 2012
Study Type/Quality	Study is peer-reviewed	Study is not peer-reviewed
	Qualitative or Mixed Methods	Quantitative
	Use of open question, and themes reported.	No evidence of contextual theme development.
Language/Location	Studies from any location, and published in English	Published in other languages

To maximise the sensitivity of detection of relevant and high-quality literature, no limits were placed on the study location, provided they were published in English and in

a peer-reviewed journal. The decision to include studies from all locations was taken to enable all young people's experiences to be understood, irrespective of culture. However, the authors did recognise that the differing spiritual and political beliefs held by those within different cultures is likely to impact how self-harm is perceived and responded to. Nevertheless, including studies from all locations these cultural differences can be explored, whilst keeping in mind the potential influence of cultural bias.

In line with CASE, articles were included in the review if the researchers indicated participant engagement in self-harming behaviours irrespective of lethal intent (Madge et al., 2008). As such, it was assumed that 'suicidal behaviour' constituted self-harm and studies exploring this were included, whereas studies focusing on suicidal thoughts were not included as this does not suggest a completed act of self-harm. Given the overlap between self-harm and suicidality (Wilson & Ougrin, 2021), to ensure relevant literature was not overlooked, studies were included if the primary aim of the research focused on self-harm. Studies which focused on other mental health problems such as eating disorders, or depression were excluded.

A focus on intentional or actual self-harm disclosure or help-seeking from either informal, formal, or online supports, was also a criterion for inclusion. Additionally, as the opinions of individuals who engage in self-harming behaviour is the primary focus of the review, studies were excluded if data was obtained exclusively from third parties (e.g. parents, professionals), or when outcomes from different informants were merged within the results section.

Studies were also included if participants were within the age range of 10-25 years old. These age parameters were adopted as the age of adolescence is understood to be between 10-19 years of age (World Health Organisation [WHO], 2018), and the age of 25 has been identified as the conventional upper limit for participation in adolescent self-harm studies (Hawton et al., 2012). Papers that did not report participants' age-range were excluded.

1.2.3. Classification of Studies

The selection process for studies included in this review was reported in line with the 'preferred reporting items for systematic reviews and meta-analyses' (PRISMA) flow diagram (Figure 1.1; Page et al., 2021). A total of 1420 potential articles were identified from the databases. Following the removal of 484 duplicates,

abstracts were manually screened, and 695 further articles were excluded for not meeting the aforementioned criteria. Additional searches of Google Scholar yielded 39 articles; a further 22 were discovered in reference lists of eligible papers.

Following this screening, 234 full text articles were assessed for eligibility in line with the criteria. The full text of these papers was studied and 218 were excluded due to either the sample not being individuals who self-harm and/or the wrong age-range, the results not reporting the phenomenon of interest, the use of an unsuitable study design or evaluation methods, or lack of evidence of conceptual development. To ensure inter-rater reliability, a second assessor checked the selected papers to determine whether they accurately reflected the inclusion criteria (Appendix G). Following this, one study was excluded and 15 papers were accepted for review.

Figure 1.1. *PRISMA flow diagram showing the selection process of studies*
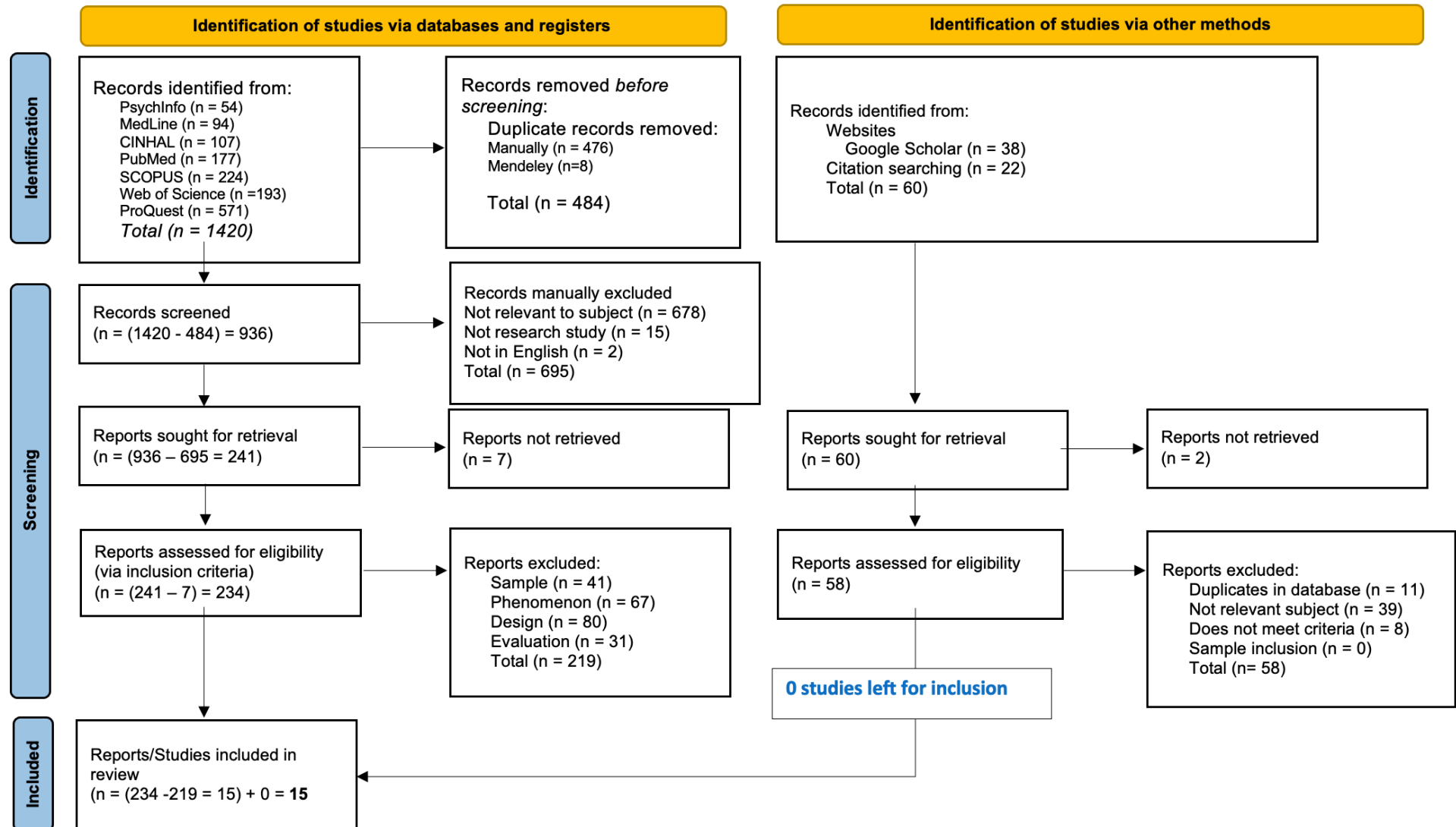
1.2.4. Quality Assessment Checks

A quality assessment for all papers was completed using the Critical Appraisal Skills Programme (CASP, 2018) for qualitative studies framework. The tool has ten questions that each focus on a different methodological aspect of a qualitative study, including the study's findings, their validity and wider value. The CASP was deemed appropriate for this review as it is frequently employed in healthcare-related qualitative evidence syntheses (Dalton et al., 2017).

Each of the 15 studies were scored against the CASP (2018) using a scoring procedure outlined by Butler and colleagues (2016). A score was ascribed to each of the 10 items on the CASP for each paper, with 0 meaning the paper did not achieve the criteria and 0.5 or 1 denoting partial or full achievement. Scores were then totalled to rate the paper as either low (total score <7.5), moderate (total score between 7.5 - 9), or high quality (total score >9). Papers were scored in line with Butler and colleague's scoring criteria (2016) and were all found to have a total quality score of 6 or higher, thus no papers were excluded from the review. Papers generally scored highly on the consideration of ethics, and the presentation of credible findings. However, many researchers did not explicitly consider how their roles influenced data analysis.

To increase reliability, a second researcher independently conducted a CASP assessment on the selected studies. To ensure this process was effective, an inter-rater reliability assessment was conducted to yield a Kappa coefficient for each article. Kappa scores ranged from $k=.57$ to $k=1$, demonstrating low-to-moderate to very strong agreement (Altman, 1999). Quality scores delineated by both raters and Kappa calculations can be found in Appendix H.

1.2.5. Characteristics of the Literature

An overview of each study is provided in Table 1.3. To ensure consistency, a second researcher also independently completed data extraction for two studies (Appendix I).

Table 1.3.

Characteristics of the Included Studies

Author/s, Date and Location	Research Aim/s	Research Design	Sample: Number, Age (M ± SD), Gender, Characteristics, Details of Self-Harm	Data Collection Method	Analysis and Approach	Key Findings in relation to Barriers and Facilitators to Help-Seeking.	Quality Rating
Aggarwal et al. (2020) Mumbai, India	Evaluate the perspective of clients and families and their explanatory styles around self-harm to inform service design. *Completed as part of a wider study.*	Qualitative	*N = 15* (youth) Age: 15-24 (m= 19.8 ± 2.81) Gender: 10 females; 5 males. Participants presented to psychiatry department following a self-harm attempt. *(N=4 Caregivers also interviewed, but findings reported separately)*	Qualitative Interview	Phenomenological Thematic Analysis	**Barriers:** *Happens in the spur of the moment and automatically.* *Seeking Secrecy.* *Not wanting to share with strangers.* *Not identifying as an individual who fits the 'self-harmer' stereotype.*	Low *k=.83*
Byrne et al. (2021) Melbourne, Australia	Examine young people's views on their experiences of seeking care for self-harm from Emergency Departments	Mixed Methods	*N = 13* Age: 17-25 (m= 21.2 ± 2.1) Gender: 11 females; 2 gender diverse individuals. 11 Australian; 1 Pilipino; 1 Fijian	Semi-Structured Interviews Quantitative: *PHQ-4* to assess distress* pre-interview.	Qualitative: Thematic Analysis Quantitative:	**Facilitators:** *Follow-up after discharge from Emergency Department.* **Barriers:** *Feeling undeserving of care and a burden on the system.* *Self-Stigma.*	Moderate *k=.62*

	Examine the feasibility of conducting research that's asks young people to recount their experiences of care for self-harm.		Participants had presented to emergency department following a self-harm attempt (with or without suicidal intent). *N=3* reported one attendance to Emergency Department; N=10 reported multiple attendances.			*Counter-therapeutic experiences.* *Lack of Privacy.* *Perceptions of negative attitudes of and interactions with staff.*	
Chen et al. (2021) Xiangya, China	Explore how adolescents think and feel about self-harm, the different methods of self-harm used, and the reasons why adolescents do not seek help from services.	Qualitative	*N = 22* Age: 12-24 (m= 18.05 ± 2.98) Gender: 19 females; 3 males 6 were 'left behind children; 9 from single-parent families. Participants must have reported two or more episodes of non-fatal self-harm. *N= 6* reported drug overdose; *N=16* reported cutting; *N = 5* reported hitting head or other body part.	Semi-Structured Interviews	Interpretative Phenomenological Analysis	**Barriers:** *Seeking Secrecy.* *Denial that self-harm is an issue.* *Others not paying attention.* *Lack of awareness about how to access support.*	Moderate *k=.57*
Frost, Casey & Rando (2016) Australia	Investigate young people's perspectives of online services for self-injury and the use of the internet as a tool to facilitate help-seeking. *Completed as part of a wider study.*	Mixed Methods	*N= 679* Age: 14-25 (m= 18.01 ± 3.01) Gender: 399 females *296 identified as heterosexual* Presence of non-suicidal self-harm measured via SHBQ (NSSI Subscale)[+] 36.8% (n= 168) of participants had previously sought help online.	Online Survey	Qualitative: Thematic Analysis Quantitative: Independent sample t-tests	**Facilitators:** *Knowing where to go for support.* *Knowing how to initiate conversations with others.* *Assurance of anonymity and confidentiality* *Non-judgemental support.*	Moderate *k=.82*

Hassett & Isbister (2017) South England, United Kingdom	Explore factors that facilitate young males' initial access and ongoing engagement in mental health services.	Qualitative	*N* = 8 Age: 16-18 (m= 16.75 ± 0.71) Gender: 8 Males Self-Harm was key feature of referral to CAMHS; two or more episodes of self-harm in 12 months prior.	Semi-Structured Interviews	Interpretative Phenomenological Analysis	**Facilitators:** *Normalising of help-seeking by external sources.* *Normalising from a 'gender perspective'.* *Others initiating conversations or help.* *Internal Motivation.* *An influential other being of the same gender.* *Being given choice and control.* *Sensitive/Individualised approach from clinicians* **Barriers:** *Difficulty 'vocalising' problems.* *Striving for Independence.* *Inability to recognise need for help.* *Help-seeking perceived as 'weak'.*	High *k=1.0*
Idenfors et al. (2015) Sweden	Explore young people's experiences, views, and awareness of professional help, prior to their first	Qualitative	*N = 10* *Age:* 17-24 (m= 20.00 ± 2.54) Gender: 4 Males; 6 Females	Semi-Structured Interview	Qualitative Content Analysis	**Facilitators:** *Several routes to care.* *Others initiating help.*	Moderate *k=1.0*

	contact with health services for self-harm.		Participants had presented to emergency department, or child and adolescent mental health clinic due to self-harm, regardless of suicidal intent. *N= 5* reported self-poisoning; *N=6* reported cutting; *N = 1* reported hitting head or other body part; *N= 1* reported attempted jump			**Barriers:** *Lack of knowledge about where to turn.* *Inaccessible information about services.* *Fear of not being taken seriously.* *Lack of confidence in the professional's ability to help.* *Inability to recognise or minimisation of need.* *Belief it is own's own responsibility to get better.* *Feeling like a burden to others.* *Fear of worrying family.* *Stigma and Shame.* *Perceptions of negative attitudes of and interactions with other.*	
Klineberg et al. (2013) London, United Kingdom	Investigate how ethnically diverse youth speak about self-harm, and their experiences of disclosure and help-seeking.	Qualitative	*N=20* *Age:* 15-16 Gender: 6 Males; 24 Females *N=2* White British; *N= 10* Asian; *N=4* Black*; N=4* Mixed Ethnicity.	Semi-Structured Interviews	Framework Analysis	**Facilitators:** *Talking to someone with specific characteristics (either similar/dissimilar) to them.* **Barriers:** *Struggling to find the words to talk about it.*	Moderate *k=1.0*

			N= 9 had self-harmed once; N=11 had self-harmed repeatedly. *(N=10 non self-harming participants also interviewed, but findings reported separately)*			*Self-harm not seen as an issue.* *Fear of negative responses and being labelled.* *Lack of emotional understanding from others.* *Lack of knowledge about where to turn or processes.* *Having to involve family members.* *Scepticism about the response they might receive.* *Not wanting others in the community to know.*	
McAndrew & Warne (2014) United Kingdom	Elicit the narratives of young people who engage in self-harm and suicidal behaviour, to identify what was helpful and unhelpful when seeking support.	Qualitative	*N=7* *Age:* 13-17 Gender: Females *N=7* White British All participants required to have experience of self-harm and/or suicidal behaviour.	Narrative 1:1 Interviews	Interpretative Phenomenological Analysis	**Facilitators:** *Immediate access to help.* *Availability of trusted adults.* *Confidentiality.* *Talking to someone who is independent of the family.* *Feeling emotionally safe.* **Barriers:** *Not having the courage to ask for help*	Low *k=1.0*

						Lack of knowledge about where to turn or processes.	
						Embarrassment and shame surrounding self-harm	
						Dismissive attitudes	
McDermott (2014)	Examine the help-seeking strategies for self-harm employed by LGBT youth.	Qualitative	*N=290* *Age:* 13-25 LGBT Youth Sample included individuals who had posted about engagement in self-harm, and included views from those who had and had not sought help for self-harm.	Online Forum Discussions and Blogs	Thematic Analysis	***Facilitators*** Forums specifically designed for the participant's population. **Barriers:** *Feelings that emotions should be hidden.* *Experience of distress being demeaned.* *Difficult to ask for help and not knowing what to say.* *Concerns about others negative perceptions* *Fear of rejection/isolation* *Fear of hurting family* *Fear that seeking help will mean they will also have to disclose sexuality.* *Sense that it easier to remain silent.* *Fear of stigmatising consequences.*	Moderate *k=.80*

						Fear of potential medical outcomes.	
Mughal et al. (2021)	Explore the help-seeking behaviour, access to and experiences of general practice of young people who self-harm.	Qualitative	*N=13* *Age:* 19-25 (m= 22.08 ± 2.18) Gender: 12 Females; 1 Transgender Male. N= 7 White British; N=1 White American; N= 1 Asian British; N= 3 Mixed; N=1 Not disclosed. N=12 in higher education; N=1 in college. All required to have experience of self-harm, of any type.	Semi-Structured Interviews	Reflexive Thematic Analysis	**Facilitators:** *Others supporting access to services* *Considerate and calm approach* *Feeling listened to and not judged* *Being involved in decision making.* *Being offered personalised care.* *Timely access to support.* *Developing trusting relationships with professionals.* **Barriers:** *Not feeling ready to seek help* *Dismissive attitudes and not feeling listened to.* *Unreliability of Professionals* *Perceptions that professionals don't know how to help.* *Preconceived negative views of care*	High *k=.62*
England, United Kingdom.							

						Loss of confidentiality	
						Fear of being hospitalised	
						Fear of being stigmatised	
						Lack of knowledge about how to access support	
						Not perceiving self-harm as something that needs support.	
Owens et al. (2016) England, United Kingdom.	Examine young people's perceptions of A&E treatment following self-harm and their views on what constitutes a positive clinical encounter.	Qualitative	*N=31* *Age:* 16-25 *(m=19.5)* Gender: 30 Females; 1 unreported. *N=30* white ethnic origin; *N=1* unreported ethnicity. Participants had previous encounters with A&E. All had self-harmed in the 4 years prior. *N= 16* reported self-poisoning; *N=31* reported cutting; *N= 22* reported restrictive eating; *N= 13* reported binge eating; *N = 14* reported burning; *N = 14* reported misuse of alcohol or drugs; *N= 18* reported other attempts	Online Forum Discussions	Inductive Thematic Analysis *(Secondary Analysis)*	**Facilitators:** *Others suggesting support is warranted* *Compassionate responses* **Barriers:** *Feeling able to treat own wounds.* *Judgemental attitudes* *Feeling like a 'timewaster'* *Hearing about other's negative experiences* *Feelings of shame and unworthiness* *Denial of care from services* *Lack of follow-up care*	Low *k=.66*

| Rosenrot & Lewis (2020)

Location, Unreported | Understand the experience of disclosure of NSSI, and the factors that facilitate or act as barriers to its disclosure. | Qualitative | *N=17*
Age: 18-22
(m= 18.82 ± 1.04)
Gender: 16 Females; 1 Male.

N=14 reported NSSI in the past year; N=16 had disclosed NSSI at least once. | Semi-Structured Interviews | Thematic Analysis | **Facilitators:**
Openness and Acceptance

Non-judgemental approach

Barriers:
Shame and Embarrassment

Others avoiding talking about it

Concerns about causing pain to others

Fear of being a burden

Fear that others might regard them as a 'specific type' of person.

Fear of being perceived differently | Moderate
k=1.0 |
| Stänicke et al. (2020)

Norway | Explore girls' experiences of beginning and quitting self-harm. | Naturalistic Multiple Case-Study | *N=19*
Age: 13-18
(m=15.9)
Gender: Females

Self-harm, with or without suicidal intent, was documented during a clinical assessment. N=15 reported cutting; *N* = 2 reported burning; *N* = 1 reported scratching; *N= 1* reported self-poisoning. | Semi-Structured Interviews | Interpretative Phenomenological Analysis | **Facilitators:**
Others initiate help-seeking

Feeling respected and welcomed by professionals

Barriers:
Belief that treatment won't be helpful.

A need to be independent

Feeling undeserving of help.

Ambivalence towards change | High
k=.74 |

Tillman et al. (2018)	Understand the lived experience of middle school females who self-harm and attitudes towards seeking professional help.	Qualitative	*N=6* Age: 13.8 (m= 13.8 ± 0.41) *Gender: Females* *N=4 White; N=2 multiracial.* *N=4 heterosexual; N=1 bisexual; N=1 asexual.*	Semi-Structured Interviews	Interpretative Phenomenological Analysis	**Facilitators:** *Non-judgemental approach* *Having a safe space to be themselves* **Barriers:** *Not seeing self-harm as a problem.*	Moderate *k=1.0*
United States			*All participants reported a personal history of self-harm.* *N= 6* reported cutting; *N = 4* reported burning; *N = 6* reported scratching; *N= 4* reported self-poisoning; *N = 7* reported misuse of alcohol or drugs; *N = 4* reported hitting; *N = 6* reported scratching.			*Fear of being dismissed Being dismissed by others* *Fear of being perceived as overdramatic* *Fear of consequences of disclosure.* *Lack of health insurance*	
Wadman et al. (2018)	Explore young women's experiences of self-harm in the context of interpersonal stressors and supports.	Qualitative	*N=14* Age: 13-18 (m= 16.00) Gender: Female White British	Semi-Structured Interviews	Interpretative Phenomenological Analysis	**Facilitators:** *Openness and Acceptance* **Barriers:** *Protect others from the impact of self-harm*	Moderate *k=.58*
United Kingdom			Participants had self-harmed in the sixth months prior to the study.			*Unhelpful responses from others (trivialising/dismissive)* *Unresponsive services*	

*PHQ-4; Patient Health Questionnaire (Kroenke et al., 2009)

+ SHBQ; Self-Harm Behaviour Questionnaire (Gutierrez et al., 2006)

Six studies were conducted in the UK (Hassett & Isbister, 2017; Klineberg et al., 2013; McAndrew & Warne, 2014; Mughal et al., 2021; Owens et al., 2016; Wadman et al., 2018), two studies took place in Australia (Byrne et al., 2021; Frost et al., 2016), and one in each of the United States (Tillman et al., 2018), Norway (Stänicke et al., 2020), Sweden (Idenfors et al., 2015), India (Aggarwal et al., 2020) and China (Chen et al., 2021). Two studies failed to explicitly state the study's location (Rosenrot & Lewis, 2020), however, one of these took their results from an online sample (McDermott, 2014). Six studies were conducted within two years of this review.

Sample sizes ranged from 6 (Tillman et al., 2018) to 679 (Frost et al., 2016) and included a diverse group of participants. Participants had all self-harmed at least once previously, although it is unclear how many had sought formal or informal help for this. The studies combined sampled 1164 adolescents and/or young adults, the majority of whom were females, with 6 studies including males (Aggarwal et al., 2020; Chen et al., 2021; Hassett & Isbister, 2017; Idenfors et al., 2015; Klineberg et al., 2013; Rosenrot & Lewis, 2020). At least 27 males, 1 transgender male and 2 'gender-diverse' individuals were included across all studies (two studies failed to report full gender demographics of their sample [Frost et al., 2016; McDermott, 2014]).

Two studies focused primarily on experiences of disclosing self-harm and help-seeking (Rosenrot & Lewis, 2020; Klineberg et al., 2013), three studies investigated youths' perceptions of seeking help from health services (Byrne et al, 2021; Mughal et al., 2021; Owens et al., 2016; Idenfors et al., 2015), and one explored facilitators to online help-seeking (Frost et al., 2016); the remaining studies focused on general experiences of self-harm. Two studies used mixed methods (Frost et al., 2016; Byrne et al., 2021), one employed a Naturalistic Multiple Case-Study (Stänicke et al., 2020) the remainder used qualitative designs and analysis. Studies utilised a variety of data collection methods including online surveys (Frost et al., 2016), data from online forums and blogs (McDermott, 2014; Owens et al., 2016), narrative interviews (McAndrew & Warne, 2014), and semi-structured interviews.

1.2.6. Analytic Review Strategy

As the systematic review aimed to identify key issues and summarise collective conclusions within narrative content rather than the meaning of experiences, a Thematic Synthesis (TS) was utilised (Bearman & Dawson, 2013). Historically, syntheses of

qualitative data have been criticised for a lack of methodological rigour as key steps of the analysis are often not adequately reported and analytic themes are often under-developed (Dixon-Woods et al., 2006). However, TS overcomes these limitations as it outlines rigorous steps of data analysis to identify and amalgamate common and conflicting themes from various studies to deepen the original findings (Ring et al., 2011). In addition to its methodological advantages, TS was considered appropriate for this review as it is commonly utilised to answer research questions relating to barriers and facilitators to mental health care and recovery (e.g. Maund et al., 2019).

The TS was completed in line with the three stages outlined by Thomas and Harden (2008): (1) coding of findings, (2) developing descriptive themes, and (3) generating analytical themes. The results or findings section of each study was extracted and inductive line-by-line coding was completed on all text. During this process, the research question was 'side-lined' and the content and meaning of each line was coded, then collated in a codebook. Descriptive themes were generated by searching for patterns across the codes. With the review's question in mind, the descriptive themes were then used to make inferences to develop analytical themes (Appendix J depicts this process). This stage aimed to produce a new interpretation of barriers and facilitators to help-seeking for self-harm which advanced the themes outlined in the included studies. To ensure inter-rater agreement, sub-themes and themes were further developed and refined through research team discussions.

1.3. Results

Three analytical themes *Inner Conflict*, *Learned Apathy*, and *Navigating Services* were identified through the TS of the included studies (See Figure 1.2.). To ensure that the participants voices are acknowledged, quotation excerpts from the original studies were used to illustrate outlined themes. The contributions of each study to the reported themes are highlighted in Table 1.4., with the majority of studies presenting data that reflects each theme's concept. Therefore, the outline of the findings will focus on studies particularly relevant to each theme.

Figure 1.2

Hierarchical Map of Analytic Themes and Subthemes.

Inner Conflict	Characterological Shame and Guilt
	Changing Sense of Identity
	Ambivalence
Learned Apathy	Varied Responses
	Lack of Adequate Care
Navigating Services	Finding the Words
	The Quest for Knowledge
	Need for Responsive and Individualised Care
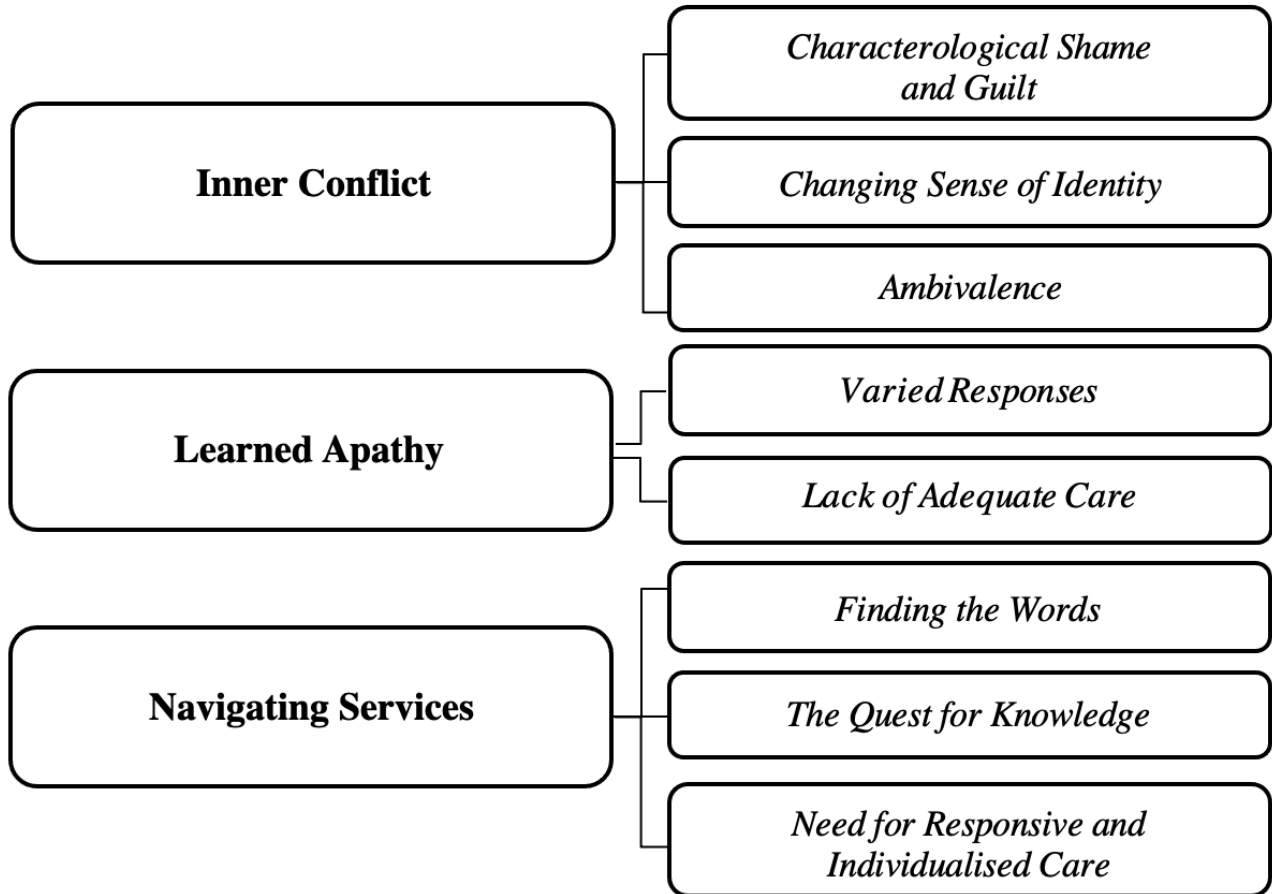
Table 1.4.

The occurrence of analytic themes in each study.

Main Theme	*Inner Conflict*			*Learned Apathy*			*Navigating Services*	
Subtheme	*Characterological Shame*	*Changing Sense of Identity*	*Ambivalence*	*Varied Responses*	*Lack of Adequate Care*	*Finding the Words*	*Responsive and Individualised*	*The Quest for Knowledge*
Aggarwal et al., (2020)		✓		✓	✓		✓	
Byrne et al. (2021)	✓			✓	✓	✓	✓	
Chen et al., (2021)			✓	✓	✓		✓	✓
Frost et al. (2016)				✓		✓	✓	✓
Hassett & Isbister (2017)		✓	✓	✓		✓	✓	✓
Idenfors et al. (2015)		✓		✓	✓	✓	✓	✓
Klineberg et al. (2013)			✓	✓	✓	✓	✓	✓
McAndrew & Warne (2014)	✓			✓		✓	✓	✓
McDermott (2014)	✓	✓	✓	✓		✓		
Mughal et al (2021)	✓	✓	✓	✓	✓		✓	✓
Owens et al. (2016)	✓			✓	✓		✓	
Rosenrot & Lewis (2020)	✓	✓		✓		✓		
Stanike et al., (2020)	✓	✓	✓	✓	✓	✓	✓	
Tillman et al (2018)	✓		✓	✓	✓		✓	
Wadman et al. (2018)	✓			✓	✓		✓	

1.3.1. Inner Conflict

Participants in all but one study (Frost et al., 2016) highlighted the experience of 'inner conflict', where intense shame and a potential disintegration of identity seemed to make disclosing self-harm or asking for help more challenging. Additionally, the conflicting feelings of ambivalence about the significance of self-harm and the need for help often inhibited help-seeking.

1.3.1.1. Characterological Shame and Guilt

Young people described contempt towards themselves and their self-harm, prompting internal shame and disgust. Characterological shame was not reported by participants in studies taking place in India and China (Aggarwal et al., 2021; Chen et al., 2021), although this was depicted in Western cultures. McDermott's (2014) study of young LGBT writing online highlighted the complex intersection between sexuality and self-harm, further intensifying experiences of characterological shame. Feelings of shame were accompanied by a sense of inadequacy with many expressing self-attacks about their character through comments like "*I make myself sick*" (McDermott, 2014; pg.11). This shame can be silencing, leading to concealment of self-harm and creating a barrier to help-seeking.

If participants were able to seek help, these feelings accompanied them to healthcare provisions, with many reporting feeling undeserving of treatment. A study of a diverse Australian sample, who had sought help from an emergency department following self-harm, highlighted participants' self-perception of being "*selfish*" and "*needy*" for presenting to services (Byrne et al., 2021, pg.5). This creates an internal dilemma wherein young adults recognise that help is needed but worry about whether they 'deserve' care.

> *"You're kind of fighting between two sides of, 'I want to tell you that I need to be here', but then you're also fighting this urge in your head, like 'Don't be an attention seeker. You really aren't that bad in comparison to everyone else here'."* (Byrne et al., 2021, pg.5)

Feelings of guilt were also evoked by the fear that disclosure would burden or upset others (Rosenrot & Lewis, 2020). To manage the shame and guilt of needing to ask for help regarding self-inflicted wounds, participants omitted details or deceived others about the origins of their injuries.

1.3.1.2. Changing Sense of Identity

The idea that help-seeking for self-harm would result in some form of divergence from the individual's identity was a common belief. This was particularly salient in the young British male's narratives analysed by Hassett and Isbister (2017); beliefs around masculinity initially prevented them from seeking support as this was considered "*weak*" and it was important to "*cope independently*". Nevertheless, a need for an identity emanating "independence" was common among young people of all genders and sexualities. This often acted as a barrier to help-seeking as young people shared views such as:

"...*being independent and managing things by myself is so important to me.*" (Stanike et al., 2020, pg.617)

Furthermore, several participants believed that their identities did not align with those who they perceived as being part of an 'out-group'. Whilst discussing reasons for not help-seeking in Aggarwal and colleagues' study (2021), young people from India felt they did not belong to the group of individuals who engage in self-harm.

"*Wrong people do so. People who are in love and breakup... I don't want to be thought of as one of them.*" (Aggarwal et al., 2021, pg.7)

For this participant, the decision to not seek help could be considered a method of identity preservation. The discomfort of being perceived as part of an unfavourable social group was well recognised, with participants expressing fears of being seen as an "*emo chick*" (Rosenrot & Lewis, 2020, pg.127) or being identified as a "*patient*" (Hassett & Isbister, 2020, pg.7). These concerns created resistance to fully committing to the help-seeking process:

"*But I really don't like everything (help) represents. I do not want to be ill. I do not want to be a patient. I want to be the therapist. Not the crazy one.*" (McDermott, 2014, pg.9)

The idea of needing help potentially creates inner conflict as it necessitates a changing sense of identity. Consequently, young individuals seem to become absorbed in an evolving process of negotiating their need for help as they battle with the consequences for their image and identity.

1.3.1.3. Ambivalence

Young people's accounts of their experiences and attitudes towards help-seeking also signified a sense of 'ambivalence' about the need to end self-harm. This conflicting internal experience was succinctly described by one LGBT participant, who stated "*this ambivalence is killing me. I want help but I don't*" (McDermott, 2014, pg.9).

Chen and colleagues (2021) highlighted a sense of indifference towards self-harming behaviour, where one Chinese youth stated "*I do not think self-harm is a problem for myself*"(pg.4*)*. Such positions highlight that the lack of intention to change, initiated by denial, creates an internal barrier to help-seeking. A sense of denial was reiterated in the views of American teenagers who highlighted that self-harm has 'no effect' on them (Tillman et al., 2018), and in British youth who rationalised that they had to be in the 'right frame of mind' to accept support (Mughal et al., 2021). A study of Norweigan help-seeking females accentuated that even if young adults recognise a need for support, the rewarding aspects of self-harm can obstruct full investment in the help-seeking process (Stänicke et al., 2020, pg.618):

> "*It's like a drug, in a way—people use it to escape, and you don't think about your problems anymore.*"

Here, ambivalence may be understood as an incongruity between the immediate advantages and potential longer-term negative consequences of continuing self-harm. As such, overcoming ambivalence might facilitate the engagement in the journey of help-seeking, from commencement and throughout professional therapeutic support.

1.3.2. Learned Apathy

Experiences of others' unhelpful responses and inadequate care were reported in all studies. The culmination of these experiences could be understood as 'Learned Apathy', where young people come to expect aversive and unchangeable outcomes. The consequence of such helplessness is threefold: reinforcement of the young individual's feelings of shame and hopelessness, adverse health consequences, and further secrecy and avoidance of help-seeking. Nevertheless, experiences of compassion and validation counteract such consequences.

1.3.2.1. Varied Responses

Many young individuals in the studies in this synthesis reported experiences of stigmatising and shaming attitudes in relation to their self-harm. Such attitudes were particularly pronounced in the narratives of young people who had sought medical help. British females described how stigmatising attitudes promoted discrimination, as they were refused standard care on account of having self-inflicted injuries:

> *"They refused to treat me!! . . . basically 'cos it's self-harm . . . I feel like giving up. What's the point if no-one even wants to try and help?"* Owens et al., 2016, pg.288).

These prejudices reinforced their desire for secrecy (Klineberg et al., 2013), often at the cost of their physical health with one individual sharing they have *"ended up with numerous infections from not getting wounds treated"* (Owens et al., 2016, pg.288).

Furthermore, many individuals highlighted how revealing self-harm, either accidentally or purposefully, was often met with avoiding or ignoring responses. This was prominent for youths living in China, with individuals describing how disclosures were met with inaction by both parents and teachers who "*just let it be*" (Chen et al., 2021, pg.4). Avoidance in talking about self-harm was also prominent in professionals and families in Western cultures (McAndrew & Warne, 2014; Mughal et al, 2021). These interactions often left participants feeling silenced and isolated, encouraging shame, hopelessness and further secrecy:

> *"…we just never spoke about it [...] I didn't stop, it didn't help me stop, I just hid it better…" (*Rosenrot & Lewis, 2020, pg.130)

Young individuals also expressed frustration that their self-harm was dismissed. Their age may have contributed to a minimisation of distress by others who saw self-harm as normal teenage behaviour (McAndrew & Warne, 2014), attributing self-harm to 'hormones' (McDermott, 2014). This resulted in participants feeling that the legitimacy of their distress was being questioned, perhaps reflected in the perceived lack of care or empathy from A&E staff (Byrne et al., 2021). Such dismissive responses negatively impacted their decision to seek future help:

"I left the conversation feeling perhaps I was assigning more importance to this that it requires […] I've never been to see the GP since" (Mughal et al., 2021, pg.748)

In contrast, eight studies reported that experiences of compassionate and calm responses from influential others, facilitated the help-seeking process (McAndrew & Warne, 2014; Owens et al., 2016; Tillman et al., 2018; Wadman et al., 2018; Rosenrot & Lewis, 2020; Stanike et al., 2020; Byrne et al., 2021; Mughal et al, 2021). Compassionate responses incorporated active listening and fostered feelings of emotional safety through a non-judgmental, open approach. Importantly, compassionate interactions fostered feelings of respect and a sense that they were being taken seriously. These experiences instilled optimism and a belief "*that things will be okay*" (Byrne et al., 2021, pg.7), perhaps counteracting feelings of learned apathy by ending "*the overwhelming shame*" (Rosenrot & Lewis, 2020, pg.132).

1.3.2.2 Lack of Adequate Care

Overall, participants felt 'let down' by a lack of adequate care. Such dissatisfaction was consistently reported across nationalities and healthcare settings, including emergency departments (Owens et al., 2016) and community and inpatient mental health services (Wadman et al., 2018; Mughal et al., 2021; Idenfors et al., 2015; Chen et al., 2021). The participants reflected that professional care did not fulfil its expected therapeutic function. For example, those seeking care from Australian emergency departments described these as "*just somewhere for me to be*" rather than a service that provides therapeutic care (Byrne et al., 2021, pg.6). Furthermore, young participants accessing counselling in India highlighted how this "*should have been more helpful*" (Aggarwal et al., 2020, pg.6), and British youth shared despondency in being recommended strategies despite their inefficacy:

"[CAMHS] just giving me the same solutions over and over again […]. It was just 'have you tried this' and I'd just be like 'no it doesn't work', and she'd just be like 'well try it again'." (Wadman et al., 2015, pg.126)

These experiences led to decreased confidence in professionals' abilities, ultimately diminishing trust in services. Furthermore, participants felt 'bounced around', either not meeting thresholds for mental health services or being sent home

from emergency care as they *"couldn't really do much"* (Byrne et al., 2021, pg.6). This created a sense of hopelessness and deterred future help-seeking.

1.3.3. Navigating Services

Individuals must navigate complex healthcare services which can affect their decision to seek treatment. Several barriers to accessing services exist, including lengthy waiting times and limited mental health literacy. Furthermore, the modes of communication preferred by services are not conducive to young people, unless they are willing to have an adult do this for them. Services that provided individualised, responsive, and easily accessible support often promoted the engagement of young people. This theme was reflected in all studies.

1.3.3.1 Finding the Words

The difficulty in constructing a coherent narrative and 'finding the words' to explain their experiences of self-harm to others was a common barrier to help-seeking. The struggle to articulate their complex experiences and "bring up the subject" was identified by Australian youth (Frost et al., 2016) and prominently featured within LGBT+ youths' online discussion:

"Thanks for putting the Samaritans number on this site I think I need to give them a call. I'm scared I don't know what to say exactly" (McDermott, 2014, pg.9).

Here, the uncertainty of what to say to initiate help was anxiety-provoking, and many may not find the "courage" to overcome this fear (McAndrew & Warne, 2014). Nevertheless, young British males indicated a sense of "relief" when others initiated conversations about their self-harm (Hassett & Isbister, 2017). The helpful role of informal support in facilitating help-seeking was extended into navigating professional services, as friends and family often supported participants' contacts with services, advocating for their needs when they were not in "*a place to communicate well*" (Byrne et al., 2021, pg.8; Idenfors et al., 2015).

The samples considered methods of communication which may enable them to vocalise their need for help. Email and SMS communication methods with services were a preferred option, allowing time to "think about" what to say (Hassett & Isbister, 2017) and providing privacy and confidentiality (Byrne et al., 2021; Klineberg et al., 2013).

Consequently, the communication method directly influenced the decision to establish contact:

> *"Because many also feel it is difficult to express what you feel in writing. But I feel that sometimes it can be easier [...] I know that if I had an e-mail address to write to I would have done it a long time ago" (*Idenfors et al., 2015, pg.181)

1.3.3.2 The Need for Responsive and Individualised Support

Reflections on the type of support required to encourage help-seeking formed a key part of participants' accounts. The impulsive nature of self-harm often prevented individuals from seeking 'real-time' support (Aggarwal et al., 2021). Consequently, when discussing their hopes for online services, 73 participants in Frost and colleagues' (2016) study endorsed the need for instant, 24/7 access to support where individuals *"wouldn't have to wait for over 5 min to talk"* (pg.72). The wish for timely support was also echoed by British youth:

> *"you need to see them there or then, or not at all ... like it's very instant, so like if you're gonna self-harm or have self-harmed, there is no point seeing them in two weeks."* (Mughal et al., 2021, pg.747).

Indeed, participants found benefits in online support as help was immediate (McAndrew & Warne, 2016). Long waiting times for specialist services in the UK and Sweden (Wadman et al., 2021; Idenfors et al., 2016), and in emergency departments in Australia (Byrne et al., 2021), were described by participants who recognised that these experiences led them to believe they were being ignored. This exacerbated the individual's distress, promoted further self-harming (Idenfors et al., 2016), and had the potential to deter help-seeking (Mughal et al., 2021).

Participants endorsed individualised professional support, in person and online. There was a sense that professionals in frontline services depersonalised the individual's distress, giving out broad advice and asking a rigid set of questions (Mughal et al., 2021; Owens et al., 2016). However, each young person recognised their struggle as 'unique', highlighting the need for professionals to understand their story and develop a tailored intervention plan (Tillman et al., 2018; Hassett & Isbister, 2017). Participants identified that they required bespoke interventions that helped them to understand their distress

(Klineberg et al., 2013; Stänike et al., 2020). Such experiences facilitated engagement in the help-seeking process as individuals felt 'heard' and valued.

1.3.3.3. The Quest for Knowledge

There was an overall sense in participants that mental health literacy concerning self-harm and knowledge regarding how to seek help was limited:

"There's sort of a lack of knowledge about how healthcare systems work and booking GP appointments is scary ... also it's sort of around knowledge where I didn't necessarily realise that me self-harming was wrong" (Mughal et al., 2021, pg.748)

This promoted fear and uncertainty over what help-seeking would look like and bring in their future. Mughal and colleagues' (2021) study investigating British youth's experiences of help-seeking from general practitioners (GPs) revealed fears that seeking support may result in being sectioned or detained:

"I thought they'd hospitalise me immediately. I thought they'd panic and push me away as if, 'no, you've gotta — you know, you've got to go into an inpatient unit, and we've got to inform your family, and you've got to quit your course'." (Mughal et al.,2021, pg.748)

Many advocated the need for accessible and relevant information to bolster their knowledge. Notably, Frost and colleagues' (2016) investigation into a large Australian sample's perspectives into the use of the internet to facilitate help-seeking, highlighted young people's wishes to understand the "*common reasons why people self-harm*"(pg.72). The power of increasing awareness of the prevalence of self-harm and use of services was also illustrated by young British males and Swedish youth, who recognised that when they became aware of others' experiences they felt less isolated, and subsequently more inclined to seek professional support themselves (Hassett & Isbister, 2017; Idenfors et al., 2015). Correspondingly, individuals recognised the value of enhancing public mental health literacy in reducing the stigma around self-harm:

"…my age group we have grown up learning […] that all mental illness is a serious thing like mood disorders and schizophrenia and yeah so if I did tell

someone, I don't think there would be any sort of judgment or any sort of shame whatsoever" (Hassett & Isbister, 2017, pg.7)

Furthermore, participants described feeling "*lost*" and did not have a clear idea of where they might go for professional help or what to expect from services (McAndrew & Warne, 2014; Idenfors et al., 2015; Mughal et al., 2021). One British participant did not recognise mental health support could be sought from GPs (Klineberg et al, 2013). As such, the lack of knowledge about healthcare services created an intrinsic barrier to help-seeking.

1.4. Discussion

This review aimed to explore the barriers and facilitators to help-seeking for self-harm faced by adolescents and young adults. The findings provide a novel insight into a young individual's turbulent journey to help-seeking; youths experience *inner conflict* and develop a sense of *learned apathy,* as they *navigate services* which are often unfamiliar or inaccessible.

1.4.1. Discussion of Findings

The findings identify complex internal dilemmas that inhibit young individuals' desire to help-seek, opposing previous conclusions that there are few intrapsychic barriers to help-seeking (Rowe et al., 2014). The findings revealed elevated internal shame and guilt were present throughout the help-seeking process, both prior to and during disclosure to close others (Rosenrot & Lewis, 2020), and in the instigation of professional help (Byrne et al., 2021; Mughal et al., 2021). The shame reported by young individuals was contiguous characterological shame, which arises from discomfort with one's personal habits or self-identity (Gilbert et al., 2010). Indeed, previous quantitative literature has reported that individuals' non-disclosure is associated with increased levels of characterological shame (Swan & Andrews, 2003). Interestingly, characterological shame was not reflected in the narratives of individuals from non-Western cultures (Chen et al., 2021; Aggarwal et al, 2021), which could be explained by divergent cultural understandings of shame (Zhong et al., 2008). For example, in Eastern cultures, shame is a collective phenomenon, where the shameful behaviour of one risks shaming the whole community (Yakeley, 2018). This was certainly apparent in the narratives of ethnically diverse youth in Western societies, whose fear of their community finding out prevented help-seeking (Klineberg et al., 2013).

The findings emphasised how shame and self-harm secrecy seemed to be further compounded by young individuals' perception of their identity; they appeared to place great importance on how they are perceived, emphasising a need for independence and to not be considered different. This concords with Gilbert and Irons (2009) who hypothesise that, during adolescence and young adulthood, individuals become highly focused on gaining autonomy and presenting themselves in a light that encourages social inclusion. However, asking for help requires youth to voice their dissimilarity from their peers, risking deviation from expected developmental or societal norms (McDermott, 2014). Acknowledging or sharing these differences may bring precarity to the young individual's identity and promote feelings of failure and inadequacy. It is conceivable that not seeking help for self-harm is a method of self-preservation.

Furthermore, the rewarding qualities of self-harm also created ambivalence regarding investment in the help-seeking process (Stänicke et al., 2020). Self-harm has been recognised as a means of finding emotional relief (Edmondson et al., 2016), which might create hesitancy around discontinuation if this behaviour functions as a coping mechanism (Gray et al., 2021). Therefore, for young people who often have limited control over their environment, seeking help might equate to the loss of a much-needed coping strategy. This is perhaps why some individuals refuted that self-harm was an issue that needed changing. The level of ambivalence experienced is concerning given self-harm's well-documented negative consequences (Kiekens et al., 2018). It is evident that individuals need to feel ready to change their behaviour (Klineberg et al., 2013). Thus, the process of help-seeking appears to evolve through several internal and external shifts that diffuse ambivalence and move individuals into an 'action-focused' stage of change (Kruzan & Whitlock, 2019; Tofthagen et al., 2017).

In line with previous reviews, it was clear that there were many interpersonal barriers to help-seeking (Rowe et al., 2014). Stigmatising attitudes towards self-harm are well documented in healthcare literature (Saunders et al., 2012), but these were particularly prominent in A&E departments where individuals highlighted experiences of discrimination and denial of medical care (Owens et al., 2016). Young people's accounts of clinical services also highlighted feelings of being let down by the system (Wadman et al., 2018). Given the impetus for healthcare that is equitable for mental and physical illness (Mitchell et al., 2017), the lack of adequate healthcare for self-harm is concerning. Poor care can leave a young person feeling unworthy of help, encouraging them to leave future

wounds untreated, and creating further feelings of shame and hopelessness (Wadman et al., 2020).

The experience of stigmatisation has been reflected across the adult population of those who self-harm (Quinlaven et al., 2020). However, minimising responses seem to be unique to adolescent experience where self-harm was attributed to hormonal changes. Perhaps these responses reinforced the desire for individualised and thoughtful healthcare as the reduction of self-harm to 'teenage angst' without an appreciation of underlying needs, may make individual's more likely to perceive their treatment is simply procedural. Avoidance and dismissal were also common in responses to self-harm, which may be the consequence of the responders' own internal discomfort (Curtis et al., 2018; Hall & Melia, 2022). However, such experiences have the potential to further exacerbate internal shame for young people (Gilbert, 1998), predicting poorer psychological outcomes than not disclosing in the first instance (Ullman, 2010). Moreover, in line with other findings (Chaudoir & Fisher, 2010), the positive influence of parents and peers in stimulating open discussions about self-harm was important in the facilitation of disclosure (Rosenrot & Lewis, 2020) and in supporting the navigation of healthcare services (Idenfors et al., 2016).

An individual's battle between internal conflicts and need for help is an exhausting process (MacDonald et al., 2020). Therefore, it is unsurprising that structural barriers to help-seeking were widely recognised by young people; navigating complex healthcare systems when experiencing heightened distress often deterred help-seeking. Consequently, young people voiced a need for services that are instantly accessible and provide timely support. This is unique, as other reviews considering help-seeking for mental health determined that young people hold minimal concern regarding practical barriers (Velasco et al., 2020). Such discrepancies perhaps reflect the impulsive experience of self-harm compared to other mental health difficulties, where instant support is required.

Consequently, it is plausible that experiences of stigmatising attitudes, unhelpful responses, inaccessible services, and poor health care contribute to a reinforcing cycle of characterological shame and apathy. This causes negative self-evaluation and promotes hopelessness, eventually resulting in an individual not trying to change their situation and hiding self-harm. It is evident that personal experience of negative responses, attitudes

and inadequate care is not a requirement of learned apathy; hearing about others' vicarious experiences can also contribute to an individual's passivity around help-seeking (Owens et al., 2016). Nevertheless, experiences of compassionate, validating, and non-judgemental responses to self-harm have the power to change this trajectory. Positive disclosure and help-seeking experiences promote openness and optimism, which may facilitate future disclosures and help-seeking (Rosenrot & Lewis, 2020; Byrne et al., 2021). The advantages of compassionate responses are well-documented, with research highlighting their direct impact on improved mental health outcomes and self-harm reduction (Cully et al., 2020).

1.4.2. Implications

The findings of this review have several implications. At a policy level, interventions designed to enhance mental health literacy are warranted. These interventions should capitalise on important facilitators to help-seeking by focusing on improving young people's knowledge of self-harm and education on accessing help and its advantages. Once the efficacy of the interventions has been established, widespread dissemination within schools, colleges and universities to both young individuals and stakeholders is critical. On an individual level, this perhaps would discourage avoidance and minimisation of self-harm, facilitating open discourse and reducing shame. Furthermore, raising awareness of self-harm may not only reduce societal stigma, but also help those ambivalent about help-seeking recognise that self-harm is an understandable, but unhelpful, coping strategy that deserves attention. This will be important given the negative trajectory of unmanaged self-harm (Hawton et al., 2012).

These findings can inform health authorities in their development of care models, as highlighted in the NHS Long Term Plan (2019). Given that young people can struggle to verbalise distress (Norman et al., 2021), digital tools might facilitate access to support for self-harm. This could include ensuring there are several routes to access services, including self-referrals through text-messages and emails. However, attending services in person might still be a barrier to accessing support, especially for those seeking privacy (Frost et al., 2016) or independence (Hassett & Isbister, 2017). The benefits of online support in overcoming some of these barriers to help-seeking have been advanced in the literature (Pretorious et al., 2019). Therefore, health authorities should commit to developing trustworthy online resources and psychological services, facilitating access for

these hard-to-reach individuals by promoting anonymity and independence (Radez et al., 2021).

These recommendations will be implemented in vain if the care received by young individuals when accessing services is not addressed. A training programme that emphasises the feelings of shame experienced by these young people might promote health professionals' understanding of this behaviour and compassionate responses. However, given the enduring history of healthcare staff's stigmatising attitudes towards self-harm, changes to policy and culture need to be implemented to make a meaningful difference. Trauma-Informed Care (TIC) is a model that acknowledges the importance of understanding an individual's context to provide successful healthcare (Menschner & Maul, 2016) and advocates for organisational policies and practices that promote trust, choice, and safety. The experience of TIC can be validating for individuals who self-harm and may improve engagement and health outcomes (Asarnow et al., 2019) and decrease overall service costs (Menschner & Maul, 2016).

1.4.3. Limitations and Future Research

This review should be considered in the light of certain limitations. To capture the unique experiences of those who self-harm, this review excluded the studies exploring solely suicidal behaviours. However, distinguishing suicidal behaviours and self-harm is challenging (Zayas et al., 2010) as suicidal intention is fluid and variable (Salter & Platt, 1990). Indeed, participants within the studies suggested they had made suicide attempts (Owens et al., 2016). Consequently, the unique insights of individuals who have self-harmed by attempted suicide were not fully explored within this review. Further research including the experiences of young people is warranted to understand the evolution of self-harm into suicide attempts and how this intersects with help-seeking.

While attempting to overcome shortcomings of previous reviews by including research relating to young adults, the review may be inadvertently affected by the same limitations. Participants retrospectively discussed their experiences, and many of the studies either did not specify how many years had passed since help had been sought or acknowledged that young adults often reflected on their adolescent experiences (e.g. Rosenrot & Lewis, 2020). Therefore, further to the accounts being subject to potential errors in recall, the synthesis may have unintentionally captured the adolescent rather than 'young adult' help-seeking experience. Thus, the generalisation of these results to young

adults should be done with caution. Longitudinal studies are needed to ascertain whether the barriers and facilitators to help-seeking change in line with developmental stages.

While the results were drawn from several high-quality studies, many of the included papers were of low (n=3) or moderate quality (n=8). This was mostly due to limited discussion around researcher reflexivity, thus the results of these studies may have been more representative of researcher biases than the participants' lived experiences. Furthermore, many studies were limited by the lack of transparency around recruitment processes and reasons why individuals may have declined participation. In the context of increased shame and secrecy around self-harm, these results may have been subject to self-selection bias and may not align to experiences of those who did not participate. Consequently, the accuracy of the findings of this review are unclear. When designing and conducting future qualitative studies, researchers should consider appraisal criteria and endeavour to meet these as far as possible.

Nevertheless, the use of critical appraisal tools can also pose challenges to the systematic review procedure. The CASP was employed to appraise the quality of the studies within this review. However, the psychometric properties of this tool have not been firmly established and its interpretative, evaluative and theoretical validity has been criticised (Hannes et al., 2010). Furthermore, whilst measures were taken to set discrete parameters around the criteria (e.g. by using scoring criteria and inter-rater checking), the criteria are somewhat open to researcher interpretation (Dixon-Woods et al., 2007). It is also possible that strict publishing wordcounts limited what authors reported, therefore omitted key information affirming quality may not have been assessed. As such, the conclusions drawn around the quality of the included studies should be taken with caution.

1.5. Conclusion

The collective findings of reviewed studies further advance understandings around the barriers and facilitators to disclosing or seeking help for self-harm, highlighting the multifaceted journey of disclosure and help-seeking which relies on the individual to overcome internal dilemmas and external responses, and navigate inaccessible services. The culmination of heightened shame with negative interpersonal experiences and inadequate healthcare, seems to lead to a sense of learned apathy where individuals eventually withdraw and self-harm in secret. Troublingly, hopelessness can be learned vicariously from others. Nevertheless, open and compassionate responses that aim to

understand unique experiences can instil hope and promote the instigation or continuation of professional help. Furthermore, improved mental health literacy and accessibility were recognised as key in supporting confidence when navigating unfamiliar services. These accounts have several implications for both policy and practices across healthcare, education, and wider society, which if implemented comprehensively, will support a trauma-informed and open discourse around self-harm. However, these findings and recommendations are no panacea, and further research is needed to overcome the limitations of this review to establish the experiences of the young adult population and those 'harder to reach' individuals.

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Chapter Two

Empirical Paper

Educational Staffs' Experiences of Recognising and Supporting Student Self-harm

Overall Chapter Word Count:7991
(Excluding Abstract, Titles, Tables, Figures, and References)

This chapter is written for submission to the *School Mental Health* Journal

2.0. Abstract

Background: In recent years, adolescent self-harm has become increasingly prevalent and is commonly recognised and supported within schools. As such, the Department of Health has emphasised the crucial role of schools in the timely identification of adolescent self-harm and in signposting suitable support. An enhanced understanding of the impact caused by responding to student self-harm would provide insights regarding how teachers can be supported in this challenging role. Nevertheless, few studies to date have examined the experiences of staff supporting students who self-harm in British secondary schools and colleges.

Aims: The aim of the current research is to gain an understanding of the impact on secondary school and college staff of recognising and responding to student self-harm.

Methods: Fourteen participants with experience of responding to student self-harm were recruited from secondary schools and colleges across the Midlands and Southwest of England. One-to-one semi-structured interviews were conducted to ascertain their experiences and subsequently analysed using Reflexive Thematic Analysis.

Results: Three overall themes were identified from the analysis: (1) *Way of Being,* describing how school staff conduct themselves and their approach to the management of student self-harm; (2) *Complex and Evolving Internal Processes*, reflecting the evolving impact of managing self-harm where school staff experience complex and paradoxical affective and cognitive processes; (3) *A Rock and a Hard Place,* describing the barriers and dilemmas faced by school staff when trying to manage self-harm in pressured and unresponsive systems.

Conclusion: The results highlight how educators are highly committed to ensuring that student self-harm is supported in a compassionate and responsive way, although they often face several internal conflicts and external pressures that constrain their effective management of self-harm. The negative psychological impact of self-harm on staff can be both acute and enduring, though exposure and experience lessens the impact over time as school staff find their own ways of coping. Alongside limitation and recommendations for future research, the clinical implications regarding support and training for school staff are discussed.

Key Words: *school, experiences, impact, self-harm, adolescent, mental health, qualitative, thematic analysis*

Word Count: 320

2.1. Introduction

Self-harm, described as an intentional act with a non-fatal outcome encompassing a range of methods including cutting, overdosing and self-battery (Madge et al., 2008), is a major public health concern. Research highlights that the global lifetime prevalence rate for self-harm in adolescents is 16-18% (Muehlenkamp et al., 2012). For most adolescents, self-harm is a way to regulate intense emotions, manage self-critical thoughts, and communicate distress to others (Stänicke et al., 2018). However, whilst self-harm can serve many adaptive functions, such behaviour can increase the risk of completed suicide (Olfson et al., 2018). Furthermore, adolescents who self-harm are at increased risk of enduring mental health difficulties and issues including substance misuse and relationship difficulties in adulthood (Daukantaité et al., 2020; Mars et al., 2014).

Given the range of adverse outcomes related to self-harm, the need for early identification and intervention is crucial. However, only an estimated 12% of adolescents seek professional help for self-harm, while many remain hidden from health services (Doyle et al., 2015). Consequently, the National Institute for Health and Care Excellence (NICE, 2022) has recently advocated for the shared responsibility of the prevention and management of self-harm with universal services. Nevertheless, this may be met with reluctance. The increased risk of suicide or accidental death associated with self-harm can understandably make non-mental-health professionals anxious to intervene for fear of exacerbating the situation by acting beyond the scope of their expertise (Foster et al., 2013). However, students have highlighted the role of schools and teachers as key to the prevention of self-harm (Fortune et al., 2008). Literature relating to help-seeking patterns among adolescents who self-harm corroborates students' perspectives, further highlighting the essential role of school staff in the early identification of self-harm and encouragement to seek formal support (Evans et al., 2005).

2.1.1. Adolescent Self-Harm within the Educational Setting

Schools hold a unique position in terms of identifying and responding to student self-harm (De Riggi et al., 2017). Indeed, nearly 70% of staff have reported encountering at least one student who has engaged in this behaviour (Berger et al., 2015). It is also likely that staff may identify self-harm soon after it has occurred. Crowe and colleagues (2020) found that self-harm accounted for 5.05% of all incidents reported by Australian schools to emergency services; when compared to other incidents that caused harm to students, self-harm was 8.37 times more likely to require emergency medical intervention.

Although the Department of Health (DoH, 2012) states that all school staff should receive training on how to intervene and manage self-harm, it is unclear how well schools are prepared for this kind of work. In a recent study involving 153 schools in England and Wales, just 52% of schools had received training on adolescent self-harm, with only 22% considering this to be of high-quality (Evans et al., 2019). Without training, school staff often do not feel confident and experience confusion about how to respond to self-harm (Berger et al., 2015). Furthermore, staff highlight a lack of time and resources and the fear of contagion as major barriers to addressing self-harm within school (Evans et al., 2019). The culmination of these barriers might lead to inadequate referrals, follow-up, and interventions for young people.

Inadequate training about self-harm may lead to damaging consequences. As well as interfering with staff's ability to efficiently identify and signpost students to appropriate support (Lewis et al., 2020), a limited awareness regarding the nature of self-harm may perpetuate staff's negative attitudes and beliefs (Timson et al. 2012). Several studies have highlighted that beliefs held about self-harm's motivations are potential barriers to the gatekeeper role (Hatton et al., 2017). For example, Carlson and colleagues (2005) found that many teachers in their sample endorsed student self-harm as 'attention-seeking' or 'a minor problem'. Holding such beliefs may mean that teachers do not recognise self-harm as a behaviour requiring emotional support. This may lead to adolescents who self-harm feeling misunderstood and further stigmatised, impeding further help-seeking and increasing the risk of subsequent self-harm (De Riggi, et al., 2017).

2.1.2. School Staff Experiences of Adolescent Self-Harm

Whilst considerable attention is being given to the development of educational policies for the management and prevention of adolescent self-harm (Matthews et al., 2021), few studies have examined the impact of responding to self-harm on educational professionals.

In a preliminary study, Best (2005) interviewed thirty-four British school workers and found that responding to student self-harm had led to emotional reactions including shock, panic, and anxiety. These feelings were exacerbated when self-harm was being encountered for the first time, or when staff had inferred a connection between self-harm and suicide. Subsequent feelings of powerlessness led to frustration and sorrow. Similar themes were highlighted by secondary school staff directly involved in responding to

student mental health issues in Scotland (Stoll & McLeod, 2020). Findings from interviews with support staff highlighted a sense of helplessness about their inability to provide support and improve their pupils' situations. Many of the participants within this study also shared experiences of high levels of anxiety and fear, often impacting their homelife and highlighting a negative impact on their wellbeing.

An emotional impact was identified by Simm and colleague's (2010) who investigated primary school teachers' experiences of self-harm. The employment of Interpretative Phenomenological Analysis on responses from fifteen participants from British schools highlighted that staff experienced feelings of fear and sadness in response to self-harm. However, it was evident that with experience, teachers became more confident in their responses. Dowling and Doyle (2017) presented similar findings regarding the experiences of teachers and guidance counsellors within Ireland, suggesting that self-harm provoked negative emotions, with less experienced staff reporting increased anxiety.

2.1.3. Research Rationale and Aim

Previous research considering healthcare professionals supporting young people who self-harm highlights the potentially traumatising nature of these interactions (Sabin-Farrell & Turpin, 2003; Akinola & Rayner, 2022). Such experiences may be likened to concept of 'vicarious traumatisation', which is characterised by negative cognitive and emotional changes in response to working with survivors of trauma and being exposed to traumatic material (McCann & Pearlman, 1990). As school staff are often the recipients of self-harm disclosures, it is conceivable that they will be exposed to such traumatic situations, where they may be the first to see severe wounds and hear harrowing stories from their pupils around the context of their harm. Furthermore, a sense of 'burnout', characterised by feelings of emotional exhaustion and incompetency, is common amongst education professionals (Garcia-Carmona et al., 2019), who highlight that their wellbeing often diminishes when they feel unable to meet their student's needs (Rothi et al., 2008). To date, research to date has not fully explored the psychological impact of managing student self-harm on school staff, which is concerning given the ever-increasing likelihood that they will encounter this at some point throughout their career (Berger et al., 2015). An improved understanding of their experiences would raise awareness of how school staff can be supported in this role and their wellbeing promoted.

Furthermore, it is likely that teacher burnout and vicarious traumatisation may further impede student outcomes, as poor wellbeing in school staff can compromise the potential effectiveness of school-based mental health interventions (Wasserman et al., 2015). It is therefore evident that research aiming to understand the impact of managing student self-harm holds several clinical advantages and will be invaluable to field of Clinical Psychology. Key to the work of a Clinical Psychologist is the development and provision of high efficacy interventions, which often relies on engaging the team around an individual to promote the best possible mental health outcomes (Whittington & Lake, 2020). Given their influential position, Educational Professionals represent a key part of this team, thus research surrounding their experiences will provide insights into how the 'system' can be supported and the efficacy of school-based interventions promoted. Promoting access to and engagement with support is also within the remit of Clinical Psychology. Therefore, given the importance of the initial response to self-harm on the adolescent's future help-seeking (Toste & Heath, 2010), an understanding of teachers' experiences may provide further insight into a young persons' experience and contribute to more timely positive outcomes.

While there is a general paucity of research focusing on self-harm in educational settings, this is even more acute when it comes to qualitative research located within the UK. To the author's knowledge, since Best's (2005; 2006) preliminary studies, the impact of managing self-harm on secondary school and college staff has not been qualitatively researched in Britain. Owing to differences in UK education and healthcare organisations, these results may not represent educational professionals within the UK. Furthermore, though Stoll and McLeod (2020) considered the impact of supporting general mental health difficulties for UK school staff, given the additional physical health complexities of self-harm, these unique experiences warrant further investigation. Finally, whilst qualitative studies have previously reported that exposure to self-harm can promote teachers' confidence in managing this (Best 2006; Dowling & Doyle, 2017), little attention has been paid to the processes behind this psychological growth.

Therefore, through the employment of a qualitative methodology, the present study aims to address the gap in the literature and to further enhance understanding of what it is like for education professionals to respond to and support students who self-harm. The current study aims to understand educators' experiences by investigating the

following research question*: What is the impact on secondary school and college staff of identifying self-harming behaviour in their students?*

2.2. Methods

2.2.1. Research Design

To make sense of the participants' collective perceptions and experiences, this study utilised a Qualitative Design. Specifically, Reflexive Thematic Analysis (RTA; Braun & Clarke, 2006) was selected for the research. This method reflects the ideologies of a qualitative paradigm whilst respecting the subjectivity of participant accounts, the contexts in which they arose, and the reflexive influence of the researcher's interpretations (Byrne, 2021). As the research objectives aimed to focus on a specific aspect of the participants' experience, the use of RTA was considered vital as it supported flexible engagement with the data (Braun & Clarke, 2021a).

2.2.2. Participants

2.2.2.1. Sampling & Eligibility Criteria

The study employed a non-probability, purposive sampling design (Vehover et al., 2016). Participants were selected from a wide range of roles and responsibilities across various educational settings, in line with criteria that were established during discussions with the research team (Table 2.1.).

Table 2.1.

Inclusion and Exclusion Criteria for Study Participation

Criteria	Inclusion	Exclusion
Education Professionals	Education, Pastoral or Support staff	School Counsellors
Education Settings	Any secondary school, further education colleges and sixth forms.	Primary schools and special educational provisions.
Experience of identifying and supporting Self-harm	Prior experience of identifying and/or supporting an individual who has self-harmed.	No prior experience of identifying and/or supporting pupils who self-harm.
Participant language	Fluent in English	Other language British (or other) Sign Language
Geographical Region	England, United Kingdom	All other locations

Individuals were eligible to participate if they were educational staff who had experience of self-harm as defined by an intentional act with a non-fatal outcome encompassing methods such as cutting, self-battery, and overdosing (Madge et al., 2008). This definition was selected as it is widely used in the European Literature (e.g. Hawton et al., 2012). To ensure homogeneity, staff from primary or special-educational needs provisions were excluded as these educational contexts differ from secondary school, and the presentation of self-harm is considered distinctive for these students (e.g. Townsend et al., 2022; Minshawi et al. 2014). Furthermore, only school staff in England were included as education systems differ across the UK. School Counsellors were excluded as they have specialist training, thus their experience of supporting self-harm may be different to those who are not trained mental health professionals.

2.2.2.2. Recruitment

Participants were recruited over a six-month period. Information regarding the study was sent to headteachers of all mainstream secondary schools and colleges across the Midlands. Gatekeepers cascaded the study information to their staff, and prospective participants responded to the researcher directly if they wished to participate. As there was limited uptake to the study following initial recruitment through schools, the research was also advertised within online teaching forums. Each participant was provided with a participant information sheet (PIS; Appendix K) to ensure they were fully informed about the research before consenting to take part. To confirm that prospective participants had relevant experience, an operational definition of self-harm was provided in the PIS. Participants were screened to ensure that they fitted the eligibility criteria. Two participants were not selected due to working internationally.

2.2.2.3. Participant Characteristics

A total of 14[1] participants (4 Males; 10 Females) were recruited from several educational contexts, including state schools and academies (*n=8*), independent/grammar and boarding schools (*n=5*), and a Further Education College (*n=1*). Sampling stopped at 14 participants as at this point no new themes were identified from the interviews, and the data was considered 'saturated' (Guest et al., 2006). Participants mainly worked in schools located across the Midlands, however two participants worked in the South of England. The job roles of the participants included: Head of Wellbeing (*n=2*), Deputy/Assistant

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[1] There is no clear view on what is considered an appropriate sample size for Reflexive Thematic Analysis (Braun & Clarke, 2021b), however, a sample-size of 10-20 participants has been suggested appropriate for a medium sized project (Braun and Clarke, 2013, pg.48).

Head (*n=2*), Pastoral Leader or Support (*n=5*), Teacher (*n=1*), Learning Mentor (*n=1*), House Mistress/Matron *(n=2)*, and School Business Managers *(n=1)*. The length of experience ranged from 1 to over 30 years. All participants described having at least two experiences of student self-harm, although for many this was a common occurrence.

2.2.3. Ethical Process

Ethical approval for the study was granted through Coventry University in May 2021 (Appendix L), prior to the research commencing. Ethical issues were also considered in accordance with the British Psychological Society (BPS) Code of Human Research Ethics (BPS, 2014), the Code of Ethics and Conduct (BPS, 2021), and published guidelines around researching self-harm in educational settings (Hasking et al., 2019).

Prior to participation in the research individuals read the PIS and completed a consent form (Appendix M). Participants were made aware that they had the right to withdraw, their information would be confidential, and they, their students and employing institution would remain anonymous. Consequently, the participants were asked to withhold pupil names or use a pseudonym and identifying details of their employing institutions were not collected. A safeguarding statement was made prior to the interview, and it was made clear that confidentiality would only be breached if the safety of the participant or others was considered at risk (Hasking et al., 2019). No such concerns were raised during this research. Participant data was anonymised and managed in line with the guidance from the General Data Protection Regulations (GDPR).

The subject of self-harm may be emotionally evocative and sensitive, thus potentially risking psychological harm. Therefore, a research distress protocol was devised to ensure participants were supported should the interview have caused distress (Appendix N). This was not required. All participants were debriefed and provided with signposting information (Appendix O).

2.2.4. Procedure

2.2.4.2. Materials

A semi-structured interview was utilised to explore school staff's experiences. An interview guide was developed in line with concepts identified within the literature (Appendix P) and covered experiences of identifying and responding to self-harm, the

impact of this, and factors that facilitate and hinder coping. Questions and prompts were designed to be neutral and open-ended (Breakwell, 2006) and flexibility in the guide allowed for elaboration on important concepts as they arose (Pietkiewicz & Smith, 2014). To confirm that the content was accessible and applicable to the research question (Smith, 1995) the schedule was reviewed by two teachers.

2.2.4.3. Interview Procedure

A virtual meeting was set up at a time of the participant's choosing. Participants were asked to attend the meeting from a private location, preferably within the school. To create a sense of safety prior to commencing the interview, time was given for questions about the study and the collaborative consideration of how signs of participant distress would be recognised. The semi-structured interviews lasted between 28-71 minutes. Interviews were video recorded using the online platforms' (Zoom/Microsoft Teams) recording tool, and the file securely stored.

2.2.5. Data Analysis

Data analysis were undertaken in concordance with Braun and Clarke's (2006) guidelines for using RTA, which outlines a six-phase methodical approach to theme development (Table 2.2.).

During the familiarisation process participant interviews were manually transcribed verbatim. To ensure themes were driven by the data an inductive coding was undertaken to capture the participant's communicated meaning (Braun & Clarke, 2013). However, 'pure' inductive coding was not possible as the author's experiences and assumptions likely influenced this process (Byrne, 2021). Semantic codes were initially used, but as the researcher became more immersed in the data, latent codes naturally started to form (Appendix Q provides an example). These codes were loosely arranged into candidate themes, which were reworked as the researcher reviewed them against the transcripts. Themes were determined by whether it expressed something valuable and meaningful regarding the overall aim of the study (Braun & Clarke, 2006), rather than on recurrence across accounts. Data analysis was a recursive process; the researcher moved across stages as they developed and refined the themes (Terry et al., 2017; see Appendix R for snapshots of this process).

Table 2.2.

Stages of Reflexive Thematic Analysis (based on Braun & Clarke, 2006; 2022)

Stage of Analysis	Details of Stage
1) Data Familiarisation (Immersion)	• Transcription • Reading and re-reading transcripts • Writing familiarisation notes
2) Generating Codes	• Systematic coding of data • Development of meaningful codes to all data relevant to the research question. • Collate code labels • Compile relevant segments of data
3) Constructing Candidate Themes	• Identification of shared pattern of meaning across the dataset • Compile clusters of codes that have shared meaning • Collate all coded data relevant to each candidate theme
4) Developing and Reviewing Themes	• Checking themes make sense in relation to coded extract and whole dataset. • Diagramming or Mapping themes • Collapsing overlapping themes
5) Refining and Naming Themes	• Writing a brief synopsis of each theme • Ascribing an informative name to each theme • Fitting the broader story of the data set to respond to the research question • Cycling between the dataset and identified themes to organize the coherent story
6) Writing the Report	• Weaving together an analytic narrative • Selection of compelling data extracts • Presenting of a concise account of the data

2.2.6. Researcher Reflexivity

2.2.6.1. Reflexivity and Epistemological Position

The study was designed from the epistemological position of *contextualism*, where the production of knowledge is considered local, provisional, and situation dependent (Jaeger & Rosnow, 1988), and partly reflecting the researcher's position (Tebes, 2005). Furthermore, the ontology of the study ascribes to that of *critical realism*,

and acknowledges the assumption that whilst language is informative, it does not straightforwardly mirror reality and a degree of interpretation is needed (Willig, 2012).

In line with the epistemological position of the researcher, RTA emphasises the researcher's active role in knowledge production (Braun & Clarke, 2019), where themes are considered to represent the researcher's interpretations of meaning. Therefore, the researcher was considered a resource rather than a threat to knowledge production (Gough & Madill, 2012). However, the researcher's "reflective and thoughtful engagement with their data and the analytic process" was vital (Braun & Clarke, 2019, pg. 594). Thus, the researcher acknowledged their subjectivity as they approached the data collection and analysis (Gough & Madill, 2012). Furthermore, as the participants were presented with a safeguarding statement around duty of care prior to the interview and were aware of the researcher's current position as a Trainee Clinical Psychologist, the researcher was mindful that the educational professionals may have modified their responses, possibly due to a fear of professional judgement.

2.2.6.2. Reflexivity during Data Analysis

Underpinning RTA is the expectation that no two researchers will interpret the data in the same way (Braun & Clarke, 2022). Consequently, this method discourages attempts at pursuing 'reliable' coding. Nevertheless, coding does require a reflexive researcher who recognises how "their assumptions might shape and delimit their coding" (Braun & Clarke, 2021a, pg. 39). Therefore, the researcher kept a reflective journal to document their internal processes throughout the analysis. The supervision team were also used as a reflexive tool to sense-check ideas, bracket assumptions, consider how the researcher's background influenced data analysis, and to explore multiple data interpretations (Byrne, 2021).

2.3. Findings

The aim of this study was to explore the impact on school staff of recognising and supporting self-harm in their students. Following the application of RTA three main themes were identified from the data: *A Way of Being*; *Complex and Evolving Internal Processes*; and *A Rock and a Hard Place*. Themes and their associated subthemes are depicted in Figure 2.1.

Figure 2.1.

Thematic Map of Identified Themes and Subthemes
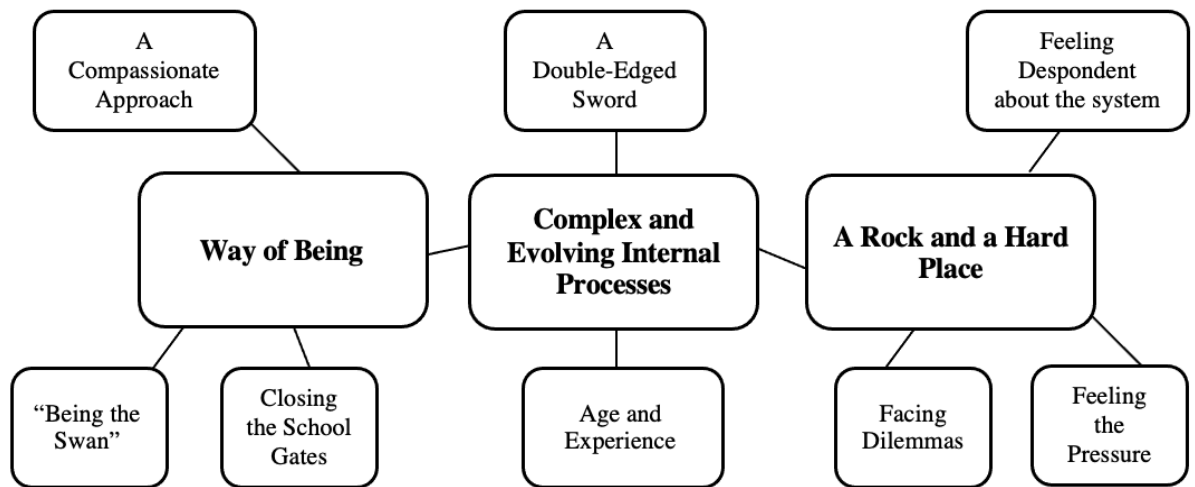
2.3.1. Way of Being

A 'Way of Being' indicates how school staff conduct themselves and their approach in the management of student self-harm. There was an overall sense that a compassionate approach was integral to school staff's way of supporting students, and they remained mindful of how they presented to their students as they navigated emotionally charged situations. Central to their way of being was the development of strong emotional boundaries, to ensure their well-being across all environments.

2.3.1.1. A Compassionate Approach

Self-harm was considered as just the "*the tip of the iceberg*" for pupils, and it was perceived that this behaviour is caused by underlying "*deeper things*". School staff intuitively attributed adolescent self-harm to adverse childhood events (ACEs) and other contextual factors such as feeling "*pressured*" or "*ashamed*".

> *Self-harm isn't the issue (…) it's what's under the water, it's all the ACEs… the trauma (PP11)*

Accordingly, self-harm was understood as a way for adolescents to manage or cope with the "*pain*" of these difficult life events, or to communicate their distress.

…they're having all these mixed emotions and mixed thoughts, how do they get an element of control over themselves? They can physically self-harm and feel pain… (PP13)

Getting to "*root*" of these problems was seen as key to supporting their students, and school staff often had to navigate "*tough*" conversations with parents. Consequently, school staff must manage angry or "*distraught*" parental reactions Although this could create frustration for the school staff, they also expressed empathy and compassionate understandings for parents, recognising how difficult it must be for parents to understand self-harm given how counterintuitive it can seem.

I think the danger is that a lot of parents take it personally and feel that they have failed in some way. That's not the case at all, everybody needs support don't they? (PP2)

School staff appeared to place high importance on adopting a compassionate demeanour when responding to self-harm. Therefore, participants worked hard to create an open, validating, and non-judgemental environment. They aimed to actively listen to concerns and to allow time for students to talk about self-harm at their pace, with the hope that this would facilitate trusting relationships.

I suppose it's making it feel like a warm environment that is kind of open, and I it's giving them time and space where they don't feel like they're being stared at, and kind of put under that pressure… (PP6)

For some, this seemed an innate part of their practice with a compassionate response being something they "*have always done*", whereas others seemed to have learnt to embody compassionate responses through training and experience. Some experienced inner discomfort when reflecting on their previous approach to self-harm, which was "*not the nicest thing to think about*". When one participant reflected on their previous experience in schools, they noted:

In every school I taught at when there were kids who had those sorts of problems, either they luckily found a mentor[…]or we punished them, we just kept punishing them. I'm not proud of it, but that's what happened (PP3)

2.3.1.2. "Being the Swan"

Feelings of anxiety and shock at the severity of some self-harm were shared. It was not uncommon for staff to be the first to witness fresh wounds or respond to self-harm (with and without suicidal intent) as this was happening. This appeared to create a heightened sense of responsibility, where school staff feared that their response could lead to detrimental consequences, with the student disengaging from support or escalating the severity of their self-harm (or both).

> *you're thinking 'okay my response is really important here', it can either go one way or the other…. I'm scared to say almost the wrong thing, and I can make him even more angry or distressed (PP7)*

> *I've only got to say one thing and she could completely shut down, and not do anything, and I didn't want that to happen. (PP9)*

During heightened situations, there appeared to be a conflict between remaining professional and allowing more raw 'human' responses to be shown. Staff believed they should not show an emotional response and likened this to "*being a swan*", appearing "*calm on the outside*" whilst "*kicking underneath*".

> *It was the deepest the wounds were horrific […] I was like I'm gonna (big inhale of breath). I couldn't…I didn't release it, but I probably should have because it was so traumatic… (PPS11)*

School staff attempted to remain self-aware during their interactions by monitoring their responses. In situations where emotions did take over, there seemed to be an uncertainty around whether this was appropriate. Following finding a student attempting to take their life, one participant noted:

> *'I got him. I did what you're not supposed to, which is to hug him' (PP3)*

2.3.1.3. Closing the School Gates

School staff recognised the importance of establishing emotional boundaries between them and their students. They acknowledged that this was key to coping with the impact of self-harm, recognising that in becoming "*too emotionally involved, that way*

madness lies". School staff valued having a 'relational' and 'physical' distance from the school and students. One participant likened this to 'closing the school gates', and this aided their ability to cope.

> *I am very good at the at leaving at the gates […] when you leave the school, you have a point, and you leave everything at that point and you pick it up on your way back in (PP14)*

When they are not able to have a break from school, the emotional burden of self-harm appeared all-encompassing, often infiltrating their personal life and impacting their ability to sleep.

> *Then you'd get home and then you'd be there, and you don't really feel that you get a break [...] the night was the worst, because as soon as you close your eyes you're actually thinking about seeing something… have you missed something else? […] you leave the surroundings, but you don't quite leave it (PP13)*

Having a space to offload and reflect on incidents of self-harm was a valued resource. Some turned to compensatory strategies such as 'over-working' to ensure "*all boxes had been ticked*" and risk had been handed over for a "*peace of mind*" before they finished.

2.3.2. Complex and Evolving Internal Processes

This theme reflects the emotional impact of managing self-harm where school staff experience complex and paradoxical affective and cognitive processes. Increased exposure and experience assist an ever-evolving process in managing the emotional impact of self-harm, although this process can fluctuate in response to complex and challenging cases.

2.3.2.1. A Double-Edged Sword

Supporting student self-harm was experienced as a 'double-edged sword'. The experience can be "*emotionally draining*", often because of the "*mental load*" of holding responsibility, ensuring safety of the pupil and all processes are followed, and trying to instigate appropriate support. School staff were burdened when their response

did not feel satisfactory, experiencing increased feelings of self-doubt and guilt, and subsequent cognitive rumination.

> *I think you feel guilt that you're almost not supporting them or you're doing something wrong, or it's not going to change. You just feel like you're letting them down (PP12)*

However, although it can feel like a challenging process, this also generates a subsequent sense of reward and pride. Having students seek-help for their difficulties was relieving, and school staff felt "*privileged*" to be in a role that allowed them to help.

> *I didn't want to carry on teaching English every single day and marking the semi-colon wrong every single day. And it's true, sometimes you feel you have made a bit of a difference (PP3)*

2.3.2.2. Age and Experience

The approach to managing self-harm was considered as evolving in nature, changing with experience and "*maturity*". Increased exposure to self-harm encouraged a 'desensitisation' process; negative emotional responses gradually diminished, further facilitating emotional distance. Furthermore, age and experience aided confidence in managing self-harm, setting personal limits in what can be offered, and advocating what is needed for the student.

> *I think I'm old enough and wise enough now, I've got big shoulders it doesn't bother me. I think that's really key, your age makes a difference […] having been through it personally and at work, I think I'm quite resilient toward it all. (PP1)*

Acquired knowledge of self-harm and familiarity of processes were attributed as key factors in promoting confidence when managing student self-harm and personal growth.

> *It's as I've grown as an individual …as I have upskilled myself and obviously got training [,,,]that I've developed to be able to deal with that within the school. So yeah, it's about training and getting more confident (PP14)*

Newer school staff appeared to imagine their more experienced colleagues as omniscient, believing they are more able to manage a situation as experience and exposure enables them to "*learn an ability to get through that moment*". Nevertheless, even with exposure and the building of emotional 'barriers' there were occasions that student self-harm could have an enduring impact. Sadness was often experienced when managing "*the big tough cases*", where the student was living in complex and unchangeable contexts. When reflecting on their experiences, one individual recognised the long-lasting impact of some cases of student self-harm:

> *I suppose the main ones stayed with me, and will stay with me forever won't they? The boy with the bandages and the deep wounds, and the girl that was sectioned… yeah they'll never leave me. They've made a deep wound, haven't they? (PP11)*

2.3.3. A Rock and a Hard Place

In their endeavour to manage self-harm, school staff are faced with dilemmas and obstacles to overcome. These hurdles arise in a context of pressured educational and healthcare provisions that are under-resourced, and within systems and societies that indirectly and directly work to promote student self-harm. Consequently, school staff find themselves between *'a rock and a hard place'*.

2.3.3.1. Facing Dilemmas

School staff described having to put 'the process' before the person, which exacerbated personal and professional inner conflicts. It was noted that the student can often become 'lost', whilst processes are followed to ensure professional accountability.

> *It's a horrible thing to say, but all the boxes have to be ticked. Have we done the risk assessment? have we done the safety plan? have parents been informed? [….] In that somewhere is a child who struggling, and just wants to stop hurting and you have to remind yourself that (PP4)*

They highlighted the conflict of balancing the wishes of the student, whilst ensuring risk is being managed by breaking their confidentiality. School staff can find themselves working against their own values, as breaking confidentiality may break the student's trust. Whilst this can be a challenging experience, school staff rationalised that

the main priority is to keep the student physically safe, recognising that this part of the process will always be "*the rocky bit*".

> *It's like the dilemma of the responsibility ultimately of having this information and*
> *wanting to do the best by the student, but being concerned about the outcome and*
> *then not making the situation worse with student (PP6)*

A heightened sense of responsibility is experienced by individuals who are in leadership or pastoral roles, as they are often must fight for support. Until this is established, there is a sense that they are "*left holding the baby*"; holding responsibility for the student's safety whilst not feeling skilled to provide the specialist support deemed required. Subsequently, staff can feel pulled into working harder to support the student, often at the cost of their own wellbeing.

> *Sometimes I go through this stage where I'm like 'we're doing too much, let's stop*
> *doing all this stuff because I can't, we can't, cope'…but what would happen if we*
> *didn't do that stuff? (PP8)*

2.3.3.2. Feeling the Pressure

School staff reported a recent increase in the prevalence of student mental health difficulties, with self-harm being one of the main issues they encounter. The methods used to self-harm were vast, with students finding ever-changing and extreme ways to harm. There was an overall sense that this is just the beginning of a crisis, with school staff foreseeing a further escalation in these difficulties.

> *We've had students jump in rivers, say they're going to run out in front of a car,*
> *attempt suicide by ligatures around their neck, or pills or, you know, alcohol […]*
> *so I think, we're in for some real trouble soon…we really are (PP4)*

There were frustrations towards the education system that places higher importance on academia than student mental health, and recognition that these pressures exacerbate pupil distress.

> *I would say it's related to the crazy kind of society and education system that we*
> *have, which is so much about exam results and achievements, and not admitting*

to weakness and all that sort of stuff [...]I think that's created several generations of young people who really suffering (PP3)

However, the increasing prevalence of self-harm and societal/professional expectation, also places pressure on the school staff who must manage these competing demands.

If something goes wrong in the day, it's all filtered down to us so it can be quite stressful when you're managing multiple concerns that come in on top of your actual day job (PP8)

There was a sense that this work was being completed in vain; no matter how the school staff try to improve educational outcomes, if the students were in mental distress their learning would be negatively impacted.

I know we're in education, I know they need an education[...] but they're not going to do that if mentally they are hurting themselves (PP10)

2.3.3.3. Feeling Despondent about the System

Mixed experiences of working with the systems around the student were apparent. School staff shared frustrations towards CAMHS and Social Services, highlighting collective difficulties in accessing timely intervention due to strict referral criteria.

Getting them (CAMHS) to pick up things is hard, because the threshold is so big because ... well because they are oversubscribed aren't they? (PP5)

It was also apparent that services were not set up in ways that promoted help-seeking, with many pupils disengaging and turning to school staff for support.

Then they end up talking to the staff member at college about what's going on for them and really, they should be having that conversation with (CAMHS)...do you know what I mean? (PP8)

School staff subsequently see escalation in the severity of the behaviour with sometimes fatal consequences, which promotes anger at the system that "*further abuses the child*".

It just makes you so angry... you've got sort of all the services who are there to support them, but they are actually not there… and the reason being is because certain protocols come into place (PP10)

These experiences culminate in feelings of helplessness and hopelessness, and a sense that there is nowhere left to turn.

I sat at my desk and cried for an hour, because I was like I don't know what else to do […] it's like everything that I'm trying to put in place just keeps falling apart really quickly… and she just keeps losing trust in me (PP12)

School staff are also faced with several unhelpful social influences, which perpetuate their plight. Peers were understood to play a causal role in the instigation of self-harm, with many describing students being introduced to this through friendship groups. Alternatively, peers may stigmatise self-harming behaviour.

I've seen children that will say things like 'go kill yourself, go cut yourself'… it's brutal (PP12)

Other people within the system could also inhibit the work of the school staff, creating additional frustration. This was often due to the lack of understanding about the student's wider context, with decisions being made by management that were not always perceived to be in student's best interests. In certain cases, parental responses were also viewed as a barrier, where parents did not always follow through with the recommendations made by school.

Or when you do speak to them (parents), they just pay lip service to things that they should be doing and then the young person comes in the next day and nothing has changed. No, that can be really tricky (PP8)

2.4. Discussion

The present study explored the impact of student self-harm on British school staff. To date, limited research has investigated school staff's experiences, even though most have encountered student self-harm at some point in their career (Berger et al., 2015). Consequently, it was important to develop an understanding of the psychological impact

of staff's experiences to raise awareness of how they can be supported in this pastoral role. The findings are now discussed in the context of existing theory and literature, and clinical implications and future research directions considered.

2.4.1. Discussion of Findings

School staff's responses were characterised by three themes that demonstrated how the management of self-harm can impact them during and following a self-harm disclosure or incident, and how they learned to cope with this in the face of internal conflicts and external pressures.

2.4.1.1. Way of Being

Key to the staff's experience of managing student self-harm was the need to demonstrate a compassionate *way of being*. The importance of an accepting and non-judgemental approach when managing self-harm is emphasised in adolescent research (McAndrew & Warne, 2014), with such experiences facilitating disclosure (Rosenrot & Lewis, 2020). Consequently, these findings highlight that school staff are approaching the issue in a way that is not only de-stigmatising (Dimitropolous et al., 2021), but also encouraging of help-seeking behaviour (Halladay et al., 2020). This is significant given the adverse consequences of adolescent self-harm and lack of professional help-seeking in this population (Doyle et al., 2015).

Although these findings replicate themes from previous research into teacher's approaches to responding to mental health concerns (Dimitropolous et al., 2021), they contrast conclusions from literature relating to professional attitudes to adolescent self-harm (Timson et al., 2012). Extensive literature highlights poor understanding and stigmatising approaches towards self-harm by healthcare professionals (Akinola & Rayner, 2022), with similar themes being illustrated in literature relating to educators. Though Dowling and Doyle (2017) highlighted the expression of concern from educators towards self-harm, they also evidenced negative attitudes, particularly if students were perceived to be from 'privileged' backgrounds. Conversely, the narratives explored within this study highlight non-judgemental attitudes to pupils regardless of their background. Distinctively, compassionate attitudes towards student self-harm were apparent regardless of level of experience, which contradicts previous research highlighting that those with lengthier teaching experiences hold more favourable attitudes towards self-harm (Heath et al., 2011). Perhaps the findings in this study reflect a wider shift towards more nuanced

and non-judgemental attitudes towards self-harm (Fox & Flower, 2021) or the outcomes from recent mental health training drives in schools (Townsend et al., 2018).

Staff interviewed placed importance on establishing emotional boundaries during and following their interactions with student self-harm. Comparable to staff in other research, their in-the-moment reactions to self-harm sometimes included shock and anxiety (Best et al., 2005). However, they worked hard to not show these emotions to their students. They shared fears held by other educators that their responses could make the situation worse (Ekornes, 2017). It was evident that school staff had developed their own coping strategies that facilitated an emotional 'detachment'. Although 'detachment' has previously been highlighted as a maladaptive response (Dunkley & Whelan, 2006), for these individuals an emotional detachment from their pupils promoted their wellbeing. This detachment was often facilitated by adopting their own compassionate frame of mind (Gilbert & Irons, 2005) where staff rationalised that their resources were finite and they could only do so much. However, in situations that encouraged more emotional investment, they recognised that the anxiety surrounding their students could infiltrate their home life, a finding that has been replicated in other literature (Dowling & Doyle, 2017).

2.4.1.2. Complex and Evolving Internal Processes

School staff expressed a range of complex and contrasting cognitive and emotional processes when managing student self-harm. Alongside the "mental load" from their strong feelings of responsibility to manage risk, school staff experienced self-doubt and guilt. Similar themes were reported in Stoll & McLeod's (2020) study of secondary school staff's experiences of supporting pupils with mental health concerns, where participants reported feeling guilty for not 'giving enough' to their pupils. These experiences are akin to the concept of 'burnout', characterised by feelings of emotional exhaustion and incompetency, and reduced feelings of personal accomplishment because of stressful work events (Maslach, 2003). Burnout is a common experience for educators and can lead to poor psychological wellbeing and teacher retention (Burić et al., 2019; Skaalvik & Skaalvik, 2020).

Nevertheless, many participants portrayed a dichotomy between negative affect and enjoyment and fulfilment from their role; contributing to their students' progress was a privilege, leading to feelings of pride and reward. Although not previously mentioned

in schools-based qualitative research, similar themes have been reflected in the experiences of CAMHS nurses who described contrasting emotional experiences when working with adolescent self-harm (Leddie et al., 2021). The authors proposed that long-term therapeutic work may have influenced the nurses' positive affect (Leddie et al., 2021) as they could follow a person through their care and develop a thorough understanding of adolescent self-harm (O'Connor & Glover, 2017). Similar explanations could be maintained for school staff, given that their work involves daily contact with pupils that extends over the adolescent lifespan. Alternatively, school staff could be experiencing 'compassion satisfaction': a protective factor characterised by the sense of reward or pleasure derived from helping others (Stamm, 2010). Whilst little is known about this phenomenon for educators, preliminary research has highlighted their positive affect when supporting students who have experienced trauma (Fleckman et al., 2022). Thus, the present study could provide novel insights into school staff's experience of compassion satisfaction when working with students who self-harm.

Comparably to previous school-based research, participants described a gradual reduction in the negative impact of self-harm (Berger et al., 2014). Such 'desensitisation' processes have been described as a vital self-protective mechanism (Thompson et al., 2008). Furthermore, evidence of psychological growth was highlighted in school staff's narratives; as they became more exposed to student self-harm and familiar with the procedures to manage this, they noticed a growth in self-confidence. Conceivably, their exposure to self-harm over time aided the transformation of knowledge they had acquired through training and research into procedural knowledge of how to apply key skills (i.e., active listening and pacing) in their interactions with pupils (Binder, 1999; Bennett-Levy, 2006), facilitating a sense of self-efficacy. This was reflected in newer staff's beliefs that only through experience can individuals learn the ability to manage the interaction. Therefore, it could be argued that psychological growth is an intrinsic consequence of managing self-harm; amassing experience of working with adolescents who self-harm enhances the understanding of and confidence in supporting this, subsequently reducing experienced anxiety (Carter et al., 2018).

2.4.1.3. A Rock and a Hard Place

School staff's compassion was evident. However, managing self-harm in a context of increased pressure and unhelpful systems fostered feelings of hopelessness and frustration. Participant's experiences concorded with those described by mental health

professionals (Fox, 2011) in which individuals felt conflicted when placed in a position that directly opposed their compassionate instincts and called them to follow fixed professional protocols. Such conflicts were particularly prominent in cases where participants had to enact their 'duty of care' and break confidentiality against the student's will. This is a seemingly common yet challenging experience for school staff (Dowling & Doyle, 2017); even though it was accepted that confidentiality should be broken, managing the consequences of the relationship rupture with the student was emotionally demanding.

The issue of managing student self-harm in pressured educational contexts is common (Berger et al., 2015). However, demands are intensified by the additional constraints placed on schools in the context of performance agendas, and under-resourced services. The problem of accessing CAMHS services is not unique; research has highlighted substantial barriers to accessing specialist support, including high access thresholds and limited-service capacity (Rice et al., 2017). School staff are therefore left to manage high risk, alongside their other working commitments. However, their lack of specialist training in risk management and therapeutic skills promotes feelings of despondency. Regular exposure to others' trauma and feelings of powerlessness to change their situation can culminate in emotional exhaustion and cynicism (Brunsting et al., 2014): a process known as 'vicarious traumatisation' (Pearlman & Saakvitne, 1995) or compassion fatigue (Hydon et al., 2015). Eventually, this may lead to disengagement, low morale, and mental health symptoms that extend into educators' personal lives (Lawson et al., 2019).

2.4.2. Clinical Implications

Given the myriad of potential negative consequences of supporting student self-harm, such as vicarious traumatisation and burnout, it is vital that organisations emphasise practices in school policies that effectively support staff. As well as mitigating the negative impact on staff wellbeing, effective support may be of further significance as the improved mental health of school staff facilitates improved student outcomes and workforce retention (Madigan & Kim, 2021; Scott, 2019).

The significance of systemic support and team cohesiveness has been highlighted in the current and previous research (Dimitropoulos et al., 2021), where working in cultures that promote strong working relationships supports staff wellbeing. However, it

was apparent that peer, parental and leadership attitudes could impede effective work. Evidently, there is a need for an approach to managing self-harm that fosters a collaborative culture across the entire school community. Trauma-informed approaches could meet this requirement as these emphasise the creation of safe and trusting work atmospheres when supporting individuals with mental health difficulties (Bloom, 2013). Organisational changes facilitated by the implementation of trauma-informed practices and policies have been reported to positively impact staff working in healthcare settings (Hales et al., 2017). Whilst development of trauma-informed schools is now receiving stake-holder attention, this approach was not always being executed by organisations. Implementation of trauma-informed approaches could mitigate many of the issues faced by teachers: its non-shaming approach may deter negative responses towards self-harm from the system, the enhancement of school environments may promote learning and achievement of academic targets, and its emphasis on self-care could support staff wellbeing. As such, the findings of this study advocate for the wider implementation of such approaches within schools.

The management of high-risk pupils is beyond the remit of schools, who do not have access to specialist training in risk management or therapy, nor would this be appropriate (Mazzer & Rickwood, 2015). Given the ever-increasing prevalence of self-harm in schools, there is an apparent need for more collaborative practice between schools and CAMHS. Considering CAMHS pressures, this could be achieved by placing trained mental health workers within schools. Promisingly, steps have been taken towards this, with a recent Green Paper advocating the need for a schools-based mental health workforce (DoH, 2017). However, it is unclear whether the management of self-harm will be within their purview as initial role descriptions focus on the management of low-risk mental health difficulties (Ludlow, et al., 2020). Nevertheless, given the high prevalence of self-harm and potential for rapid escalation, it would be beneficial for these workers to use their skills to support the complex case-management of self-harm within schools.

Given the importance of exposure to self-harm on teacher confidence, it appears that the development of training programmes that are less didactic and provide opportunities for skill practice are warranted. Experiential methods through case-studies and roleplays are common in the training of mental health professionals and aid the transformation of declarative knowledge into 'when' and 'how' to apply these skills in the real-world (Bennett-Levy, 2006). A focus on conversations around breaking

confidentiality could be particularly beneficial. Embedding such training in teacher training programmes may encourage new staff to approach self-harm in an assured manner rather than avoiding the subject. Additionally, it is recommended that staff receive specific training from skilled professionals regarding counselling skills and recognising potential countertransference responses, and how these can impact feelings of efficacy (Ryle & Kerr, 2020). These training opportunities could further enhance school staff's confidence and work satisfaction, as well as improving health outcomes for their students (Karman et al., 2015).

Supervision and reflective practice provide a space to process emotions in relation to clinical work, which is considered key to mitigating the negative impacts of vicarious trauma (Lonn & Haiyasoso, 2016). Access to these practices has been highlighted as invaluable to educators who manage self-harm (Dowling & Doyle, 2017; Best et al., 2006); it was evident, however, that these are not widely available within schools. These practices are considered fundamental to the work of practitioners involved with adolescent self-harm (NICE, 2011) as they ensure staff are practising safely and within their competencies. Consequently, it could be argued that there is a role for clinical psychologists within schools as they are well placed to provide supervision to those working closely with pupils who self-harm and can facilitate reflective practice or debriefing for staff-groups who are working in complex systems (BPS, 2017). These provisions could not only address the potential dangers of staff burnout and re-traumatisation, but also capitalise on Compassion Satisfaction (Dehlin & Lundh, 2018) and enhance the quality of the school staff's response to self-harm.

2.4.3. Limitations and Future Directions
Whilst this study presents important themes and implications, there are limitations that should be acknowledged. Though it was deemed important to include a sample of participants that represented staff in diverse educational contexts and roles, the responsibilities of each participant when managing self-harm varied considerably according to their job role, leading to varied experiences. The use of a heterogenous sample may have inhibited the generation of meaningful cross-party themes during the analysis (Robinson, 2014). Therefore, though the findings gave an overarching insight into the experiences of school staff, distinctive experiences regarding specific job roles were not fully explored. Future qualitative research, pinpointing the unique experiences

of those in each job role (i.e. pastoral, designated safeguarding lead, teacher), would enable support and training to be tailored to individual needs of each staff group.

While steps were followed to enhance researcher reflexivity, it is important to acknowledge the possible impact of researcher bias (Horsburgh, 2003) and researcher–participant interactions (Råheim et al., 2016). It is possible that the results from this study were impacted by demand characteristics or researcher effects, whereby the presented statement of safeguarding and knowledge of the researcher's role may have inhibited how honestly staff recounted their experiences. Therefore, the future use of methods that guarantee absolute confidentiality such as online forum discussions or surveys could be used to ascertain an 'uncensored account' of staff experiences (McDermott et al., 2013).

Moreover, participants self-selected and were experienced in working with self-harm, which potentially harboured a particular interest in this topic. While it was promising to see student self-harm being viewed through a compassionate lens, it is possible that school staff who have less involvement or interest in student self-harm may experience self-harm differently. Future research in this area with larger participant samples would be beneficial.

2.5. Conclusion

This study's unique findings contribute to the largely incomplete body of literature on how school staff are impacted by identifying and responding to self-harm in the school setting. They highlight how educators are highly committed to ensuring that student self-harm is supported in a compassionate and responsive way, yet they often face several barriers that constrain their effective management of self-harm. Alongside the challenging in-the-moment emotional impact of self-harm and resultant worry and anxiety, staff often must manage feelings of hopelessness which are promoted by the systems and contexts they are working in. There are several practical considerations that can be made by employing institutions, teaching bodies, and health authorities to improve support and training for staff supporting students who self-harm. Embedding these into routine practice may not only improve outcomes for students, but help other educators to experience 'compassion satisfaction' when they inevitably encounter self-harm throughout their career.

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Chapter Three

Reflective Piece

A Reflective Exploration of my Research Journey

Overall Chapter Word Count:3748
(Excluding Abstract, Titles, Tables, Figures, and References)

3.1. Introduction

At the culmination of their training experience, Trainee Clinical Psychologists should demonstrate the skills of 'reflective scientist practitioners' (British Psychological Society [BPS], 2019), where self-reflection is afforded equal importance to scientific evidence. Therefore, as well as applying "psychological science" to decrease human distress, they should remain "cognisant of importance of self-awareness and the need to appraise and reflect on their own practice" (BPS, 2008, pg. 8).

Although there are conceptual differences in definition of reflection and related ideas such as 'reflexivity', or 'reflective practice', at its core is the idea of the use of "*intellectual and affective activities in which individuals engage to explore their experiences in order to lead to new understandings and appreciations*" (Boud et al., 1985, pg. 19). Engaging in reflective practice requires an individual to recognise how intersubjective elements impact their means of relating and behaving (Berger, 2015). Throughout my training experience I have benefitted greatly from such practices. Considerations of my clinical practice through supervision and reflective groups, have facilitated a great deal of introspection about my professional and personal values. Furthermore, the use of reflection has aided the self-evaluation of my practice, supporting my skill-development and confidence as a clinician (Bassot, 2016). Given that researchers have an unavoidable influence over all domains of the qualitative research process (Mortari, 2015), the value of reflection has also extended into my research practices.

Berger (2015) posited the need for qualitative researchers to understand their identity and role in the creation of knowledge, and to appraise the influence of their assumptions and personal experiences on all aspects of their research. It is therefore unsurprising that the use of reflection has been described as "*some of the most challenging, yet important work, in qualitative research*" (Mitchell et al. 2018, pg. 673). As such, the use of 'reflection-in-action' (Schön, 1983) was key to my engagement with the research process. Through 'in-the-moment' reflexivity, I aimed to recognise the influences of my own experiences and biases, as I was conducting interviews and generating knowledge through the development of codes and themes. Taking moments to step away from the research process, and discuss my insights, experiences, and understandings with my research team and cohort aided my retrospective 'reflections-on-action' (Schön, 1983). Through these conversations, I was able to critically consider my role, process my own experiences and consider how these paralleled those of the participants.

With reference to these in-the-moment and retrospective reflections, the following piece will bring together some of the key and poignant moments of my research journey. With reference to key literature and psychological theory, I will consider how I influenced the research process, and in turn, how the research process influenced me

3.2. The Start of My Research Journey

3.2.1. My History, Values and Research Decisions

When embarking on my qualitative research journey, it was important that I considered my own 'history, values, assumptions, perspectives, and politics' (Braun & Clarke, 2013, pg.36), and took responsibility for my "own situatedness within the research" (Berger, 2015, pg. 220). I recognised that some of the principles of narrative therapy reflected these ideas, which appreciates that social, cultural, or political contexts influence the stories we develop (White & Epston, 1990; White & Denborough,1998). Thus, to support my understanding of how I developed stories within my research, I drew upon a narrative therapy tool known as the 'Tree of Life' (ToL; Ncube, 2006; Ncube & Denborough, 2007). This employs the features of a tree to provide a holistic metaphorical representation of elements of a person's life; that is, the 'roots' represent an individual's history and culture, the 'ground' denotes the current important aspects of their life, the 'trunk' symbolises an individual's skills and roles, the 'leaves' represent important people, the 'branches' signify hopes and wishes, and finally, the clouds represent challenges (Ncube & Denborough, 2007; Ncube, 2017). The development of my own ToL (see Figure 3.1.) provided a unique opportunity to consider how my own identity and morals shaped the development of my research process.

Figure 3.1.

Personal Tree of Life

Self-Criticism

Perfectionism

Family

School
Friends

Cohort

Colleagues

Build a Family Home

Stay connected with hobbies

Appraisal Tutors

Improve the lives of others

Teachers

Travel

Qualify as Clinical Psychologist

Supervisors

Get Married

Thoughtful
Inclusive
Caring Honest
Friend
Trainee Clinical Psychologist
Sister Daughter
Compassionate
Creative

Partner

Completing Doctorate

Wedding Planning

Strong Moral Compass

Integrity/Honesty

Animal Lover

Suburban Lifestyle

Farming Community

Good Academic Opportunities

Safe and Supportive Family

Positive Peer Groups

Before I embarked on training, I had never really considered the merits of qualitative research. During my undergraduate and postgraduate studies, I was very much drawn towards quantitative methodologies, where data analysis and findings are 'concrete'. This was perhaps reflected by a historical belief developed in my school years that the subjective nature of interpretation was not a personal strength, and instead objective subjects like 'science' and maths suited me better. However, during my

experiences on the doctorate, through teaching, therapy, and formulation work, I started to recognise that a single phenomenon in the human experience is likely to have multiple interpretations rather than one absolute truth. This open and curious approach fitted my values of understanding the unique experiences of individuals and aligned more to the epistemological principles of 'interpretivism' (Myers, 1997). Subsequently, I decided to let go of the safe, ordered, and familiar, and stepped into the complexities of the human experience.

There were several factors that contributed to my decision to research this topic area. Core to the Clinical Psychology profession is the striving to minimise exclusion and inequalities and ensure all individuals are valued and treated with respect (BPS, 2019). When choosing my systematic literature review, I opted to examine a topic that spoke to these values and intended to advocate for people's rights and improve healthcare for marginalized groups of individuals. My experience as a clinician ignited an interest in the subject of self-harm as I noticed that many reduced this to 'attention-seeking' behaviour, an unfortunately common occurrence (e.g. Sandy, 2013). When hearing the stories of service-users experiences of care, I became invested in promoting a person-centred and compassionate way of supporting individuals who self-harm, and fervently contributed to the implementation of Trauma-Informed Services. However, I wanted to expand this interest further and a wider audience, hence my decision to investigate young people's experiences of seeking support for self-harm and how these can be improved.

My own critical thinking, political positioning, and hope for social justice also had a potential influence over my decision to undertake research in schools. Having worked in stretched NHS services, I have become increasingly aware of the bureaucracy that promotes tensions and conflicts between organisations as they manage increasing pressure in relation to budget-cuts and performance-related targets. During my professional liaisons with school staff when working in CAMHS it was increasingly apparent that self-harm created a sense of anxiety, yet schools were expected to manage increasing levels of risk and complexity on top of their already heavy workload. This was justified by the fact that schools were best placed to support young people. However, this created a personal sense of discomfort as I felt the issue of self-harm was effectively being passed to those who did not have the specialist skills to support this behaviour. In my personal relationships with friends and family members who work in school it was increasingly evident that help and support was not routinely available for teachers, and I knew many

who were leaving the profession because of this. As such, I hoped that I could undertake qualitative research to provide a voice to school staff who are expected to meet ever-rising expectations, but whose views are rarely considered in research, government policy, or until very recently healthcare policy (Roxby, 2022).

3.3. A Rocky but Rewarding Excursion

3.3.1. A Way of Being

Thurairajah (2019) suggests that the "relationship that exists between the qualitative researcher and their participants is perhaps the most important to their work" (pg. 134). In my approach to all professional relationships I attempt to adopt an 'I-Thou' way of being (Fife et al., 2014), where I am mindful of the position of power I hold as a psychologist (BPS, 2017), and work to foster relationships where both parties are seen as equal.

Concordantly, as I adopted the role of 'researcher', I strove to use practices that promoted participant power. However, I recognised that no matter how hard I tried to mitigate power differentials, they were inherent to process (Grove, 2017). In line with ethical requirements (BPS, 2021), during a pre-interview conversation I informed participants of my role and duty regarding safeguarding. As the interviews progressed, I started to notice that participants would often clarify some of their answers with phrases such as *'obviously I followed safeguarding procedures'*. This prompted me to question how I was being experienced by the participants, and whether the insights I was gathering were a true or censored reflection of their experience. I consequently recognised my own cognitive dissonance as two personal values were pulled into conflict. I felt bound by my ethical and professional code of conduct but realised that I was not allowing my participants' truth to be heard. Indeed, balancing power dynamics whilst conforming to the hierarchies of the researcher–participant relationship is a recognised challenge to the researcher's enterprise (Karnieli-Miller et al., 2009). Interestingly, on reflection, I also noticed how this paralleled the experiences of the school staff who were bound by the duty of care to their pupils, but had to work against their values by exerting their power over the young person when breaking confidentiality. I took this as a useful learning point, recognising that whilst research can challenge your values, the process itself can provide invaluable insights into the lived experiences of others that allows you to approach the data from a truly empathic position.

I instead focused my attention towards 'the changeable' and made sure the relationship felt as safe and as trusting as possible, as "it is only when there is trust that researchers can know the 'real' story" (Thurairajah, 2019, pg. 135). In many ways, my personal qualities, and the clinical skills that I have developed throughout training, as highlighted on the trunk of my ToL, supported me with this endeavour. Despite the active power differentials, through active listening, curiosity, and unconditional positive regard, I was able to create a space that promoted rich discussion. However, I recognise that at times I was pulled between my two conflicting roles, that of a researcher and that of a clinician. Indeed, the literature highlights the common occurrence of contending dual-role experiences for clinician-researchers undertaking qualitative research (Holloway & Weaver, 1995; Hay-Smith et al., 2016). I noticed I experienced the 'clinical patterns catalyst' where at times I felt drawn into the role of a 'clinician' and compelled to share my expertise with participants (Hay-Smith et al., 2016). This was particularly apparent when school staff were questioning some of the underlying functions of self-harm; it was challenging to step away from my clinical instincts and not share my trauma-informed understandings of distress (Johnstone & Boyle, 2018). Fortunately, many of participants seemed to naturally align to this way of this thinking, so this tension was short-lived. However, this experience has highlighted the potential for clinician-researcher conflicts in my future practice and has revealed to me that while I am proud of my strong person-centred values, there is a right time and place for these in research. I acknowledge that will have several opportunities to share psychological thinking (e.g. in my research writing); to include my agenda during interviews and privilege my own voice, would have done a disservice to both my participants and my own values.

3.3.2. A Rock and a Hard Place

Inherent to the research journey is the need to make a number of complex, yet pivotal decisions regarding epistemological positions, design and analysis (Braun & Clarke, 2022). At many times during the development of my thesis I found myself stuck between my own 'rock and hard place'. For example, when developing exclusion and inclusion criteria within my systematic literature review, whichever decision I made would have limited my research. I either included studies involving suicidal behaviour and risked reducing the validity of my results, or I excluded them and potentially missed important findings. Similar conflicts arose during the recruitment process, where conflicting advice about the number of participants needed for a 'viable' thesis created

confusion and uncertainty. I felt like I could not do right for doing wrong. I was stuck by indecision, and at times this felt stifling and led to procrastination. On reflection, as I faced these dilemmas, I recognise that there were more internal and historical, belief-based, processes at play.

Defined as an enduring act of setting exceptionally high-performance standards, whilst engaging in overly critical self-evaluation (Frost et al.,1990), perfectionism is a common trait of Trainee Clinical Psychologists (Pica, 1998). Indeed, during clinical supervision, I had often reflected on my desire for 'perfection'. However, I quickly recognised that the idea of being a 'perfect clinician' is unachievable in the 'messy' world of human relationships and experience. When embarking on my research process I, somewhat naively, did not consider how the beliefs I held around perfectionism would impact my research experience. I have always held myself to exceptionally high standards and stepping into the unfamiliar territory of qualitative research reignited a historical self-doubt about my academic abilities. I became fixed on the idea that what I was doing was not of a high enough standard for doctorate, that I was unskilled, and that I would be found out as an 'imposter'. With every decision I faced, I noticed my self-criticism increase and my confidence waver, which ultimately kept me stuck in a cycle of uncertainty, hopelessness, and procrastination.

On reflection, it is likely I was moving through the 'stages of competence' outlined by Broadwell (1969), who theorised that learners progress through stages of awareness and competence as they acquire new skills. As I was learning about the intricacies of qualitative research, and faced with challenging dilemmas, it was likely that I was becoming increasingly conscious of my incompetence. Indeed, the intersection of perfectionist traits and feelings of incompetence often leads to poor psychological outcomes (Shafran et al, 2002; Ferrier-Auerbach, 2009), possibly explaining some of my negative affect. However, as I advanced through the research, I started to recognise that the concept of 'perfection' in qualitative research is an unachievable ambition. A quote by Braun and Clarke (2022) bought this sharply into my focus:

> *"There isn't a perfect analysis of your data, waiting in the cloud, that someone will use to judge 'your' analysis against […] but the very nature of the task means there is no perfect final product to identify" (pg. 92)*

Consequently, I was able to 'let go' of perfectionism and found the 'good-enough' position I try to embody when I am working therapeutically with individuals (Sachs, 2019). Concordantly with the human experience, I recognised that qualitative research is muddled and full of nuance. My research would never be 'perfect' and, as long as I could justify the decisions I made, my position as a researcher was secure. Furthermore, as I started to receive feedback of my drafts from my supervisors, I noticed the confidence in my abilities start to grow, conceivably reflecting a move to the 'consciously competent' position. This perhaps reflected the experiences of my participants, where knowledge and experience acquired over time promoted personal growth. I am aware that feelings of incompetency are likely to follow me as I transition into the role of qualified clinician, where I will be responsible for making key clinical decisions. Therefore, I will draw upon these experiences, and ensure I capitalise on the expertise of my colleagues and supervisors to inform my decisions when I feel stuck, and gain regular feedback to promote my conscious competence in clinical practice.

3.3.3. Complex and Evolving Internal Processes

Undertaking a doctorate has been described as an isolating, and emotionally demanding experience (Lally, 2012). At times, this has reflected my experience. During the research process, I noticed an increase in intrusive and anxious thoughts, which at times, affected my ability to engage with my data. These thoughts often centred around missing something important in the data, or not giving enough voice to every participant by excluding quotes. However, I was particularly concerned about misrepresenting the experiences of my participants. It has been suggested cognitive biases prompt us to find and value highly results we expect to see or fit with our pre-existing beliefs (Buetow, 2019). Whilst I had reflected on my beliefs and assumptions in my reflexive journal and conversations with my supervision team, the very fact that I was aware of them made me doubt that what I was interpreting was 'correct'. For example, I recognised that my political positioning made me hyper-alert to ideas relating to government pressures and funding issues, and therefore when conducting my analysis, I worried that I was ascribing too much importance to something that was not actually a 'thing'. Braun and Clarke's (2019) position that a researcher has an active-role in knowledge production helped to reduce some of this anxiety, but discomfort still remains. Confirming my interpretations through 'member-checking' would have alleviated my concerns around misrepresentation, although I recognise that time pressures did not allow for this. Ultimately, reflection has enabled me to find an acceptance that my biases are likely to

influence my work, but I appreciate the importance of being open and aware of these. However, if I truly want to work to my values and give voice to others, it will be important to seek out the expertise of those with lived experience to ensure they are fully heard.

However, it is undeniable that there were wider factors that influenced some of the anxiety I experienced during the research process. To me, this thesis has been the pinnacle of my career so far, and the stakes have felt very high. The thought of failing the thesis and subsequently the course, bought into focus a personal identity crisis, where I often questioned *'who am I, if I am not a psychologist?'*. The idea of failing to reach a long-term aspiration was abhorrent and promoted a sense of internal shame, and I recognise that I adopted unhelpful behaviours to manage the threat I felt from this (Gilbert, 2009). I became fixed to the idea that I 'should' dedicate all of my time to my research to ensure I produced a publishable piece of work, and therefore withdrew and over-worked. When I did take a break, I felt guilty and ruminated over all of the things I still had left to do. On reflection, in becoming so fixed on trying to reach the end goal, I ultimately lost connection with my values or, as depicted on my ToL, my 'roots' and 'branches'. Through learning about the effects of 'burnout' whilst writing my empirical discussion, I became aware of the parallels between this and my own personal experience (Maslach et al., 2001). Knowing the evidence-base behind the use of self-compassion (Wilson et al., 2019), I have always endeavoured to help others develop their 'compassionate-self'. However, I appreciate that I forgot to do this for myself; allowing time for self-care and protecting my work-life balance, would have made the research process slightly easier. Moving forward, as I face demanding clinical and research pressures, I hope to continue to remain mindful of my need to engage in regular self-care and compassionate exercises for my own wellbeing.

Despite the challenges I faced, the experience of research has been wholly rewarding. Once I was able to sit with some of the negative 'chatter', I started to enjoy the process and found satisfaction when my work started to come together. In essence, my thesis has been my own 'double-edged sword'. Indeed, it was likely that the reward of research will be long-lasting. Palaganas and colleagues (2017) highlight that the process of research can bring about changes to the researcher, and on reflection it is apparent that I have been shaped by the individuals I have met and the theoretical knowledge I have acquired throughout this journey. In narrative therapy, acquired learning and personal growth would be considered 'fruits' on the ToL (Ncube, 2017). Accordingly, as part

reflexive process, I have developed a new ToL that incorporates the 'gifts' I have received through conducting my research (See Figure 3.2.).

Figure 3.2.

A revised Personal Tree of Life.
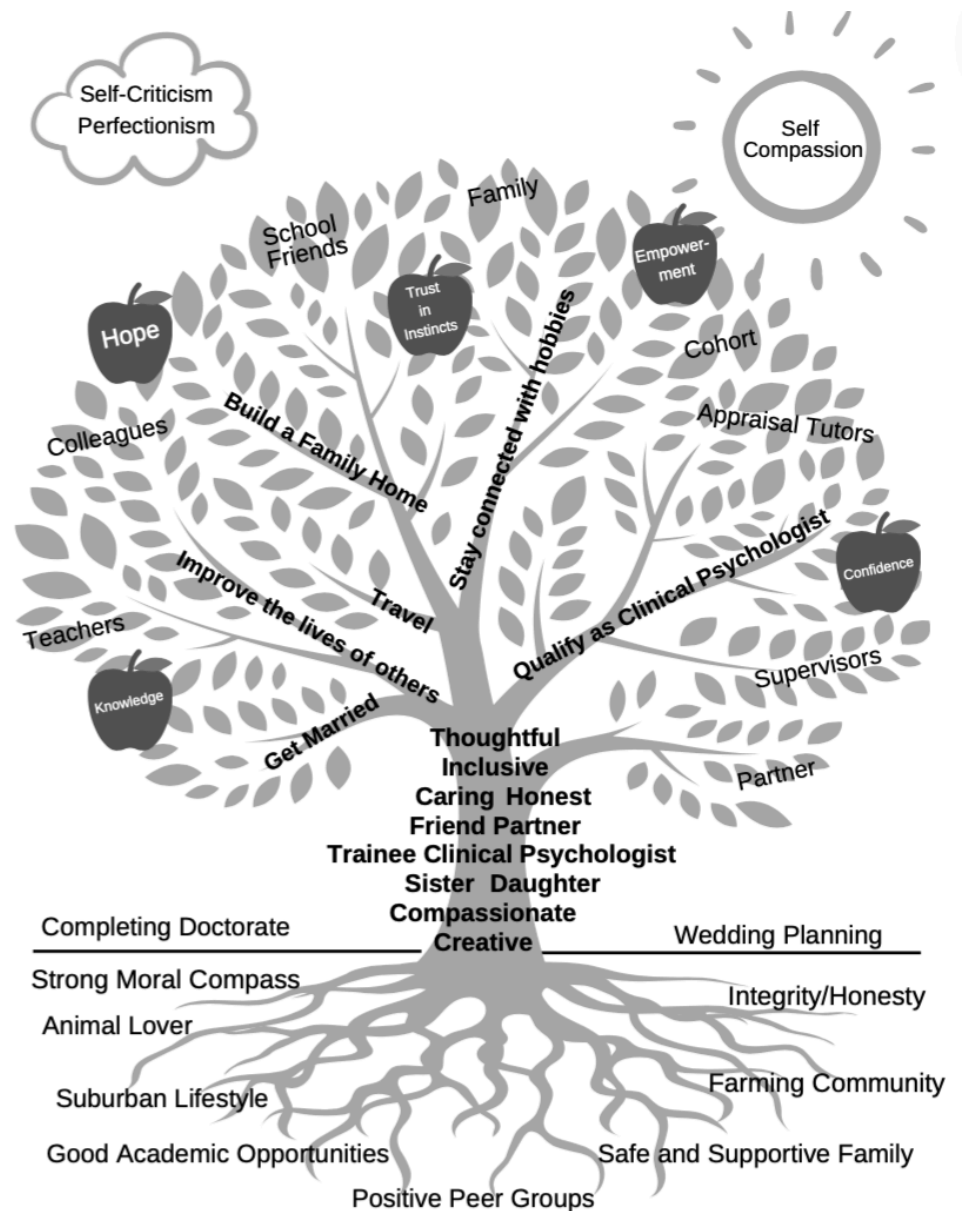
As I come to the end of the process, it is evident that I have been offered several 'parting gifts'. It was a privilege to spend my time talking to caring and passionate individuals and being trusted to voice their stories. Given my experiences in my clinical work and the literature around attitudes towards self-harm (Sandy, 2013), I recognise that I had expected to hear a dismissive rhetoric around this phenomenon. However, I was pleasantly surprised, and I left my interviews and data-analysis feeling fulfilled and with

a sense of hope that society is changing to be more accepting of difference. Furthermore, whilst I felt apprehensive about writing the discussions for my research papers, I discovered the empowering effect that this had. When talking about the real-world applications of my findings, I felt I was able to truly integrate my passions and identities as a clinician and researcher, to thoughtfully assert my recommendations to make a difference to school staff and young people. Finally, I have been reminded that I should trust my instincts as a both a researcher and clinician, as my knowledge learnt through training and experiences, and my inherent compassion and thoughtfulness will naturally steer me to best possible outcome.

3.4. Future Directions

Whilst reflecting on my experiences throughout this piece, I have been reminded of an idea often used in Acceptance and Commitment Therapy (Harris, 2009), which philosophises that 'in your pain you find your values' and vice versa, that is, they are two sides of a coin. I can now see that I was anxious about aspects of research because at times it tested my values of compassion, giving voice to and improving the lives others, which is ultimately why I endeavoured to become a Clinical Psychologist. With a heightened awareness of my own personal values, 'pulls' and 'blind-spots', I feel increasingly assured that I am an open and thoughtful reflective-scientist practitioner.

Though the research process has been challenging, it has culminated in a fuller understanding of the potential challenges of research within clinical psychology, but importantly I have also been enlightened to the multitude of rewards conducting research can bring. I have been taught valuable lessons about my professional and personal identities, that will follow me into the next part of my journey. Moving forward, as a researcher I will endeavour to continue to combine my research and clinical skills to 'lend power' to marginalised groups, and ensure they receive the best quality evidence-based care. As a clinician, I will continue to remain open-minded and notice my own biases, recognising how these influence the sense I make of others' stories. As a 'person', I will remain mindful of when I am losing connection to my passions outside of psychology, and importantly will offer myself the level of compassion I strive to show the individuals I encounter in my work.

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Appendix A.
Child and Adolescent Mental Health Journal Author Guidelines

Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Innovations in Practice; Narrative Matters; Debate Articles.

CAMH considers the fact that services are looking at treating young adults up until the age of 25, with the evidence that brains continue to develop until the age of 25, as well as the fact that a lot of issues that affect young adults and students are also relevant and topical to older adolescents. CAMH offers a discretionary approach and will take into consideration papers that extend into young adulthood, if they are pertinent developmentally to the younger population and contribute further to a developmental perspective across adolescence and early adult years.

Review Articles
These papers offer a critical perspective on a key body of current research relevant to child and adolescent mental health. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g., The International Prospective Register of Systematic Reviews, or PROSPERO). These articles should aim to inform readers of any important or controversial issues/findings, as well as the relevant conceptual and theoretical models, and provide them with sufficient information to evaluate the principal arguments involved. All review articles should also make clear the relevancy of the research covered, and any findings, for clinical practice.

Manuscripts reporting systematic reviews or meta-analyses will only be considered if they conform to the **PRISMA Statement**. We ask authors to include within their review article a flow diagram that illustrates the selection and elimination process for the articles included in their review or meta-analysis, as well as a completed PRISMA Checklist. The journal requires the pre-registration of review protocols on any publicly accessible platform (e.g., The International Prospective Register of Systematic Reviews, or PROSPERO).

Your Review Article should be no more than 8,000 words excluding tables, figures, and references and no more than 10,000 including tables, figures and references.

Ethics
Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the ***Ethical principles of psychologists and code of conduct*** (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (**ICJME**) and is also a member and subscribes to the principles of the Committee on Publication Ethics (**COPE**).

Informed consent and ethics approval
Authors must ensure that all research meets these ethical guidelines and affirm that the research has received permission from a stated Research Ethics Committee (REC) or Institutional Review Board (IRB), including adherence to the legal requirements of the study county. Within the

Methods section, authors should indicate that 'informed consent' has been appropriately obtained and state the name of the REC, IRB or other body that provided ethical approval. When submitting a manuscript, the manuscript page number where these statements appear should be given.

Preparation

Manuscripts should be double spaced and conform to the house style of *CAMH*. The title page of the manuscript should include the title, name(s), and address(es) of author(s), an abbreviated title (running head) of up to 80 characters, a correspondence address for the paper, and any ethical information relevant to the study (name of the authority, data and reference number for approval) or a statement explaining why their study did not require ethical approval.

Papers submitted should be concise and written in English in a readily understandable style, avoiding sexist and racist language. Articles should adhere to journal guidelines and include a word count of their paper; occasionally, longer article may be accepted after negotiation with the Editors.

Summary: Authors should include a structured Abstract not exceeding 250 words under the sub-headings: Background; Method; Results; Conclusions.

Headings: Original articles should be set out in the conventional format: Methods, Results, Discussion and Conclusion. Descriptions of techniques and methods should only be given in detail when they are unfamiliar. There should be no more than three (clearly marked) levels of subheadings used in the text.

Referencing[1]: CAMH follows a slightly adapted version of APA Style **http: www.apastyle.org/**. References in running text should be quoted showing author(s) and date. For up to three authors, all surnames should be given on first citation; for subsequent citations or where there are more than three authors, 'et al.' should be used. A full reference list should be given at the end of the article, in alphabetical order.

References to journal articles should include the authors' surnames and initials, the year of publication, the full title of the paper, the full name of the journal, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to chapters in books should include authors' surnames and initials, year of publication, full chapter title, editors' initials and surnames, full book title, page numbers, place of publication and publisher.

Tables: These should be kept to a minimum and not duplicate what is in the text; they should be clearly set out and numbered and should appear at the end of the main text, with their intended position clearly indicated in the manuscript.

Figures: Any figures, charts or diagrams should be originated in a drawing package and saved within the Word file or as an EPS or TIFF file.
See **http://authorservices.wiley.com/bauthor/illustration.asp** for further guidelines on preparing and submitting artwork. Titles or captions should be clear and easy to read. These should appear at the end of the main text.

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[1] Please note references with this Thesis followed the APA 7th Edition Style in line with University Requirement

Reference: The Association for Child and Adolescent Mental Health (n.d.). *Author Guidelines*. https://acamh.onlinelibrary.wiley.com/hub/journal/14753588/forauthors.html

Appendix B.
School Mental Health Author Guidelines

School Mental Health: A Multidisciplinary Research and Practice Journal is a forum for the latest research related to prevention, treatment, and assessment practices that are associated with the pre-K to 12th-grade education system and focuses on children and adolescents with emotional and behavioural disorders. The journal welcomes empirical studies, quantitative and qualitative research, and systematic and scoping review articles from authors representing the many disciplines that are involved in school mental health, including child and school psychology, education, paediatrics, child and adolescent psychiatry, developmental psychology, school counselling, social work, and nursing.

Coverage in *School Mental Health* includes innovative school-based treatment practices; training procedures; educational techniques for children with emotional and behavioural disorders; racial, ethnic, and cultural issues; and the role of families in school mental health.

- The latest research related to prevention, education, and treatment practices that target the emotional and behavioural health of children in the education system.
- Publishes empirical studies, theoretical papers, and review articles.
- Includes the work of authors from the wide range of areas involved in school mental health, including education, paediatrics, psychiatry, psychology, counselling, social work, and nursing

Preparation

APA Style: Please follow the 7th Edition of the APA Style Guide. Text must be double-spaced, 12-point Times New Roman with standard 1-inch borders around the margins. Page Length: 35 pages.

Abstract: Please provide an abstract of 150 to 250 words. The abstract should not contain any undefined abbreviations or unspecified references.

Keywords: Please provide 4 to 6 keywords which can be used for indexing purposes.

Text Formatting: manuscripts should be submitted in Word.

- Use a normal, plain font (e.g., 10-point Times Roman) for text.
- Use italics for emphasis.
- Use the automatic page numbering function to number the pages.
- Do not use field functions.
- Use tab stops or other commands for indents, not the space bar.
- Use the table function, not spreadsheets, to make tables.
- Use the equation editor or Math Type for equations.
- Save your file in docx format (Word 2007 or higher) or doc format (older Word versions).

Headings: please use no more than three levels of displayed headings.

Abbreviations: abbreviations should be defined at first mention and used consistently thereafter.

Citation: cite references in the text by name and year in parentheses.

Authors are encouraged to follow official APA version 7 guidelines on the number of authors included in reference list entries (i.e., include all authors up to 20; for larger groups, give the first 19 names followed by an ellipsis and the final author's name). However, if authors shorten the author group by using et al., this will be retained.

Reference list: *The list of references should only include works that are cited in the text and that have been published or accepted for publication. Personal communications and unpublished works should only be mentioned in the text.*

Reference list entries should be alphabetized by the last names of the first author of each work. *Journal names and book titles should be* italicized. *If available, please always include DOIs as full DOI links in your reference list (e.g., "https://doi.org/abc").*

Tables:

- All tables are to be numbered using Arabic numerals.
- Tables should always be cited in text in consecutive numerical order.
- For each table, please supply a table caption (title) explaining the components of the table.
- Identify any previously published material by giving the original source in the form of a reference at the end of the table caption.
- Footnotes to tables should be indicated by superscript lower-case letters (or asterisks for significance values and other statistical data) and included beneath the table body.

Figures Numbering and Captions:

- All figures are to be numbered using Arabic numerals.
- Figures should always be cited in text in consecutive numerical order.
- Figure parts should be denoted by lowercase letters (a, b, c, etc.).
- If an appendix appears in your article and it contains one or more figures, continue the consecutive numbering of the main text. Do not number the appendix figures,"A1, A2, A3, etc." Figures in online appendices [Supplementary Information (SI)] should, however, be numbered separately.
- Each figure should have a concise caption describing accurately what the figure depicts. Include the captions in the text file of the manuscript, not in the figure file.
- Figure captions begin with the term Fig. in bold type, followed by the figure number, also in bold type.
- No punctuation is to be included after the number, nor is any punctuation to be placed at the end of the caption.
- Identify all elements found in the figure in the figure caption; and use boxes, circles, etc., as coordinate points in graphs.
- Identify previously published material by giving the original source in the form of a reference citation at the end of the figure caption.

Reference:
Springer. (n.d.). *School Mental Health: Submission Guidelines*
   https://www.springer.com/journal/12310/submission-guidelines#Instructions%20for%20Authors

Appendix C.
Completed Spider Model for the Systematic Literature Review.

Spider Model	
Sample	The population are young people who self-harm. This includes adolescents and young adults but excludes adults and children. Sample includes all genders and ethnicities, and participants from LGBTQ communities. Participants must have actively engaged in Self-harm.
Phenomenon of Interest	The factors that facilitate and inhibit help-seeking behaviour. Help-seeking behaviours includes disclosure. Help-seeking can be from both informal (e.g., family, friends, colleagues), formal supports (e.g., GP's, Mental Health Professionals, School/University Staff, Counsellors) or online supports. Individuals can actively help-seek or intend to seek help.
Design	All research Qualitative designs will be included. The research methods may include employment of interviews, questionnaires, surveys or focus groups. Methods of Analysis can include (but are not limited to) IPA, Grounded Theory, Thematic Analysis, Content Analysis.
Evaluation	Looking to evaluate experiences, perceptions, attitudes and opinions of help-seeking and disclosure.
Research Type	Research can be qualitative, or mixed methods.

Coventry University

Certificate of Ethical Approval

Applicant: Bethan Smith

Project Title: Perceived Barriers and Facilitators to Formal and Informal
                                             Help-Seeking Behaviours in Young People who Self-Harm

This is to certify that the above named applicant has completed the Coventry University Ethical
Approval process and their project has been confirmed and approved as Low Risk

Date of approval: 23 Nov 2021

Project Reference Number: P130062

PROSPERO
International prospective register of systematic reviews

NHS
National Institute for Health Research

UNIVERSITY *of York*
Centre for Reviews and Dissemination

Systematic review

A list of fields that can be edited in an update can be found here

1. * Review title.

Give the title of the review in English

Perceived Barriers and Facilitators to Formal and Informal Help-Seeking Behaviours in Young People who

Self-Harm

2. Original language title.

For reviews in languages other than English, give the title in the original language. This will be displayed with the English language title.

3. * Anticipated or actual start date.

Give the date the systematic review started or is expected to start.

01/11/2021

4. * Anticipated completion date.

Give the date by which the review is expected to be completed.

30/06/2022

5. * Stage of review at time of this submission.

This field uses answers to initial screening questions. It cannot be edited until after registration.

Tick the boxes to show which review tasks have been started and which have been completed.

Update this field each time any amendments are made to a published record.

The review has not yet started: No

Review stage	Started	Completed
Preliminary searches	Yes	No
Piloting of the study selection process	Yes	No
Formal screening of search results against eligibility criteria	Yes	No
Data extraction	No	No
Risk of bias (quality) assessment	Yes	No
Data analysis	No	No

Provide any other relevant information about the stage of the review here.

6. * Named contact.

The named contact is the guarantor for the accuracy of the information in the register record. This may be any member of the review team.

Bethan Smith

Email salutation (e.g. "Dr Smith" or "Joanne") for correspondence:

Miss Smith

7. * Named contact email.

Give the electronic email address of the named contact.

smithb32@uni.coventry.ac.uk

8. Named contact address

Give the full institutional/organisational postal address for the named contact.

10. * Organisational affiliation of the review.

Full title of the organisational affiliations for this review and website address if available. This field may be completed as 'None' if the review is not affiliated to any organisation.

Coventry University

Organisation web address:

https://www.coventry.ac.uk

11. * Review team members and their organisational affiliations.

Give the personal details and the organisational affiliations of each member of the review team. Affiliation refers to groups or organisations to which review team members belong. **NOTE: email and country now MUST be entered for each person, unless you are amending a published record.**

Miss Bethan Smith. Coventry University
Miss Jacqueline Knibbs. Coventry University
Dr Claudie Fox. University of Warwick

12. * Funding sources/sponsors.

Details of the individuals, organizations, groups, companies or other legal entities who have funded or sponsored the review.

This Systematic Literature Review is being completed as part of NHS funded Doctoral Training in Clinical

Psychology, and will make up part of my Thesis.

Grant number(s)

State the funder, grant or award number and the date of award

13. * Conflicts of interest.

List actual or perceived conflicts of interest (financial or academic).

None

14. Collaborators.

Give the name and affiliation of any individuals or organisations who are working on the review but who are not listed as review team members. **NOTE: email and country must be completed for each person, unless you are amending a published record.**

15. * Review question.

State the review question(s) clearly and precisely. It may be appropriate to break very broad questions down into a series of related more specific questions. Questions may be framed or refined using PI(E)COS or similar where relevant.

What are the perceived barriers and facilitators to formal and informal help-seeking behaviours in young

people who self-harm?

16. * Searches.

State the sources that will be searched (e.g. Medline). Give the search dates, and any restrictions (e.g. language or publication date). Do NOT enter the full search strategy (it may be provided as a link or attachment below.)

Databases relevant to the field of psychology including PsycINFO, PubMed, Proquest, Scopus and Web of

Science will be employed for the searches. Furthermore, an additional search will be carried out on Google

Scholar as the combination of this search engine with databases is considered optimal for literature searches

(Bramer et al., 2017). Search terms will be combined using Boolean operators. In addition to the initial

searches, the reference lists of the identified papers will be scanned for potentially relevant articles. These

searches will take place between 1st November 2021 and 30th March 2022.

Studies will be included if they employ a mixed-methods or qualitative methodology and reported

potential facilitators or barriers to help-seeking behaviour in adolescents or young people that self-harm. No limits will be placed on the year of publishing or study location. Studies that are not written in the English language will be excluded.

17. URL to search strategy.

Upload a file with your search strategy, or an example of a search strategy for a specific database, (including the keywords) in pdf or word format. In doing so you are consenting to the file being made publicly accessible. Or provide a URL or link to the strategy. Do NOT provide links to your search **results**.

https://www.crd.york.ac.uk/PROSPEROFILES/287567_STRATEGY_20211109.pdf

Alternatively, upload your search strategy to CRD in pdf format. Please note that by doing so you are consenting to the file being made publicly accessible.

Do not make this file publicly available until the review is complete

18. * Condition or domain being studied.

Give a short description of the disease, condition or healthcare domain being studied in your systematic review.

Defined as 'intentional act with a non-fatal (Madge et al., 2008), self-harm is a relatively frequent behaviour in young people. This population report the highest self-harm rates (Rodham & Hawton, 2009), with approximately 18% of adolescents and 38% of young adults engaging with this behaviour (Whitlock et al., 2011; Muehlenkamp et al, 2012).

19. * Participants/population.

Specify the participants or populations being studied in the review. The preferred format includes details of both inclusion and exclusion criteria.

The population are young people who self-harm. This includes adolescents and young adults, but excludes adults and children. Sample includes all genders and ethnicities, and participants from LGBTQ communities. Participants must have actively engaged in Self-harm.

Studies will be excluded if participants are not within the age range of 10-26 years old. Studies that do not give an age range will also excluded. As the aim of this review is to understand the processes behind help-seeking for those who self-harm, papers that focused on other mental health problems such as eating disorders, psychosis, suicidality, depression and anxiety will not be included. Furthermore, papers will meet the exclusion criteria if the self-harm definition employed did not meet the principles outlined by CASE. Additionally, as the research is looking at the perceptions of those who engage in self-harm, studies will be excluded if the data was obtained exclusively from third parties (i.e. research with parents), or when outcomes from both parties are not separated.

20. * Intervention(s), exposure(s).

Give full and clear descriptions or definitions of the interventions or the exposures to be reviewed. The

preferred format includes details of both inclusion and exclusion criteria.

The factors that facilitate and inhibit help-seeking behaviour in young people and adolescents who self-harm.

Help-seeking behaviours includes disclosure. Help-seeking can be from both informal (e.g family, friends,

colleagues), formal supports (e.g GP's, Mental Health Professionals, School/University Staff, Counsellors)

or online supports. Individuals can actively help-seek or intend to seek help. Studies will be excluded if there

is no reference to potential barriers or facilitators to help-seeking, if studies do not report on experiences

relating to self-harm, or the definition of Self-Harm not in line with CASE (i.e 'intentional act with a non-fatal

including cutting passing a range of lethality').

21. * Comparator(s)/control.

Where relevant, give details of the alternatives against which the intervention/exposure will be compared
(e.g. another intervention or a non-exposed control group). The preferred format includes details of both
inclusion and exclusion criteria.

Not applicable

22. * Types of study to be included.

Give details of the study designs (e.g. RCT) that are eligible for inclusion in the review. The preferred format
includes both inclusion and exclusion criteria. If there are no restrictions on the types of study, this should be
stated.

Studies will be included if they used a mixed-methods or qualitative methodology and reported potential

facilitators or barriers to help-seeking behaviour in adolescents or young people that self-harm. The research

methods may include employment of interviews, questionnaires, surveys or focus groups. Studies that have

a quantitative design will not be included.

23. Context.

Give summary details of the setting or other relevant characteristics, which help define the inclusion or
exclusion criteria.

Studies that include participants from all settings and locations will be included (e.g education, healthcare,

community).

24. * Main outcome(s).

Give the pre-specified main (most important) outcomes of the review, including details of how the outcome is
defined and measured and when these measurement are made, if these are part of the review inclusion
criteria.

This review will aim to establish the facilitators and barriers to young people's disclosure of self- harm, and

their help-seeking from both formal and informal sources.

Measures of effect

Please specify the effect measure(s) for you main outcome(s) e.g. relative risks, odds ratios, risk difference,
and/or 'number needed to treat.

25. * Additional outcome(s).

List the pre-specified additional outcomes of the review, with a similar level of detail to that required for main

outcomes. Where there are no additional outcomes please state 'None' or 'Not applicable' as appropriate to the review

Not applicable

Measures of effect

Please specify the effect measure(s) for you additional outcome(s) e.g. relative risks, odds ratios, risk difference, and/or 'number needed to treat.

26. * Data extraction (selection and coding).

Describe how studies will be selected for inclusion. State what data will be extracted or obtained. State how this will be done and recorded.

Full text articles will be obtained and assessed for eligibility for review according to the inclusion and exclusion criteria. A second reviewer will also assess a portion of the studies against the inclusion criteria to ensure inter-rater agreement. The PRISMA checklist will be followed to ensure transparent reporting of the systematic review, and the numbers of excluded/included studies will be reported at each phase. Study characteristics, participant demographics and relevant data to the research question (barriers/facilitators) will be extracted.

27. * Risk of bias (quality) assessment.

State which characteristics of the studies will be assessed and/or any formal risk of bias/quality assessment tools that will be used.

Once the appropriate papers for review have been determined their methodological vigour will be evaluated using an appropriate quality assessment measure. As it is anticipated that the study designs will be limited to those that are qualitative or mixed methods in nature, assessment tools that can be applied to the characteristics of these designs will be used (e.g The Joanna Briggs Institute Checklist for Qualitative; Mixed Methods Appraisal Tool for mixed method studies).

28. * Strategy for data synthesis.

Describe the methods you plan to use to synthesise data. This **must not be generic text** but should be **specific to your review** and describe how the proposed approach will be applied to your data. If meta-analysis is planned, describe the models to be used, methods to explore statistical heterogeneity, and software package to be used.

As the aim of this systematic review centres around the identification of key issues and patterns within narrative content, rather than the meaning of experiences, a Thematic Synthesis will be the preferred method. Findings relating to the barriers and facilitators of help-seeking for self-harm will be synthesised through the process outlined by Thomas & Harden (2008). This will include free line-by-line coding of textual findings in the results/findings sections from included primary studies. These codes will then be organised into 'descriptive' themes, and from these 'analytical' themes will be generated. As such, the reviewer will aim to produce a new interpretation of barriers and facilitators to self-harm which further explores and extends the themes outlined in the included studies.

29. * Analysis of subgroups or subsets.

State any planned investigation of 'subgroups'. Be clear and specific about which type of study or participant will be included in each group or covariate investigated. State the planned analytic approach.

Not applicable

30. * Type and method of review.

Select the type of review, review method and health area from the lists below.

Type of review
Cost effectiveness
Yes

Diagnostic
No

Epidemiologic
No

Individual patient data (IPD) meta-analysis
No

Intervention
No

Living systematic review
No

Meta-analysis
No

Methodology
No

Narrative synthesis
Yes

Network meta-analysis
No

Pre-clinical
No

Prevention
No

Prognostic
No

Prospective meta-analysis (PMA)
No

Review of reviews
No

Service delivery
No

Synthesis of qualitative studies
Yes

Systematic review

31. Language.

Select each language individually to add it to the list below, use the bin icon to remove any added in error.
English

There is not an English language summary

32. * Country.

Select the country in which the review is being carried out. For multi-national collaborations select all the countries involved.

England

33. Other registration details.

Name any other organisation where the systematic review title or protocol is registered (e.g. Campbell, or The Joanna Briggs Institute) together with any unique identification number assigned by them. If extracted data will be stored and made available through a repository such as the Systematic Review Data Repository (SRDR), details and a link should be included here. If none, leave blank.

34. Reference and/or URL for published protocol.

If the protocol for this review is published provide details (authors, title and journal details, preferably in Vancouver format)

Add web link to the published protocol.

Or, upload your published protocol here in pdf format. Note that the upload will be publicly accessible.

No I do not make this file publicly available until the review is complete

Please note that the information required in the PROSPERO registration form must be completed in full even if access to a protocol is given.

35. Dissemination plans.

Do you intend to publish the review on completion?

Yes

Give brief details of plans for communicating review findings.?

This review will form part of my thesis. It is anticipated that it will be submitted for publication and presented

at conferences.

36. Keywords.

Give words or phrases that best describe the review. Separate keywords with a semicolon or new line. Keywords help PROSPERO users find your review (keywords do not appear in the public record but are included in searches). Be as specific and precise as possible. Avoid acronyms and abbreviations unless these are in wide use.

self-harm; help-seeking; help seeking; adolescents; disclosure; non-suicidal self injury; self injury; young

adults; barriers; facilitators

No.	Databases (Total 5)	Search Terms	Results Total = 1420
1	*Psychinfo (via EBSCOhost)*	(*"young person*" or "teen*" or "child*" or "adolescen*" or "youth" or "young adult"* [ABSTRACT]) AND ("self-harm*" or "self harm*" or "non-suicidal self-injur*" or "non suicidal self injur*" or "non suicidal self-injur*" or "non-suicidal self injur*" or "NSSI" or "DSH" or "self-injury" or "self injury" or "self-injurious behav*" or "self-mutilation" or "deliberate self-harm" or "cutting" or "self-cutting" or "self-burning" or "self-poisoning" or "parasuicide" [ABSTRACT]) AND ("disclos*" or "self-disclosure" or "help-seek*" or "help seek*" or "support seek*" [ALL TEXT]) AND ("barrier" or "hurdle" or "obstruct*" or "block*" or "promot*" or "facilitat*" or "support*" or "encourage*" or "inhibit" or "stigma" or "shame" [ALL TEXT])	54
2	*CINAHL (via EBSCOhost)*	(*"young person*" or "teen*" or "child*" or "adolescen*" or "youth" or "young adult"* [ABSTRACT]) AND ("self-harm*" or "self harm*" or "non-suicidal self-injur*" or "non suicidal self injur*" or "non suicidal self-injur*" or "non-suicidal self injur*" or "NSSI" or "DSH" or "self-injury" or "self injury" or "self-injurious behav*" or "self-mutilation" or "deliberate self-harm" or "cutting" or "self-cutting" or "self-burning" or "self-poisoning" or "parasuicide" [ABSTRACT]) AND ("disclos*" or "self-disclosure" or "help-seek*" or "help seek*" or "support seek*" [ALL TEXT]) AND ("barrier" or "hurdle" or "obstruct*" or "block*" or "promot*" or "facilitat*" or "support*" or "encourage*" or "inhibit" or "stigma" or "shame" [ALL TEXT])	107
3	*Medline (via EBSCOhost)*	(*"young person*" or "teen*" or "child*" or "adolescen*" or "youth" or "young adult"* [ABSTRACT]) AND ("self-harm*" or "self harm*" or "non-suicidal self-injur*" or "non suicidal self injur*" or "non suicidal self-injur*" or "non-suicidal self injur*" or "NSSI" or "DSH" or "self-injury" or "self injury" or "self-injurious behav*" or "self-mutilation" or "deliberate self-harm" or "cutting" or "self-cutting" or "self-burning" or "self-poisoning" or "parasuicide" [ABSTRACT]) AND ("disclos*" or "self-disclosure" or "help-seek*" or "help seek*" or	94

		“support seek*” [ALL TEXT]) AND (“barrier” or “hurdle” or “obstruct*” or “block*” or “promot*” or “facilitat*” or “support*” or “encourage*” or “inhibit” or “stigma” or “shame” [ALL TEXT])	
4	**Pubmed**	(*“young person*” or “teen*” or “child*” or “adolescen*” or “youth” or “young adult”* [TITLE/ABSTRACT]) AND (“self-harm*” or “self harm*” or “non-suicidal self-injur*” or “non suicidal self injur*” or “non suicidal self-injur*” or “non-suicidal self injur*” or “NSSI” or “DSH” or “self-injury” or “self injury” or “self-injurious behav*” or “self-mutilation” or “deliberate self-harm” or “cutting” or “self-cutting” or “self-burning” or “self-poisoning” or “parasuicide” [TITLE/ABSTRACT]) AND (“disclos*” or “self-disclosure” or “help-seek*” or “help seek*” or “support seek*” [ALL FIELDS]) AND (“barrier” or “hurdle” or “obstruct*” or “block*” or “promot*” or “facilitat*” or “support*” or “encourage*” or “inhibit” or “stigma” or “shame” [ALL FIELDS])	**177**
5	**SCOPUS**	(*“young person*” or “teen*” or “child*” or “adolescen*” or “youth” or “young adult”* [TITLE/ABSTRACT]) AND (“self-harm*” or “self harm*” or “non-suicidal self-injur*” or “non suicidal self injur*” or “non suicidal self-injur*” or “non-suicidal self injur*” or “NSSI” or “DSH” or “self-injury” or “self injury” or “self-injurious behav*” or “self-mutilation” or “deliberate self-harm” or “cutting” or “self-cutting” or “self-burning” or “self-poisoning” or “parasuicide” [TITLE/ABSTRACT]) AND (“disclos*” or “self-disclosure” or “help-seek*” or “help seek*” or “support seek*” [ALL FIELDS]) AND (“barrier” or “hurdle” or “obstruct*” or “block*” or “promot*” or “facilitat*” or “support*” or “encourage*” or “inhibit” or “stigma” or “shame” [ALL FIELDS])	**224**
6	**Web of Science**	(*“young person*” or “teen*” or “child*” or “adolescen*” or “youth” or “young adult”* [ARTICLE TITLE/ABSTRACT/KEYWORDS]) AND (“self-harm*” or “self harm*” or “non-suicidal self-injur*” or “non suicidal self injur*” or “non suicidal self-injur*” or “non-suicidal self injur*” or “NSSI” or “DSH” or “self-injury” or “self injury” or “self-injurious behav*” or “self-mutilation” or “deliberate self-harm” or “cutting” or “self-cutting” or “self-burning” or “self-poisoning” or “parasuicide” [ARTICLE	**193**

		TITLE/ABSTRACT/KEYWORDS]) AND ("disclos*" or "self-disclosure" or "help-seek*" or "help seek*" or "support seek*" [ALL FIELDS]) AND ("barrier" or "hurdle" or "obstruct*" or "block*" or "promot*" or "facilitat*" or "support*" or "encourage*" or "inhibit" or "stigma" or "shame" [ALL FIELDS])	
7	**ProQuest**	(*"young person*" or "teen*" or "child*" or "adolescen*" or "youth" or "young adult"* [ABSTRACT]) AND ("self-harm*" or "self harm*" or "non-suicidal self-injur*" or "non suicidal self injur*" or "non suicidal self-injur*" or "non-suicidal self injur*" or "NSSI" or "DSH" or "self-injury" or "self injury" or "self-injurious behav*" or "self-mutilation" or "deliberate self-harm" or "cutting" or "self-cutting" or "self-burning" or "self-poisoning" or "parasuicide" [ABSTRACT]) AND ("disclos*" or "self-disclosure" or "help-seek*" or "help seek*" or "support seek*" [ANYWHERE]) AND ("barrier" or "hurdle" or "obstruct*" or "block*" or "promot*" or "facilitat*" or "support*" or "encourage*" or "inhibit" or "stigma" or "shame" [ANYWHERE]) (no limits set)	**571**

Appendix G.
Study Inclusion Peer Review

These tables are inclusion criteria checklists completed by the researcher (Table 1) and independently by a second reviewer (Table 2) to ensure that the studies satisfied the inclusion criteria. One study (Haum et al, 2014) was excluded following this.

Table 1. Researcher's Checklist.

Researcher	Publication Type	Study Characteristics						Research	Notes
		Sample		Phenomenon of Interest	Design*	Evaluation			
Reference	English	Age 10-25	Individuals who have self-harmed+	Barriers/Facilitators to help-seeking for self-harm	description of the findings in themes	Experiences, perceptions, opinions of or attitudes	Self-harm main focus of study	Qualitative/ Mixed Methods	
Aggarwal et al., (2020)	✓	✓ M	✓ M	✓ R	✓ R	✓ R	✓ Ab	✓ Ab	
Byrne et al. (2021)	✓	✓M	✓ M	✓R	✓ M, R	✓ Ab, I	✓ Ab	✓ Ab, M	Mixed Methods Includes some individuals who had suicidal intent
Chen et al., (2021)	✓	✓ M	✓ Ab	✓R	✓ R	✓ Ab	✓ Ab	✓ Ab	
Frost et al. (2016)	✓	✓ M	✓ Ab, M	✓ Ab, M	✓ R	✓ Ab	✓ Ab	✓ Ab	Mixed Methods – Thematic Analysis
Hassett & Isbister (2017)	✓	✓ Ab	✓ M	✓R	✓ R	✓ Ab	✓ Ab	✓ Ab	Clearly states PPS must have engaged in self-harm in methods
Haum et al (2014)	✓	✓R	✓M	✓R	✓R	✓ Ab	?	✓M	Over 50% over 25
Idenfors et al. (2015)	✓	✓ M	✓ M	✓ M	✓ R	✓ Ab	✓ Ab	✓ Ab	Thematic Analysis Interviews
Klineberg et al. (2013)	✓	✓ Ab	✓ M, R	✓ Ab, R	✓ R	✓ Ab	✓ Ab	✓ Ab	Seperately discusses non-self-harmers perspectives
McAndrew & Warne (2014)	✓	✓ M	✓ M	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab, I	

Reference	English	Age 10-25	Individuals who have self-harmed+	Barriers/Facilitators to help-seeking for self-harm	description of the findings in themes	Experiences, perceptions, opinions of or attitudes	Self-harm main focus of study	Qualitative/ Mixed Methods	Notes
McDermott (2014)	✓	✓ M	✓ R	✓ R	✓ R	✓ Ab	✓ M	✓ Ab	Research Question is focused on self-harm
Mughal et al (2021)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab, I	✓Ab	✓ Ab	Thematic Analysis
Owens et al. (2016)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab	
Rosenrot & Lewis	✓	✓ M	✓ M	✓ Ab, R	✓ R	✓ Ab	✓ Ab	✓ Ab	Thematic Analysis
Stanike et al., (2020)	✓	✓ Ab	✓ M	✓ R	✓ R	✓ I	✓ Ab	✓ Ab	
Tillman et al (2018)	✓	✓ M	✓ M	✓ R	✓ R	✓ Ab	✓ Ab	✓ M	School Age
Wadman et al. (2018)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab	

Ab=Abstract; Int=introduction; M=Methods; R=Results; D=Discussion

*focus groups/ interviews, questionnaires/surveys/ text analysis

+ 'intentional act with a non-fatal outcome encompassing a range of methods including cutting, overdosing and self-battery'

Table 2. Second Reviewer's Checklist.

Second Reviewer	Publication Type	Study Characteristics							Notes
		Sample		Phenomenon of Interest	Design*	Evaluation		Research	
Reference	English	Age 10-25	Individuals who have self-harmed+	Barriers/Facilitators to help-seeking for self-harm	description of the findings in themes	Experiences, perceptions, opinions of or attitudes	Self-harm main focus of study	Qualitative/ Mixed Methods	
Aggarwal et al., (2020)	✓	✓ M	✓ M	✓ R	✓ R	✓ R	✓ Ab	✓ Ab	
Byrne et al. (2021)	✓	✓M	✓ M	✓R	✓ M, R	✓ Ab, I	✓ Ab	✓ Ab, M	Mixed Methods Includes some individuals who had suicidal intent
Chen et al., (2021)	✓	✓ M	✓ Ab	✓R	✓ R	✓ Ab	✓ Ab	✓ Ab	

Frost et al. (2016)	✓	✓ M	✓ Ab, M	✓ Ab, M	✓ R	✓ Ab	✓ Ab	✓ Ab	Mixed Methods – Thematic Analysis
Hassett & Isbister (2017)	✓	✓ Ab	✓ M	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab	Clearly states PPS must have engaged in self-harm in methods
Haum et al (2014)	✓	????	????	✓ R	✓ R	✓ Ab	✓ Ab	✓ M	Ages unclear Not all have self-harmed
Idenfors et al. (2015)	✓	✓ M	✓ M	✓ M	✓ R	✓ Ab	✓ Ab	✓ Ab	Thematic Analysis Interviews
Klineberg et al. (2013)	✓	✓ Ab	✓ M, R	✓ Ab, R	✓ R	✓ Ab	✓ Ab	✓ Ab	Seperately discusses non-self-harmers perspectives
McAndrew & Warne (2014)	✓	✓ M	✓ M	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab, I	
McDermott (2014)	✓	✓ M	✓ R	✓ R	✓ R	✓ Ab	✓ M	✓ Ab	Research Question is focused on self-harm
Mughal et al (2021)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab, I	✓ Ab	✓ Ab	Thematic Analysis
Owens et al. (2016)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab	
Rosenrot & Lewis	✓	✓ M	✓ M	✓ Ab, R	✓ R	✓ Ab	✓ Ab	✓ Ab	Thematic Analysis
Stanike et al., (2020)	✓	✓ Ab	✓ M	✓ R	✓ R	✓ I	✓ Ab	✓ Ab	
Tillman et al (2018)	✓	✓ M	✓ M	✓ R	✓ R	✓ Ab	✓ Ab	✓ M	School Age
Wadman et al. (2018)	✓	✓ Ab	✓ Ab	✓ R	✓ R	✓ Ab	✓ Ab	✓ Ab	

Using the guidelines stated by Butler et al. (2016) both reviewers independently assessed each paper using the CASP Qualitative Review Form. See Table 1 for the researcher's appraisal scores and Table 2 for the second reviewers. The Kappa outputs to assess inter-rater reliability are also provided for each study.

Table 1. Researcher's Quality Ratings.

Authors	CASP Rating										Total Score	Quality Rating	Include?
	Q:1	Q:2	Q:3	Q:4	Q:5	Q:6	Q:7	Q:8	Q:9	Q:10			
Aggarwal et al. (2021)	1	1	0.5	0.5	1	0	1	1	0.5	0.5	7	Low	Yes
Byrne et al. (2021)	1	1	1	1	0.5	0.5	1	1	1	1	9	High	Yes
Chen et al. (2021)	1	1	1	0.5	0.5	0	1	1	1	1	8	Moderate	Yes
Frost et al. (2016)	1	1	0.5	1	0.5	0.5	1	0.5	1	0.5	7.5	Moderate	Yes
Hassett & Ibister (2017)	1	1	1	0.5	1	1	1	1	1	1	9.5	High	Yes
Idenfors et al. (2015)	1	1	0.5	1	1	0.5	1	1	1	0.5	8.5	Moderate	Yes
Klineberg et al. (2013)	1	1	0.5	1	1	0	1	1	1	1	8.5	Moderate	Yes
McAndrew & Warne (2015)	1	1	1	0.5	0.5	0	1	0.5	1	1	7.5	Moderate	Yes
McDermott (2014)	1	1	1	1	1	0	1	0.5	1	0.5	8	Moderate	Yes
Mughal et al. (2021)	1	1	0.5	1	1	1	1	1	1	1	9.5	High	Yes
Owens et al. (2016)	1	1	0.5	0.5	0.5	0	1	0.5	1	1	7	Low	Yes
Rosenrot & Lewis (2020)	1	1	1	0.5	1	0.5	1	1	1	1	9	High	Yes
Stanicke et al. (2020)	1	1	1	0.5	0.5	1	1	1	1	1	9	High	Yes
Tillman et al. (2017)	1	1	0.5	1	1	0	1	0.5	0.5	1	7.5	Moderate	Yes
Wadman et al. (2018)	1	1	1	0.5	0.5	1	1	1	0.5	0.5	8	Moderate	Yes

Table 2. Second Reviewer's Quality Ratings.

Authors	CASP Rating										Total Score	Quality Rating	Include?
	Q:1	Q:2	Q:3	Q:4	Q:5	Q:6	Q:7	Q:8	Q:9	Q:10			
Aggarwal et al. (2021)	1	1	0.5	0.5	1	0	0.5	1	0.5	0.5	6.5	Low	Y
Byrne et al. (2021)	1	1	1	1	1	0.5	1	1	1	1	9.5	High	Y
Chen et al. (2021)	1	1	1	0.5	1	0	0.5	1	1	1	8	Moderate	Y
Frost et al. (2016)	1	1	0.5	1	0.5	0	1	0.5	1	0.5	7	Low	Y
Hassett & Ibister (2017)	1	1	1	0.5	1	1	1	1	1	1	9.5	High	Y
Idenfors et al. (2015)	1	1	0.5	1	1	0.5	1	1	1	0.5	8.5	Moderate	Y
Klineberg et al. (2013)	1	1	0.5	1	1	0	1	1	1	1	8.5	Moderate	Y
McAndrew & Warne (2015)	1	1	1	0.5	0.5	0	1	0.5	1	1	7.5	Moderate	Y
McDermott (2014)	1	1	0.5	1	1	0	1	0.5	1	0.5	7.5	Moderate	Y
Mughal et al. (2021)	1	1	0.5	1	1	1	1	1	1	0.5	9	High	Y
Owens et al. (2016)	1	1	0.5	0.5	0.5	0	0.5	1	1	1	7	Low	Y
Rosenrot & Lewis (2020)	1	1	1	0.5	1	0.5	1	1	1	1	9	High	Y
Stanicke et al. (2020)	1	1	1	0.5	0.5	1	1	1	1	0.5	8.5	Moderate	Y
Tillman et al. (2017)	1	1	0.5	1	1	0	1	0.5	0.5	1	7.5	Moderate	Y
Wadman et al. (2018)	1	1	1	0.5	0.5	1	0.5	1	0.5	1	8	Moderate	Y

Aggarwal et al. (2021)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.831	.161	3.333	<.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Byrne et al. (2021)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.615	.337	2.108	.035
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Chen et al. (2021)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.565	.279	2.302	.021
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Frost et al. (2016)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.818	.155	3.017	.003
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Hassett & Isbister (2017)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	3.162	.002
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Idenfors et al.(2015)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	3.162	.002
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Klineberg et al.(2013)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	4.135	<.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

McAndrew & Warne (2015)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	3.985	<.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

McDermott (2014)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.804	.186	3.324	<.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Mughal et al. (2021)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.615	.337	2.108	.035
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Owens et al. (2016)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.655	.228	2.583	.010
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Rosenrot & Lewis (2020)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	3.162	.002
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Stänike et al. (2020)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.737	.241	2.415	.016
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Tillman et al. (2017)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	1.000	.000	3.985	<.001
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

Wadman et al. (2018)

Symmetric Measures

		Value	Asymptotic Standard Error[a]	Approximate T[b]	Approximate Significance
Measure of Agreement	Kappa	.583	.262	1.845	.065
N of Valid Cases		10			

a. Not assuming the null hypothesis.

b. Using the asymptotic standard error assuming the null hypothesis.

The table below was completed by a second reviewer as part of the peer review process. Data was extracted from two randomly selected studies to ensure accuracy of the characteristics reported.

Author/s, Date and Location	Research Aim/s	Research Design	Sample: Number, Age (M ± SD), Gender, Characteristics, Details of Self-Harm	Data Collection Method	Analysis and Approach	Key Findings in relation to Barriers and Facilitators to Help-Seeking.	Quality Rating
Aggarwal et al., 2020 (Mumbai, India)	To evaluate the perspectives and explanatory styles of young people who have self-harmed and their family members to inform the design of an evidence-based intervention for self-harm in young people in a non-Western cultural setting	Qualitative - phenomenological thematic analysis	Number - 15 Age - 19.8 ± 2.71 Gender - 10 female, 5 male Characteristics - marital status, education or employment, living with, mental illness diagnosis Details of self-harm - number of attempts, number of hospital admissions	In-depth qualitative interviews	Phenomenological thematic analysis	Five themes: (i) contextual factors related to self-harm including interpersonal factors, intrapersonal factors and socio-cultural factors; (ii) formulation and current feelings about the attempt; (iii) family members and friends as the perceived supports and deterrents for future self-harm attempts; (iv) treatment related experiences with counselling, inpatient and outpatient treatment and barriers to treatment; and (v) coping strategies	6.5
Frost at el., 2016	To investigate the perspectives of young people who	Mixed methods - independent sample t-tests and	Number - 457 Age - 18.01 ± 3.01 Gender - 399 female	Online survey	Independent sample t-tests and descriptive	Seven themes re. preferences for future online help-seeking: information; guidance;	7

| (Brisbane, Australia) | self-injure regarding online services, with the aim of informing online service delivery | descriptive analyses for quant. data, thematic analysis for qual. data | Characteristics - heritage, languages spoken at home, sexual orientation, location Details of self-harm - lifetime history of self-injury, method of self-injury, frequency, onset and recency of self-injurious behaviour, disclosure of self-injury, need for medical assistance | | analyses for quant. data, thematic analysis for qual. data | reduced isolation; online culture; facilitation of help-seeking; access; and privacy |

Appendix J.
Mapping of Analytic Themes

The following images depict the evolving theme development during Thematic Synthesis of papers.

<u>V1. Initial Map of Themes</u>
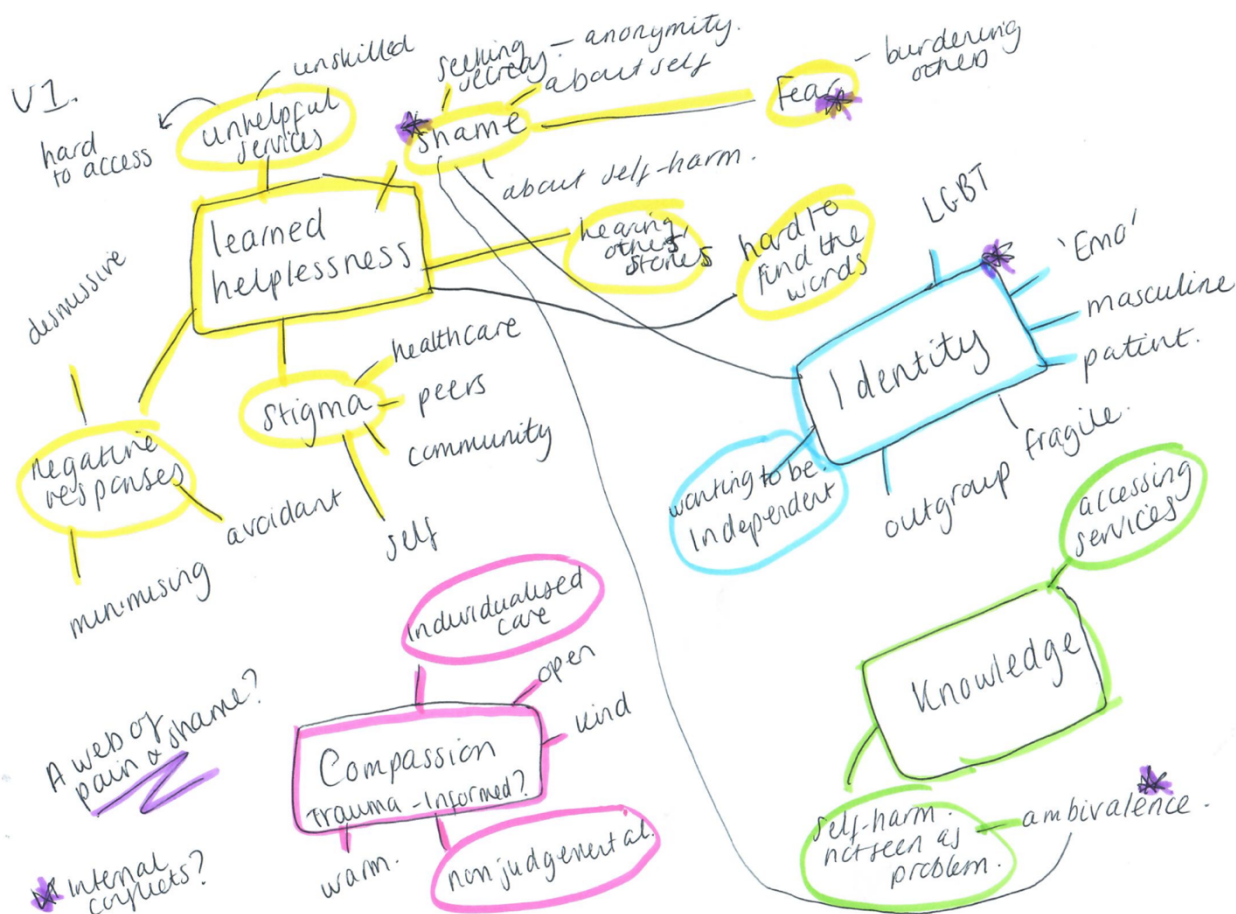
V2. Provisional Hierarchical Map of Them

V3.

Internal Conflicts
- Shame
  - for self-harm — upsetting others.
  - about identity
  - self-attacking language.
- Ambivalence
  - rewarding nature of SH.
  - denial?
  - wanting help but not wanting help
- Identity
  - the 'outgroup'!
  - masculine
  - independance

? ??

Learned helplessness
- attitudes
  - stigmatising
  - not treated
- responses
  - minimising / dismissive
  - avoidant / silencing
  - compassionate / non-judgemental.
- Inadequate Care
  - robotic
  - unhelpful treatment
  - unskilled staff.

Navigating Services
- finding the words
  - difficult to express
  - needing other forms of communication
- mental health literacy
  - services - access / set up
  - self-harm.
- responsive care
  - individualised
  - timely (24/7).

Teachers' Experiences of Identifying and Responding to Student Self-harm.
PARTICIPANT INFORMATION SHEET

You are being invited to take part in research regarding teachers' experiences of identifying and responding to student self-harm. Bethan Smith, Trainee Clinical Psychologist, at Coventry University (CU) is leading this research. Before you decide to take part, it is important you understand why the research is being conducted and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?
The purpose of the study is to explore the experiences of secondary school and college teachers who identify and respond to student self-harming behaviour. Specifically, the research will focus on experiences of identifying self-harm in students, and any possible consequences of this.

Why have I been chosen to take part?
You are invited to participate in this study because you are a member of staff at a secondary school, college or sixth form who has identified and responded to a student's self-harm, defined as 'an intentional act with a non-fatal outcome encompassing a range of methods including cutting, overdosing and self-battery'.

What are the benefits of taking part?
By sharing your experiences with us, you will be helping Bethan Smith and Coventry University to gain an in-depth understanding of school staff's experiences of identifying and supporting student self-harm. An improved awareness of the impact caused by responding to self-harm would aid the understanding of how teachers can be supported in this role.

Are there any risks associated with taking part?
This study has been reviewed and approved through Coventry University's formal research ethics procedure. There are no significant risks associated with participation. However, the interview may encourage you to share some quite sensitive information about your experiences. If you experience distress during the interview the researcher will follow a distress protocol, which will ensure you are supported. The researcher will discuss with you prior to the interview. You will also have the right to not answer questions and can freely withdraw from the interview at any time.

Do I have to take part?
No – it is entirely up to you. If you do decide to take part, please keep this Information Sheet and complete the Informed Consent Form to show that you understand your rights in relation to the research, and that you are happy to participate. Please note down your participant number (which is on the Consent Form) and provide this to the lead researcher if you seek to withdraw from the study at a later date. You are free to withdraw your information from the project data set at any time up until the **31st March 2022.** You should note that your data may be used in the production of formal research outputs (e.g. journal articles, conference papers, theses and reports) following this date and so you are advised to contact the university at the earliest opportunity should you wish to withdraw from the study. To withdraw, please contact the lead researcher (contact details are provided below). Please also contact Jacqueline Knibbs, so that your request can be dealt with promptly in the event of the lead researcher's absence. You do not need to give a reason. A decision to withdraw, or not to take part, will not affect you in any way.

What will happen if I decide to take part?
You will be asked a number of questions regarding your experiences of responding to student self-harm, and the impact that this had on you. You will also be asked to consider factors that helped you to manage and cope, and your beliefs regarding your ability to manage this situation in the future. The interview will take place virtually (via Microsoft Teams/Zoom) at a time that is convenient to you. We would like this interview to take place in space that feels safe for you, however as we will be talking about school/work related issues it is preferred that this takes place in a quiet and confidential space in your place of work. The interview should take around 60 minutes to complete.

Ideally, we would like video record your responses for transcription purposes (and will require your consent for this), so the location should be in a fairly quiet area.

Following the interview (and your consent), to ensure that themes are accurate and reflect your experiences it is also possible that the researcher will contact you via email to review the themes identified by the research team during the data analysis (respondent validation).

Data Protection and Confidentiality
Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All information collected about you will be kept strictly confidential. Unless they are fully anonymised in our records, your data will be referred to by a unique participant number rather than by name. If you consent to being video/audio recorded, all recordings will be destroyed once they have been transcribed. Your data will only be viewed by the researcher/research team. All electronic data will be stored on a password-protected computer file on the research supervisor's university OneDrive. This will allow the supervisor to contact you, if required, should the researcher be on leave. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach. The research supervisor will be responsible for deleting the data after 5 years in line with CU procedures.

However, whilst the information you share will be confidential, there are limits to confidentiality. If the researcher identifies a potential risk of harm to you or others, they have duty of care to report this to other relevant agencies. In this event, the lead researcher would discuss this with you first.

Data Protection Rights
Coventry University is a Data Controller for the information you provide. You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation and the Data Protection Act 2018. You also have other rights including rights of correction, erasure, objection, and data portability. For more details, including the right to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk. Questions, comments and requests about your personal data can also be sent to the University Data Protection Officer - enquiry.igu@coventry.ac.uk

What will happen with the results of this study?
The results of this study may be summarised in published articles, reports and presentations. Quotes or key findings will always be made anonymous in any formal outputs, pseudonyms will be adopted and identifiable information including references to specific schools and locations will be removed.

Making a Complaint
If you are unhappy with any aspect of this research, please first contact the lead researcher, Bethan Smith (smithb32@uni.coventry.ac.uk). If you still have concerns and wish to make a formal complaint, please write to:

Jacqueline Knibbs,
Clinical Tutor,
Clinical Psychology Doctorate Programme,
Faculty of Health and Life Sciences,
Coventry University,
Coventry, CV1 5FB
Email: j.knibbs@coventry.ac.uk

In your letter, please provide information about the research project, specify the name of the researcher, and detail the nature of your complaint.

The psychological impact on teachers who identify a student's self-harming behaviour.

P116930

Certificate of Ethical Approval

Applicant: Bethan Smith

Project Title: The psychological impact on teachers who identify a student's
                                              self-harming behaviour.

This is to certify that the above named applicant has completed the Coventry University Ethical
Approval process and their project has been confirmed and approved as Medium Risk

Date of approval: 26 May 2021

Project Reference Number: P116930

Participant Informed Consent Form

Participant No.

INFORMED CONSENT FORM:
Teachers' Experiences of Identifying and Responding to Student Self-harm.

You are invited to take part in this research study for the purpose of collecting data regarding the experiences of secondary school teachers who identify and respond to student self-harming behaviour.

Before you decide to take part, you must **read the accompanying Participant Information Sheet.**

Please do not hesitate to ask questions if anything is unclear or if you would like more information about any aspect of this research. It is important that you feel able to take the necessary time to decide whether or not you wish to take part.

If you are happy to participate, please confirm your consent by circling YES against each of the below statements and then signing and dating the form as participant.

1	I confirm that I have read and understood the *Participant Information Sheet* for the above study and have had the opportunity to ask questions	YES	NO
2	I understand my participation is voluntary and that I am free to withdraw my data, without giving a reason, by contacting the lead researcher and the Research Support Office at any time until the 31st of March 2022	YES	NO
3	I have noted down my participant number (top left of this Consent Form) which may be required by the lead researcher if I wish to withdraw from the study	YES	NO
4	I understand that all the information I provide will be held securely on the research supervisor's OneDrive account and treated confidentially.	YES	NO
5	I am happy for the information I provide to be used (anonymously) in academic papers.	YES	NO
6	I am happy for the interview to be audio/video recorded for transcription purpose.	YES	NO
7	I agree to take part in the above study	YES	NO
8	I am happy to be contacted by the researcher via email at a later date for the purpose of 'respondent validation'.	YES	NO

Thank you for your participation in this study. Your help is very much appreciated.

Participant's Name	Date	Signature
Researcher	Date	Signature

Teachers' Experiences of Identifying and Responding to Student Self-harm.

PARTICIPANT DISTRESS PROTOCOL

Prior to Interview

Discuss signs that the researcher might notice if the participant was to become distressed.

Signs Of Distress

A participant expresses that they are feeling distressed **OR** A participant shows behaviours that suggest the interview is causing distress (e.g, crying, shaking, agitation, withdrawal).

Initial Response

The researcher stops the interview and offers the participant immediate support (e.g. time out). **THEN** The researcher checks in with Participant, asks how they are feeling and current thought processes, and if they feel safe to continue.

Review

Resume the interview if the participant feels able to **OR** proceed to secondary response if participant remains distressed.

Secondary Response

Discontinue interview and encouraged participant to seek support from their usual contact points (e.g. GP) and Education Support Service **OR** With consent, the researcher makes contact with a named person given by the Participant.

Participant Follow Up

All participants to be given a debrief sheet with relevant organisations contact details for support. If participant consents follow up with a courtesy phone call at a time agreed with the participant.

Appendix O.
Participant Debrief Sheet

PARTICIPANT DEBRIEF SHEET

Thank you for taking part in this study, your contribution is very helpful to us.

The aim of the research is to understand the experiences of secondary school and college teachers who identify and respond to student self-harming behaviour.

Current and Previous Research

Adolescent self-harm is a major public health concern (Department of Health [DoH], 2015), however only a small minority of this population seek professional help for their difficulties. (Doyle et al., 2015). Subsequently, the DoH (2017) have highlighted the essential role of education staff in the early identification of self-harm and signposting to appropriate support. Therefore, school and college staff are potentially the only professionals who may be aware of a young person's self-harm. However, little is known about the impact this has on them and how they might be best supported to respond to distressed students.

Some preliminary research has suggested that staff feel ill-equipped to effectively respond to self-harm, with less experienced staff reporting increased anxiety. However, this field has not been thoroughly qualitatively researched in Britain with most research taking place overseas or over a decade ago, meaning these results may not represent teachers currently practising within the UK. This project seeks to explore the experiences of education staff and understand the short and long-term impacts of this.

An improved awareness of the psychological impact caused by responding to self-harm would aid the understanding of how teachers can be supported in this role. Furthermore, given the significance of the initial response on young people's future help-seeking (Toste & Heath, 2010), an understanding of teachers' experiences could lead to more timely positive outcomes for students.

Continued support
We understand that answering questions regarding your experiences of student self-harm might be challenging.

Initially, we would recommend that any support should be sought from your own line manager, Senior Leadership Team or any other relevant methods of support within your school. However, should you need any additional support regarding your mental health please contact your GP who will also be able to advise you about alternative support in your area.

The following sources of support are also available for teaching staff:

- A free wellbeing support helpline or counselling available from Education Support *08000 562 561* or *www.educationsupport.org.uk*

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- The Headspace app is available free of charge for educators from *www.headspace.com/educators-covid-19.*

Withdrawing from the Research

If you have changed your mind about taking part in this research project, you are welcome to withdraw your data up to the 31st March 2022. After this time, your data will be anonymised and transcribed for the purposes of the research project. Please contact the lead researcher, Bethan Smith, using the details below, if you wish to withdraw within the allocated time frame.

Respondent Validation

If you have consented to be contacted at a later date, we might be in touch with you in via email once we have analysed your responses and the responses of others who took part in the study. This aims to ensure that the derived themes are accurate and reflect your experiences.

Research Team Contact Details:

Bethan Smith, Lead Researcher, Coventry University, Coventry, CV1 5FB	Jacqueline Knibbs Coventry University Coventry, CV1 5FB	Dr Claudie Fox University of Warwick Coventry, CV4 7AL
smithb32@uni.coventry.ac.uk	j.knibbs@coventry.ac.uk	claudie.fox@warwick.ac.uk

If you are interested in this area of research, you may like to access the following article:

Dowling, S., & Doyle, L. (2017). Responding to self-harm in the school setting: the experience of guidance counsellors and teachers in Ireland. *British Journal of Guidance & Counselling*, 45(5), 583-592.

Thank you again for your participation

INTERVIEW Script & Plan

Teachers' Experiences of Identifying and Responding to Student Self-harm.

Introduction

Thank you for joining me, I really appreciate the time that you have taken out of your busy schedule to be here. Before we get started, I just wanted to introduce myself and my role during the next hour.
So, I'm Bethan Smith, a trainee psychologist from Coventry/Warwick university and I'm currently working in SERVICE, but today I will be in my other role as a researcher who has a strong interest in child mental health and schools.

Before we start, I just wanted to share a few guidelines relating to the next 60 minutes. I hope that this will be a containing space and that you'll feel able to safely share your thoughts about your experiences of student self-harm. The information you share will be confidential. However, there are limits to confidentiality and if I feel that you or others are at risk of harm, I have a duty of care to report this to other relevant agencies. If this was the case, I would discuss this with you first.

I also want to ask that you protect the identity of the pupils that you talk about and withhold names of the | children who were involved in the events that you discuss. Or alternatively you are welcome to use a pseudonym.

Some of the content that we discuss might be quite sensitive, so it's important that before we start, we think of ways that we can make sure the space is as safe as possible for you. (brief individual safety plan)

You also have the right to refuse to answer questions, and you can withdraw from this interview at any time. You can do this by asking me to stop the interview or to not answer that particular question. There will be no repercussions if you do choose to withdraw.

As mentioned previously the interview will be recorded for transcription purposes only. The recording will not be shared and will be deleted after it has been transcribed. Is this ok?

And just more practically, if there are any connection problems and we get cut off. I will call you and we can either try to reconnect of continue our conversation over the phone.

So, before we get started, do you have any questions about these guidelines or about the project as whole?

Are you ok to get started?

Interview

1. *Demographics*
    1.1. What is your current job role?

    1.2. And how long have you been in your role?
        And how long have you been working in schools?

    1.3. What type of school or college do you currently work at?
    Comprehensive? Inner city? Rural? Grammar? Fee-paying? Academy?

    1.4. How many cases of student self-harm have you been involved in?
    Self-Harm defined as 'an intentional act with a non-fatal outcome encompassing a range of methods including cutting, overdosing and self-battery'

1.5. **Level of child vulnerability?**
SEN? LAC? Pupil Premium? English as an additional language? Vulnerable/Social issues? Safeguarding referrals?

2. <u>*Identification/Discovery*</u>
I'm really interested in hearing your experiences of discovering and responding to self-harm in your pupils.
*If there is only one incident - what were the good/bad aspects of the single incident.

   2.1. **Could you tell me about/narrate a time when you felt this went well?**
What did you notice? How and what did you identify? How did you respond? Were there any additional considerations that you had to make? Any consequences? Nature of the child/family? Confidence in the situation being responded to. How prepared were you?

   2.2. **Could you tell me about/narrate a time when it did not feel that it worked so well?**
What did you notice? How did you identify? How did you respond? Were there any additional considerations that you had to make? Any consequences? Nature of the child/family? Confidence in the situation being responded to. How prepared were you?

3. <u>*Impact*</u>
   3.1. **How did you feel that managing this situation impacted you?**
How so? How did this leave you feeling? Work life? Homelife? Relationships? Was this long lasting?

   3.2. ***What helped you to manage/cope?***
e.g., support-seeking (within school - safeguarding leads/line managers; outside of school), avoidance, anxiety management strategies, how did you adjust work/practice?

   3.3. ***What didn't help?***

   3.4. ***How would it feel to manage a similar situation in the future?***
What's different between now and then?

   3.5. ***Do you have any suggestions for colleagues who haven't had this experience yet?***

ENDINGS

So that concludes the questions from me.

4. ***Is there anything you would like to add to your responses?***

Again, I'd like to thank you for your time, and for sharing your experiences with me.

I understand that answering questions regarding your experience during a difficult time may be challenging and leave you with some difficult feelings. If this is the case, I would recommend that you follow up with the support outlined on the debrief form.

I'd also like to make you aware, that you are able to withdraw from this project from any time up until 31st March 2022. After this time, your data will be anonymised and transcribed for the purposes of the research project. Please contact me if you wish to withdraw within the allocated time frame, my contact information can also be found on the debrief form.

Appendix Q.
Example Extract of Coding

Excerpt from a participant's transcript depicting inductive semantic and latent coding. Complete Coding was undertaken, where only items of interest to the research question were given codes. Bold comments identified semantic codes and italicised comments highlight latent codes and further conceptual development.
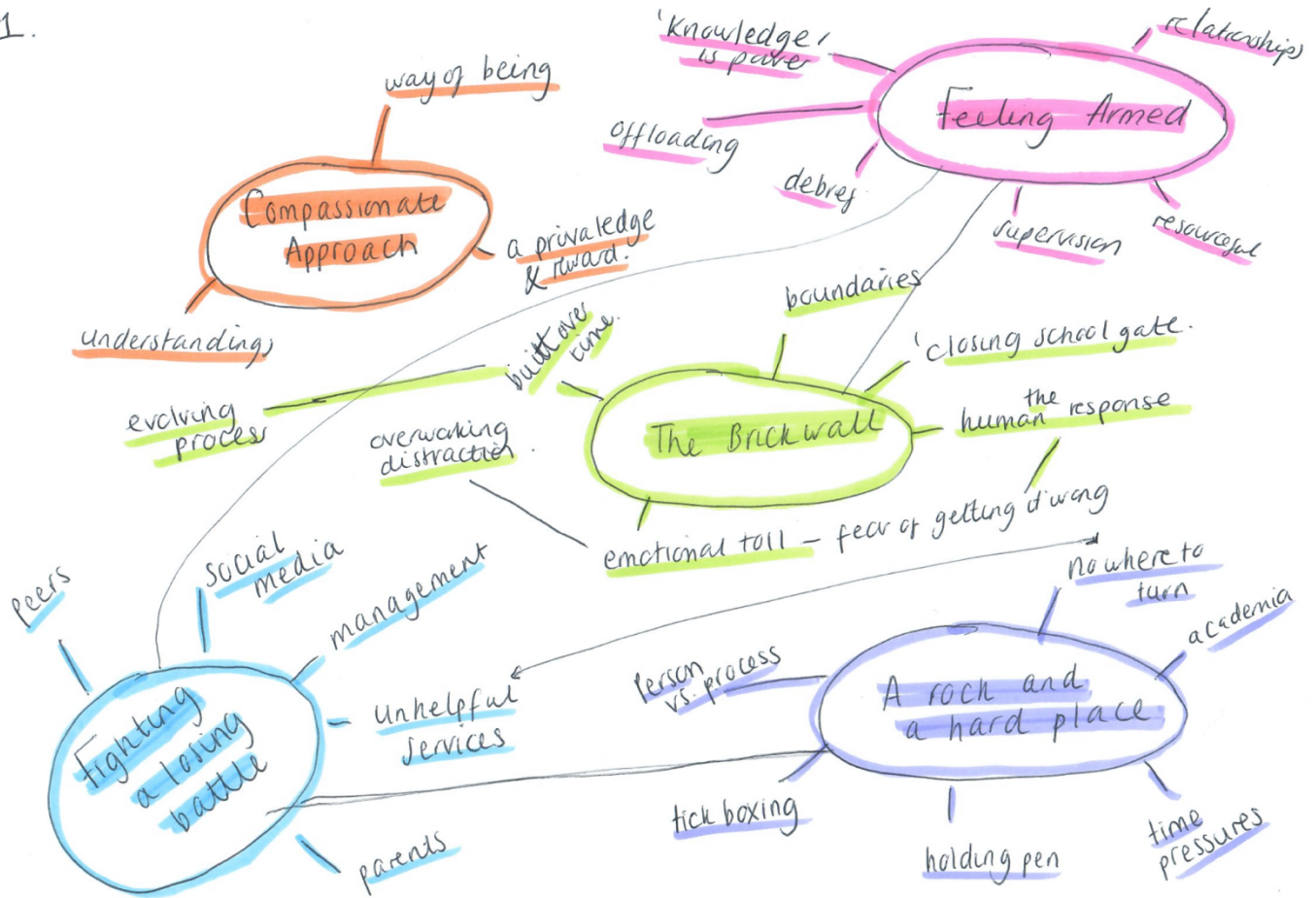
Line	Transcript	Code
69	kind of unpack what's gone on and how they're feeling, you know we also have to do bag check	**Bethan Smith** **Time given to understand what has happened**
70	for certain students as well. It's because of that bond, well not so much bond, but that	
71	relationship built up.. urm ...it does tend to work really effectively in that, you know, they will	**Bethan Smith** **Establishing a relationship with the pupil supports the process**
72	come and speak to me you know if they're feeling particularly low or if they are feeling like	
73	they might want to self-harm at all, they will come and they will be very open with me and be	**Bethan Smith** *Providing an open space is key/open door policy*
74	you know we can talk it through. I think that works well, that we've got that relationship, which	**Bethan Smith** *A Compassionate Response*
75	is such a privilege really to be in the role that I'm in that we can do that. You know, I appreciate	**Bethan Smith** **A privilege to support students**
76	that in a lot of schools and a lot of positions that wouldn't be possible, and I think that's vital	
77	in our successes really in overcoming these difficulties. They also know that throughout the	**Bethan Smith** *Relationships as key to supporting self-harm*
78	day they can just drop me an email or I've got a mobile phone, a school mobile phone, that if	**Bethan Smith** **Not always possible to build relationships**
79	they are feeling a bit vulnerable, they can just text me and I'm kind of there within, you know,	
80	a couple of minutes. So, I think that works well in the position that I'm in at the moment. I	**Bethan Smith** Providing timely support to pupils
81	found in the primary setting that wasn't quite so easy, obviously, because you know, you're	**Bethan Smith** Making themselves available to students
82	literally teaching aren't you from the minute you hit the classroom in the morning until when	
83	you go home at night, there is no room to breathe and then with all the best will in the world	**Bethan Smith** **Having the dedicated time for pastoral care is helpful**
84	you haven't got the time for that level of pastoral care. Um... so in the setting that I was in I	**Bethan Smith** **Time pressures means it is difficult to support pupils**
85	was kind of relying on somebody else to build that relationship that had the capacity to do that,	
86	but it's never the same as you delivering it if you know what I mean., and you know, different	**Bethan Smith** *Wanting a sense of control over the situation*
87	people's responses are different aren't they? It's also very difficult within that setting to	
88	support the member of staff as well, urm... because you're so time pressured it's very difficult	**Bethan Smith** **Needing time and space to de-escalate**
89	to meet at the end of the day and de-escalate, and you know, I think time is vital. That being	**Bethan Smith** **Importance of a debrief**
90	said, its also vital to set boundaries within that. You know, i'm not inexhaustible supply, do you	**Bethan Smith** **Need enough time to provide support**
91	know what I mean? You know, there do need to be boundaries and then I think setting those	
92	boundaries in is important for their own discipline, and a lot of their own self-care is discipline	**Bethan Smith** *Pressurised Contexts*
93	and having that ability to self-regulate...urm...so yeah, it's important set those boundaries as	**Bethan Smith** **Protecting own resource by setting boundaries**
94	well.	**Bethan Smith** Setting boundaries is helpful for students

Appendix R.
Visual Mapping of Theme Development

The evolution of the data analysis and corresponding themes are depicted in the following thematic maps. Potential themes are highlighted in the ovals, with lines representing the relationships between each theme.

Version 1. Early Theme Development

V1.

way of being

'Knowledge is power'

relationships

Compassionate Approach

Feeling Armed

offloading

debrief

supervision

resourceful

a priviledge & reward.

understanding)

boundaries

'closing school gate.

evolving process

built over time.

The Brickwall

the human response

overworking distraction.

emotional toll — fear of getting it wrong

nowhere to turn

academia

social media

management

Person vs. process

A rock and a hard place

peers

unhelpful services

Fighting a losing battle

tick boxing

holding pen

time pressures

parents

V3

Being the Swan — fear of things going wrong/escalating

not showing emotions

Way of being

educations pressures

feeling the pressure.

Tsunami of mental health

A Rock and a hard place

Closing the school gates

less likely to open over time

A compassionate Approach

understanding

skills

Peers. parents management

dependent about the system

CAMHS unfit for purpose.

emotional boundaries

Coping strategies

An emotional toll

A double-edged sword.

A privilege & reward.

Complex and evolving internal process

process vs person.

facing dilemmas

holding the baby

emotional parental mental health

familiarly

Upskilled

desensitisation

Age & Experience

confidence

maturity