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Family Therapists' Experiences of Working with Adolescents who Self-Harm
and their Families: A Grounded Theory Study

Colette Richardson

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ABSTRACT

This study is a qualitative enquiry into family therapists' experiences of working with young people who self-harm and their families. To date, in spite of self-harm being a serious public health concern, there is relatively little exploration of the subject in family therapy literature. The study attempts to describe, understand and illuminate family therapists' experiences: the therapeutic issues encountered, the stances adopted in response to the issues encountered, and the emotional impact on the therapist of working with this client group.

A total of nine experienced family therapists participated in semi-structured interviews. The study employed a grounded theory method for data analysis. The analysis yielded a theory of therapists' experiences that included a Core Category and three Main Categories.

The Core Category that emerged was:

- Cultivating the Practice of Hope – Withstanding the Pull to Hopelessness.

The three Main Categories were:

- Making the Situation Safe
- Conversing Therapeutically – The Practice of Hope
- Team and Organisational Processes: Supporting Therapists.

The Core Category is the central feature of this theory. It proposes that the central concern for the therapist is how to stay engaged with the family and the young person in the context of serious risk of self-harm and in situations where change is difficult to achieve and hopelessness can pervade. The therapist has to try to understand and make sense of family members' distress, and be touched by and open to their feelings of despair and hopelessness without becoming overwhelmed and despairing themselves. The therapist response to this dilemma is the stance of hopefulness. It is both a therapeutic stance and orientation, and is enacted in practice through finding ways to cultivate hope in the therapeutic encounter.

While the Core Category is the central 'story' the three Main Categories are linked to the Core Category.

The Main Category, Making the Situation Safe describes the initial stage of the work, with its focus on ensuring the safety of the young person.

The Main Category, Conversing Therapeutically – the Practice of Hope describes how the therapists enacted the 'practice of hope'.

The Main Category, Team and Organisational Processes: Supporting Therapists describes how the context in which the therapists work, the nature of relationships, the team and organisational structures, play a critical role in supporting therapist hope, so that they can withstand the pull to hopelessness.

This study aims to make a contribution towards articulating a framework for family therapy with adolescents who self-harm and introduces a new vocabulary – the language of hope and hopelessness.

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1. INTRODUCTION

The initial impetus for this project began several years ago when I was working in a new post as a family therapist in an adolescent inpatient unit. This was my second job in a hospital setting and I was excited about the work, though also apprehensive – since although the ‘inpatient’ experience was not new to me, the presenting problems were significantly different to those I had previously encountered.

The young people admitted to the unit were within the 13 to 18 age-range, and presented with a range of problems including psychosis, depression, self-harm, obsessive-compulsive disorder and post-traumatic stress. Those admitted because of self-harm would normally have made a serious suicide attempt, with the self-harm typically involving the young person taking an overdose, usually Paracetamol. Some young people, more often the boys, would have attempted suicide by hanging. Prior to admission the young person would often have made several attempts of a less lethal nature.

I found the clinical work both demanding and challenging. The young people were often reluctant to engage in family therapy, and their parents, while clearly upset and distressed, were also often reluctant to engage. Sessions frequently had the quality of ‘walking on egg-shells’. Family members found it difficult to verbalize what they were feeling and to engage in dialogue about the self-harm, its meaning and impact. As the sessions unfolded and parents began to trust more, they would often eventually speak about their fear that talking about self-harm would trigger a further attempt on the part of the young person.

The challenge presented by this work spurred me to try to find out how others worked with self-harm, and I consulted the available literature in family therapy. To my surprise very little had been written, leaving therapists like myself wishing to develop their skills in this area with little guidance. Much of what had been written came from the early stage of family therapy development, often described as the cybernetic phase. Most of the articles described working with

young people and their families from a predominantly strategic model of family therapy.

The combination of a lack of guidance from the literature, and the challenges I encountered in the work with these families, set the ground for this study. My initial project involved enquiring into the impact of therapists' preferred ideas and biases on the families they worked with, and from this to generate information useful to therapists for their clinical work with young people who self-harm and their families.

The research design was to include interviews with the young person, their family and the therapist and, in addition, observation of video-taped therapy sessions. This project proved untenable, due to various factors including recruitment difficulties. Despite having received approval from the National Research Ethics Service (NRES), individual NHS Trust research departments were reluctant to give approval for the project. Negotiations with the Trusts regarding the recruitment of families and therapists, answering questions, filling out forms etcetera, continued over a two-year period. Two of the Trusts I approached did eventually approve the project.

However, I experienced further difficulties. Family therapy colleagues while being interested in the research and agreeing to participate, later reported that they were unable to recruit suitable families. Despite this, the setbacks provoked me to think more deeply about the importance of research in the area of self-harm and I decided nevertheless to continue and redesign the research project.

Before introducing the new study, it may be interesting to consider why the first project proved untenable. My hypothesis is that the difficulties I experienced were related to the issue of risk. Trusts were perhaps anxious about the possible consequences of allowing research to take place that involved young people for whom there was a risk of suicide, and may have been worried about what might be the legal and other implications. Likewise the family therapists may have worried that involvement in the project could increase risk, leaving them open to blame had anything untoward happened.

It is interesting to consider these difficulties encountered in the light of some of the findings of this present study. It would seem that the wider context mirrored the families' fears of triggering self-harm.

Returning to the present study, to reiterate, it was triggered by both clinical experience and the absence of literature on the subject. My aim in designing this grounded theory study was to try to unearth the experience of family therapists working with young people who self-harm, to learn from them through exploring their concerns and dilemmas, and through this process to generate ideas useful for clinicians working in this area. The Research Purpose Statement, Question and Sub-questions are set out overleaf.

1.1 Research Purpose Statement And Research Questions

Research Purpose Statement:

The purpose of this grounded theory study is to describe, understand and illuminate systemic therapists' experiences of working with young people who self-harm and their families. In conducting this research I am seeking to understand the clinical dilemmas and concerns faced by therapists, explore how they make sense of their experiences and explore their ideas about what has to happen for change to take place. The overall aim of the study is to generate information useful to therapists in their clinical practice.

Overarching Research Questions:

1. How do family therapists experience working with this client group?
2. What dilemmas and problems arise?
3. What have family therapists learnt over time about working with adolescents who self-harm and their families?

Sub-Questions:

1. What therapeutic issues are encountered?
2. How do therapists make sense of the issues encountered?
3. What stances do they adopt in response to the issues encountered?
4. How does the issue of risk of suicide impact on the therapy and therapists?
5. What feelings are evoked in therapists?
6. What are therapists' preferred ways of working with this client group?

2. CHAPTER ONE: LITERATURE REVIEW

Overview of Literature Review

This Literature Review will include a summary of what is known about self-harm in terms of prevalence, risk and protective factors, and the characteristics of young people most at risk of self-harm. The Literature Review will also include an exploration of the evidence base for family therapy and family interventions for self-harm. The clinical literature for family therapy and self-harm will then be reviewed, focussing on how family therapists approach treating young people who self-harm, and their families. The limited qualitative literature on family therapy for self-harm, and finally qualitative research that has focussed on the emotional experience of the therapist involved in working with self-harm, is then discussed.

In structuring the literature as described above, my aim was to show what is known in the field and the previous work conducted and in doing so, to demonstrate what others have thought was important to research about self-harm and from this to show the gap in the literature that prompted this research study. This necessitated incorporating evidenced-based literature both systemic and non-systemic. It also incorporates research conducted in the U.K. and in the U.S., and some research conducted in Australia and New Zealand. The literature on Non-Suicidal Self-Injury (NSSI) has not been included as the focus of the study was on self-harm that involved a risk of suicide.

The Literature Review begins with a section on defining self-harm.

2.1 Defining Self-Harm

There is considerable confusion regarding the definition of self-harm across different countries with a variety of terms used: self-harm; deliberate self-harm; self-injurious behaviour; attempted suicide; para-suicide; self-poisoning; suicidal behaviour. This has implications for research on the prevalence of self-harm, given the different definitions (Ougrin and Zundel, 2010).

A central issue is about intention, and the question as to whether or not suicide was intended. Both the terms 'attempted suicide' and 'para-suicide' have been criticized as they imply suicidal intent which may not be present (Hawton and Catalan, 1987). In the U.S. the term Non-Suicidal Self-Injury (NSSI) is used in reference to cutting or repetitive superficial bodily harm without suicidal intent. NSSI usually excludes overdoses and methods of high lethality, (Skegg, 2005; Ougrin et al., 2010). Attempted suicide in the U.S. is the term used when there is some suicidal intent. In Europe the term 'para-suicide' is commonly used (Skegg, 2005). However, Evans et al. (2005) state that deliberate self-harm is the term that is increasingly being used in Europe, and refers to non-fatal acts of self-harm irrespective of the intention.

The debate about terminology is part of an on-going discussion about diagnostic categories and distinguishing between different types of self-harm. Ougrin and Zundel, (2010) believe that at present there is limited evidence for different types of self-harm representing different diagnostic categories and that self-harm can be seen in terms of a broad-spectrum of behaviours. He succinctly captures the issue when he says, 'it would seem absurd to treat two near-lethal overdoses differently on the basis of reported differences in intent. On the other hand it would be equally absurd to treat a near lethal hanging in the same way as a superficial scratch' (Ougrin and Zundel, 2000, p.13). In the U.K. the Royal College of Psychiatrists, Child and Adolescent Faculty adopted the term self-harm to describe 'all acts and events in which a person causes harm to themselves by whatever means' (Council Report CR64, 1998; Council Report CR158, 2010). This includes, self-poisoning and deliberate self-injury by cutting or burning. It includes suicidal and para-suicidal acts.

The National Institute for Health and Care Excellence (NICE) (July, 2004) defines self-harm as 'intentional self-poisoning or injury, irrespective of the apparent purpose of the act'. In recent years there has been a move away from the use of the term 'deliberate self-harm' and the term 'self-harm' has been adopted by NICE (Ougrin and Zundel, 2010).

The term 'self-harm' will be used in this Study in line with the definition proposed in the NICE Guidelines 16 (2004). This definition was chosen

because it is the most frequently used definition. It is also neutral in its language with respect to intention and causality.

A review of the psychological literature highlights a focus on establishing prevalence, identifying at-risk groups, and risk factors.

2.2 Prevalence of Self-Harm in Adolescents

Adolescents who self-harm are a major public health concern. In the U.K. it is estimated that 20,000 to 30,000 young people between the ages of 12 and 17 present at accident and emergency departments every year (Hawton et al., 2006). The number who actually self-harm is likely to be higher as many young people do not present at accident and emergency departments, (Melzer et al., 2001; Hawton et al., 2002; Green et al., 2005; Madge, 2008). A review by Evans et al. (2005) of 128 studies, which included 513,188 adolescents, reported that 13.2% had self-harmed at some stage in their life. This Study is considered the most comprehensive review on the prevalence of self-harm (Ougrin et al., 2010).

The Child and Adolescent Self-harm in Europe (CASE) Study (Madge et al., 2008) which compared data across seven countries, from 15 to 16 year-olds completing anonymous questionnaires in schools, found that 13.5% of female adolescents and 4.3% of male adolescents reported having self-harmed in their lifetime (Madge et al., 2008). The Study also reported on intent of self-harm and found that 50% of young people had a wish to die as either their only, or one of their reasons for self-harm. Other reasons given were to get relief from a 'terrible state of mind' and to 'punish myself'. The most recent report on suicide rates from The World Health Organization (WHO) show that in the U.K. the number of young people who commit suicide is 4.9 per 100,000 of the population in the age group 15 to 24 and in the younger age group, 5 to 14, the rate is 0.1 per 100,000 of the population. Suicide is the third most common cause of death in adolescents in the U.S. and second in the U.K. in young people aged 15 to 24 (Kerfoot, 1996) and self-harm is one of the strongest predictors of death by suicide in adolescents (Hawton and Harriss, 2007).

Self-harm is more prevalent in girls, with girls being four times more likely to self-harm than boys (Fox and Hawton, 2004). Hawton and Harriss (2008) estimated the ratio as being as high as 6.5:1. While self-harm is more prevalent in girls, boys are more likely to use more dangerous or lethal methods of self-harm (Shaffer and Pfeffer, 2001) and are more likely to commit suicide (Ougrin et al., 2012).

In the U.K. the most common form of self-harm is self-poisoning, with self-poisoning by Paracetamol accounting for two-thirds of overdoses (Hawton et al., 2000).

In terms of age, onset of self-harm is usually associated as beginning in early teens, normally at age 13, peaking in late teens (Ougrin and Kyriakopoulos, 2010, p.28). A Study into how self-harm changes over time was conducted in New Zealand. In this Study participants were followed-up over a period of 25 years. Those who reported suicidal thoughts and behaviours in adolescence were more likely to have suicidal thoughts and behaviours in young adulthood as well as major depressive disorder (Ougrin and Kyriakopoulos, 2010). The findings from studies identifying rates of self-harm in minority ethnic groups in the U.K. are inconsistent and studies about adolescents are few, with limited attention to the diverse ethnic groups (Bhui et al., 2007). One Study showed a higher risk of self-harm (Bhugra et al., 2003) while another (Hawton et al., 2002b) showed a lower risk of self-harm in South Asian girls. There is evidence that self-harm is higher in South Asian young women in the 16 to 24 age group, than in White young women in the same age group. The rates of self-harm were also lower in South Asian young men compared to South Asian young women and also compared to White young men.

In a recent Study conducted by Cooper et al. (2010) higher rates of self-harm were identified in young Black females age 16 to 34, compared to White or South Asian females. This Study, conducted in the U.K., used data collected from self-harm attendances to hospitals to examine risk factors for repetition of self-harm. The results found that risk of repetition was significantly lower in the ethnic minority groups, compared to the White group. The researchers suggest that this finding may be explained by 'disillusionment with statutory services'

(Cooper et al., 2010, p.216). This differs however from the findings of Bhugra et al. (2003) where rates of self-harm were higher among South Asian girls age 10 to 14, compared to White girls in the same age range.

Bhugra's Study also found that South Asian patients are less likely to receive referral for specialist psychiatric and follow-up services than White patients. Similarly Cooper et al. (2010) found that young Black females were less likely to receive a specialist psychiatric assessment or be referred for psychiatric outpatient or inpatient care following self-harm compared to White females.

Given these findings it would seem that there is an urgent need to develop services that are more culturally sensitive and take account of how emotional distress and mental health concerns are communicated in different ethnic groups.

In summary, the research into prevalence of self-harm identifies it as a serious problem, not just in the U.K., but across Europe, the U.S., Australia and New Zealand. In the U.K. 20,000 to 30,000 young people present at accident and emergency (A&E) departments with self-harm (Hawton et al., 2006). Studies have consistently shown that self-harm is more common in girls than boys, but boys are more likely to complete suicide. As stated above, the research on prevalence of self-harm among Ethnic Minority Groups is limited and contradictory and does not reflect the diverse ethnic groups present in the U.K.

2.3 Associated Psychological Difficulties

Fox and Hawton (2004) state that one of the most challenging and troublesome areas for research is about identifying why self-harm occurs. Various factors have been identified as risk factors for self-harm. These include, repetition of self-harm, psychiatric disorders, sexual and physical abuse, stressful life events, individual characteristics and family factors. No single risk-factor is considered to be the cause of self-harm, but is rather the outcome of a number of factors coming together at one time (Fox and Hawton, 2004).

(i) Repetition of Self-Harm

Repetition of self-harm is a key issue. A prior attempt has been found to be one of the more important risk factors among those who complete suicide (Shaffi et al., 1985). Bridge et al. (2006) state that the single biggest risk factor for completed suicide after controlling for a psychiatric disorder, is a previous attempt, and Beghi et al. (2013) found that the strongest predictor of a repeat attempt is a previous attempt.

There is evidence that the overall risk of suicide increases after a self-harm episode. Approximately 5% of those who attended A&E departments due to self-harm commit suicide within nine years (Skegg, 2005). A Study conducted in the U.K. by Hawton et al. (1999) found that those who repeat self-harm scored more highly than non-repeaters for depression and hopelessness. The Study concluded that depression is a key factor associated with risk of repetition of self-harm and of suicide risk.

(ii) Psychiatric Disorders

Research has shown that there is a significant association between suicidal phenomena and the presence of a mental health disorder (Evans et al., 2004). In completed suicides 90% of adolescents had been diagnosed with a psychiatric disorder (Bridge et al., 2006).

Psychiatric disorders that have been linked to self-harm include depression, (Brent et al., 1993; Garrison et al., 1991; Hollis, 1996), personality disorders, (Gispert, 1987; Stein, 1998) drug and alcohol abuse, (Wasserman, 1993; Brent et al., 1993), conduct disorders, (Achenbach, 1995; Wessley et al., 1996). Self-harm is also associated with behavioural problems, such as substance abuse and aggressive or criminal behaviour (Andrews and Lewinshon, 1992; Garnefski et al., 1992; Shaffer et al., 1996; Kerfoot, et al., 1996; Lewinshon, 1996).

Beautrais et al. (1998) in a Study conducted in New Zealand found that 89% of suicide attempters had a current psychiatric disorder. This finding is supported

by other studies (Brent et al., 1988, 1993; Shaffer et al., 1988; Shafii et al., 1988; Martunen et al., 1991). The Study also found that young people who made serious suicide attempts had extensive and recent contact for psychiatric problems with a range of services before the suicide attempt. The authors note that most prevention strategies are population based. They further suggest that little focus has been given to suicide prevention through emphasizing the treatment and management of young people with psychiatric disorders. They propose better recognition and early treatment, recognition of co-morbid conditions, long-term surveillance of young people with psychiatric disorders and intensive follow-up after suicide attempts. They also suggest regular reviews of symptoms of depression, suicidal ideation, and changes in life stressors to take account of the fact that risk of suicide may change over time while the young person is in treatment.

Depression is the most commonly associated mental health disorder connected with self-harm (Shaffer et al., 1996; Brent et al., 1999; Houston et al., 2001), and is a key factor associated with repetition of self-harm (Hawton et al., 1999). Evans et al. (2004) in an international review of factors associated with suicidal phenomena found that there was evidence for a strong and direct relationship between depression and suicidal phenomena. Kerfoot et al. (1996) found that 67% of adolescents who self-poisoned had a diagnosis of major depressive disorder. A Study conducted in the U.S. by Weismann et al. (1999), found the clinical course of adolescent onset of Major Depressive Disorder (MDD) to include a high rate of suicide and suicide attempts, re-occurrence of MDD and an increased occurrence of psychiatric hospitalisation, and impaired functioning in work, social and family life.

In the U.K., Houston et al. (2001) conducted a Study into the characteristics of young people who have completed suicide aged 15 to 24, using the psychological autopsy approach. The results showed that the most common psychiatric disorder was depression. The authors note that the suicides were often the culmination of long-term difficulties extending back to childhood or early adolescence and conclude that the process leading to suicide in young people is often long-term, with untreated depression in the context of personality and or relationship difficulties.

In summary, there is significant evidence connecting self-harm with the presence of psychiatric disorders in adolescents. The strongest association is for depression, with depression being a key factor in repeated attempts of self-harm. Adolescents experiencing depression are therefore at increased risk of suicidal behaviour (Evans et al., 2004). The evidence would point towards careful assessment of depression in adolescents presenting with self-harm.

(iii) Hopelessness

Hopelessness has been found to be associated with suicidal ideation and suicidal behaviour in adolescents. However, prior to the 1980s, there were few studies examining this factor in children and adolescents, with most studies focusing on the adult population (Kashani et al., 1989).

Kazdin et al. (1983, 1986) conducted a Study in the U.S. to evaluate hopelessness, depression and suicidal intent in 66 hospitalized children, ages 8 to 13. To assess hopelessness they developed a scale modelled on the adult hopelessness scale (Beck et al., 1974). Hopelessness was defined as 'negative expectancies towards oneself and towards the future' (Stotland, 1969). The results of the Study showed that children with suicidal intent, or attempts, showed greater hopelessness than children without these symptoms, and in addition suicidal intent was more consistently correlated with hopelessness than with depression.

Kashani (1989) also found that children who had a high hopelessness score were at greater risk of suicide and depression as well as being at greater risk for developing a psychiatric illness and they also reported significantly more school-related problems. This Study was conducted in a community sample of 210 school children in the U.S. In a further Study, also a community sample conducted in the U.S., Kashani et al. (1995) investigated the relationship between personality traits and hopelessness. The results of the Study showed that sensitive adolescents with less impulse control had a high hopelessness score. Sensitive adolescents were defined as 'feeling discontented, pessimistic and guilty'. A further finding was that adolescents with social intolerance,

defined as 'indifference to the feelings of others', was associated with hopelessness. Two factors were found to decrease hopelessness: co-operative behaviour and parental care. The authors suggest that treatment plans encouraging interaction with others, concern about the feelings of others and group activities may help reduce hopelessness in adolescents. Marciano and Kazdin (1983) found that children admitted to an acute inpatient facility in the 6 to 13 age-range reported significantly greater levels of depression, hopelessness and lower self-esteem in suicidal children compared to non-suicidal children.

In the U.K. Kerfoot et al. (1996) looked at the correlates of self-poisoning in adolescents and found that suicidal ideations and hopelessness were significantly higher in those that had taken an overdose than in community control groups. The Study was conducted with 40 adolescents in the age range of 11 to 16 attending casualty departments in hospitals in Manchester. Measures assessing hopelessness and depression were by self-report.

Hawton et al. (1999) conducted a Study to explore the relationship between psychological variables and repetition of self-harm in 13 to 18 year-olds admitted to a General Hospital following an overdose. Standard measures, both self-report and observer-rated, were used to measure depression, hopelessness, suicidal intent, impulsivity and self-esteem. The Study found that those who had history of self-harm and/or who repeated self-harm within a year following the Study scored higher for hopelessness, depression, trait anger, lower self-esteem and poorer problem solving skills. When depression was controlled for, the researchers concluded that depression was an overwhelming factor associated with repetition of self-harm and therefore clinicians needed to screen carefully for depression when assessing adolescents who self-harm.

In New Zealand, McGee et al. (2001) examined how individual and family characteristics in early childhood may lead to suicidal ideation in early adulthood. The Study focused on hopelessness and self-esteem, as these two variables have been shown to be significant. The researchers posited a connection between family background, for example poor family functioning and low socio-economic status as affecting suicidal behaviour, increasing the

adolescent's sense of hopelessness about the future and consequently their vulnerability to suicidal ideation.

The Study found that childhood levels of hopelessness, low self-esteem and thoughts of self-harm are significant predictors for suicidal ideation in early adulthood, and that half of the young adults in the Study reporting suicidal ideation were not diagnosed as depressed. The findings for both boys and girls were somewhat different. For boys, socio-economic disadvantage appeared to be particularly important, and predicted both lower levels of self-esteem and higher levels of hopelessness. Harsh parent-child interaction predicted early thoughts of self-harm in boys. For girls, socio-economic disadvantage predicted lower levels of self-esteem, and harsh parent-child interaction predicted higher levels of hopelessness in childhood.

Thompson et al. (2005) explored the role of anxiety, depression and hopelessness as mediators between known risk factors and suicidal behaviours in high school drop-outs in the U.S. The findings suggest that anxiety heightened feelings of both depression and hopelessness. For males the influence of anxiety on suicidal behaviour was mediated by both depression and hopelessness. For females the effect was mediated by hopelessness but not depression. Depression therefore seems to have a stronger effect on suicidal behaviour in males. Andrews and Lewinshon (1992) found that more males than females who attempt suicide are depressed. In contrast to Thompson et al. (2005) an earlier Study by Joiner and Rudd (1996) reported that hopelessness remained a predictor of suicidal ideation after controlling for depression.

Failure to engage in treatment and early drop-out from treatment has been linked to hopelessness and will be addressed in the next section. Brent (1997) has stated that hopelessness is a critical issue to attend to and needs to be addressed early in treatment.

In summary, the relationship between hopelessness and self-harm is not clear. Some studies report a direct relationship, while others link hopelessness to both depression and anxiety. Evans et al. (2004) suggest there is reasonable evidence for an association between self-harm and hopelessness but that it is

unclear whether this association is direct. Hopelessness has also been linked with the family environment, its role in promoting a hopeful view of the future, and the quality of family relationships, particularly harsh parent-child interaction. In addition there is a link between hopelessness and socio-economic disadvantage, and finally the research evidence suggests that there is a link between hopelessness and failure to engage in treatment and therefore a need for clinicians to focus on hopelessness at the initial stages of treatment.

(iv) Lack of Engagement

Lack of engagement in treatment by adolescents has been linked with increased suicidality (Rotherham-Borus et al., 2000) and hopelessness (Pillay and Wassenaar, 1995).

Ougrin and Latif (2010) summarised the factors associated with lack of engagement. These include, age and gender (Piacentini et al., 1995), low socio-economic status, severity of psychopathology, substance misuse and anti-social behaviour (Pelkonen et al., 2000), poor therapeutic alliance (Granboulan et al., 2001), family and service barriers to treatment participation (Spirito et al., 2002), parental psychopathology and attitude to treatment (Taylor and Stansfeld, 1984). Young people's experiences in A&E and the attitudes of staff have been associated with poor engagement (Rotheram-Borus et al., 1999). Time delay between initial and follow-up appointment was also a factor (Clarke, 1988). Hor and Taylor (2010) found that the only consistent protective factor for suicide was delivery of, and adherence to, effective treatment.

(v) Stressful Life Events and Traumatic Stress

Overholser (2003) identified different kinds of life stressors associated with self-harm in adolescents. These include interpersonal factors, death, separation and divorce, and physical illness. Overall there is evidence to support a link between life stressors and suicidality (Cohen-Sandler et al., 1982; Brent et al., 1993; Lewinshon et al., 1994; Gould et al., 1996; Beautrais et al., 1997).

Berman et al. (2006) identified interpersonal conflict and social isolation with adolescent suicidality. Recent stressful life events such as rejection, conflict or loss following the break-up of a relationship, were identified by Hawton et al. (2003). The nature of the stressors seems to vary according to age, with younger adolescents describing family stress and older adolescents describing peer-related stressors (Gould et al., 2003; Hawton et al., 2003).

Loss of a parent through either separation or divorce or death has been found to be more common with fatal rather than non-fatal suicide attempts (Brent et al., 1994; Lewinsohn et al., 1996). Agerbo et al. (2002) found an association between loss of a parent prior to age 12 and multiple suicide attempts. The evidence in relation to separation and divorce as a risk factor is mixed and contradictory, with some studies showing no association (King, 2001; Overholser, 2003). Berman et al. (2006) suggest that it is not the presence in itself of life stressors that cause suicidality, but they may act as triggers in a vulnerable adolescent who may be already at risk, for example an adolescent with a history of repeated self-harm. Kelly (2000) suggests that divorce is not the issue on its own, but the level of conflict is the more important factor, and Gould et al. (2001) suggest that the significant factor is parental mental illness. Similarly the studies connecting family constellation and self-harm are mixed. Fox and Hawton (2004) found that half of the children presenting with self-harm live with only one parent due to separation and divorce. Wagner et al. (2003) also found that suicide attempts seem to occur more in single parent households, however Gould et al. (2001) found no association.

(vi) Individual Factors

Individual factors that place adolescents at risk of suicide include impulsivity (Hawton et al., 1982; Kingsbury 1999), hopelessness (Steer, 1993; Kerfoot, 1996; Fox and Hawton, 2004), perfectionism (Boergers et al., 1998), poor problem-solving skills (Hawton et al., 1999) and increased levels of anger and hostility (Simmonds et al., 1991).

(vii) Sexual Orientation

Young people identifying themselves as homosexual are two to seven times more likely than their heterosexual peers to attempt suicide (Bagely and Tremblay, 2000; Cochran and Mays, 2000). It is not sexual orientation in itself that is linked to self-harm but the experience of victimisation and, for some, negative reactions from family members (Brown, 2002).

(viii) Peer Influence

Studies have indicated that peer factors are related to adolescent suicide and related behaviour. Sun et al. (2006) found that conflict and being a victim of bullying and intimidation were associated with self-harm. Several studies both in the U.K. and the U.S. (Bjarnason and Thorlindsson, 1994; Borowsky et al., 1999) identified suicidal behaviour in a peer as a risk factor. In a school Study in the U.K., Hawton and Rodham (2006) found that having a school-friend who had recently self-harmed was strongly associated with self-harm, with girls more likely to self-harm if they had a friend who self-harmed. Brent et al. (1996) explored the effects on peers of adolescents who had committed suicide and found that exposure to suicide does not increase self-harm among friends and acquaintances; however it does have a long-term impact for depression, anxiety and Post Traumatic Stress Disorder (PTSD). Those exposed to a friend's suicide and who had knowledge of their friend's plans were at the greatest risk of depression and PTSD.

(ix) Family Factors

Difficulties in family relationships have been identified as a significant risk factor in adolescent self-harm and there is a large body of research focussing on family risk-factors (Wagner et al., 2003). Family risk factors are associated with both fatal and non-fatal self-harm among children and adolescents (Bridge, 2006). Berman et al. (2006) state that the influence of the family and parental

system has been one of the most researched variables in relation to adolescent suicide and self-harm.

Different studies have identified different aspects of family functioning. Tulloch et al. (1997), in a Study conducted in New Zealand with 52 adolescents presenting in A&E, found a very strong association between the absence of a family confidante and adolescent self-harm, and further the absence of a family confidante was linked to poor communication. Several different self-report measures were used, including a parent/adolescent communication scale and the family adaptability and cohesion evaluation scale. Gould et al. (1998), in a Study investigating factors moderating the effect of separation and divorce, found that poor communication with fathers significantly increased the risk of suicide in adolescents regardless of whether parents were together or separated. Tousignant et al. (1993) also identified that negative father-child relationships were associated with suicidal behaviour in adolescents. Orbach, (1986), Pfeiffer, (1986) and Richman, (1986) reported that communication problems such as secretiveness and avoidance of direct expression of emotion are also associated with self-harm.

Fergusson and Lynskey (1995) found that lack of perceived parental support or availability is associated with attempted suicide in adolescents. Yuen et al. (1996) also identified perceived lack of parental support to be a risk factor.

Family conflict was identified by Neiger and Hopkins (1988), Kosky et al. (1990), and Brent et al. (1994). Wagner (2003) found ineffective parenting as a risk factor. Hollis (1996), and Jacobs (1971) identified hostile and punitive parenting styles. Hollis (1996) found that family relationship factors make an independent contribution to the risk of adolescent suicidal behaviour beyond the effects of depression. The Study involved using clinical data summaries from a large sample of adolescents who attended an outpatient clinic. The family factors studied included family discord, lack of warmth, hostility in the parent-child relationship, and inadequate family communication.

Parental high Expressed Emotion (EE) particularly criticism, is associated with adolescent self-harm (Wedig and Nock, 2007). In a community sample of adolescents in the U.S. age 12 to 17, Wedig and Nock (2007) examined the

relationship between adolescents' self-injurious thoughts and behaviours, (SITB) and parental expressed emotion. Parents of the adolescents completed the Five Minute Speech Sample (FMSS) (Magana et al., 1986). The Study examined whether high levels of parental EE, including criticism and emotional over-involvement (EOI) are associated with the presence and frequency of SITB. The results showed that high parental criticism is associated with increases in SITB, and that EOI was not associated. The research contributes to previous research showing that high EE but not EOI is related to psychiatric disorders (Wedig and Nock, 2007). The research showed that when there are both high levels of self-criticism in the adolescent and high levels of parental criticism there is an increase in SITB. High levels of self-criticism do not lead to SITB when parental criticism is low, and when there is low-level self-criticism in the adolescent parental criticism has less of an impact.

Fergusson et al. (2000), and Houston et al. (2001), identified marital disruption, socio-economic adversity and poor-parent child attachment. Wagner (2003) also found poor parent-child attachment to be associated with adolescent self-harm.

Wagner et al. (2000) found that mothers of adolescents showed greater concern and caring from immediately before the suicide attempt to the day after the attempt, which they conclude may indicate a possible attachment-related function of the suicide attempt. Hostile feelings were experienced by 50% of mothers across the time points, but these feelings were less likely to be expressed and parents reported being careful about what they said. Similarly to mothers, fathers' caring, and sad feelings increased after the suicide attempt, and they were less likely to respond with anxiety. Hostility was the most common emotion coded from fathers' narratives in the immediate aftermath of the suicide attempt. However, the majority of fathers did not express their feelings of hostility, and were careful about what they said.

A further finding was that mothers of adolescents who had self-harmed just once were more likely to respond supportively than mothers of children who had made several attempts. The authors hypothesized that this could be due to a parent emotionally withdrawing to protect themselves from further emotional

pain. The authors conclude that the suicide attempt may represent the adolescent's wish for reconnection with their parent, and from an attachment perspective the parent's increase in anxiety, sadness and caring may represent a wish for reconnection with the adolescent. This Study was conducted in the U.S. and included 34 mothers and fathers, of 23 adolescents. Family members were assessed shortly after the attempt was made and were interviewed about their emotional reactions the day before, upon discovering, and on the day after the suicide attempt. From a clinician's perspective this Study is useful: despite the small sample size it speaks to clinical experience, particularly the way that suicidal behaviour seems to elicit both caring and hostile responses in parents.

Adam et al. (1996) used the adult attachment interview (George et al., 1985) to compare the attachment status of 69 adolescents with a history of suicidal behaviour to that of 64 psychiatric controls. They found that suicidal adolescents who were classified as having a combination of 'preoccupied' attachment and 'unresolved' attachment had the highest likelihood of being in the suicidal group. Another Study conducted by Klimes-Duggan et al. (1999) found that attachment status in childhood predicted suicide attempts in adolescence.

Some data suggests an association between suicidality and lower levels of parental care and availability (Blair-West et al., 1999). In a review of 12 studies examining the relationship between low parental care and parental over-protection, Goshin et al. (2013), found that the studies showed a significant association between poor parental bonding in the form of low care and suicidal behaviour, and further that affectionless control – the combination of low care and over-protection – seemed to be more strongly associated with suicidality.

Greydanus and Shek (2009) identified severe family neglect and early separation from parents. Both physical and sexual abuse are also high risk factors for self-harm (Brent et al. 1994, 1995; Briere et al., 1997; Brown et al., 1999; Fergusson et al., 2000; Evans et al., 2005; Greydanus and Shek, 2009). Brown et al. (1999) researched the relationship between child maltreatment and adolescent suicide behaviour and found that the risk of repeated suicide attempts were eight times greater for adolescents with a history of sexual

abuse. Perkins and Hartless (2002) found a clear association between abuse, both sexual and physical, and frequent suicidal thoughts and suicide attempts in adolescents, regardless of gender or ethnicity.

Kaplan et al. (1999) investigated the connection between physical abuse and adolescent suicide. They found no difference in the proportion of adolescents attempting suicide between the group who had been physically abused and the control group; however, the group who had been physically abused showed a significantly greater exposure to risk factors for suicide.

Some studies have suggested that adolescents who self-harm are more likely to perceive themselves as unwanted by parents or as a burden to the family (Rosenthal and Rosenthal, 1984; Woznica and Shapiro, 1990). In a community sample Wagner and Cohen (1994) found that the sibling who perceived his or her relationship with parents as less warm and more harsh was likely to report more suicidal ideation than the other sibling.

Compared to normal adolescents, suicidal adolescents report poorer family relationships and more interpersonal conflict with parents and less affection (Brent et al., 1993; Slap et al., 1989; Warner et al., 1995; Wagner et al., 2003). Kashani et al., (1998), examined family characteristics of suicidal and non-suicidal children and found that suicidal youngsters were more likely to describe their families negatively, perceiving them as less trustworthy, unable to confide in and respect each another. They were also perceived to be less adaptable. McKenry et al. (1983) found that suicidal adolescents hold more negative views of their parents.

As discussed previously, the evidence in relation to separation and divorce as a risk factor is mixed and contradictory, with some studies showing no association (Gould et al., 1998; King, 2001). Hawton and Rodham (2006) however identified parental separation and divorce as a significant risk factor. Hawton and Rodham (2006), also found that 40% of adolescents who self-harm will have spent time in care.

Research into family risk factors for Ethnic Minority Groups is limited. Of the studies undertaken, Kingsbury (1994) in a Study conducted in the U.K. found

that Asian adolescents were more isolated and confided in their parents less often and were more likely to have problems with their siblings than their peers. Handy et al. (1991) found that culture conflicts were the most important factor in the suicidal behaviour of Asian children. Thompson and Bhugra (2000) suggest that conflict between what is expected of female Asian adolescents traditionally, and what they strive for as part of Western society, is a source of stress. In addition, the combination of the pressures of adolescent development experienced by all adolescents and the pressure related to the 'cultural conflict' leads to a higher rate of suicide and self-harm.

In summary, as stated earlier, there is a large body of research on family risk factors that have been associated with self-harm and point to the significant role that family environmental factors play. These include communication, lack of parental support, family conflict, ineffective parenting and hostile and punitive parenting styles, high expressed emotion, marital disruption, parental child attachment, particularly preoccupied and unresolved attachment styles, being unwanted or perceived as a burden, physical and sexual abuse and neglect. These factors would point towards interventions that reduce criticism and conflict in families, address how parental support is communicated and experienced, screen for both sexual and physical abuse and address the quality of attachment in the family. There is, to date, very little research on family risk factors for Ethnic Minority Groups. Studies reporting on the Asian community would suggest that a focus on cultural conflict is important.

Most of the studies reporting on family factors have been based on self-report with few observational studies (Wagner et al, 2003). In addition it is not clear whether these factors were present prior to the suicidal symptoms and whether they are associated with just one episode of self-harm or a recurring history of self-harm. Family therapists working in the field need to be aware of the research into family factors, however many of these risk factors are also risk factors for other types of distress in adolescents and therefore they may not be specific to self-harm and suicidal phenomena (Wagner et al., 2003) This leaves the therapist with little direction as to what factors may be specifically important to focus on in self-harm.

(x) Family History

Parental mental illness and substance abuse are significant risk factors in adolescents who self-harm (Brent et al., 1995; Bridge et al., 2006). A history of suicidal behaviour in a parent is associated with adolescents who engage in self-harm (Pfeffer et al., 1998; Hawton et al., 2000a), and a family history of self-harm is associated with both fatal and non-fatal suicide attempts in adolescents (Brent et al., 1994; Gould, 1996; Agerbo et al., 2002).

Hawton et al. (2002b) investigated whether there are differences between the characteristics of adolescents who self-harm with a family history of suicidal behaviour compared to those without a family history of suicidal behaviour. The Study took place in Oxford and involved 146 adolescents presenting to A&E following an episode of self-harm. A positive family history of suicidal behaviour was found in 35.6% of the participants, with self-harm in mothers six times more frequent than in fathers. A further finding was an association between a family history of suicidal behaviour and greater anger in adolescents presenting with self-harm. A family history of completed suicide significantly increases suicide risk independently of a history of mental illness (Qin et al., 2002). Parental affective disorders have also been associated as a risk factor for adolescent self-harm (Garber et al., 1998; Kilmes-Dougan et al., 1999; Fergusson et al., 2000) and parental alcohol abuse is associated with self-destructive behaviours, both attempted suicide and drug addiction in adolescents (Christoffersen and Soothill, 2003).

In summary, the evidence suggests that parental mental illness may be a key factor in families of adolescents who present with self-harm, particularly a history of self-harm or suicide.

2.4 Protective Factors

Very few studies have focused on factors that may be protective against self-harm (Evans et al., 2004). Some studies have found that family cohesion, positive parent child connection, spending time together, parental supervision, and high parental academic and behaviour expectations are protective

(Borowsky et al., 1999; Resnick et al., 1999). Wagner et al., (2003) also found family cohesion, emotional support, and appropriate supervision to be protective factors in preventing suicidal behaviour. Evans et al. (2004) suggest that factors that have particularly strong protective effects are good communication with family members and involvement in family activities. Wright (1985) and Stewart et al. (1999) identified family harmony as a protective factor. Maimon, Browning et al. (2010) found that family attachment reduces the likelihood of adolescent suicide attempts. Flouri et al. (2002), in a Study exploring whether parental involvement can protect against adolescent suicide attempts, found that adolescents who had attempted suicide were more likely to report lower levels of parental interest.

In a Study conducted in New Zealand secondary schools, Fleming et al. (2007) found that risk of suicide was lower in secondary school students who reported a caring home environment and a fair, safe school environment. Sheftall et al. (2013) suggest that peer attachment may be protective when peers promote healthy behaviours but a risk factor when they engage in risky behaviours.

Some studies have shown that religious affiliation protects against self-harm (Statham et al., 1998; Dervic et al., 2004). Societal factors have also been named as having a protective factor, but exactly what is protective in some societies has not been identified (Skegg, 2005).

Brent et al. (2013) reviewed studies reporting on treatment interventions for suicide attempt, and suggest that treatments that focus on protective factors such as parent support and positive affect may be beneficial in preventing repetition of self-harm. Borowsky et al. (2001) and Prinstein et al. (2001), suggest that high levels of protective factors lower the risk for suicide attempt in adolescents even in the presence of other high risk factors.

To summarise, the evidence suggests that attention and focus on protective factors is an important buffer against self-harm and suicidal behaviour. The identified family-protective factors include positive child/parent interaction, parental supervision, family cohesion, emotional support and good communication. In addition a fair, safe school environment is protective and some studies have found religious affiliation to be protective. For a family

therapist a focus on protective factors fits well with an approach that foregrounds family strengths and resilience.

In this section of the Literature Review I have tried to give an overview of the research evidence relating to different risk factors that are associated with self-harm in adolescents and in addition I have presented an overview of the factors that are considered to be protective of adolescents. Given the significant contribution of family factors to the presentation of self-harm in young people, it would seem to suggest that family therapy can play a significant role in the treatment of self-harm. Family therapists in their day-to-day work will focus on many of the factors associated with self-harm, and as previously mentioned these include addressing communication, addressing high levels of expressed emotion, focusing on the quality of parent-child interaction and attachment, and on the impact of parental mental illness and increasing resilience and protective factors.

In the following section an overview of the systemic clinical literature on working with self-harm is presented, followed by an overview of the evidence base for family therapy for self-harm.

2.5 Systemic Clinical Literature

When working with self-harm family therapists are likely to draw on a range of ideas from the different models of family therapy, depending on their theoretical orientation and training. This overview of the systemic clinical literature aims to describe the range of ideas and practices that are currently in the family therapy literature.

(i) Clinical Literature of Family Therapy for Self-Harm

The on-line search of the family therapy journals produced a small number of articles giving clinical accounts of therapeutic work with self-harm. As will be seen, the accounts draw on different models including solution-focused, strategic and narrative models. Two authors, Larner (2009) and Pocock (2009),

describe an approach that involves integrating into their practice theoretical models both from within the systemic family and from non-systemic traditions. One article, (Bickerton et al., 2007) describes a model that takes account of both clinical and organizational factors.

A solution-focused approach¹ to risk assessment is described by Softas-Nall and Francis (1998). They comment on the strengths of the model in helping families to communicate with each other about issues of safety, concern and risk. They also describe the use of circular questioning (Selvini-Palazzoli et al, 1980) to assess the seriousness of the suicidal act by getting perspectives from all family members present and not just the suicidal member. This is in addition to the use of scaling questions. In addressing issues of safety they focus on a detailed exploration of times when the person felt safe, as opposed to times when the person felt at risk. They also placed an emphasis on the engagement of family members in the creation of a safe context for the suicidal member. Kondrat and Teater (2010) describe their use of a solution-focussed approach to assessing risk in the context of an A&E department. They suggest that using a therapeutic approach can impact on the person's level of hopelessness and create a context for change. They further suggest their approach as an alternative to using standardized assessment instruments as it allows opportunities for a brief therapeutic intervention.

Bickerton et al. (2007) describe their approach to working systemically with high-risk young people. Their approach, the 'Safety First Model' uses a five-level hierarchy of interventions. The first level focuses on establishing safety, the second on assessment and formulation, the third on creating a shared understanding of the formulation with the family, the fourth on collaborative planning and the fifth on specific therapies, which involve discharge planning and hand-over to other services for on-going/longer-term therapy. In their introduction the authors acknowledge the challenges for clinicians when working with this client group. They have tried to create not only a way of

¹ Developed by Steve de Shazer (1985, 1988) in the early 80's Solution-focused therapy assumes that people have the resources to find their own solutions. It is a collaborative model based on social constructionist ideas. The therapist intervenes therapeutically through asking questions about the present and the future, and in particular about exceptions to the problem – those times when the problem is not present or is less intense.

working with the young person and their family, but they have also thought about the context that the clinicians work in, and make a strong case for creating a working environment that is safe for the clinician as well as safe for the clients: 'ICAT (Intensive Care and Assessment Team) embraces a philosophy that only safe clinicians can assist clients in keeping safe' (Bickerton et al., 2007, p.123). Their model provides a clear framework that addresses both organizational structures and clinical structures which serve to guide both clinicians and managers.

Their clinical model is based on a collaborative approach, which begins with a clear focus on establishing safety, then an assessment of the young person's difficulties in the context of her relationships. This is followed by creating a shared understanding of the presenting problems in a relational context, and the final phase focuses on collaborative planning with the family in identifying goals for change and future options. The authors discuss some of the dilemmas they experience, for example, trying to strike a balance between the need to be directive in the safety-led part of the work and then moving to a more exploratory mode as safety is achieved.

Boston et al. (2011) describe their work with an adolescent in which they draw on systemic and narrative approaches. The focus of their article is on highlighting points of risk and the challenging dimensions of the work. The authors draw attention to how self-harm in adolescence is a 'tragic event' in that it happens at a time when the adolescent is developing autonomy, while at the same time acting to destroy that possibility. They highlight how a critical concern for therapists is to both respond in ways that protect the young person while not constraining their need for independence and experimentation. Boston et al. (2011) highlight that in their context the young person will already have been individually risk-assessed and a referral made to family therapy, however the level of risk could rise during the course of family therapy and therefore the family therapist needs to be able to respond appropriately to the increase in risk level.

The authors also draw attention to how parents can find it difficult to adequately respond to a high level of risk. They suggest that this can put the therapeutic

relationship under constraint, with the therapist acting overly responsible, which in turn can impact on the client's sense of agency. Through the use of a case example Boston and colleagues highlight some of the main themes in the work. These include a focus on a sense of being overwhelmed by emotions and the meaning of the emotions expressed, managing despair whilst at the same time noticing small changes, the use of individual sessions to 'scaffold' (White, 2007) a bridge to communication in the family, a focus on parenting styles and problem resolution, and a focus on the future.

The authors also discuss issues of safety that arise through the course of therapy and how these are managed by the therapy team. They briefly mentions some of the aspects of the 'self of the therapist', for example, monitoring of level of anxiety, confidence in managing the situation, feeling overwhelmed, irritated, and losing optimism, and some of the ways that the therapist felt supported in managing these reactions. The author raises the question about the context that therapists work in and how this affects their responses when involved in the work of effecting change in families in which a young person has self-harmed.

This article offers a family therapist a very useful overview of some of the issues encountered in the work. These include managing changes in risk levels during on-going treatment, the response of parents to high levels of risk at times being inadequate, the effect of this on the therapeutic relationship, the risk of therapists becoming overly responsible, and the dilemma for the therapist in ensuring protection without inhibiting the young person's bid for autonomy. The authors also draw attention to the centrality of emotions in the work and to addressing both the experience of being overwhelmed by emotions and the meaning of emotions. In addition, the authors refer to the impact of the work on the therapist, for example feeling overwhelmed, losing optimism, feeling anxious and feelings of irritability.

Earlier models of family therapy have conceptualized self-harm as a symptom of an incongruent hierarchy (Madanes, 1981; 1984) in which the young person is simultaneously defined as helpless and as powerful. This perspective is echoed in the work of Reder et al. (1991). They viewed the attempted suicide

as an attempt to resolve relationship conflicts that are spiralling out of control. The act of self-harm is seen as a metaphor for problems of hostility, loss and responsibility in the adolescent's close relationships. It is an act that brings family members face to face with the prospect of loss.

Hollis (1987) also conceptualized the attempted suicide as a symptom of an incongruent hierarchy. He discusses some of the difficulties encountered in working with this client group, emphasizing the way in which parents collusively ally with the young person and deny the difficulties in order to avoid further distress. He highlights the danger for therapists in accepting the family's position, thereby colluding with one or other parent or the adolescent. In these situations therapists are left without therapeutic leverage and find themselves in a position where they carry all of the concern.

Given the more collaborative approach that current family therapy models propose, earlier models using more negative descriptions of families could easily be rejected. However, I think both Reder et al, (1991) and Hollis (1987) highlight some important themes that can be usefully explored with families. Similarly to Boston et al. (2011), they suggest that parents may not be able to adequately respond to the risk involved. Hollis describes some of the problems encountered by therapists; for example becoming overly responsible and holding all of the concern.

Asen (1998) describes a systemic approach to risk assessment. He frames the suicidal act as a strategy to maintain family relationships at a time of change and escalating conflict. Again, as Reder et al. (1991) suggests, he sees the suicidal adolescent as simultaneously being in a helpless and powerful position. Asen (1998) addresses some of the difficulties encountered in the context of making an assessment in a hospital setting and emphasizes some of the unhelpful attitudes that may be present. He also discusses the importance of understanding how suicide is understood in different religions.

Additionally, he outlines the central issues that need to be addressed in the first session with the family, stating that one of the major tasks is a decision about whether or not it is safe for the young person to be cared for by the family. This will involve the clinician working with the family to enable them to take

responsibility for managing their adolescent, assessing to what extent the adolescent is being listened to and encouraging the adolescent to 'talk with words' rather than through the suicidal action (Asen, 1998).

Asen proposes the use of interventive questioning (Tomm 1987, 1988) to create self-questioning and self-reflection for the adolescent and family members. He suggests that the work goes through a number of different phases, starting with the initial crisis and then when safety is no longer a concern, addressing other issues in the family. He suggests the importance of combining an individual and family approach.

Jurich (2008) has written the first family therapy handbook devoted entirely to the family therapy of self-harming suicidal adolescents. He writes from a strategic family therapy model², but incorporates cognitive behavioural techniques and teaches coping skills. Jurich opens with a focus on the impact on the therapist when faced with a suicidal young person. He discusses the normal feelings aroused in therapists including anxiety, the feeling of needing to shoulder a higher sense of responsibility for change, and a feeling of helplessness and isolation. He also usefully addresses crisis intervention and how a therapist working with self-harming adolescents needs to be prepared for a situation in which the adolescent becomes actively suicidal during the course of therapy.

(Jurich, 2008, p.87) discusses the movement between being in 'intervention modality' and 'therapeutic modality' and when to shift from one to the other. He suggests that planning a suicidal crisis intervention in advance helps the therapist from over-reacting to the suicidal crisis. He also addresses issues of engagement and highlights the need to focus on blame, and create a therapeutic environment in which it is possible to talk about fear, shame, guilt and blame while also addressing issues of responsibility with the aim of re-establishing safe, secure and trusting family relationships.

² The Strategic model of family therapy was founded by Haley (1973, 1976), Watzlawick (1974) and Fisch and Weakland (1982) and was very influenced by the work of Milton Erickson (1973). The strategic approach frames the client's symptoms as the attempted solution to a problem. They see the problem or symptom as embedded in repetitive interactional sequences, which maintain it. Strategic therapists intervene to change the interactional patterns maintaining the problem through interventions which involve giving family members tasks to carry out as homework. These tasks can be either directive or paradoxical.

His approach incorporates an exploration of the family interactions that may be helping to maintain the suicidal behaviour and an emphasis on validating family members' perspectives and emotional experiences. He discusses how the experience can be overwhelming for families and how the use of behavioural interventions, for example developing a safety plan, can help to make change more manageable. Finally he addresses situations of therapeutic impasse and suggests ways of intervening. Similarly to Hollis (1987) and Reder (1991), the language of strategic therapy may feel a bit alien to therapists coming from more current theoretical positions. However, Jurich addresses some very key aspects of working with self-harming adolescents and their families, offers practical advice, suggests ways of intervening, and addresses some of the common responses that parents make to the attempted suicide of their adolescent.

From about 2005 there had been a move away from practicing solely from within an individual model of family therapy to one of integration either across different conceptual models of family therapy or integrating family therapy with theoretical models from different disciplines. The overall trend in family therapy in relation to the treatment of self-harm seems to be that of moving to a position of incorporating perspectives from outside of systemic practice and theory; chiefly attachment theory, psycho-educational models, mentalization-based therapy and affect-regulation. This is perhaps partly due to the current stage in the development of family therapy in which family therapists are increasingly open to incorporating alternative models. Larner (2003, p.211) describes this move as being an 'ethic of hospitality' towards other therapy discourses. The move towards incorporating other perspectives may also be in response to the complex presentation of self-harm and the dilemmas and challenges faced by family therapists in trying to both ensure safety and achieve change.

Both Larner (2009) and Pocock (2009) represent this preference for incorporating alternative models in their accounts of working with self-harming adolescents. Larner (2003, 2009) describes working with an adolescent boy at risk of self-harm who is severely depressed and suicidal. He draws on the evidence-base for working with depression and incorporates both systemic and individual therapy using cognitive and narrative approaches. In his introduction,

Larner (2009) discusses how difficult it is for therapeutic teams not to get caught up in a sense of panic when there is serious suicidal risk. He highlights the potential for therapists to experience burn-out, and for team morale and effectiveness to be impacted upon. He suggests that teams can mirror family processes and experience feelings of incompetence, powerlessness and hopelessness. He also suggests that family therapists 'can play an important role in helping teams to contain anxiety, responsibility and blame and establish a healthy balance between hope and hopelessness' (Larner, 2009, p.214).

His preferred way of working is 'integrative', with individual therapy using cognitive approaches, narrative therapy and art therapy, alongside systemic conversation with the family and, in addition, a psycho-educational focus. Larner (2009, p.214) describes the individual therapy as a context 'in which a young person's thoughts and feelings can be explored, held, reconfigured and taken back to the family'. He uses narrative therapy to help expose the impact of suicidal thinking, describing suicidal thinking as 'like a virus that traps you, keeping it secret which increases its power' (Larner, 2009, p.226). He encourages the young person to confide in others and supports him in doing this in the context of a systemic family session. Larner works to create a safety net in relation to the young person's suicidal risk, he addresses attachment issues, he focuses on issues of autonomy and he also liaises with the young person's school to help reduce academic anxieties.

Pocock (2011, p.63) suggests that self-harm can be systemically understood 'as an attempt to regulate and preserve important relationships'. He draws on several theoretical models as a framework for understanding self-harm. These include, Attachment Theory (Crittenden 2008), Mentalization (Fonagy et al., 2004), Inter-Subjectivity Theory (Benjamin, 1999) and Emotional Regulation (Beebe and Lachmann, 2002). Pocock suggests self-harm may be a way of avoiding being in touch with unbearable feelings of sadness, shame, guilt, envy and despair. He identifies two contrasting types of self-harm that are seen in Child and Adolescent Mental Health Services (CAMHS). One he calls 'communicative/other regulatory' and the other 'secretive/self-regulatory'. He sees the communicative/other regulatory type as being 'an emotionally driven move to attempt to feel better and safer' (Pocock, 2011, p.64).

Self-harm can be seen as an ambivalent attachment strategy aimed at organizing parental concern, control and safety. Secretive/self-regulatory self-harm describes the type of self-harm that involves repetitive cutting of different parts of the body. Self-harm in this form achieves safety and control not through expressing distress aimed at regulating the behaviour of others, but through not expressing distress and anger as a way of taking over the responsibility for the well-being of others. These young people often present as very compliant and un-assertive.

Pocock outlines two therapeutic interventions 'bridging' and 'guessing'. The therapist 'bridges' the two parts of the young person presented individually and in the family session. The second strategy he discusses is 'guessing'. He suggests the first meeting should be with the young person and the parent with whom they feel safest, and he spends time with the young person on their own. Later in the course of therapy he includes other family members. He stresses the importance of creating a sense of safety in the first meeting so that the young person can begin to risk communicating through words. He focuses on emotional expression in the family and frames the self-harm as protective of relationships.

When working individually with the adolescent Pocock draws on a mentalizing approach (Fearon et al., 2006) with the aim of enhancing the young person's capacity to think about their own emotional states and those of others. The therapist may need to use their own emotional reactions in the session to address emotions that may be unarticulated by the young person. When working with adolescents who present with the 'communicative/other' regulatory pattern, he suggests that the therapist focuses on calming heightened emotions through careful listening; ensuring that the young person has been heard. This is a way of addressing situations in which parents say they have no ideas as to why their daughter or son has self-harmed. The therapist first meets with the young person and explores their reasons for self-harming, the therapist then negotiates with the young person if they would be willing to open up some of the issues in conversation with their parent/parents. If, for example, in the individual session the adolescent has revealed feeling very angry with their

parent, the therapist, in the joint session invites the parent to guess at some of the reasons why their child might be angry with them.

Pocock prefaces this account by saying that he felt that the mother in this situation was fairly robust and would be able to cope with being confronted with her daughter's anger. He concludes the article by stating that self-harm is a relatively unexplored territory for family therapists and that his ideas should be treated as emergent.

To summarise, the systemic clinical literature described above suggests a number of focuses when working with adolescents who self-harm, incorporating both modern and post-modern perspectives. The accounts described included both systemic assessments for self-harm as well as describing the elements that need to be addressed in the on-going therapeutic work. The solution-focused accounts emphasize engaging family members in communication about issues of safety, concern and risk and in the making of a safety plan. Attention to context was also an important focus. Systemic therapists, when conducting assessments in accident and emergency departments, need to be aware of context and the possible negative attitudes held by professionals. The work context of the therapist was highlighted as needing attention so that there could be both safety for the young person and safety for the therapist with support systems in a place for clinicians, so that they can better engage in this work.

Most of the clinicians addressed the effect of a rise in risk levels in the course of the therapeutic work and how clinicians needed to be prepared for this and be able to move between the domains of 'production' and 'aesthetics'. This requires the therapist to be more directive at times of heightened risk and also perhaps in the early stages of therapy.

Central themes in the accounts were about protection versus autonomy, parents being unable to respond adequately to the level of risk versus therapists' becoming overly responsible and holding all of the concern. There was focus on engagement and the importance of addressing themes related to feelings of shame, guilt and blame. The centrality of emotions was highlighted in some of the accounts, the importance of enabling family members to express

emotions, manage overwhelming emotions and to help young people think about their own emotional states and those of others. There was a strong emphasis on family therapists structuring the work to include both individual sessions with the young person alongside systemic family sessions, the individual work being framed as a bridge to help the young person communicate with family members.

Finally, there were some references to the impact on the therapist and the set of emotions that a therapist will experience as part of the work, mirroring perhaps the emotional experiences of family members. Several of the clinical accounts propose drawing on different models of family therapy as well as incorporating models from other traditions.

This research study aims to describe and illuminate family therapists' experience of working with adolescents who self-harm, understand the concerns and dilemmas faced by family therapists, how they manage these concerns and their ideas about how change is best facilitated. The above clinical literature gives a very good 'insight' into some of these issues, and will help to frame areas of enquiry and discussion with the participants in this Study.

2.6 Research On Family Therapy For Self-Harm

In recent years the field of family and systemic therapy has begun to gather an evidence base and the emerging evidence is suggesting that family therapy is effective across a range of presentations (Asen, 2002; Cottrell and Boston, 2002; Shadish and Baldwin, 2003; Eisler and Lask, 2007; Stratton, 2011; Sprenkle, 2002, 2012).

Cottrell and Boston (2002) found that there is strong evidence that family interventions are effective for conduct disorders, substance misuse, and eating disorders. Similarly, Asen (2002) found strong evidence for conduct problems in children and eating problems in adolescence. Carr (2000a, 2000b 2009, 2014) summarised the evidence base for systemic practice for both child and adult focused problems. He included both family therapy and family-based approaches in his review. He found that the evidence supports the

effectiveness of family therapy either as the sole intervention or as part of a wider set of treatments for child abuse and neglect, conduct disorders, somatic problems, eating disorders and emotional difficulties. Emotional difficulties include anxiety, depression, grief, bi-polar disorder and suicidality.

Carr (2009) named six studies that had proved effective in the treatment of attempted suicide through the use of family interventions (Harrington et al., 1998; Rotheram-Borus et al., 2000; Rathus and Miller, 2002; Huey et al., 2004; Katz et al., 2004; King, et al., 2006;). These approaches include engaging the young person and their family in an initial risk assessment process, and developing a plan to reduce risk, which includes individual therapy for the adolescent, family therapy and social support networks (Carr, 2009). In a recent review, Carr (2014) included Attachment-Based Family Therapy (ABFT) (Diamond, 2013).

Carr cites Multisystemic Therapy (MST) (Huey et al., 2004), Dialectical Behaviour Therapy (DBT) (Miller, 2007; Rathus and Miller, 2002; Katz et al., 2004), and Youth-Nominated Support Team (King et al., 2000, 2006) and Attachment-Based Family Therapy (Diamond, 2013) as having the elements described in the previous paragraph. He concludes that treatment for attempted suicide should involve 'prompt, intensive, initial individual and family assessment followed by systemic intervention including both individual and family sessions to reduce individual and family based risk factors and should include the option of brief hospitalisation or residential placement where families do not have the resources to reduce the risk on an outpatient basis' (Carr, 2009, p.24). These studies will be described more fully in the following paragraph.

Brent et al. (2013) reviewed randomized clinical trials for self-harm. He concluded that treatment elements relating to positive outcomes include family involvement or mobilisation of non-family sources of support, a sufficient 'dose' of treatment, attention to motivation to change and commitment to treatment, a focus on strengthening of protective factors such as parental support and on the quality of parent-child relationships, promotion of positive affect and attention to alcohol abuse and sleep difficulties. The studies reviewed also suggest that

adolescents who have been hospitalized should get intensive treatment post-discharge as the risk of recurrence is highest post-discharge.

Huey et al. (2004) report on a Study using multi-systemic family therapy to reduce attempted suicide and provide an alternative to hospitalisation. The Study took place in the U.S. with 156, mostly male African American youths, who had been identified as needing emergency hospitalisation because of suicidal ideation, planning or attempted suicide. The Study aimed to improve the young person's affective state, in relation to depressive affect and hopelessness, and improve parental functioning, as in parental control. Additionally it strove to provide a more effective intervention than hospitalisation in decreasing attempted suicide and suicidal ideation. Self-report measures were used, including the Family, Friends and Self Scale (FFFS), Child Behaviour Check List (CBCL).

The MST treatment principles were adapted for use with this client group and included four core strategies to minimize the risk of self-harm – development of a safety plan with the family, containment and monitoring of the young person by their caregivers/parents, disengagement from deviant peers who may precipitate a suicidal episode and helping responsible adults within the young person's 'natural ecology' provide monitoring and structure to diminish suicide risk (Huey et al., 2004). Treatment took place in the home environment and was delivered by therapists trained in the model, using evidence-based interventions, for example contingency contracting, communication training and behavioural parent training. The intervention is intensive but brief and the therapists carry a small caseload of four to six families.

The results of the Study showed that MST was significantly more effective than psychiatric hospitalisation at reducing attempted suicide at one-year follow-up. However, MST appeared to have no long-term effects on suicidal ideation, depressive affect or parental control. The authors acknowledge the difficulty of generalization to other populations as the sample was composed of African-American youths from low-income households.

King et al. (2006) conducted a randomized control trial comparing Treatment As Usual (TAU) with Youth-Nominated Support Team (YST 1). This social network

intervention was designed to enhance routine care for suicidal adolescents in the 12 to 17 age-range, following psychiatric hospitalisation. The support persons nominated by the adolescent could either come from within or outside the family. The support persons participated in psycho-educational sessions designed to help them understand the adolescent's psychiatric disorder and treatment plan, suicide risk factors and strategies for communicating with the adolescent. The results showed no overall intervention effects for reducing suicidality. However, the female adolescents in the Study reported a modest effect in reduction of suicidality, and they perceived higher levels of emotional support and encouragement from their support persons. Those who showed greater reduction in suicidal ideation had more support people involved for a longer period of time, and their support persons had more contact with the staff of the project.

Rathus and Miller (2002) conducted a Study using a quasi-experimental investigation of an adapted form of DBT for a group of adolescents with a history of self-harm and with symptoms of Borderline Personality Disorder. The intervention involved 12 weeks of twice-weekly Individual DBT, and a Multi-Family Skills Training Group. The Treatment As Usual group (TAU) received 12 weeks of twice-weekly individual therapy (supportive psychodynamic) and weekly family therapy.

The results showed that the DBT group had fewer hospital admissions during treatment and a higher rate of treatment completion than the TAU group. There was no difference between the two groups in terms of number of suicide attempts made during treatment. There was a significant reduction in suicidal ideation, general psychiatric symptoms and symptoms of Borderline Personality Disorder. The authors concluded that DBT was a promising treatment for suicidal adolescents with borderline personality characteristics.

In a further Study Katz et al. (2004) conducted a pilot Study evaluating the feasibility of DBT for inpatient adolescents with a history of attempted suicide and suicidal ideation, compared to TAU. This was a two-week intensive programme adapted from the 12-week DBT model for outpatients (Miller et al.,

2007). The results of this Study showed significantly reduced behavioural incidents on the unit compared to TAU.

Rotherham-Borus et al. (2000) conducted a quasi-experimental Study in the U.S. to research the impact of a specialized emergency room (ER) care intervention following a suicide attempt by female adolescents. The participants were 140 Hispanic female adolescents (12 to 18 years) and their mothers, with a history of self-harm. The intervention consisted of specialized ER care aimed at enhancing adherence to outpatient therapy by providing a 'soap opera' video regarding suicidality, a family therapy session, and staff training, as compared to standard ER care. The video presentation addressed the dangers of ignoring suicide attempts and the potential benefits of treatment. The family therapy session focused on eliciting expressions of caring between the adolescent and their parent, identifying personal strengths and planning strategies for processing of future suicidal feelings.

The adjustment of the young person and their mothers was evaluated over an 18-month follow-up period. The adolescent's adjustment improved over time on most mental health indices. Rates of suicide re-attempts and suicidal re-ideation were lower than anticipated and were similar across both the specialized ER programme and the standard ER care. The results indicated that the parents of adolescents who were highly symptomatic demonstrated greater reduction in emotional distress over time. Adolescents' attendance at therapy sessions following the ER visit was significantly associated with family adaptability. The researchers concluded that specialized ER interventions may have substantial and sustained impact over time, particularly for the parents of adolescents with high psychiatric symptomatology.

ABFT was developed by Diamond (2005) for working with adolescents who are depressed and anxious and has been adapted for working with self-harming adolescents (Diamond, 2010). It is designed to target family processes associated with depression and suicide. Diamond draws on Attachment Theory (Bowlby, 1969), Structural Family Therapy (Minuchin, 1974, 1981) and Multidimensional Family Therapy (MDFT), (Liddle, 1999; Liddle et al., 2001).

ABFT aims to 'improve the family's capacity for problem solving, affect regulation and organization. This strengthens family cohesion which acts to buffer against suicidal thinking, depression and risk behaviours' (Diamond et al., 2010). From an attachment perspective, the model focuses on building security-promoting parenting. There is also an emphasis on the use of enactment and on re-establishing the parental hierarchy.

In Diamond's model adolescent self-harm is seen as a failure of attachment, based in family conflict and difficulties in negotiating autonomy. Diamond et al. (2010) tested the efficacy of ABFT for reducing suicidal ideation in adolescents. Compared to usual care in the community, ABFT demonstrated greater and more rapid reduction of suicidal ideation and was associated with greater rates of clinical recovery and greater treatment adherence. However, there was relatively short follow-up of six months. In a later Study (Shpigel et al., 2012), addressed specific change mechanisms underlying the treatment. Results from this Study suggest that ABFT is associated with increases in parental autonomy-granting behaviour and reducing psychological control.

Two studies conducted in the U.K., Harrington et al. (1998), and Harrington et al. (2000), found that suicidal ideation reduced in adolescents who received home-based family therapy, and in addition their parents were more satisfied with treatment. This Study aimed to establish whether brief family intervention (one assessment session and four home visits), conducted by child psychiatric social workers would reduce suicidal feelings and improve family functioning. One hundred and sixty two families of adolescents who had self-poisoned were included in the Study. The Study used the suicidal ideations questionnaire, a hopelessness questionnaire, and the family assessment device as outcome measures.

The results, while showing a reduction in suicidal ideation, did not impact on measures of family functioning. In addition the Study found that for those adolescents who were diagnosed with depression the intervention was not more effective than routine care. The authors concluded that a brief intervention is only likely to be effective with adolescents who have a less severe form of suicidal behaviour. Adolescents whose presentation is more severe, meaning

having more suicidal thinking and hopelessness, did not benefit from the intervention. They hypothesized that those who were depressed would come from families with more problems than the non-depressed group, but they found that this was not the case.

The intervention focused on getting parents to acknowledge and accept the reality of the suicidal episode through an exploration of the key people involved in the adolescent's life and their connection to the suicidal episode. This was done with the aim of ensuring that the adolescent felt listened to and understood, and that the seriousness of the attempt was accepted. The intervention also targeted communication, with the aim of encouraging family members to experience open and flexible approach and to increase their understanding of how stress and isolation can lead to self-harm in the adolescent. Problem-solving was also addressed with the aim of helping family members become more sensitive to each other's emotional well-being. Finally, the family was given a model for understanding adolescent development.

The finding that parents were more satisfied with treatment than those allocated to routine care does not receive any attention in the article. From the perspective of this Study, the authors do not give any indication as to the framework that the therapists were using; we only know that they had some training in family therapy and behavioural techniques. Likewise there is no information regarding the work context of the therapists, and no information regarding the experiences of those conducting the intervention.

Rossouw and Fonagy (2012) conducted a small pilot randomized trial comparing (Mentalization-Based Therapy Adapted (MBT-A) with Treatment As Usual (TAU) for adolescents whose self-harm included suicidality. Eight young people in the 12 to 17 age-group, who had at least one previous episode of self-harm and for whom self-harm was the primary reason for referral, were recruited in north-east London. The participants received weekly individual therapy and monthly mentalization-based family therapy with a focus on impulsivity and affect regulation for a period of one year.

The results of the Study showed MBT-A as being significantly more effective than TAU in terms of reducing self-harm and depression. TAU consisted of

individual therapy or supportive generic interventions or cognitive behaviour therapy or a combination of individual and family therapy. The improvement in self-harming behaviour was explained by improved mentalization and reduced attachment avoidance, although these represent the author's hypotheses, as the Study did not set out to identify the change-producing elements of the treatment.

In the U.K. currently there is a randomized control Study being conducted for family therapy of adolescents with a history of self-harm. However, this Study is still in progress and no reports have been published to date.

In summary the evidence base for family therapy of self-harm suggests that there is a small, but growing body of evidence for its effectiveness relative to various types of routine care. The evidence so far points towards models that incorporate family intervention as a component of a broader treatment. As has already been stated, the evidence points to the need for a prompt response, intensive input particularly at the beginning phase of therapy, attention to interventions that target engagement and adherence to treatment, and the provision of both individual and family therapy.

The evidence also suggests that therapists need to work with family members to create a safety plan and to focus on helping parents and carers to contain and monitor their young person. Attention to communication and parental support and the provision of psycho-education for parents is indicated. In one Study (King et al., 2006) parents of girls whose self-harming behaviour was reduced, remained longer in the programme and had more interaction with the staff of the programme: this may indicate that the parents felt supported and may in turn have been able to be more supportive of their adolescent.

The evidence also points to the usefulness of conceptualizing self-harm within an attachment framework, addressing attachment ruptures, increasing autonomy-granting behaviour by parents and reducing parental control. There is also some evidence as to the benefit of utilizing a mentalization-based approach. However, apart from two studies most have been conducted in the U.S. and therefore the findings may not be straightforwardly applicable in a U.K. context.

As a family therapist it is reassuring to know that there is evidence to support systemic interventions for self-harm and to have indicators as to what elements seemed to be significant in reducing self-harm. However, knowing that family intervention and family therapy work, is not sufficient for a clinician. We also benefit from studies that show what the change elements are, in positive outcomes. So far this has not been the focus of the research into family therapy for self-harm.

In relation to this current study, outcome studies do not provide accounts of the challenges and dilemmas faced by family therapists when involved in working with self-harm, neither are they designed to address how therapists manage their emotional responses during the process of therapy.

(i) Qualitative Research on Family Therapy for Self-harm

Qualitative Research in family therapy is a developing field. In 2002, Faulkner, Klock and Gale conducted a content analysis of four of the main journals of family therapy from 1980 to 1999. They found that the majority of research was focused on three areas – therapy process, divorce and family relationships.

Carr (2004, 2006, 2008, 2010, 2012) conducted thematic reviews of the content of family therapy articles published in the principal family therapy journals. In his reviews, Carr describes qualitative research that focuses on client creativity (Morgan and Wampler, 2003); engagement in therapy (Masi et al, 2003); family and therapists' perspectives on helpful events, (Lemmens et al, 2003); client views of therapy (Chenail et al, 2012); couples therapy (Knudson et al, 2005; Davis and Piercy, 2007); blaming events in therapy (Bowen et al, 2005), physical health (Davey et al, 2005); parental alienation (Ellis, 2005); the inner conversation of the therapist (Rober, 2008); home-based family therapy (Thompson et al., 2007), and the therapist as a common factor (Sexton, 2007).

As can be seen from the above list, despite there being a broad range of areas focussed on by qualitative researchers, no qualitative studies on family therapy for self-harm have been reported.

A comprehensive search of PsychInfo, Medline and PubMed, and an on-line search of the major family therapy journals was conducted, and it revealed no qualitative studies relating to family therapy for self-harm.

One qualitative Study conducted for family therapy of childhood depression is included here, as depression is the most prevalent mental health disorder associated with self-harm and suicide (Brent et al, 1999; Houston et al, 2001; Shaffer et al, 1996; Evans et al, 2004; Hawton et al, 1999). This Study conducted by Campbell et al. (2003) used thematic analysis in a process Study exploring significant moments in family therapy for childhood depression. The researchers identified eight significant themes from 59 'significant moments'. The themes were; addressing safety and risk, keeping hope alive, staying connected in the therapy relationship, reframing depression in relational terms, actively involving fathers, reclaiming parenting, hearing the child's voice, re-editing fixed narratives and building networks. The Study provides a very rich account of the therapy and highlights significant themes that may be relevant for therapists to pursue. In addition, the authors provide some useful tips for therapists working with childhood depression.

2.7 Therapists' Emotional Experience Of Working With Self-Harm

(i) Quantitative and Qualitative Research

Clinicians' emotional responses to patients who self-harm have received little attention in the literature. An electronic review of the literature on systemic and family therapists' emotional experiences of working with self-harming adolescents produced no results.

Broadening the search to psychotherapists and mental health nurses resulted in some studies which are described below, although these tend to be more adult focussed.

One Study conducted by Yaseen et al. (2013), found that clinicians treating adult suicidal patients had less positive feelings towards these patients than for

non-suicidal patients. The clinicians had higher hopes for the outcome of treatment while feeling more overwhelmed, distressed and avoidant of the patients.

Thompson et al. (2008) conducted a qualitative Study using Interpretive Phenomenological Analysis (IPA) to enquire into community psychiatric nurses' experiences of working with adults who self-harm. The results of the Study suggest that the participants found the work stressful. The stress was in response to managing the emotional impact of the work and in managing the boundaries of their professional responsibilities in relation to managing risk. Several themes emerged from the interviews. These included the difficulty in making sense of self-harm, the need to monitor risk and be aware of the possibility of a fatal action. All of the participants identified themselves as feeling anxious. The nurses reported feeling over-responsible and at the same time they wanted to give responsibility back to the client, and further they worried about being blamed.

In addition to anxiety and concern about being blamed, the participants also reported feelings of frustration, hopelessness and anger. They reported that good supervision, support from colleagues and team atmosphere that was non-judgemental and safe as being vital. At the same time they reported a worry about burdening colleagues and therefore sometimes did not seek support as often as they needed to. Experience, which led to greater confidence made the work seem more predictable and therefore less anxiety-provoking. However, some participants believed that feeling less anxious was connected to feeling 'burnt-out'.

Another Study exploring nurses' experiences of caring for adult patients who self-harm was conducted in Norway by Wilstrand et al. (2007). This involved a qualitative content analysis Study. A significant finding was that the nurses reported feelings of fear, frustration, and abandonment, which created a sense of burden and difficulty in caring for their patients. The nurses also reported feelings of uncertainty and powerlessness. They felt they needed to be constantly aware of risk as self-harm could be fatal. They reported feelings of frustration and anger towards patients, and at times, a loss of control of their

emotions. They also reported feeling a lack of support from peers and managers, feeling isolated, experiencing a lack of involvement, needing confirmation from co-workers, and regular supervision.

Another Study reported on psychotherapists' experiences of working with suicidal adult patients. Richards (2000) surveyed 100 psychotherapists and interviewed a small number of respondents. Some participants had experienced the suicide of a patient and some had experience of patients attempting suicide while in therapy. Both groups reported similar emotional reactions.

A content analysis of the data from the interviews identified several themes. One theme, concerning the effect on the therapist, showed that psychotherapists experienced intense feelings when working with suicidal patients. The feelings most commonly cited were feelings of hopelessness and helplessness, a sense of failure, feeling upset, distressed and sad. They experienced anxiety following an attempt and increasing concerns about the patient's self-destructiveness. Several participants reported feeling angry, both with the patient and also with psychiatric colleagues, and some reported feelings of self-doubt and lack of confidence.

The therapists identified the need for good supervision and support, institutional back-up, and cooperation with other relevant professionals as essential when engaging in this kind of work.

The above studies, while all reporting on work with adults, are nonetheless interesting in that several of the studies report on nurses working with self-harming patients experiencing difficult emotions; the kind of emotional responses named by family therapists in the clinical literature section of this Literature Review. In addition, the survey and interviews of psychotherapists report similar experiences. Furthermore, these studies point to aspects of the work environment that nurses and psychotherapists find supportive: these include relationships with other team members and with psychiatric colleagues, institutional back-up and supervision.

One of the aims of this Study is to explore the feelings and emotional reactions of family therapists and how these affect the therapeutic work. The above studies seem to suggest a set of emotional experiences that may be common and usual reactions when working with clients who self-harm and these will be taken account of when interviewing the participants in this Study.

My interest in this area is not so much about identifying particular emotional responses, but more about how the therapists understand these emotional responses and how they act as a resource to the therapist in the therapeutic work.

3. RATIONALE FOR THE STUDY

Self-harming adolescents represent a serious public health concern and require considerable levels of input from mental health services. Further, self-harm is the most important risk factor for completed suicides (Owens, 2002) and for future self-harm (Kapur et al., 2005).

As has been previously described there is a large body of research detailing the risk factors for self-harm in adolescents, incorporating individual factors, peer influences, family history, mental illness, family structure and family environment. Research that is largely focused on prevention of self-harm, identifying groups who are most at risk and identifying risk factors is not sufficient for therapists whose task it is to treat this vulnerable group of young people who self-harm. A major concern for therapists is about how to work effectively with these adolescents and their families.

There is a limited but growing body of evidence-based research on the effectiveness of family therapy for self-harm (Hawton and Rodham, 2006). Given the emphasis on ascertaining risk factors and the resulting picture of family structure and relationships as having a major impact, the small number of studies researching family therapy for self-harm, both quantitative and qualitative, is surprising (Fox and Hawton, 2004). In addition, the range of published clinical literature on systemic approaches to working with this client group is also limited. Pocock (2011, p.66) suggests that self-harm 'is a relatively unexplored territory for family therapists'. It would seem therefore that in the published arena, there is limited available knowledge about how to work systemically with young people who self-harm, and yet these adolescents populate the caseloads of most CAMHS settings and also are strongly represented in the caseloads of family therapists working in psychiatric hospitals for adolescents.

Larner (2004) suggests that research needs to be grounded in 'real life' clinical practice. By interviewing therapists and exploring their clinical experience, the author hopes to add to the knowledge-base of how to work with this client group

by researching a small group of family therapists' experiences of working systemically with adolescents who self-harm. The aim is that of providing a rich and detailed description and understanding of their experience: that is, the issues and dilemmas encountered in the course of working with families and young people presenting with self-harm; how the therapists understand and respond to these issues; their perspectives on what enables and constrains the work; and how they are affected emotionally. The overall purpose is to generate information useful to other family therapists involved in working with self-harm.

4. CHAPTER TWO: THE METHOD

Introduction

This chapter describes the methodological assumptions that influenced the study and sets out the reasons for choosing a qualitative methodology. It also describes the qualitative method used for data analysis and the relevance of the method chosen. It gives an account of the overall design of the study, the steps taken during the process of the research including the selection of participants, data collection and ethical issues.

4.1 A Qualitative Study

The aim of this research study is to describe, understand and illuminate a small group of systemic therapists' experience of working with self-harming adolescents. The experience referred to includes the therapeutic issues encountered, the stances adopted by the participants in the face of these issues, their preferred ways of working with this client group and the emotional impact of the work on the person of the therapist.

As previously discussed the definition of self-harm used in this study is taken from the NICE guidelines. The NICE guidelines defined self-harm as 'intentional self-poisoning or injury, irrespective of the apparent purpose of the act' (NICE Clinical Guidelines, 16, 2004).

A qualitative rather than a quantitative study is appropriate for this study as qualitative studies are best suited for addressing how people make sense of their experience. Qualitative research methods are concerned with interpreting texts rather than with measurement and the causal relationship between variables (Denzin and Lincoln, 2000). Qualitative methodologies have their origins in non-positivistic approaches to understanding human behaviour; they are generally concerned with exploring, understanding, and describing experiences of participants and the specific meanings attributed to those experiences (Turpin et al., 1997; Ashworth, 2003). Qualitative approaches fit

well with the orientation of systemic therapists who are concerned with meaning, context and processes (Burck, 2005).

Willig (2001) describes qualitative research as being concerned about meaning in context. She argues that since qualitative research requires the researcher to actively engage with the data, this therefore assumes a subjective element, meaning the perspective and view of the researcher is involved.

All research is about trying to add to body of knowledge, but that knowledge has to be situated within the context of a chosen perspective on how that knowledge is generated, in other words within our chosen world view about reality. Madill (2000) classifies world views about reality on a continuum from naïve realism to radical relativism. Cresswell (2007) discussing the changes in the landscape of qualitative research, points to how the self-reflective nature of how research is conducted has become more dominant, and that those who have embraced the interpretive 'turn' include grounded theorists such as Charmaz. The knowledge generated during the course of this study cannot be taken as unbiased or objective. The whole study from the formulation of the research area of interest and research statement to the generation of the data in interaction with the participants and the analysis of the data will be influenced by the beliefs and experiences – both personal and professional – of the researcher. Therefore the 'knowledge' produced by the study will constitute one 'reading' of the data.

4.2 Grounded Theory – An Overview

Grounded theory methods are used to study both individual processes and interpersonal relations (Charmaz, 2003). In grounded theory research participants, meanings, intentions and actions are the focus of the inquiry. The method is inductive rather than deductive; building from the specific to the generic. It is not about hypothesis testing.

Through a process of creating conceptual categories from the accounts of participants' experiences the researcher generates an explanation or theory as to what the data indicates and in this sense the theory is grounded in the data.

The theory generated is described as being a 'middle range' theory that explains behaviour and processes (Charmaz, 2003).

When conducting grounded theory, the analysis begins with open coding of the data. This is similar to identifying themes. The data is fractured through the open coding process into concepts and categories, and sub-categories. Categories are made up of groups of events or processes that share similarities with each other (Willig, 2001). The data is then put back together again in new ways by making connections between a category and its sub-categories.

The main categories are integrated to form the theoretical framework out of which a central story-line is generated. This is a narrative about the central phenomena of the study which is the core category (Pandit, 1996). Strauss and Corbin (1998) describe the story-line or core category as the sun 'standing in orderly systematic relationships to its planets'.

Grounded theory advocates theoretical sampling to develop the emerging theory. This involves collecting more data from new participants or returning to earlier participants about new aspects that may be emerging or to deepen an understanding of a category. Memo writing is used to help explain and elucidate categories and develop the emerging theory. Constant comparison is used throughout the coding process to find similarities and differences in the data. The researcher compares statements within an interview, across interviews and also compares specific data with the criteria for, or definition of, a category.

The original grounded theory model (Glaser and Strauss, 1967) was essentially realist in its epistemological orientation and according to Reicher (2000) takes the position that language is a reflection of internal categories of understanding and therefore can tell us what people really feel and think. This makes sense, given the context in which grounded theory evolved. It was a method that was developed to show that qualitative methods could produce outcomes that were as significant as outcomes produced by quantitative methods which was the predominant research method of the time. Glaser and Strauss (1967) wanted to produce a method that was equivalent to the quantitative tradition of the times. The theory of knowledge underpinning was positivist. Reality therefore

was 'knowable' and could be discovered. However, Bryant and Charmaz (2006) contend that while the positivist underpinnings predominated, there were other perspectives present in the work which were not incorporated into the model and which eventually allowed for a repositioning of grounded theory in line with the theoretical and methodological developments of the 21st Century (Charmaz, 2006). As grounded theory gained acceptance a divergence in views between the originators led to the emergence of two different strands, one led by Glaser (Glaser, 1992) the other by Strauss in collaboration with Corbin (Strauss and Corbin, 1990). The difference between these two strands of grounded theory lies in the debate about inductive versus deductive analysis.

In more recent times the model has been re-positioned to take account of epistemological developments, moving it away from its positivist assumptions towards a model that can sit also within post-modern perspectives. (Bryant, 2002; 2003; Clark 2003, 2005; Charmaz, 2006). Charmaz states that researchers can use basic grounded theory guidelines; coding, memo-writing, and constant comparison as a path through the research process. How the researcher uses these 'tools' is influenced by their assumptions and therefore can be used in line with current epistemological perspectives. Charmaz's constructivist grounded theory approach does not discover theory but sees it as constructed through the perspectives and experiences of the researcher.

(i) Why a constructivist grounded theory was chosen?

Several factors were involved in the choice of both grounded theory and specifically constructivist grounded theory. At the time when the study was initiated, little had been written from a systemic perspective about working with self-harming adolescents. Grounded theory with its focus on inductive rather than deductive enquiry is considered an appropriate method in areas that are under-theorized (Strauss and Corbin, 1998). Grounded theory combines both rigour and flexibility. The researcher is required to stay close to the material generated in the research interviews and, in so far as it is possible, to resist imposing theoretical concepts onto the data generated. This guides the researcher to pay close attention to the concerns of the participants and to allow

their concerns to shape the direction of the research and through this hopefully protect the research endeavour from being solely organized by the interests of the researcher. It also allows the researcher to follow new leads and pursue further lines of enquiry based on what is emerging. Bryant and Charmaz (2007) state that a key strength of grounded theory method is that it renders the process transparent, visible and comprehensible. It is a method that can be used by researchers of different theoretical and epistemological backgrounds, including constructivist and social constructionist perspectives (Chamaz, 2003).

Chamaz's model of grounded theory (2003, 2006) seemed to make the best fit with the researcher's preferred position that interpretations of the data are understood as being shaped by the researcher's own experiences and background, and that the interpretation of the data in the study is itself a construction (Charmaz, 2006).

4.3 Ensuring Quality

The community of qualitative researchers have set out criteria for evaluating the value of qualitative research and its contribution to knowledge (Henwood and Pidgeon, 1992; Elliott, 1999; Cresswell, 2007; Tracy, 2011). This has been in response to the criticism that qualitative research is not scientific, and to the judging of qualitative research with frameworks used for evaluating quantitative research (Smith, 2003). While there seems to be some agreement as to the range of relevant criteria, there are differences within different qualitative methods. Madill (2000) and Reicher (2000) argue that the criteria need to be tailored to fit the particular method they are meant to evaluate. There is also a need to ensure that the criteria are congruent with the epistemological framework of the study (Willig, 2002). Hammersley (2007), while accepting the need for guidelines, believes that reaching a set of common guidelines is a difficult challenge for the field of qualitative research. However, there is general acceptance that there is a need for criteria. The debate in the field is about whether the criteria can be universal or needs to be 'open-ended and context sensitive' (Lather, 1993, p.674).

In this study, the author has drawn on the criteria for ensuring quality proposed by Elliott et al, (1999) and Tracy (2011). Elliott sets out six criteria that are appropriate for qualitative research. Smith (2003) states that Elliott's criteria are wide-ranging and can be applied irrespective of the particular theoretical orientation of the method. Tracy (2011, p.839) sets out eight criteria for judging qualitative quality. She proposes that high quality qualitative research is marked by, 'worthy topic, rich rigor, sincerity, credibility, resonance, significant contribution, ethics and meaningful coherence'. She conceptualizes these criteria as the means, practices and methods through which quality is achieved; quality being the end goal.

(i) Reflexivity

Elliott et al., (1999) recommends that researchers disclose their values and assumptions so as to allow the reader to interpret the analysis. From this standpoint the reader is also free to make his or her own interpretation of the data. This is founded on the view that reality is multi-versed. Elliot's criteria of reflexivity is similar to Tracy's (2011) criteria of sincerity. Sincerity is achieved through self-reflexivity, vulnerability, honesty and transparency. Self-reflexivity encourages qualitative researchers to be frank about their strengths and shortcomings.

Tracy (2011, p.842) raises the questions as to how much self-reflexivity is needed: her suggested solution is for the researcher to 'show rather than tell self-reflexivity by weaving one's reactions or reflexive considerations of self as instrument throughout the research report'. The role of the researcher will be documented in this study through the researcher giving an account of her experience, biases and assumptions that will have influenced the research process. The researcher will also introduce reflexive comments on her experience both in the account of the data-analysis and in the chapter on method.

(ii) Situating the sample

Participants in the research should be described in sufficient detail by the researcher to allow the reader to understand their context and therefore make sense of their contribution and further allow the reader to assess the relevance and applicability of the findings (Willig, 2001). In this study the researcher has described participants' details relevant to the research.

(iii) Grounding in examples

The reader needs to be able to assess the fit between the researcher's understanding of the data and the data itself. To allow for this the researcher in this study has used extensive examples from the transcripts when writing up the findings (Chapter 4). Examples from the transcripts have also been used to illustrate the process of the data analysis as described in Chapter 3.

(iv) Providing credibility checks

Elliot suggests that qualitative researchers should check the credibility of their accounts by involving others in the interpretation of the data. This could be the participants themselves or colleagues. Tracy (2011, p.843) believes that qualitative credibility is achieved through the practice of 'thick description, triangulation, multi-vocality and partiality'.

In this study the researcher consulted colleagues and her academic supervisor to discuss her analysis of the transcripts both in terms of the meaning ascribed to the data and also the categorisation of the units of meaning and journey to the identification of the core category. In involving others in the process of the analysis the author was allowing for different views and interpretations of the data, rather than confirmation.

Tracy (2011) considers 'thick description' to be one of the most important means of achieving credibility. In this study when discussing the findings the researcher will include quotes from the interviews of sufficient length that will

permit the reader to make a judgement as to the meaning of the participants' statements. Tracy suggests that researchers should provide enough detail so that readers can draw their own conclusions, rather than telling the reader what to think.

(v) Coherence

Qualitative researchers need to be able to describe the analysis as a coherent account that creates a connection between the different categories and the core category. Tracy (2011, p.848) adopts the term 'meaningful coherence' and states that meaningfully coherent studies 'achieve their stated purpose, accomplish what they espouse to be about and use methods that fit with their espoused theories and paradigms'.

In this research the author has presented the data both visually and in a narrative account in both the chapter on the Findings, Chapter 4, and in the Discussion, Chapter 5.

A clear purpose statement is also included so that the author's intentions regarding the research are clear to the reader.

(vi) Accomplishing both general versus specific research tasks

This is about the need to be clear as to the research task. Willig (2001) talks about research that is about developing a general understanding of an phenomena, or research in which the task is to provide insight into a specific case. In both situations the issue of transferability of findings needs to be addressed. Tracy (2011) suggests that transferability is achieved when readers feel that they can intuitively transfer the research to their own situation.

In this study the aim was to use the accounts of a small group of experienced family therapists to illuminate ways of working systemically with adolescents who self-harm, the intention being that therapists working in the same area might find useful ideas for their practice or find reassurance in hearing about the

struggles that others experience doing similar work. However, this is not the same as saying that the 'findings' are generalizable. It is hoped that the research will point to some further areas for exploration. Angen (2000) when discussing validation in qualitative methods suggests that our research should have 'generative promise', opening up new questions, and stimulating new dialogue.

(vii) Resonating with readers

When reading qualitative research the account should create a feeling of resonance in the reader; its meaning, significance and relevance should be clear. Tracy suggests that one way that resonance is achieved is through aesthetic merit, meaning the report should be written in an evocative and artistic way or at the very least presented clearly, avoiding jargon and it should be understandable to the target audience. In this study clinical and academic supervisors and colleagues were asked to provide feedback on the clarity and relevance of the study to them, as family therapists and researchers. Evocative writing is a skill not shared by all researchers; this researcher's intention is at the very least to write in a manner which can be clearly understood.

4.4 Ethics

Similar to resonance and self-reflexivity, there are different practices that achieve the goal of conducting ethical qualitative research. Tracy (2011) discusses four areas – procedural ethics, situational ethics, relational ethics and exiting ethics. Procedural ethics includes issues related to ensuring privacy and confidentiality, negotiating informed consent, ensuring participants understand that their participation is voluntary and they can withdraw consent at any stage. Procedural ethics also includes, the importance of being trustworthy and honest, avoiding fabrication and omission (Tracy, 2011). In this study the steps taken to ensure procedural ethics will be discussed later in this chapter in the section titled Design of the Study. Issues of fabrication and omission will be addressed by providing as much information for the reader as possible about

the steps taken throughout the process of data analysis so that the reader can see how the core category was developed from 'the ground up'. In addition, the semi-structured interview questions are available as an appendix (see Appendices 1 and 2).

Situational ethics involves the researcher in questioning the ethics of their decisions throughout the process. In the experience of the researcher, people who offer to participate in research want to be helpful and this places them in a vulnerable position and they may inadvertently say something they may later regret, for example, by sharing a personal experience. In this study the researcher was therefore mindful of the unpredictable nature of conversation and discussed this with participants at the beginning of the interview. Participants were invited to stop the recording at any stage in the interview if they did not wish to have something recorded or they could request that a particular section be deleted.

Relational ethics involves the researcher in being respectful, caring and collaborative with participants. It is the aim and intention of this researcher to act towards the participants in a respectful and caring way: however, this can only be judged by the experience and feedback of participants. To allow for this a question about how the participants experienced the research interview is included in the semi-structured interview format.

Exiting ethics involves the researcher in thinking about the presentation of the data and how this is shared, so as to avoid unintended consequences. The researcher will take seriously the responsibility to disseminate the findings and plans to present at workshops and conferences to professionals in the systemic field.

4.5 Personal and Professional Reflexivity

Reflexivity is considered a central component in constructivist grounded theory and therefore requires the researcher to be as transparent as possible about their own standpoint so that their influence on the project allows the reader to consider how the person of the researcher has contributed to the research

question and area of interest, the research process and results. Given this it is important that the reader be acquainted with relevant parts of the author's personal and professional background and orientation.

The author is a family therapist, female and Irish. She has lived and worked in the U.K. for 18 years. She qualified as a family therapist, completing her MSc. in 1996. Since then she has worked in several different settings, which have included outpatient and inpatient contexts. Her interest in the subject of self-harm arose out of her experience when she worked in an inpatient unit where adolescents who had seriously self-harmed were admitted.

Apart from finding the work complex and demanding, it was also stressful and there were many times when the author found herself not being sure how best to proceed. At the time her solution was to try to read as much as possible, with the aim of understanding how other family therapists worked in this area, what ideas they drew on, what they tended to emphasize in terms of their practice, and what themes they identified as being important to address. However, to her surprise she found that very little had been written and that most of the writings at the time were from a structural or strategic perspective. The idea of trying to inform herself through the process of doing a research project was borne out of this experience.

The researcher had the idea that ordinary therapists working in settings such as CAMHS or inpatient units would have, through their years of practice, accumulated knowledge and wisdom about how to work with self-harm. Since beginning this project the situation has changed. In the last few years there have been some new books and articles published on the subject of self-harm for example, Selekman (2006), Jurich (2008), Diamond (2010). However, Selekman's work is focused only on non-suicidal self-injury. Others have addressed self-harm as part of the work with depressed adolescents, for example Diamond (2005) and Larner (2009).

In sharing the above background to the study, the author is signalling that she entered the research with some prior knowledge and experience of working with young people who self-harm, and their families. When this project was embarked upon the researcher was new to working with self-harming

adolescents. Her guiding theoretical model was based on the Milan/post-Milan systemic model and this approach to working with families was her primary approach. At the time she believed that it was important to practice from a 'purist' position and therefore did not tend to draw on other models of family therapy or introduce ideas from other traditions outside of the systemic family. Her therapeutic approach was underpinned by a belief that there was a connection between the meaning family members ascribed to each other's behaviour and how they acted based on the ascribed meaning. Change would come about when new meanings were generated through the therapeutic conversation and when the conversation itself was conducted according to the principles of hypothesizing, neutrality, curiosity and circularity (Selvini et al. 1980; Cecchin, 1987; Bertrando, 2007).

Central to this approach is the principal of teamwork and the author has always tried to practice in the context of a Milan style team where this was practically and 'culturally' possible. She was lucky enough to be working at the time in a setting that valued Milan style teams and promoted this way of working. To this day, she prefers to work with a team and believes that it is essential rather than optional when working with complex and difficult family situations.

The author has already described finding the work on the unit stressful and anxiety provoking. She has a clear memory of a quality of 'heaviness' when talking with families whose son or daughter had tried to seriously harm themselves. The atmosphere was akin to 'walking on egg-shells'. Family members gave a strong message of not wanting to discuss the self-harm event for fear that it would 'cause' the young person to self-harm again. There was also a strong sense of shame and a fear of stigmatisation. Families tended not to tell wider family members about what had happened and tried to keep their child's self-harm a secret. Parents were often full of anger at what their son or daughter had 'put them through' but again there was fear that expressing such feelings would lead to more self-harming behaviour. One had to work very hard to help parents to express their different emotional reactions and to articulate their fear that they could have lost their child.

Apart from the work with families, the author also had a role as a case manager and it is probably this role that highlighted the complexity involved in making decisions about risk. One particular young person still lives vividly in the researcher's mind. Jane (pseudonym) was 15 and was under the care of the local authority. She constantly threatened and carried out self-harm. She took several very serious overdoses and had to be admitted to casualty. She regularly cut herself and these cuts were often very deep and dangerously placed. It was, for the most part, impossible to predict when she would self-harm and to identify triggers. The author had several experiences of having conversations with Jane in which she gave assurances that she would keep herself safe, and then 10 or 15 minutes later she had again self-harmed.

After a long period of inpatient treatment the team had to face the challenge of preparing Jane to live outside of the hospital setting. This transitional period was probably the most challenging and anxiety-provoking time for the author and the Team, as they had to weigh up and balance the need for keeping Jane safe with the need for moving her towards more autonomy and responsibility, so that she could develop her life and learn to live independently.

The author clearly remembers several sleepless nights when she stayed awake worrying about Jane and the decision taken to allow her to stay overnight at the children's home. While the decisions about leave and spending time outside the hospital setting were made in conjunction with the consultant psychiatrist, the weight of responsibility lay very heavily with the author. Sometimes Jane managed quite well outside the hospital setting, while at other times she would be overtaken by her suicidal thoughts and would act on them. At times there was a wish to err on the side of caution. When our personal anxiety thresholds were crossed, we paid attention to these and acted cautiously.

It is not easy to articulate the impact that working with Jane had. It was necessary to work outside the usual parameters and 'fight' with the young person for their life and to withstand the temptation to disconnect from situations that scared and frightened. Being Jane's Case Manager helped the author to become more sensitive to, and mindful of, the range of emotions that parents experience and to work with parents not to disconnect, give up or become

silenced in the face of self-harm. The reader might like to know that Jane is still alive, she still struggles with life and has spent short periods of time in hospital, but she has also gone back to college and is now in third level education. She contacts now and then to let the author know how she is doing.

4.6 Design of the Study

This qualitative study took place in two stages. Stage 1 involved interviewing six family therapists using a semi-structured interview format (Appendix 1). The data from these six interviews was analysed using grounded theory and then, based on the analysis, a second set of interviews was conducted. In this second Stage, three family therapists were interviewed, again using a semi-structured interview format, but with a different set of questions to that used in the first six interviews (Appendix 2). The data from the three interviews was analysed using grounded theory (Charmaz, 2000; 2006).

(i) Participants

Family therapists were approached by the author and asked if they would be willing to participate in the research project. This was a convenience sample. The inclusion criteria was as follows: the prospective participants needed to be experienced family therapists; they needed to have been qualified for at least five years; they needed to have had experience of working with self-harming adolescents with whom there was a concern about risk, and they needed to come from a range of different clinical settings.

All of the first six participants were experienced clinicians who identified working with self-harming adolescents as a regular part of their caseload. They worked either in outpatient settings or in inpatient units. Of those who worked in outpatient settings, three worked in specialist adolescent outreach teams and the rest worked in generic CAMHS teams.

The same method of sampling was used for the second set of interviews. The therapists were approached on the basis that they were experienced and

identified themselves as having worked with families in which an adolescent had self-harmed and for whom there was concern about risk.

The nine therapists were experienced clinicians and held senior posts. One was also a teacher and trainer of family therapists, and two were team leaders who had responsibility for the overall running of a service or department. Of the nine participants three were male and six female. The number of therapists interviewed was influenced by wanting to gather a range of responses and ideas. In the first round of interviews, the author felt that data collected from the six interviewees gave a rich sense of the therapeutic experience. In the second set of interviews three different therapists were interviewed and they also provided a very comprehensive account of their experience.

On contacting the therapists, the nature of the study was explained and verbal, then later written consent, was procured. It was also explained to the participants that the interviews would be audio-recorded, with their permission. The participants were provided with a written statement regarding the purpose and aims of the study and information detailing the process and what would be required of them (see Appendices 3 and 4). Participants were informed as to how their identity would be protected. They were given assurance that anything they stated that they later felt uncomfortable about could be deleted from the recording of the interview, or from the transcription. It was also explained that parts of the transcripts would be used in the Findings Chapter (Chapter 4) in order to illustrate particular ideas. The participants were assured that any identifying details, for example their names or workplace details would be deleted and replaced with pseudonyms.

(ii) Data Collection

Data collection was via a semi-structured interview. This format was used when interviewing both sets of participants. All the interviews were audio-recorded and then later transcribed in full. The transcription format used was based on the Jefferson transcription system (Jefferson, 2004) (see Appendix 5). In qualitative research where a grounded theory method is used it is not deemed

necessary to transcribe anything more than the words of the participant. In this study the author took the decision to use a transcription system that could include transcribing incomplete sentences, false starts, repetition, emphasis in speech, unclear speech, laughter and significant pauses in terms of time. It was felt that these were important contextual elements that may influence interpretation. The interviews took place at the participants' place of work and generally lasted about one and half to two hours.

In conducting the interviews the researcher sought to explore the therapists' experience of working with self-harming adolescents. As outlined previously, the interviews took place in two stages. In Stage 1 six therapists were interviewed, and in Stage 2 three therapists were interviewed. The interviews were transcribed and analysed using grounded theory.

The questions used to guide both sets of interviews were different. In the first set of interviews, areas explored ranged from the therapists' hypotheses about self-harm, to their ideas about the process of change, their reflections on re-occurring themes in the work, engagement issues, the challenges involved and how they responded to these challenges and the emotional impact of the work (see Appendix 1). On the basis of the analysis of this first set of interviews, several themes were noted by the researcher that she felt warranted further exploration and therefore another three therapists were recruited so that these themes could be explored further. In this second set of interviews, areas explored ranged from what supports and sustain therapists when doing this kind of work to how the issue of risk impacts on the work, to the concept of hope in the therapists' practice (see Appendix 2).

A semi-structured interview format allows a researcher to identify broad areas of interest or themes that they wish to pursue, and uses open-ended questions to encourage participants to talk from their own individual perspective. This interview format also allows for flexibility and exploration of new areas of interest that might evolve in the interview. Essentially, in the interviews the researcher was trying to access the bank of knowledge and wisdom that the therapists had accumulated over time in working with this client group.

In preparation for conducting the first six interviews, the researcher used three experiences. The first experience was based on watching a video-taped interview of a first family meeting with a young person who had self-harmed. This tape would have been part of the research project had it been possible to pursue the first research design as described in the Introduction. Permission had been sought from the therapist and the family for the researcher to have access to the video-taped session as part of the previous research plan. The original research design involved the researcher identifying key events in the session from her perspective and discussing these with the therapist. Several events/themes were identified and named, for example: Taking Charge, Excavating for Agency; Tracking the Details of the Self-Harming Episode; Getting the Facts and Exploring Meaning; Strengthening Emotional Bonds; Making Summaries; Raising Anxiety; and Developing the Therapeutic Relationship. Watching this tape and noting these areas of interest helped to set the foundation for the semi-structured interview used in Stage 1 interviews. Topics were identified to guide the direction of the interview.

A pilot interview was set up to trial the interview schedule. Although some minor adjustments were made to the interview schedule, the overall format remained the same. The process of conducting the pilot interview was useful in that it highlighted to the researcher her tendency to introduce too many of her own ideas into the conversation. This was part of an approach that sought to make the interview more of a conversation between colleagues, but it had the effect of disrupting some of the interviewees' lines of thought. In response to this the author tried to use more prompts, for example, 'Could you say more about that, or could you expand on that?' rather than making comments or sharing some of her experience, to further elicit their own thinking.

The researcher also used fellow research students and course tutors who were all family therapists, to brainstorm the meaning of the word 'experience'. This helped to 'unpack' the term in all of its different meanings and therefore broaden the researcher's perspective and areas of enquiry and consideration of themes for exploration during the interviews.

All of these experiences had the effect of expanding the researcher's thinking, helping her to notice and become aware of some of her assumptions, and her influence on what unfolded in the interviews. The research participants were also asked to prepare for the interview by having in mind two recent families they had worked with in which self-harm was part of the presenting problem and in which there was a concern about risk of suicide. They were asked to select one family in which they felt that their work had gone well, and one they deemed to have gone less well. The reason for asking the therapists to have in mind two families they had recently worked with was to help ground the interviews in practice and have the therapists speak from their actual experiences as much as possible, rather than speaking from hypothetical examples.

The opening questions were practical in order to gather relevant information and to allow both the interviewer and interviewee to ease into the interview and help the participants to relax. At the beginning of each interview the researcher re-explained the purpose of the research and addressed issues of confidentiality and any other questions and concerns the participants may have had.

The researcher recognized it was important that the interviewee did not feel examined or judged in terms of their practice and took care to introduce the research and interview questions with this in mind. Consequently, at the start of the interview the researcher explained her motivations and her interest in this area. She also shared with participants her experience of working with this client group and some of the difficulties she had encountered, and some of her own dilemmas and experience. The researcher hoped to signal to the interviewee that the process was a collaborative conversation between colleagues. The danger was that the researcher would give too much information and therefore overly shape and influence the participant's responses.

The researcher also named at the beginning of the interview some possible concerns about, for example, being evaluated. This was done with humour in a light-hearted manner. Once engaged, it was then easier to be more explicit.

Trying to create an atmosphere in which the participants would feel at ease, and not feel that they were being judged or evaluated is both a methodological and ethical issue. The ethical issues are addressed in the next section.

(iii) Ethical Issues

Prior to consenting to participate in the research and as previously stated, participants were given both verbal and written explanatory details about the research project and what would be involved. They were informed that they could withdraw from the research study at any stage.

As stated earlier in this chapter, issues concerning confidentiality were addressed and procedures for protecting confidentiality were explained. Participants were informed that their names or other identifying information would not be used and they would instead be given a pseudonym. As previously described they were informed that the interviews would be transcribed in full and that quotes from the interview would be used in the write-up to highlight or make clear different issues. Participants were also told that they could ask for a particular section of the recording to be either wiped or omitted from the transcription. Participants were assured that pseudonyms would be used when using quotes from the interviews.

Participants were also informed as to how confidentiality would be assured regarding any information shared in the course of the interview regarding clients with whom they worked. Again, all identifying information including the family or young person's name and age, and the name of the service, would be either omitted or changed to protect their confidentiality.

In preparing for these interviews, the author considered the possibility that a participant could become upset during the interview. Were this to occur the author planned to stop the interview and allow the person time to recover and discuss if they felt able to continue or preferred that the interview was terminated.

The next chapter will address the process of the analysis of the data and will include examples of the steps taken from initial open coding to the development of categories and eventually the articulation of the Core Category.

5. CHAPTER THREE: GROUNDED THEORY DATA ANALYSIS

Introduction

In this chapter the author sets out the steps taken in the process of analysing the data. The author's aim is to be as transparent as possible about the data analysis process. When using qualitative methods, the trustworthiness of the data is one of the criteria used for judging the quality of a research study. It is hoped that through the process of telling the story of how the analysis was conducted and giving examples of the coding process and generation of categories the reader will be able to follow the process and be in a position to make a judgement regarding the trustworthiness of the project. The process of analysis was not without its difficulties. The author will attempt to describe some of the problems encountered and how these were resolved. The remainder of this chapter is written in the first person as this seems more fitting within the context of this chapter.

The data analysis was carried out in several stages in an iterative, non-linear fashion, which I will describe.

Stage 1 marked the start of the process with data collection; with initial data based on six interviews. These six interviews were coded and a set of higher-level categories developed. On the basis of this analysis I decided to interview another three therapists to explore specific areas, as described later in this chapter. These three interviews were then also coded and a set of higher-level categories developed, from these, which constitute Stage 2. Stage 3 then involved collating and reviewing the material from the first two stages of the data analytic work. This involved not only work to merge the codes and categories, but a frequent return to the original transcripts, revisiting my coding and categorizing decisions, re-naming the codes and categories and deliberating over the important 'story' that seemed to be emerging from the material. The main steps and stages cannot all be described but I will outline some of the key decision points in the process.

I will try to acquaint the reader in more detail with the steps taken in the analytical process in the three stages.

5.1 Stage 1

After completing each interview of the first six interviews of Stage 1, I had the interview transcribed. I chose to have the interviews transcribed by a professional transcription service rather than transcribe them myself for a timely transcript result. I then read and re-read the transcripts several times throughout the process of analysing the data and when writing up the Findings Chapter. This enabled me to get immersed in the data and familiarize myself fully with the content of each transcript.

(i) Initial Open Coding

Coding is the process of defining what the data is about. The first step in the process was to divide the transcript into units of meaning. I gave each meaning unit a code or name. I tried as far as possible at this early stage of analysis to use the language of the participants in naming the data, particularly if I felt it captured the meaning of what the participant was saying. Some meaning units were a line of the transcript while at other times meaning units were composed of several lines of transcript. Sometimes the same unit of meaning could be coded in different ways depending on the content, and therefore I gave some meaning units more than one code. Charmaz (2006) views the coding process as an interactive process between the researcher and the data. The researcher asks questions of the data in order to identify actions and significant processes (Charmaz, 2003). I found the most helpful questions were asking myself what is this about, what seems to be the therapist's main concern?

For each unit of meaning I wrote a short note underneath the quote stating what I thought the extract was about. These notes were written in order to help me think about the meaning of what was being said. Sometimes I would input a question to myself for further consideration later. These notes were also used

to help with naming codes. Using too many in-vivo codes sometimes proved unhelpful at the later stages of creating categories, so the note to myself helped to remind me what I thought the code was about. An example of the initial open coding process may be helpful at this stage. The extract here is from Rachel's interview:

"...so, for some people, I think when we're not really sure about what's happening in relation to the self-harm, or whe(n)...if they have taken, em, you know overdoses that we don't understand the context of or...so I would always, I think at the beginning particularly then try to get a good understanding of the context of those episodes". [Rachel. 2, 36-42]

My note that accompanied this unit of meaning was as follows: What she seems to be talking about mainly is the importance of context in understanding what the self-harm means. She's also saying it is important to do this at the beginning – so timing is important, and there is also a theme about 'needing to be sure' as to the meaning: is she talking about risk here? I coded the extract as 'Importance of Context, Timing and "Not Really Sure"'.

Throughout the process of coding, I compared each code with other codes both within each transcript and across transcripts. I found the whole process of coding and categorizing the data quite challenging, complex and frustrating. It seemed at times an overwhelming task.

I did eventually, after much heart-ache, find a way to manage the amount of data and try to organize it into coherent components. Large white boards lined the walls of my home. Each board was covered in white 4x4 cards with the initial codes typed on them. My 'method' involved walking up and down alongside the boards, looking at the codes and picking off those that seemed to be about the same issue, and repositioning them onto smaller white boards. I thought of each of these smaller boards as being like a mini story; these 'story boards' became the sub-categories. Black boards were then added to allow for the development of higher-level categories.

Having completed the analysis of the six interviews, I created a list with all the initial codes from the six interviews grouped into four main categories, which

was then related to a higher order category. The total number of initial codes from the six interviews was 858 codes. There were 30 sub-categories and four main categories: i) Risk; ii) Change; iii) The 'Talk' of the Therapy and iv) Therapist Ideas. There was one higher-level category: 'Ways of Working'.

Each of the main categories were created from grouping initial codes into low-level categories which then became sub-categories of the main categories.

Examples of a small number of the initial codes and their Sub-categories is given in Table 2.

Table 1 shows the Sub-categories grouped into higher-level or Main Categories and then to the Highest-level Category.

TABLE 1. Stage 1: Data Analysis of First Six Interviews – Higher-Level Category, with Main Categories and Sub-Categories

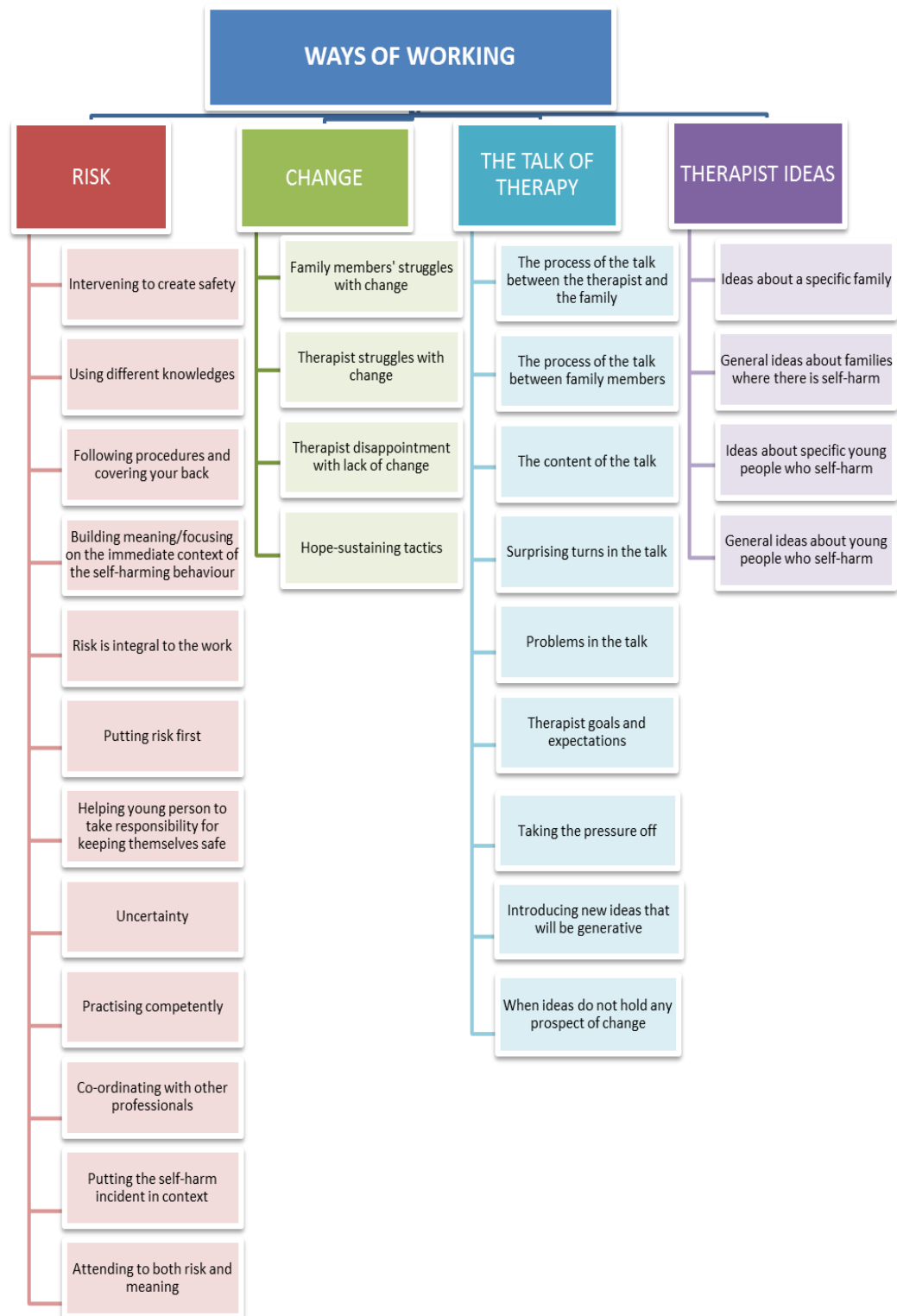


TABLE 2. Stage 1: Data Analysis of First Six Interviews – Examples of Initial Open Codes and Sub-Categories

<p>Risk</p>	<ul style="list-style-type: none"> • <i>Using different knowledges.</i> • <i>"They're just sitting on their hands not answering."</i> • <i>"It depends on how I'm feeling really."</i> • <i>Experienced therapists do not explore metaphors when risk is the issue.</i> • <i>"Running through risk factors."</i> • <i>"They've said no simplistically."</i> • <i>"Whether one of the questions I've asked made me more anxious about risk of suicidality."</i>
<p>Change</p>	<ul style="list-style-type: none"> • <i>Therapist disappointment with lack of change.</i> • <i>"23 sessions later and it's still that tendency for it to be kind of dead flat, deadless, if not depressed."</i> • <i>"The possibility of moving forward...and then she got more depressed."</i> • <i>"It felt impossible at times."</i> • <i>"It's very difficult to keep going with this."</i>
<p>The Talk of Therapy</p>	<ul style="list-style-type: none"> • <i>Therapist goals and expectations.</i> • <i>"I hope that they felt they were able to talk about the things that they needed to talk..."</i> • <i>Gold stars are not possible</i> • <i>"Giving them that safe therapeutic space."</i> • <i>Keeping young person safe at a difficult time in their life.</i> • <i>"I'm employed to see them."</i> • <i>"That they have a path to the future."</i> • <i>"Trust between me and them."</i> • <i>"I really wanted to get to her resources."</i>
<p>Therapist Ideas</p>	<ul style="list-style-type: none"> • <i>General ideas about families and self-harm.</i> • <i>"Cause it means you're bonkers."</i> • <i>A family history of suicide.</i> • <i>A history of something catastrophic happening.</i> • <i>Expression of emotion in the family.</i> • <i>Secrecy.</i> • <i>Long-standing and difficult relationship between parents.</i> • <i>Carers not able to mentalise.</i> • <i>Closeness with hostility.</i> • <i>Parents who feel attacked by the act of self-harm.</i> • <i>Self harm - a solution to emotional distance.</i>

5.2 Reflection on the Analysis of the Six Interviews

Having completed the analysis of the six interviews I had an overall sense of disappointment. It was difficult to define the reasons for this disappointment. Partly I think I was disappointed with the outcome of the analysis. I didn't experience any 'wow' moments where I felt I had discovered some new insights into working with adolescents who were self-harming. I was surprised at what seemed to me to be very vague statements about the theoretical underpinnings of the work. The link between theory and practice seemed fairly loose and not clearly articulated. There were plenty of examples of practice, but it seemed they were not integrated with, or anchored into the therapists' statements about the theoretical underpinnings of their work.

I felt guilty that I had not managed to create anything particularly interesting to my mind about working in this area. My guilt was based on the idea that I had missed something in the data and that this was a dis-service to the therapists I had interviewed. They all had been very forthcoming about their practice and I wanted to do 'justice' to what they had shared with me. They had taken the risk of exposing their practice to comment and scrutiny. I felt a sense of obligation to discern the wisdom contained in their accounts. I was very mindful of Charmaz's (2003) words that it was the researcher's responsibility to make something of the data.

I lived for some time with this 'problem', at times despairing of finding a way forward and feeling fairly hopeless. I talked things over with supervisors and colleagues. I wrote a rough summary of the findings of Stage 1, and a reflection on those findings. From this I considered different ideas that might pull the categories together, and create a story that would connect the categories and sub-categories. I thought about the idea of creativity and how difficult it is to be therapeutically creative while maintaining a focus on risk and ensuring the safety of the young person.

I also tried to think about what was missing from the accounts, which highlighted to me that there was an absence of a sense of effectiveness in many of the accounts, and very clearly in two of the accounts. I felt the therapists conveyed a strong sense of disappointment in the progress they were

making and one therapist conveyed a sense of hopelessness about the work. I remember in the interview with Steve I found it very difficult to continue with my questions, in fact I don't think I asked them all. I recall the atmosphere as very heavy, leaden almost. The therapist came across as 'flat' and tired. There was a lot of yawning and sighing. I had a strong sense from the therapist of feeling very dissatisfied with some of the work and devoid of ideas about how to improve it. This therapist worked with a team, but there was no great sense that he felt supported. A lot of my questions were answered with "I don't know"; it was as if he couldn't lift himself out of his I want to say 'depression', because that's what it felt like, but that is probably too strong a word. He seemed unable to think about his work.

I came away from the interview feeling very uninspired and disappointed, both with myself and with the interviewee. I blamed myself for not pursuing things more, for not having questions that might have been more interesting, and for being 'knocked off balance' by the atmosphere.

My second similar experience was with Jade. We had a very long and interesting interview from my point of view. Unlike Steve she didn't come across as bored in the interview, but she did come across as feeling very 'stuck'. She seemed to really value the research interview as an opportunity to reflect on her work. She reflected at the close of the interview that the meeting had provided a positive opportunity to reflect and was in that sense similar to a good supervision session.

The particular case she used to illustrate her work with self-harm was one where she felt very ambivalent about whether or not there was any progress being made. My sense was that her central belief was that the work was not progressing in any useful direction, but despite this she felt unable to give up on or call an end to the therapy because a young person was involved who was at risk of suicide and had a history of suicide attempts and other forms of self-harm. The therapist felt that she had to keep going and keep trying despite the lack of progress. There was a strong sense of 'stuckness'. I think she effectively felt trapped; she didn't think it was right to stop the work and at the same time she couldn't find a way to progress it. She made reference several

times to the amount of input she had made without any change in the situation and also she was clearly trying to clutch at any small signs or developments that indicate change or a willingness to change, for example she tried to remind herself that the family kept turning up for sessions and therefore that they must be getting something from the sessions.

Following our interview I remember feeling relieved that I wasn't working with the family and wondering about how she managed to carry on trying, and what kept her going.

Reflecting on these two interviews led me to think about the emotional tone of the other four interviews I had done and I asked myself if I thought any one of the therapists had come across as enjoying the work or as enthusiastic. Of the six therapists I felt only two really sounded upbeat and enthusiastic. What was different about these two therapists was that one worked in an inpatient unit and felt very supported by the team and the context. The other therapist's caseload was the least heavily laden with young people at risk of self-harm.

As I reflected on the interviews and my own emotional reactions, I noticed that hopelessness was not mentioned explicitly at any stage in the interviews as being a risk factor for self-harm, neither did the therapists refer explicitly to the concept of hope being an integral part of their repertoire when working with self-harm. Although there were references to hopefulness these were implied, rather than stated. The references were often about adolescence being a time of development and the young person's difficulties were very much part of their current context and life-stage. One therapist expressed the view that because a young person was suicidal now, this did not necessarily mean that they would become suicidal as adults. Another therapist when talking about a young person said that she believed that, "most of the time we want to survive".

At around this time, I read two articles that influenced the direction of the research. One was by Kaethe Weingarten. I was very interested in some of the views she expressed, in the light of my reflections on the interviews. Weingarten notes that family therapists have not been explicit about the role of hope in their work and that it tends to remain implicit and unarticulated. (Weingarten, 2010). Hope is also one of the factors that has been identified as

significant for successful therapeutic outcomes. The 'common factors' approach as described by Hubble (Hubble et al., 1999) suggests four areas that are responsible for change in therapy – the strengths and resources that clients bring to therapy, clients' capacity to hope for positive change, often referred to as the 'placebo effect', the therapeutic alliance and specific techniques and therapeutic model. These were further developed by Sprenkle et al. (2009).

Another article (Aggett, et al., 2013) that influenced me was about an organizational intervention, conducted following a series of untoward incidents, one of which was a completed suicide and another a serious suicide attempt. Reading this article made me pay more attention to what the therapists I interviewed were saying about the contexts they worked in, and whether or not they felt supported by the settings they worked in and also what constituted support.

Having reviewed and reflected on the interviews, I now understand my initial reaction of disappointment. I think first of all that I had an unarticulated expectation as to what I hoped to find in the therapists' accounts of their work. This expectation initially blinded me to noticing what was of concern to the therapists. They were saying important things about the work, but they were not about theory and technique: the therapists were more concerned about how to stay engaged in work with families in the face of high levels of risks, and minimal or no change, and they were concerned about how to look after themselves both personally and professionally.

5.3 Stage 2

On the basis of these reflections and being guided by grounded theory practice, I decided to interview another three therapists, bringing the total number of interviews to nine. This second set of interviews was designed with the intention of enquiring about what supported therapists in doing this kind of work, what sustained them, did the risk element in the work constrain them or not? and whether they thought about and used the concept of hope in their practice (see Appendix 2 for the schedule for this semi-structured interview).

As in Stage 1, the three interviews were transcribed and analysed using a constructivist grounded theory method and as in Stage 1 the process involved identifying units of meaning, coding these, then grouping these initial codes in low-level categories and then re-grouping these into higher-level categories. Again, I found the process complex and frustrating but slightly less so than when analysing the first set of interviews, mainly because I was less nervous about the task, and I had discovered a 'method' for managing the process. I had to group and re-group the initial codes using my 'story boards' before finding a category structure that best represented the material from the three Stage 2 interviews. This set of interviews yielded 900 initial codes, 19 sub-categories and four main categories. The final version is presented in Table 3.

Table 3 shows the Main Categories and their Sub-categories.

Table 4 sets out one Sub-category from each of the Main Categories with some examples of Initial Open Codes.

Table 3. Stage 2: Data Analysis of Second Set of Interviews – Main Categories and Sub-Categories

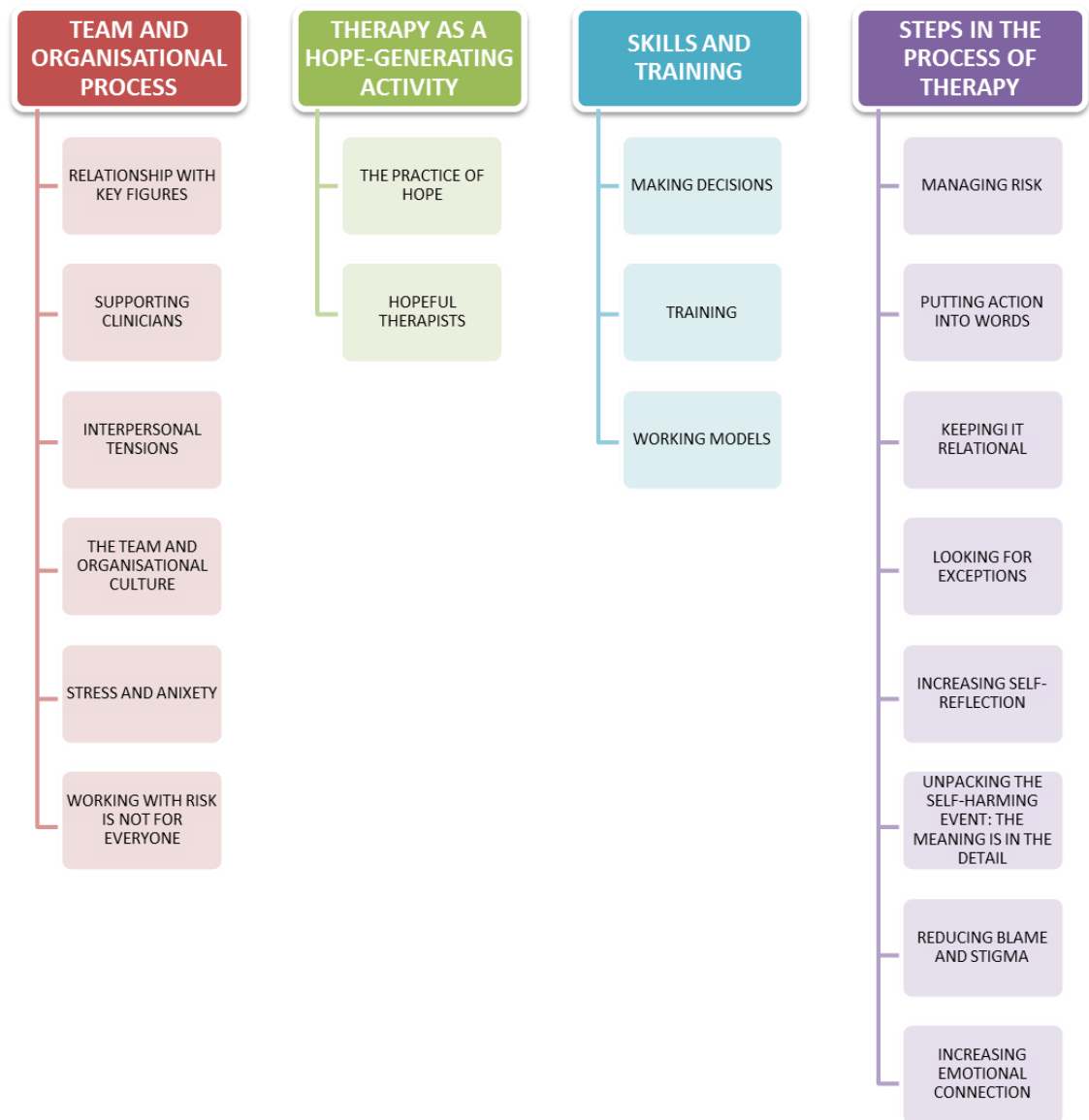


TABLE 4. Stage 2: Data Analysis of Second Set of Interviews – Examples of Initial Open Codes and one Sub-Category from each Main Category, as shown in Table 3

SUPPORTING CLINICIANS	<ul style="list-style-type: none">• <i>A Team Task</i>• <i>Timely Talk and Timely Support</i>• <i>Team Relationships - sharing doubts and seeking reassurance</i>
HOPEFUL THERAPISTS	<ul style="list-style-type: none">• <i>Commitment</i>• <i>Keeping Hope Alive</i>• <i>Time and Experience</i>
MAKING DECISIONS	<ul style="list-style-type: none">• <i>Risk Assessment is a Decision-Making Process</i>• <i>Making Decisions Requires a Framework</i>• <i>Key Questions Need to be Asked</i>
REDUCING BLAME AND STIGMA	<ul style="list-style-type: none">• <i>Externalising Blame</i>• <i>Normalising Mental Health Problems</i>• <i>Positively Connoting Intention</i>• <i>Who to Work With and When</i>

5.4 Stage 3

Once the second Stage of analysis was completed, I then returned to the analysis of the first Stage and set about combining both sets of analysis with the following results. If the reader recalls, the four Main Categories arising out of the analysis of the first six interviews were: i) Risk; ii) Change; iii) The 'Talk' of the Therapy and iv) Therapist Ideas.

The four Main Categories resulting from the analysis of Stage 2 were: i) Team and Organizational Processes; ii) Therapy as a Hope-Generating Activity; iii) Skills and Training and iv) Steps in the Process of Therapy.

The process of combining the two data sets was a lengthy and fraught one, requiring me to re-visit and review the initial coding and categorizing decisions made, and check back against the transcripts of the nine interviews. The initial codes from the two data sets came to 1,758 codes.

Combining the two sets of categories described above resulted in three Main categories:

1. What's on the Therapist's Mind / Guiding Hypotheses
2. Therapeutic Activities
3. Team and Organizational Processes.

The main changes in the Categories were as follows:

- Risk, Change and The 'Talk' of the Therapy from Stage 1 were re-positioned as Therapeutic Activities
- Therapy as a Hope-Generating Activity, Skills and Techniques, and Steps in the Process of Therapy from Stage 2 (analysis of second set of interviews) were re-positioned as Therapeutic Activities
- Therapist Ideas from Stage 1 became Therapist's Approach/Theoretical Lenses and Guiding Hypotheses

TABLE 5. Stage 3: Combining Main Categories – From the Data Analysis of Stage 1 and Stage 2

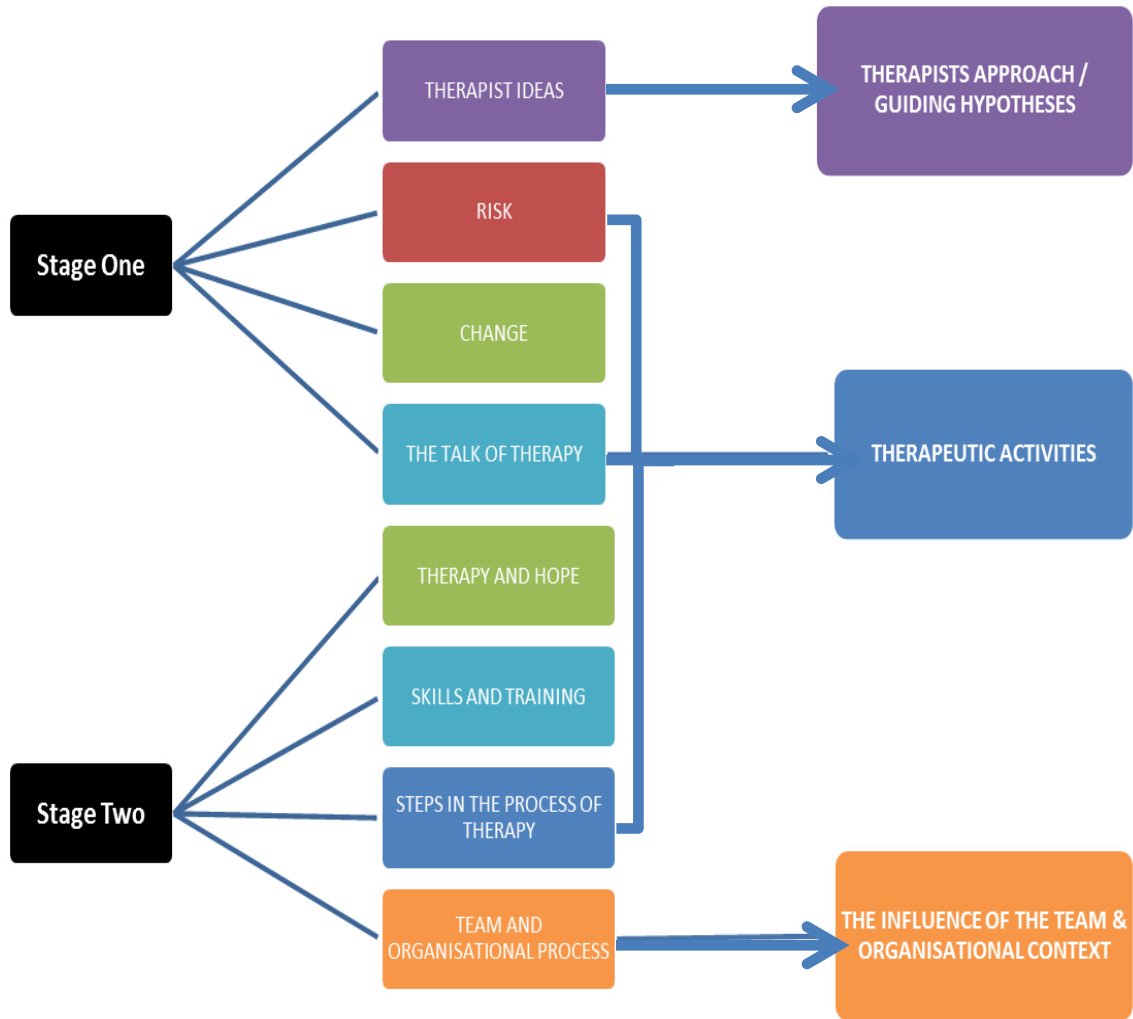


TABLE 6 sets out the new arrangement of Main and Sub-categories from the combined data analysis of both sets of interviews.

TABLE 7 shows how the codes built towards the Sub-categories, with an example of one Sub-category from each of the Main Categories.

TABLE 8 gives an example of some of the Initial Open Codes that formed the Lower-level Category, Assessing Risk, in Table 7.

TABLE 6. Stage 3: Main Categories and Sub-Categories – From the Integration of Data Sets from Stage 1 and Stage 2

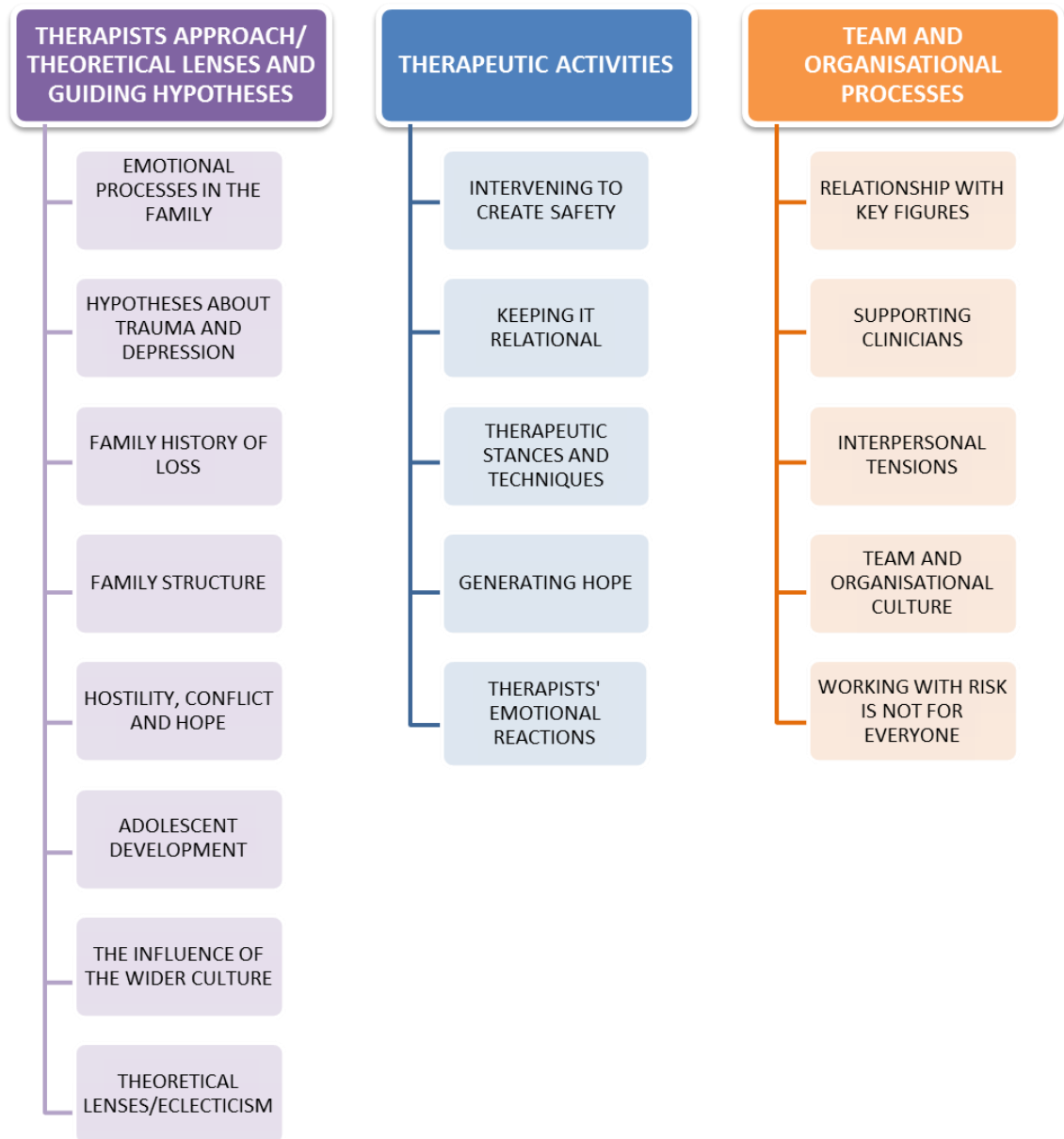
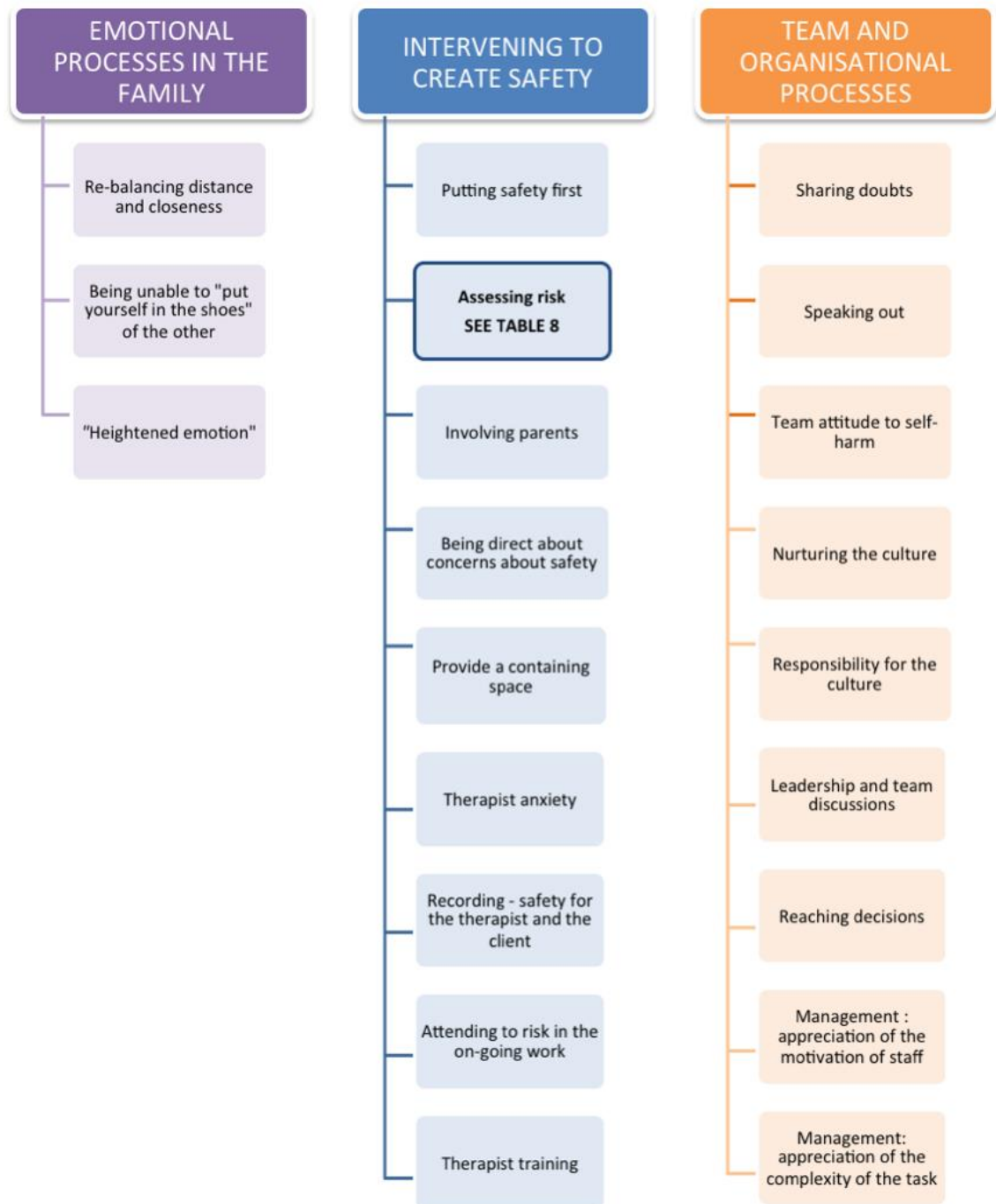
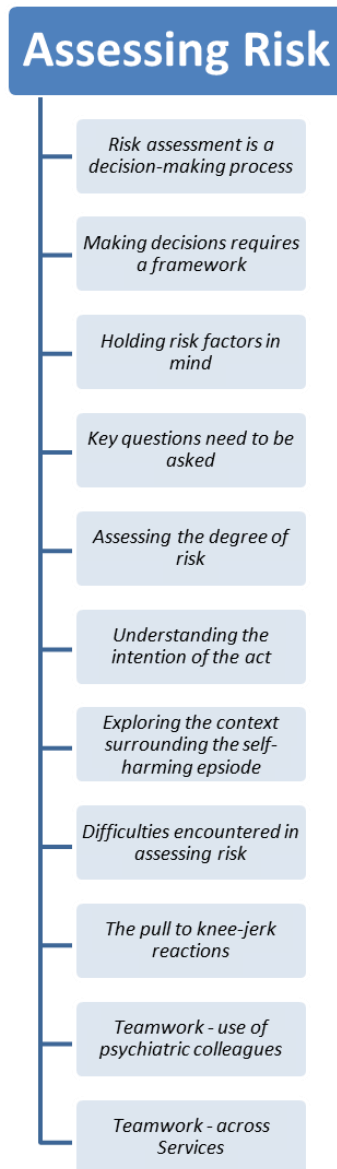


TABLE 7. Stage 3: Example of One Sub-Category from Each Main Category in Table 6 – Showing the Lower-Level Codes that Built Towards the Sub-Category.



Some of the above Sub-categories also had Lower-level codes. For thoroughness I have included an example from the Sub-category Assessing Risk.

TABLE 8. Stage 3: Example of Initial Open Codes – Forming the Lower-Level Category, Assessing Risk which Formed the Sub-Category, Making The Situation Safe.



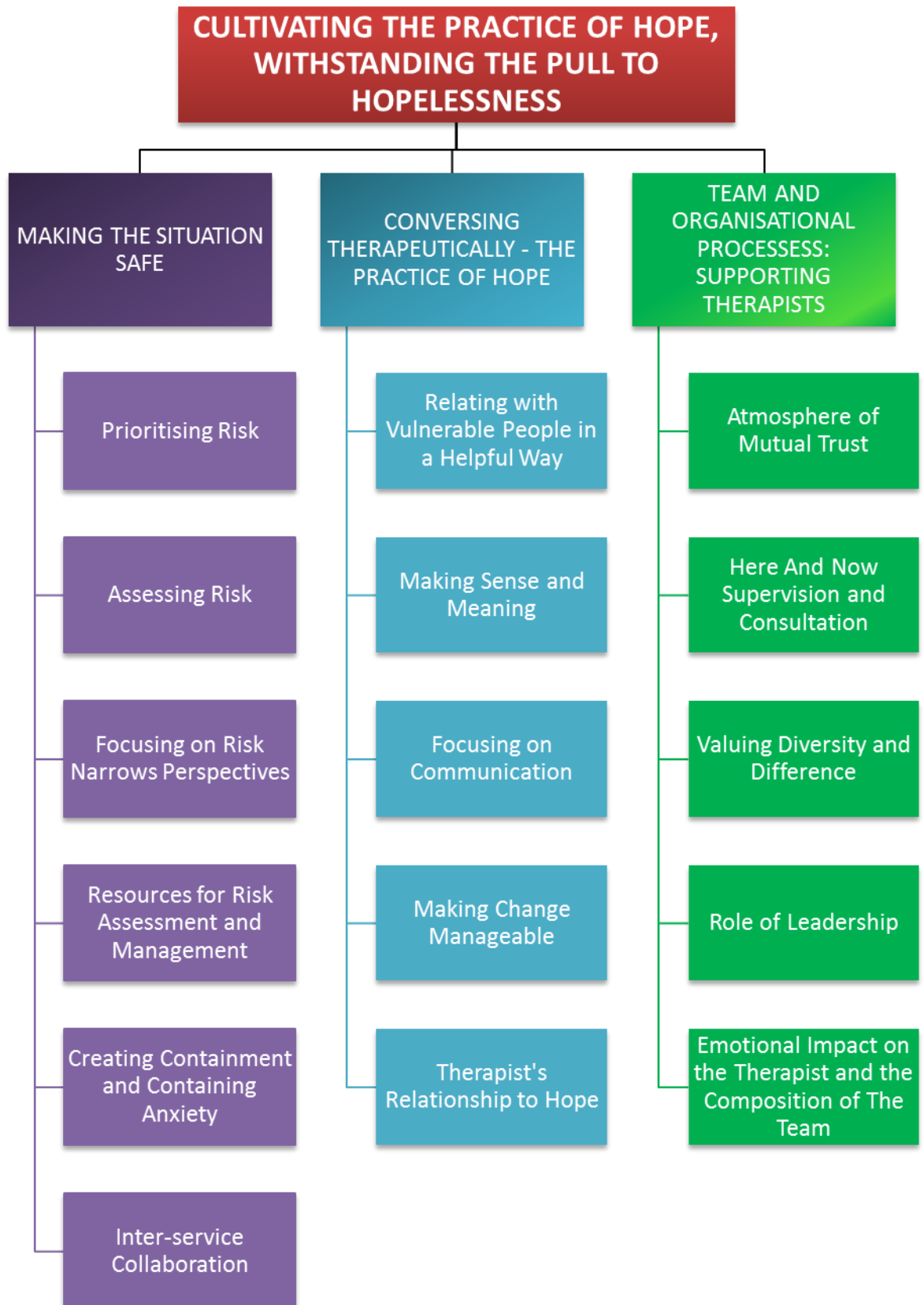
5.5 Constructing the Core Category

In Table 8 the Main Categories and Sub-categories of the data analysis following the integration of data sets from Stage 1 and 2 were presented. This table represents the penultimate step in the data analysis process. Before proceeding to the final stage of the analysis, I would like to address my understanding of what is meant by the development of a 'grounded theory' and the construction of the Core Category.

The purpose of grounded theory analysis is to generate theory. The theory generated offers an explanation about the main concern of the participants in the study and how that concern is resolved or processed (Cresswell, 2007). The generation of the theory develops from considering the relationship between the codes, categories and sub-categories generated during the analytical process. The researcher seeks to construct a narrative concept that links the data. As part of the process some data will be lost and others 'fore grounded' (Holton, 2007). Holton suggests that one of the challenges facing those undertaking a grounded theory analysis is in trusting 'one's intuitive sense of the conceptualisation process to allow a core category to emerge'. My reflections on my sense of disappointment described earlier in this chapter proved to be the first steps in this intuitive process.

The next table, Table 9, sets the final stage of the data analysis and presents the Core Category, Main Categories and Sub-categories. In constructing the Core Category some of the categories from Stage 3 are re-positioned and some have been re-named. For example the Sub-category, Intervening to Create Safety which was part of the Main Category Therapeutic Activities has been re-positioned and fore-grounded as one of the final Main Categories and re-named Making the Situation Safe. The Main Category Therapeutic Activities, was re-named Conversing Therapeutically – The Practice of Hope. The Main Category, Therapist Approach / Theoretical Lenses was re-distributed across the different categories. As in the previous Stages, the process entailed grouping and re-grouping some of the Sub-categories in order to find a category structure that best represented the material and its relationship to the Core Category (Table 9 – see overleaf).

TABLE 9. The Core Category, Main Categories and Sub-Categories



When discussing how constructivist grounded theory differs from objectivist grounded theory Charmaz (2006) suggests that theories generated in constructivist grounded theory tend to be 'plausible accounts' and do not claim any objective status. Glaser and Strauss (1967) suggest that the theory generated is substantive rather than formal and as such has the status of a hypothesis.

In the next chapter, I set out the results of my analysis and present the Core Category and its relationship to the Main Categories and Sub-categories. In doing this I will be presenting my construction or 'plausible account' or hypothesis of the data about how family therapists experience work with self-harm.

6. CHAPTER FOUR: THE FINDINGS

Introduction

This study set out to explore how family therapists experience working with families in which an adolescent has self-harmed. Emphasis was placed on describing, understanding and illuminating their experience: including the therapeutic issues encountered; the stances adopted in response to the issues encountered; the therapists' preferred ways of working with this client group; and the emotional impact of the work on the therapists.

This chapter summarises the categories emerging from the grounded theory analysis. A brief commentary is included with thoughts evoked by the findings and connections with the literature. More extensive discussion of the issues raised and the implications of these for clinical practice, and links to existing literature will also be addressed in the Discussion Chapter (Chapter 5).

In this chapter the findings from the nine interviews are presented. The analysis of the nine interviews resulted in a Core Category, three Main Categories and 16 Sub-categories, as set out in Table 9.

The chapter begins with a description of the Core Category. The Main Categories and their Sub-categories are then named and their connection to the Core Category explained. The findings are then presented in detail within each of the Main Categories and their attendant Sub, and Lower-level categories. As previously explained a comment section has been included at different points throughout the chapter.

6.1 The CORE CATEGORY: Cultivating The Practice Of Hope, Withstanding The Pull To Hopelessness

The emergent theory proposes that the central issue for the therapists is about how they stay engaged in the work with families in the face of high levels of risk of self-harm in situations where change can be very difficult to achieve and hopelessness can pervade. The picture that emerged from the analysis of the data shows that the therapists experienced family therapy for self-harm as complex, challenging and unpredictable. The work requires that the therapists manage high levels of risk while also creating therapeutic change.

The families with whom the therapists work often present as frightened and fearful, having lost confidence in their own resources. They look to the therapist to take on the responsibility of keeping their child safe. The fear generated by the self-harm results in parents feeling powerless, with no sense of agency, worried that any action could result in a repetition of the self-harming behaviour. The therapist can therefore find creating change extremely difficult and because of the level of risk the therapist feels constrained ethically and morally to keep trying. This can lead to a therapeutic impasse accompanied by feelings of powerlessness and feelings of failure. In situations of risk, fear of being blamed adds to the 'stuckness', with therapists losing the ability to think creatively and to withstand the pull towards hopelessness.

The therapists see the families' feelings of hopelessness as triggered by a range of factors, some historical, some related to a history of adversity, some because of the presence of depression either in the parents or in the young person who is self-harming, and some in response to the fear and helplessness that self-harm engenders. In the therapist's view hopelessness is experienced when the family cannot see a future, when their thinking and perspectives have narrowed, and when they do not have the energy or commitment to find new ways of thinking about their situation in order to be open to alternatives and possibilities.

The therapist has to try to understand and make sense of the family's distress and what it is that stands in the way of their ability to create change. In the process of doing so the therapist has to allow themselves to be touched by the despair and hopelessness of the family, but at the same time not become despairing themselves. The therapist has to find a way of managing the pull to hopelessness while remaining empathetic with the family's distress. The stance of hopefulness is their response. It is both a therapeutic stance and orientation, and is enacted in practice through finding ways to cultivate hope in the therapeutic encounter. The therapist faces the challenge of working with the family and the young person in such a way as to create with them a sense of hope and agency which will allow them to walk across the bridge to hope, to step into a future and create new opportunities and possibilities.

To engage with families from the position and stance of hopefulness requires therapists to have a set of practices that can achieve this. These practices are described in the Main Category, Conversing Therapeutically – The Practice of Hope.

MAIN CATEGORY: Conversing Therapeutically – The Practice Of Hope

This Main Category has five Sub-Categories:

1. Relating with Vulnerable People In a Helpful Way
2. Making Sense and Meaning
3. Focusing on Communication
4. Making Change Manageable
5. Therapist's Relationship to Hope.

These practices describe how the therapists' orient or position themselves so that change can take place. Creating change however cannot take place until the young person's safety has been ensured. The initial steps in the work with the family therefore involve a more crisis type intervention. This work is described in the Main Category, Making The Situation Safe.

MAIN CATEGORY: Making The Situation Safe

This Main Category has six Sub-Categories:

1. Prioritizing Risk
2. Assessing Risk
3. Focusing on Risk Narrows Perspectives
4. Resources for Risk Assessment and Management
5. Creating Containment and Containing Anxiety
6. Inter-service Collaboration.

When therapists engage in difficult and complex work, and particularly in situations of risk and uncertainty, they need to be supported in ways that allow them to practice to the best of their ability and in ways that are 'hope-inducing'. If hope is something that gets created between people, then the therapist's hope is also generated in the relationship between the therapist and their colleagues. The context in which they work, the nature of the relationships, the team, and organizational structures, therefore all play a vital role in helping the therapist to stay emotionally connected, resisting the pull to hopelessness and disconnection from the client.

The Main Category, Team And Organizational Processes: Supporting Therapists describes aspects of team and organizational life that support therapists and allow them to be effective clinicians, and those that do not.

MAIN CATEGORY: Team And Organizational Processes: Supporting Therapists

This Main Category has five Sub-Categories:

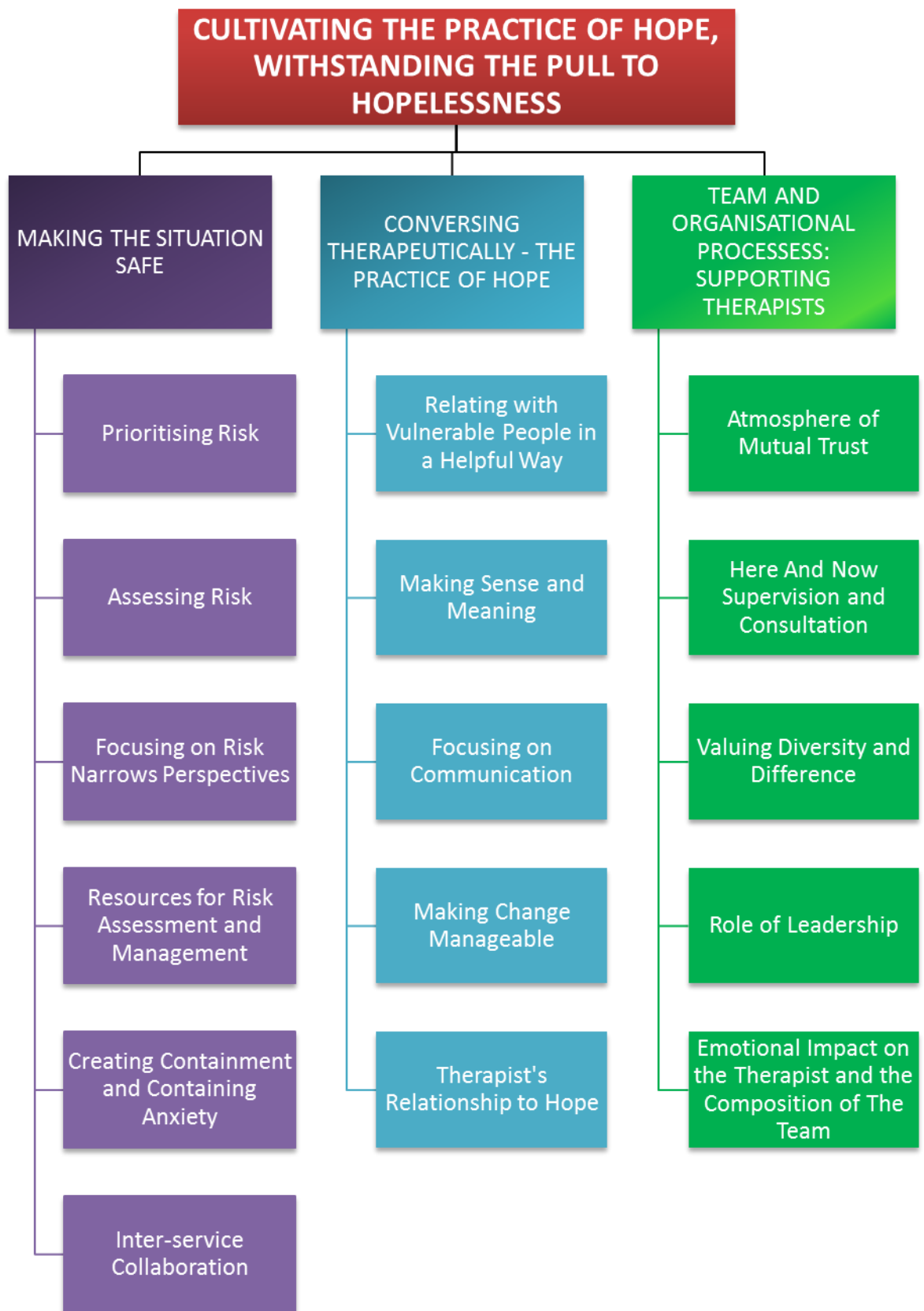
1. Atmosphere of Mutual Trust
2. Here And Now Supervision and Consultation
3. Valuing Diversity and Difference
4. Role of Leadership
5. Emotional Impact on the Therapist and the Composition of The Team.

What follows is a description of the findings from each of the Main Categories and Sub-categories.

I have tried to show how the three Main Categories relate to each other and to the central phenomena of the study: how the therapists generated and sustained hope, both in their clients and in themselves, how they lost hope when working with young people who self-harm, and their experience of the kind of contexts, both team and organizational, that helped them sustain hope and withstand the pull towards hopelessness.

Table 9 overleaf sets out the Core Category, Main Categories and Sub-Categories.

TABLE 9. The Core Category, Main Categories and Sub-Categories



6.2 MAIN CATEGORY 1: MAKING THE SITUATION SAFE

This category describes a number of processes referred to by the therapists. They suggested that one of the central aspects of working with self-harm is about assessing risk and creating safety. I see this Main Category, Making the Situation Safe, as the first step in the therapeutic process as unless safety can be created therapy cannot take place.

Creating safety sets a context in which reasonable hope³ can flourish. Reasonable hope describes actions taken by therapists to co-create hopefulness. In reasonable hope, hope becomes an action not a feeling. The first action therefore is about creating safety. It involves assessing the level of risk and intervening to create safety. By taking action to secure a young person's safety, the therapists help to alleviate the sense of powerlessness that parents face. In the following section I describe the main actions that seem to be directed towards making the situation safe.

Six Sub-categories emerged:

This Main Category has six Sub-categories:

1. Prioritizing Risk
2. Assessing Risk
3. Focusing on Risk Narrows Perspectives
4. Resources for Risk Assessment and Management
5. Creating Containment and Containing Anxiety
6. Inter-service Collaboration.

³ The concept of reasonable hope was introduced by Kaethe Weingarten (2010). Weingarten uses this term to denote the actions taken by therapists to co-create hopefulness with clients. Weingarten describes reasonable hope as a variant of hope, and distinguishes it from popular images of hope, which set up expectations that are without limits. Reasonable hope is more moderate in its aspirations and directs attention to what is within reach, rather than to what is desired but unattainable.

1. Prioritizing Risk

As previously stated the therapists described a range of activities they engaged in that were directed towards the process of making the situation safe. Central to this was the need for the therapist to remain conscious and alert to risk and not to become complacent. The issue for therapists is that initially when they start working with a young person who presents with self-harm they are very conscious about risk. As they continue to engage in therapeutic work there could be a danger that, as they begin to focus on wider issues, attention to the possibility of further self-harm could become neglected.

When discussing this, Valerie one of the therapists interviewed, expressed the view that perhaps therapists as they focus on maintaining a therapeutic alliance, can take their eye off risk and this can have tragic consequences.

“...but you cannot have an alliance with a dead patient and you can’t practice therapy if you’ve been deemed incompetent by virtue of um...it focuses the mind”. [Valerie. 15, 11-16]

Additionally, as the work proceeds and the therapist gets to know the young person and their family, they can be led into a false sense of security. Lucy was trying to convey this when she was describing her work with a young woman:

“Had I misjudged it, I don’t think I’d necessarily misjudged it, maybe what I didn’t do is pursue enough really um, her suicidal intent. And I don’t know why that was, other than I think she’d done one very quickly and also what I hadn’t taken into account that since I...you know we were going to...we’d finished in November and were gonna review her in January, things were fine but I hadn’t taken into account the life circumstances of things that had changed with her...and that she’s three months older, you know, kids between 14 and 15 can change quite a lot emotionally really, um, so that was one...I did misjudge it.” [Lucy. 27, 1-11]

Unpredictability and uncertainty are key features of working with self-harm and this explains why the therapists have to remain alert and vigilant about risk. Sometimes risk of self-harm is not part of the presenting problem, but can enter the picture during the course of the work. The therapist may notice that the young person's mood changes, or a situation may arise in which the therapist was unaware the young person had begun to self-harm and feels shaken by the discovery.

“When you’re involved in something where it [self-harm] hasn’t really been on the agenda before and...then you can get into a panic if you hadn’t thought about it or you hadn’t known about it...and then you feel did I really know what was going on for that young person, when I didn’t realize that they were self-harming?” [Valerie. 3, 4-10]

One therapist described how he almost wants to get a guarantee from the young person that they won't harm themselves but knows that there are no guarantees, and that seeking such an assurance is more about his difficulty with working in situations of uncertainty and unpredictability.

“To say you know, but also, you’ve got to be careful as well (h) because you don’t want to get into ‘you tell me’ (0.2) like you know that you’re not () you know, that you’re going to be safe and you know you can’t ask for guarantees.” [Steve. 14, 42-44]

To summarise, this Sub-category, Prioritizing Risk describes the therapists' concerns about needing to remain risk-conscious and not to take their 'eye off the ball', particularly as therapy proceeds. The therapists drew attention to the unpredictable and uncertain nature of the work and how 'un-nerving' it is when a young person begins to self-harm and the therapist has been unaware of this.

2. Assessing Risk

At the heart of making the situation safe is assessing the level of risk of suicide. Assessing risk was clearly of great concern to the therapists and was addressed by all of the participants, each pointing to different aspects they felt were important. This issue was of concern to the therapists because it is such a vital aspect of the work, and getting it wrong could have tragic consequences not only for the young person and their family, but also for the therapist.

The Sub-category of Assessing Risk includes seven Lower-level Categories:

- i. *Reaching a decision*
- ii. *Asking key questions*
- iii. *Clarifying intent*
- iv. *Assessing risk can raise therapist anxiety*
- vi. *Inadequate training*
- v. *Recording decisions: safety for the client and safety for the therapist*

- i. *Reaching a decision*

“The object of a risk assessment I think is you do something at the end of it,...and you have to be able to justify your decision: it’s real world stuff.”

[Phil. 7,10-12]

Risk assessment involves making a decision. While this might seem to be stating the obvious, I felt there was a concern being expressed by the participants that somehow this aspect of risk assessment can get lost. This lower-level category describes the key issue, as that of needing to make a decision about risk and in addition how therapists need to be supported in this task by having a framework and a set of key questions that they need to ask.

One of the participants considered that therapists would benefit from using a decision tree.

“People need a framework for making decisions. So I always thought that with something like self-harm or suicide you need a decision tree.”

[Phil. 4,10-11]

“So I think therapists can be supported in short by having a kind of decision framework and knowing what key questions they need to ask.”

[Phil. 4, 24-25]

Phil described how he had been responsible for introducing a self-harm rota that included therapists. His experience was that therapists overall were less good at keeping focused on the need to reach a decision at the conclusion of the assessment. In his view, they were very good at listening and very good at thinking therapeutically, but were not good asking the key questions.

“In many ways the therapists I have worked with are not equipped to do risk assessments.” [Phil. 7, 5-6]

“Yeah, its decision-taking. Risk is all...to me it's all about making decisions. You want to [in-breath]... You...an...and and its all about having to be able to justify those decisions and doctors do it just like that. Um and and cer...to a certain extent clinical psychologists do it, social workers are able to do it. But as therapists we we...we're, we're...we need help with it. I mean y...[0.2 in-breath] it...wh...when doing risk assessments you have to entertain a lot of hypotheses but y...you have to reach a conclusion.” [Phil. 7, 27-30 and 8, 1-3]

ii. *Asking key questions*

The ability to ask the 'right' questions was seen as a key element in the task of assessing risk. Asking pertinent questions was seen as central to the process of making a decision. There were five or six key questions that needed to be asked in order to get the kind of information that would facilitate a decision

being reached and further provide a rationale for why the specific decision reached was taken at the time.

“There are at least five or six key questions you need to ask, if you don’t ask them you’re not going to get the feedback you need to make a decision. Um, and so it will be things like um, looking at whether or not there’s a depression, so you need to ask questions about early morning waking, the length of of the mood leading up to it, [in breath], you need to ask mood, appetite, you need to ask whether they have done it before, you need to ask for the past history and you need to ask in detail about what happened leading up to the event. Um, (0.2) yeah, and and then you know if it, if there’s a presence of depression or and you...you need to look at the issues around gender and so forth. Then we’ll do this, if there isn’t we’ll do that and then you need to look at the severity, the amount, you know the number. So you ne...actually need to ask those questions.”
[Phil. 4, 11-24]

The importance of recording both the decision and the reasoning behind the decision was stressed.

“What you want in a risk assessment is four or five key points you know, I decided to...that this person is safe today because I...decided that next time I need to see them is then because...I’ve booked them back in a week rather than three weeks because...” [Phil. 7, 15-18]

iii. *Clarifying intent*

Clarifying intent is at the core of assessing for risk. This Lower-level category describes how the therapists were concerned to clarify the intention of the self-harming behaviour, and how they explore the immediate context as part of developing an understanding about the intention. This category also includes the therapists’ ideas about how to ask about intention, some of whom cautioned against the use of metaphorical language and suggested that therapists should

use direct language when enquiring about whether or not the young person had the intention to die when they self-harmed.

Rebecca describes the range of possible intentions that she holds in her mind and tries to clarify with the young person:

“Probably intent. So, there is something about um, whether or not at the moment you are, you know what the communication is, whether or not you’re trying to kill yourself, or whether or not you’re trying to communicate something to those around you or relieve a sense of profound distress...so all those things, you know, the differing reasons why people do self-harm, um, I try to understand which one you’re in (h) at that moment.”
[Rebecca. 3, 25-30]

Clarifying the meaning or intention of self-harm involves the therapist exploring the immediate context surrounding the act.

“So I would always, I think at the beginning particularly then try to get a good understanding of the context of those episodes...so you would, I would want to know what happened there...who’s doing what, how, you know the detail of it definitely.” [Rebecca. 2, 39-44]

Clarifying the intention behind the self-harm was also addressed by Lucy. She discussed how therapists need to distinguish between self-harm that is about having suicidal thoughts and plans, and self-harm that is not about wanting to die. Her concern was that as soon as the word ‘self-harm’ is used, automatically people assume suicide and this of course raises anxiety, which is unhelpful. She thought that this was more likely to occur with less experienced therapists.

“...it’s a cutter and someone says ‘ooh they’re suicidal’ I’d say, ‘well, they’re not suicidal, it’s self-harm’. You know there’s a difference”.
[Lucy. 23, 35-40]

However, distinguishing between self-harm that is about suicide and self-harm that is used as a coping strategy is not always clear and it is less easy to make a clear distinction than is commonly assumed. Jade felt that the distinction was much more blurred.

“...I think it gets quite muddled actually, although there’s a kind of this belief that you can be very clear that suicidal intent is self-harm and they’re different...I kind of think you know, I don’t quite buy this dichotomy really, it’s kind of much less clear”. [Jade. 7, 1-10]

“...but he’ll say you know...and and then actually do all sorts of, of extremely dangerous things, he doesn’t just... sometimes he’ll threaten them but every five threats he’ll do something extremely terrible like take 60 Paracetamol”. [Rebecca. 8, 1-5]

Not all the therapists interviewed felt confident about asking questions directly that related to the issue of intent of suicide.

“I won’t ask necessarily about death, I’d so ... you know like, (0.4) () I think I might ask them like what (0.2) I might ask them () you know who would miss you the most if you died, to get them to think about () or what, you know about dying, I might say something like...because I think they fear something is going to happen to them and also there’s a sense that it’s sort of ang(er). Or they might perceive it as something they’ve done wrong...I’d have a conversation about risk as opposed to death.” [Steve. 18, 24-37]

Asking directly about the intent to die is difficult for therapists: this may be partly due to a worry that somehow asking the question would make the situation more risky. In the quote above from Steve, he seems to be suggesting that the young person could feel blamed for self-harming with having an intention to die, and he tries to alleviate the sense of ‘wrong-doing’ or shame that they may feel.

Lucy also spoke about this issue of asking directly about intent to die. She described how she needs to move into a more '*linear fashion*' and cautioned against using metaphorical language. She felt she needed to ask directly about the meaning of the metaphor used by the young person, translating it into more concrete language. For example, if a young person said something about a black cloud hanging over them, Lucy would ask them, "*Do you mean you're very low?*", and then, '*Are there times when you feel it's not worth going on?*'" [Lucy, 9. 40-43].

Asking about intent is part of the process of trying to judge the level of risk. The participants described finding it helpful to think about risk of suicide as being on a continuum between high risk and low risk. Both the feedback from the questions and the '*tick box*' carried in the head of the therapist about who is more at risk, assists them in reaching a decision about the risk level.

"Yeah, I mean, I kind of also try and think 'ok, like what are the risk factors? Now we know that boys are more, four times more likely to commit suicide, so that () I, I like in my head I'd run through some [risk factors]." [Steve. 4, 28-36]

Lucy, when describing her use of the '*tick box*', also referred to the fact that apart from reminding herself about who is most at risk she also keeps in mind the fact that while suicide with adolescents is not very usual, it does happen. In the interview she recalled one suicide that had occurred in the Trust she worked in:

"So in some ways, certainly in our Trust, to my knowledge, there has only been one child in the last six years who was being seen...who killed themselves...so you know, all this sort of thing, you keep in mind really." [Lucy. 13, 5-10]

Deciding about the level of risk and where the young person lies on the continuum between low and high-level risk helped therapists in making decisions about how best to respond in terms of keeping the young person safe.

A key question for the therapist to consider is whether or not the young person's level of risk is such that working on an outpatient basis would not be safe and admission to an adolescent inpatient unit is indicated.

"...but you know if people were saying... 'I cannot say that I won't kill myself'... then they would have [to be admitted to an inpatient unit]".

[Lucy. 3, 9-13]

Comment

The findings presented above generated the following thoughts and links to the literature and to professional experience.

It has been my experience that the same young person can use self-harming behaviours both as a way to experience relief from distressing thoughts and also with the intention of suicide, which makes the issue of judging risk much more difficult and furthermore engaging in one form of self-harm can lead to the other. Hawton (2005) highlights the ambivalence in intentions that lie behind the act of self-harm.

When thinking about Steve's quote, and his description of how he asks about the intention of suicide, I was reminded of a workshop I attended on assessing risk. The training was attended by counsellors and therapists and as part of the training the participants were asked to role-play assessing risk. It was remarkable how many of those involved reported a hesitancy in asking the question directly about intention of suicide and those in the role of the client reported noticing a lot of 'beating about the bush' which actually had the effect of raising their anxiety.

While there was a very important emphasis by the therapists on the need to ask the 'right questions' and reach a decision, there is also I believe a danger of approaching the task as a 'tick-box' exercise and not placing emphasis on establishing the kind of relationship with the young person that would

encourage them to engage in therapeutic work (Ougrin, 2010; Fortune and Clarkson, 2014).

Toth et al. (2007) suggest that individuals in general and some clinicians believe that discussing suicide may lead directly to increased risk of suicide. Toth et al. (2007) also suggest that when assessing risk, it is best to use concrete words such as 'kill yourself' and 'commit suicide'.

Shea (2002) advises clinicians to notice slight hesitancy in answering, which may suggest that a person has thought about suicide. Similarly, responses such as 'no, not really' usually imply that the person has had some suicidal thinking.

Toth also suggests that therapists should monitor their own internal dialogue and feelings, and should ask themselves the question: 'Is there any part of me that doesn't want to hear the truth right now?' Toth highlights that when assessing risk, the clinician needs to be aware of the most important information needed from the client which is the current level of suicidal ideation, suicidal intentions, if there is a plan of action and what access the person has for the 'means of completion'.

Summary

In summary, this Lower-level category *Clarifying intent* describes how therapists manage the issue of addressing the intention behind the self-harming act. Addressing intention requires therapists to ask the young person directly about whether or not they intended, or still intend, to kill themselves.

Some of the therapists caution against using metaphorical language and instead advise that therapists use direct language and direct suggestions. This category also described how therapists can be helped to make decisions about level of risk and about whether or not an inpatient admission is needed.

iv. *Assessing risk can raise therapist anxiety*

Overall, experiencing anxiety was a key feature for the therapists and nearly all of the participants referred to feeling anxious. The level of anxiety seemed to be directly related to the level of risk involved.

“Well if I think it’s at the high end of the continuum then I feel anxious, if it’s at the low end of the continuum I don’t feel anxious.” [Lucy. 23, 24-25]

*“Er, (in breath) (0.1) , I...it’s just something, sometimes you manage it better than other times, sometimes it might not bother you and there are times when it will bother you () yeah and you think ‘Oh God, I ca...I need to phone them sort of you know, dash back to the office.”
[Steve. 15, 34-39]*

Therapist anxiety was also linked to how they were feeling emotionally on a given day. Steve talked about when he is not feeling ‘emotionally centred’ he will feel more anxious about risk.

*“It depends on how I’m feeling really, If I’m feeling alright or it depends (0.2), I suppose that’s the personal link in that if you’re (), if you’re not feeling centred, I think you feel more anxious about (the risk).”
[Steve. 3, 21-26]*

He very much felt burdened by the anxiety in managing situations where there was high risk of suicide and portrayed a strong sense of feeling isolated with this burden. When describing one case where the burden was lifted from his shoulders and other agencies became involved he said, *“Thank God it was not on me”, [Steve, 12, 17-18].*

The participants described other aspects of assessing risk and working with young people who self-harm that made them feel anxious. Of particular concern was the experience of working with young people who hid their suicidality behind an apparent ‘happy’ face. These young people raised a lot of

concern and anxiety for the therapists in terms of trying to ‘accurately’ assess their level of risk and safety. Some participants spoke about not feeling able to trust the word of the young person, or to trust that the young person when feeling suicidal would access help and support from their parents or other adults, including the therapist.

Lucy described a situation in which she had made a risk assessment, had asked the relevant questions and on the basis of the feedback she decided the young person was safe enough, and then later that evening the young person took a serious overdose.

“...and I saw her, talked to her about it and talked about the suicidality and everything else and, um, she wasn’t go...she wasn’t going to do it again. She went out, that night she overdosed, a serious overdose again. So that, you know, made me think”. [Lucy. 27, 8-11]

For the therapist these are very difficult situations to manage, they are fraught with uncertainty and the therapist has to live with the knowledge that there are no guarantees that the young person will not harm themselves despite having assessed their level of risk and made the best judgement they could. One of the therapists described how she manages this. She described that she tries to be transparent with the adolescent and their parents about the dilemma that she faces in trying to ascertain how the young person is really feeling.

“Um, checking that communication out, whether she...where she felt really, how, if she was [suicidal] even if I couldn’t guarantee, but at least putting it on the agenda to be discussed.” [Marilyn. 13, 6-7]

“...being transparent that I had a concern for her safety”. [Marilyn. 15, 5]

Comment

The above findings highlight some of the difficulties in assessing risk, particularly the anxiety involved for the therapist. As Fonagy (2008) suggests

there is no sure means of predicting suicidal risk, and he further states that there is a gap between the larger picture generated by research which is about identifying risk factors and high risk groups and the experience on the ground for practitioners. Toth (2007, p.1) suggests that suicide is 'one of the few topics that uniformly triggers anxiety and apprehension in clinicians, both in novice students and in the seasoned practitioner'.

Summary

To summarise, this Lower-level category *Assessing risk can raise therapist anxiety*, describes how working with high levels of risk is very anxiety-provoking for therapists. What is burdensome is not just the level of risk, but also the difficulty in ascertaining how 'risky' a young person is. This is particularly a problem when working with adolescents who hide how they are really feeling, or who make threats to self-harm and then sometimes follow-through. The therapists have to live with a lot of uncertainty, in the knowledge that despite their efforts to make 'correct' assessments there are no guarantees that a young person will not self-harm.

v. *Inadequate training*

Training in self-harm was considered by some of the participants to be inadequate and overly focused on facts and it was suggested that family therapists were less well trained and less skilled at conducting risk assessments than their colleagues from other disciplines.

"...and doctors do it just like that. Um and to a certain extent clinical psychologists do it and social workers are able to do it but as therapists we, we, need help with it". [Phil. 10, 29-30]

Another view discussed by a few of the participants was that a systemic training while being helpful to therapists when assessing risk, did however also have the potential to act as a constraint. Systemic training helps to widen out the focus and entertain multiple hypotheses, while the 'art' of risk assessment involves

narrowing the focus and reaching a decision. Further it was felt that the emphasis on the therapeutic relationship could 'blind' the therapist to the need to prioritize action over therapy. This idea was expressed by Valerie:

"...but it may well be that because we are so focused on the therapeutic alliance, um, some of us may struggle with moving into the domain of production". [Valerie. 15, 6-7]

v. *Recording decisions: safety for the client and safety for the therapist*

This Lower-level category describes how therapists are careful to follow procedures and policy both to ensure safety for their client, but also to ensure safety for themselves in the event of a serious suicide attempt or completed suicide.

"If I think someone's on a suicide continuum, I will do, I will put a risk assessment on () [electronic recording system], I will be very careful that before I go home I do my notes, so I have safety issues for myself as well, you know what would I do if they kill themselves." [Lucy. 7, 30-32]

"...so I'm not at the centre of some inquiry because one of my patients has killed themselves". [Lucy. 9,12-13]

"Well it's it's, well it's covering yourself in paperwork." [Steve. 4, 22]

Comment

Reflecting on the findings presented above, I recall that when I interviewed the therapists and we were discussing the issue of assessing of risk, one of the concerns raised was about how time-consuming it was following prescribed protocols for dealing with risk. The participants described the amount of time that had to be devoted to detailed record-keeping and how this was both a hindrance and a help. It was considered a hindrance because it took up time

that could otherwise have been better spent discussing the situation with colleagues and developing a way forward. However, it also seemed that the therapists found following procedures helpful because it created a feeling of safety for the therapist.

My impression was that following prescribed procedures gave the therapist a sense that they acted competently and responsibly, and also a sense they had done everything they could and should have. Whilst it was not stated explicitly, I had the impression that at the back of the therapists' minds was a belief that in the event of a suicide they did not feel that they could rely on being supported by their managers and that there could be an effort to apportion blame to the clinician.

Summary

In summary the Sub-category, Assessing Risk describes the issues involved for therapists in making assessments of risk. They drew attention to the need to be clear as to the core task involved. The essential issue is that of making a decision as to the level of risk, which involves asking key questions of the young person and addressing the issue of intent. The therapists described the impact of the work and how they worried about making the wrong judgement despite adhering to good practice guidelines.

3. Focusing on Risk Narrows Perspectives

This Sub-category describes the participants' reflections on how clinicians can get overly focussed on the issue of risk and ensuring safety to the exclusion of thinking about and generating an understanding as to the meaning of the self-harming behaviour.

"I think things can get a little bit knee-jerk, action is the highest context marker as opposed to thinking..." [Steve. 3, 39-40]

In the above quote Steve seems to suggest that the need to ensure a young person's safety becomes the central focus of the team and when this happens what gets neglected is thinking and reflecting, and making sense of the young person's actions. This seems to come about because of the fear evoked by the self-harming behaviour and the tendency to assume that self-harm is always about suicide.

"...so it really is (0.2) you know not having a knee-jerk reaction; oh self-harming means high risk, means suicidality, means you know some action mode rather than how can we think about this and what (0.1) can, um (0.1) modify it..." [Valerie. 3, 14-17]

In the interview with Rebecca she at one stage described self-harm as acting like a 'core in the middle' that everyone wants to talk about, and that the therapist has to try and widen out the conversation into lots of different layers. She was referring to how the family gets mesmerized by the self-harm, but it would seem that this can also happen to therapists and therapy teams. Jade was talking about this when she described how clinicians get very focused on the 'risk bits' and lose sight of contextual dimensions, treating the self-harm in isolation.

"...and I think the other bit is a fairly basic kind of systemic idea that you know you can't see it in isolation, that it's very much contextual and that people get very focussed on the risk bits around cutting, overdosing and somehow ordinary analysis and and... you know, the wider way of thinking about young people and assessment just kind of sort of gets frozen really...because of risk I think". [Jade. 6,14-22]

Exploring and generating meaning in the context of situations in which there is risk of suicide is a difficult and complex task for the therapist. The family are fearful and anxious and want the risk taken away. Their confidence is at a low ebb and they look to the therapist to take over the responsibility for safety. The therapist has the twin task of both engaging the family in creating safety, and exploring and generating meaning so that change can take place. The therapist

also has to judge when the level of risk is such that they do need to take responsibility for ensuring the young person's safety.

“Um, [0.20] um, well you have to make sure that the risk is covered I suppose with the parents and that the young person is safe... That may prescribe or limit or...I'm sure it does affect the choices you might have [of how] to intervene.” [Marilyn. 21, 38-39]

Summary

To summarise, this Sub-category, Focusing on Risk Narrows Perspectives describes how concern about risk of suicide can lead teams to focus entirely on how to keep the young person safe and neglect wider discussion about the meaning of the self-harming behaviour. This can be mirrored in the family's behaviour. They will tend to want to focus all of their attention on self-harm and the therapist has to therefore try to widen the conversation in order to generate connections and create new meanings.

4. Creating Containment and Containing Anxiety

Managing anxiety is central to achieving safety. This Sub-category describes how the therapists acted to manage levels of anxiety in both the parents and in the young person. The therapists described working to help parents remain calm so that they can be more attuned to their child's distress and more able to work with the therapist to make a safety plan and to talk about frightening issues.

Some therapists described the need to respond quickly, providing prompt appointments, out of hours contact numbers and creating a safety plan with the family.

“...quick response and continuity of care and so if you’re seeing someone, you see them again quickly and again you know...so you sort of provide (0.1) a sense of containment”. [Steve. 15, 5-6]

The therapists described how they also needed to attend to the impact of the self-harm on parents, ensuring space for them to articulate and discuss the degree of their concern.

“People are very scared indeed that their children will die and I often have to name that, I do find myself being quite straightforward...”
[Rebecca. 7, 2]

“You know very often I see parents on their own...very often and young people on their own...um (0.2) because I think often parents want to talk about their worries without thinking they can make things worse”.
[Rebecca. 9, 6-11]

“Self-harm can be a lot more frightening if you don’t, if you don’t talk about what the impact of that is...in a very straightforward way.”
[Rebecca. 8, 33-34]

The therapists described how part of the process of achieving containment and safety was working initially with different parts of the family but holding everyone in mind and bringing family members back together again. The therapist seems to act as a bridge between the young person and their parents; working with the young person and helping them to articulate what they would like to convey to their parents and then jointly working on safety plan.

“I think probably what I did is, I then saw (name) a bit on her own, and then asked mum to join us at the end...’cos seeing them the whole session together was counterproductive, um and I didn’t see any point at that stage at putting Mum behind the screen so, I, I...and that’s when I started...I saw [name] for say 20 to 30 minutes on her own, then asked

mother to join us around specific themes that we'd talked (about), so I focused it, I structured it more really.” [Lucy. 21, 39-45]

While it wasn't explicitly named by the therapists, part of the work would have involved helping parents to notice and respond to their child's distress, which is I think what Rebecca was saying when she talked about helping parents stand in the shoes of their child.

“...your ability to...put yourself in the other's shoes”. [Rebecca. 5, 13]

A central part of the work for the therapist in creating containment is to communicate to the family that the setting is one in which difficult and frightening issues can be talked about.

“You could create a context that was safe to explore things, I think in the w...perhaps in relation to self-harm...perhaps one has to have, provide a containing space that you're not frightened by it, you are able to hold it, you are able to deal with very difficult things, because I think if they don't have that sense...that the risk can be held too and you can help them to think about it.” [Marilyn. 24, 33-41]

The therapists were drawing attention to how essential it is to create a sense of safety. This involves being able to discuss parents' worst fears and concerns early on in the work, and creating safety through a structured approach, ensuring that parents can work together to provide safety and reduce risk of self-harm. It may mean that temporarily, exploring meaning will need to be put on hold.

“...and it's not saying you're not going to explore meaning...but you'd certainly want to have um, some sense of it being held by the parents or carer, that there was a safety plan”. [Marilyn. 26, 21-26]

Comment

From the preceding section, the following thoughts and links with the literature were generated.

I thought that Rebecca when discussing a parent's ability to 'put themselves in the other shoes' may have been referring to using Mentalization-based ideas (Asen and Fonagy, 2011) to promote understanding of the young person's emotional experience and to reduce distress. Asen and Fonagy (2011, p.362) suggest that an emphasis on mentalization helps family members to become 'more receptive to tuning into each others' thoughts and feeling states', and further that difficulties in mentalizing may lead to feeling misunderstood, which in turn creates distress. Hopelessness in children occurs when parents are temporarily or chronically unavailable and when there is an absence of relational mentalizing, 'a pessimistic sense that feelings can never change may take over' (Asen and Fonagy, p.357).

Marilyn, when assessing risk, takes into account the parents' capacity to create a safety plan. Carr (2002, p.37) suggests that 'the commitment on the part of parents to monitor the adolescent constantly until all suicidal intention has abated' is a key protective factor when assessing risk. In my experience, parents who feel hopeless and powerless can lose the willpower to take steps to create safety and this can have the effect of increasing risk (Pentecost and McNab, 2007).

Summary

In summary, this Sub-category, Creating Containment and Containing Anxiety describes how the therapists were concerned to work on containing anxiety from the earliest encounter with the young person and their family. This involved responding quickly, giving contact numbers and early follow-up appointments and also working with parents to help reduce their anxiety so that they are in a better place to respond to their child's distress and able to take steps to keep their child safe, collaborating with the therapist in developing a safety plan.

5. Resources for Risk Assessment and Management

This Sub-category describes the theoretical resources that the participant therapists draw on to underpin and guide their clinical work with young people who self-harm. They articulated a need to draw from different models and not rely solely on one perspective. The importance of the relationship with psychiatry colleagues and other team members is also described.

This category has two Lower-level Categories:

- i. *Theoretical resources*
- ii. *Professional relationships*

i. *Theoretical resources*

This Lower-level category describes the participants' views about the different theories that they draw on, which act as a resource for them. One of the participants emphasized that when managing risk they needed to draw on a range of different theoretical models, utilizing different techniques from the different models.

"I love the mid-range theory which...I think all disciplines should use...you can draw these out of the therapy discourses which are really helpful in managing risk, for example projective identification is really useful...you don't need...the whole of the psychoanalytic paradigm to find that a really useful theory in managing risk." [Phil. 33, 1-5]

The view expressed was that clinicians didn't need to 'buy into' a whole theory, but could access particular aspects that were helpful, for example, to ask good 'circular' questions does not require knowledge of the whole Milan Systemic Theory.

"You don't need to ha[ve]...do a four-year training to be able to ask questions of somebody who has just taken an overdose." [Phil. 33, 11-12]

Phil also believed that when conducting risk assessments clinicians needed to have a model, or a map that guided them when assessing risk and that adhering to a single model may not be the most effective approach because of the complex picture that self-harm presents.

“I draw on a bit of systemic, a bit of CBT, a bit of cognitive (), a bit of psychodynamic,...I think it’s profoundly un-useful to stick within one paradigm when it, when its managing risk, I think you need multi-paradigms.” [Phil. 33,15-22]

When explaining his model, Phil described it as a mid-range model that can be applied and taught:

“...a ‘mid-range’ model. You can apply that, you can teach that, you don’t have to buy into the whole of...to do a four-year Masters in systemic...you can teach that to anybody”. [Phil. 35, 8-11]

Overall the therapists seemed to suggest that what supports them in terms of theory when assessing and managing risk is what is useful and what is practical.

Comment

Reflecting on the findings presented above, what struck me was the therapists’ emphasis on using ‘what works’ and ‘what is useful’. What was unclear however, was whether eclecticism or integration was being suggested. Without knowledge of where different theories come from, I think it would be very difficult to be integrative. Integration requires the ability to have the different discourses dialogue with each other, while eclecticism allows ideas to sit beside each other as separate entities (Larner, 2009). In my view, experienced therapists over time, develop the ability to draw on different modalities in a ‘holistic’ way. I don’t think this is the same for inexperienced or recently qualified therapists. While the urge to do what works is understandable, I also believe it deserves to be approached critically.

ii. *Professional relationships*

In addition to theory and training, the therapists also described other sources of support – these were having good relationships with colleagues and easy access to psychiatry colleagues.

“I think what’s crucial (0.1) for a therapist to manage risk is a very good er community [0.2] er communication (0.2) er (0.4) I’m trying to think of the word – loop ...with the consultant – I think that’s crucial and equally to have a very good supportive team.” [Gary. 2, 14-18]

Phil also talked about the need for “access to good people” and considered himself lucky to work in a setting where there were four psychiatrists. He felt there was a disadvantage to small teams because there were not enough people around: “...you need people in the moment” [Phil. 20, 20-21].

When describing a particularly worrying situation in which a young woman had “an active plan to jump out of a window” Valerie turned to her colleagues for a psychiatric assessment.

“...whereas if I do involve other colleagues and I hadn’t previously, it would be (0.2) for a particular reason, I would actually be wanting a psychiatric assessment and to be on sturdier ground myself”. [Valerie. 4, 10-12]

The therapists needed to feel they could draw on their team as a resource, but in some situations they encountered unhelpful attitudes, as Valerie suggests.

“There can be some colleagues who are quite blasé about risk, who quite like um, appearing to be un-phased by risky situations. I find that quite stressful.” [Valerie. 11, 7-8]

“When you are thinking about self-harm, you want an atmosphere in which people aren’t going to say simply ‘oh she’s a self-harmer’ or you know, ‘he’s a self-harmer’, um as though it’s one thing or as though it’s simply

um, something histrionic, demonstrative but doesn't really mean very much. You want it to be thought about, you know, in each instance: what does it mean, what kind of communication is this?" [Valerie. 5, 2-7]

Comment

The preceding section on *Professional relationships*, prompted the following thoughts and links with the literature and with personal professional experience.

I think that Valerie, when describing some of the unhelpful attitudes of her colleagues, is drawing attention to the fact that there are unhelpful discourses in our culture about self-harm and that these discourses influence the attitudes and behaviour of people working in this area. In my experience, parents and young people will often refer to being treated unsympathetically by for example, accident and emergency staff.

Self-harm and suicidal behaviour seem to evoke strong emotional responses in people. Several studies have reported on the attitudes of staff working in the context of accident and emergency services (Horrocks et al., 2005; Taylor et al., 2009). Anderson (1998) refers to how some of the behaviour observed in hospital staff may represent the 'footprint' of historical attitudes to suicide and self-harm.

The discourses we draw on influence how we approach and deal with the issue of self-harm. Until fairly recently the term 'deliberate self-harm' was a common term used by mental health professionals and was abandoned because of its judgemental inference.

How young people and their parents are received and treated by medical staff in A&E departments can play a significant role in whether or not treatment options are pursued. Asen (1998) points out that the interactions between staff and families in A&E departments has the potential to help family members feel positive about receiving therapy and therefore improve the likelihood of engagement with therapeutic services.

Summary

To summarise, this Sub-category, Resources for Risk Assessment and Management, describes the therapists' views about what theoretical resources help in the assessment of risk, and the category also includes a focus on how important it is for therapists to have supportive relationships with psychiatric colleagues whom they can call on. The therapists highlighted how unsupportive it is when colleagues hold unhelpful attitudes about self-harm and display a 'blasé' approach.

6. Inter-service Collaboration

This Sub-category describes the therapists' views about the need for good cross-service collaboration as part of creating a safe context for the young person. This includes ensuring that decisions and interventions are clearly recorded in a way that the other service can know what has already been addressed. Inter-service collaboration is important not only between CAMHS and A&E, but also at the point of discharge from hospital to community services.

"...I think it's useful for the patient...because I think if they go into a ward and, you know the people who are seeing them can see the history, can see the themes, on [name of electronic recording system]...I tend to...I only write anything people can read, I might write themes of what we've talked about, with someone I think there's suicidal intent I'll be very clear about what I've said, I've asked them, are they going to kill themselves, they've said no simplistically...that's my own protection really".

[Lucy. 7, 36-46; 8, 1-5]

In discussing the importance of collaboration across services, Lucy focused her comments on the relationship between CAMHS and A&E. She stressed the need for good record-keeping so that the work of one service could inform the other service in creating a framework for keeping the young person safe. One can see in Lucy's words the concern about the need to accurately and clearly

record her actions as a way of protecting herself in the event of an inquiry. The theme of safety is central in the work with self-harm, safety for the young person and safety for the therapist.

Inter-service collaboration is also central to keeping a young person safe at the point of transition between inpatient and outpatient services. Gary, who worked in an inpatient setting, believed that this transition point is the most risky phase in treatment. He emphasized the need for good working relationships between the inpatient team and the outpatient team who will carry on the work post discharge. This transition is of concern for therapists because the family will be feeling very anxious and very conscious of the different levels of support between the two settings.

“Sometimes it is just one or two meetings, but I think it is important for the family to know they will be carried over and to feel that they are fully (0.2) integrated in the other service and with a new therapist.” [Gary. 7, 4-7]

Careful planning and holding joint sessions prior to discharge with the team that are taking over are helpful ways forward and act to increase the confidence of the family and young person in the outpatient team.

Ideally, in Gary’s view, outpatient and inpatient services need to work as one service. Inpatient units need to avoid acting in isolation, and foster relationships with the outpatient team by keeping in touch regularly, establishing from the beginning the kind of relationships with colleagues that will support the transition when it happens.

Summary

In summary this Main Category, Making the Situation Safe describes the many aspects of the participants’ practice aimed at creating safety. The therapists highlighted the need to be always risk-conscious and to ask the ‘key’ questions when assessing risk, and enquire into the intention behind the act of self-harm. They drew attention to the way that clinicians can get drawn into a very limited frame, concentrating on the actions that needed to be taken to secure a young

person's safety and not also prioritizing reflection and understanding. They described some of their own reactions and worries, and how part of the task was learning to live with uncertainty and the knowledge that suicides do happen, despite people's best efforts.

Therapists spoke about the need to create a sense of safety through the kind of therapeutic relationship that conveyed confidence, care and trust: by attending to parental distress and fear, creating clear plans for ensuring the young person's safety, encouraging the noticing of distress and responding to that distress the relationship enabled the family to take responsibility for keeping their child safe. The therapists also described some of the resources they draw on when doing this work – both theoretical and relational – and finally the issue of inter-service collaboration and the ways in which this can aid the creation of a safety net for a young person.

Taking the necessary steps to ensure a young person's safety involves the building of a safe and trusting relationship between the therapist, the adolescent and their parents. Ensuring that the young person is safe and that parents can be active in keeping their child safe is the first step in creating a context for change. Creating change involves the therapist in engaging in the kind of conversation with the family that helps them begin to feel a sense of agency and move out of positions of rejection or helplessness so that they can start to see a way forward. From a position of safety, the first steps towards making change become possible and parents can begin to feel more hopeful, and have the courage and commitment to withstand their feelings of hopelessness.

6.3 MAIN CATEGORY 2: Conversing Therapeutically – The Practice Of Hope

This Main Category describes the stances and activities engaged in by the therapists in generating a context, a conversational space in which hopefulness is co-created and change can take place.

Five main Sub-categories emerged:

1. Relating with Vulnerable People in a Helpful Way
2. Making Sense and Meaning
3. Focusing on Communication
4. Making Change Manageable
5. Therapist's Relationship to Hope.

1. Relating with Vulnerable People in a Helpful Way

This Sub-category describes how therapists positioned themselves so that they could engage with families in creating a working alliance and therapeutic relationship. The therapists described how they went about the task of trying to create the kind of relationships with families that would allow them to enter into meaningful conversations, the kind of conversations that have the potential to create change. Central to this task was a recognition of how vulnerable family members can feel when engaging with helping agencies, how exposing and risky it can feel to put oneself in a help-requesting position even when the presenting problem is itself accompanied by fear and danger. When family members are distressed and frightened about the future they may also worry as to how the therapist might judge or even reject them.

This Sub-category has five Lower-level categories:

- i. *Exploring the meaning of engaging with mental health services*
- ii. *Lifting the burden of blame and shame*
- iii. *Creating a 'conversational space' in which frightening and difficult issues can be spoken about*
- iv. *Holding hope temporarily, believing in client resourcefulness*
- v. *Challenges faced in relating with vulnerable clients.*

i. *Exploring the meaning of engaging with mental health services*

This Lower-level category describes how the therapists recognize and address the impact and meaning for the family of attending a mental health service, paying particular attention to the sense of shame that family members may be experiencing. Taking time and trouble to attend to this helps the family to understand the meaning of the therapists' questions and is a step in the process of building a working relationship.

Lucy drew attention to the importance of recognizing and discussing with families the impact of coming into contact with mental health services and the meaning it holds for them.

"I think you know, certainly when...in the first few sessions they are preoccupied you know, I...for some people it brings them into the context of mental health for the first time...so what[']s the meaning of that really, cos it means you're bonkers...so you know, how is that for (them)? And I think a big thing for people that um, you know they...kids may make an impulsive overdose and find themselves in the mental health system, unless you can talk to them about what the meaning of the mental health system [is]...then they won't understand the meaning of your questions really." [Lucy. 11, 37-46 and 12, 1-4]

Lucy takes trouble to explore the meaning of attending a mental health service for the family and she also takes time to explain to the family about mental health services so that they can make sense of the questions she is asking. By doing this she is trying to reduce the stigma that families can feel when they have to engage with mental health services. In her experience the meaning of attending mental health services is often understood as "*cos it means you're bonkers*".

ii. *Lifting the burden of blame and shame*

Communicating with the family about feelings of shame and blame was an aspect of the work that some of the therapists referred to as being central to their work. They described how they try to remain sensitive to the expectation of blame that many families experience when encountering mental health professionals. They explained how they work to lift the burden of shame and blame that families may feel, conveying acceptance and openness to what the family bring, and conveying their belief that the process could be helpful to the family, and a hopeful outcome possible. The therapists described how they try to reduce blame through normalizing problems and through the use of systemic techniques such as externalizing⁴ (White, 1990) and positive connotation⁵ (Selvini et al., 1980; Boscolo et al., 1987).

“They’re worried about being blamed. This is the first time they have come across a helping professional, so they’re going to be worried about blame.” [Phil. 6, 2-3]

Marilyn talked about how she works to convey to the family that she will not judge them, but also that she can be of help to them. In this way she both addresses the family’s sensitivity to being blamed and is also seeding the idea of a hopeful outcome.

“...but I think they have to feel that they’re not going to be sort of judged in a negative way, that they’re going to have a sort of um, an interested listening space that’s non-judgemental that actually is helping them solve problems”. [Marilyn. 23, 37-39]

⁴ Externalising is a therapeutic technique introduced by Michael White (1990) as part of the repertoire of narrative therapy interventions. Externalising involves viewing the person as being separate from the problem, and exploring how the problem impacts on the person’s life and relationships. The aim is to increase agency and help the client develop new and different stories about themselves.

⁵ Positive Connotation is a concept developed by the Milan Team (Selvini et al., 1978; Boscolo et al., 1987). It is a therapeutic stance adopted by the therapist, in which he or she takes the position that a positive intention is motivating the behaviour of family members. Positive connotation is based on the assumption that family members cannot change under a negative connotation (Dallos and Draper, 2000). The aim of this therapeutic stance is to reduce blaming interactions and in so doing help family members to develop new and different meanings about the behaviour of members of the family and the problem.

The therapists also described how they sought to normalize mental health problems by giving examples either from their own lives and experience, or from the experience of other families they had worked with.

“...and I would do a lot of normalizing about stigma, myself, I’d spend a lot of time you know generalizing and normalizing and saying what was useful for me and so forth and other people I have known and other clients, you know”. [Phil. 41, 10-13]

The participants described how they try to place the young person’s difficulties within the frame of adolescent development. Lucy expressed the view that talking to parents about adolescent development and ‘re-wiring’ in adolescence was a way towards reducing blame as it situated a lot of ‘problem’ behaviour within the context of adolescent development.

“I do talk to people about that, I think it somehow, it can be a let-out for children and parents, not an excuse but a let-out in terms of ‘well this is what all adolescents are doing’ um, I think in terms of a process of development.” [Lucy. 16, 1-6]

Lucy’s strategy of contextualizing the young person’s difficulties within a developmental framework not only serves to mitigate against blame, but it also seeds a sense of hope and the possibility that both the present and the future is not fixed, and as a result is therefore open to change (Weingarten, 2010).

Comment

The preceding material prompted a series of thoughts and connections with literature and with personal professional experience.

The therapists referred to how they intervened to reduce feelings of blame and shame. Several of the therapists described the use of techniques from both the Milan and Narrative models, particularly positive connotation and externalizing respectively, as being helpful in their efforts to reduce blame. One influential

idea was that when family members both blame each other and feel blamed, they cannot change. The therapeutic stance of positive connotation 'infuses' all of the therapist's attitude and orientation towards family members and thus is not just a technique. It can help to create greater empathy between family members, and between the therapist and the family, and is therefore a key component in the building of a therapeutic relationship. The use of positive connotation helps to change how the family view the problem and each other, and can lead to a more hopeful outlook.

Jurich (2008) refers to the aspect of taboo that still exists in relation to suicide in Western society, and therefore how the adolescent may feel very shameful for having suicidal thoughts or actions. He also believes that parents find it very difficult that their child has had suicidal thoughts or intentions. He suggests that they can feel a similar burden of shame and may find it hard to actually say the words: my child has thoughts of killing himself/herself.

One of the therapists, Marilyn, described how she tries to convey to the family that she will not judge them and also that she can be of help to them. This is supported by Sprenkle et al., (2009, p.102) who discuss how most clients are demoralized when they first come into therapy and suggest that the therapist needs to build a 'reality-based optimism about the change process'.

The therapists place great emphasis on normalizing the family's and young person's experience through giving examples from their own lives. This finding echoes Hof (1993) who suggests that therapist's sharing their own similar experience is part of what can create hope for clients as it normalizes the client's experience.

When working with self-harm the therapist has the dual task of trying to reduce blame, while at the same time working towards parents taking responsibility for the safety of their young person and for changing how they relate with each other and with their child. This can be difficult to achieve, particularly when trying to disentangle blame and responsibility. Because of the element of risk, in my experience there can be a tendency for a therapist to 'push' parents into a

position of taking responsibility, which can then result in parents feeling attacked and blamed. Madsen (1999) suggests that externalizing conversations can be helpful with this issue as they help to create a separation between blame and responsibility. He further suggests that through externalizing, family members can be helped to consider their relationship to the problem. This can result in an increased sense of agency in relation to the problem, accompanied by an increase in the taking of responsibility for dealing with the problem.

Summary

In summary, this Lower-level category *Lifting the burden of blame and shame* describes how the therapists try to address issues of blame and shame in their work with the family. They describe needing to be alert to, and sensitive about, the family's expectation of being judged or blamed by professionals. Addressing these themes in the therapeutic conversation increases the likelihood of making a good connection with the family and building a relationship in which the family feels respected and accepted. It also creates a context in which making change becomes realizable and family members can begin to feel hopeful about their situation.

iii. *Creating a 'conversational space' in which frightening and difficult issues can be spoken about*

In addition, the therapists thought it vital to convey to the family that this conversational space is one in which frightening and difficult issues can be talked about, and that as a therapist one is capable of managing that in a helpful way. The therapists described how they wanted to convey this, and reassure families that they were open to hearing whatever needed to be shared.

"...I think there is something about conveying a sense of...there was nothing we haven't heard before". [Rebecca. 16, 23-24]

Having humility in the face of what others have to cope with helps a therapist to 'walk with' the family in their distress, not leaving them isolated and alone, and

vulnerable to hopelessness. I think Rebecca was trying to convey something of this when she said:

“Yeah, I think people sometimes...really need an experience of being helped through what happens to them...you know I can’t underestimate that support.” [Rebecca. 14, 21-24]

Rebecca, when describing some of the families she works with, said that they often appear “frozen out from each other” because of the levels of distress and anxiety they are experiencing, and she works to help them understand what’s happening to them, encouraging them to speak about it with each other.

Being transparent with families was considered by the therapists to be a key component of the therapeutic relationship, both in terms of building trust and safety, but also as part of laying a foundation for taking therapeutic risks.

“Um (0.3), well it’s interesting what...we were talking about being straightforward before because I think if you don’t take risks as a therapist you don’t create a place of safety, whereas if you take risks people can trust that they are hearing what you think so you know...”
[Rebecca. 17, 38-41]

“I value that they know what I think or that they feel as though I’m not kind of thinking something that I’m not (saying).” [Rebecca. 16, 19-20]

Rebecca links being straightforward and transparent with families as part of laying the foundation for taking therapeutic risks and that conversely, taking risks meaning being transparent about your thinking, creates safety.

Some of the participants discussed how when parents are faced with the seriousness of their child’s behaviour they will very often feel fearful that it could happen again and they shy away from talking about their worst nightmare – ‘What if she had been successful?’ The therapists found that parents will often hold the belief that talking directly about these issues will make the situation

worse and will trigger further self-harm. The therapists found that being able to speak about this directly challenges the idea that talking will make things worse. Rebecca in the following quote describes how by articulating a parent's worst fears she helps to reduce their anxiety and panic and puts the unspeakable into words.

"...people are very scared indeed that their children will die and I often have to name that. I do find myself being quite straightforward about...because I, I'm not sure people often will say that, particularly after an overdose, I think that's my experience that, that maybe they're kids are saying 'well I'm fine now, don't talk about it now' but the parents are still absolutely terrified that they are going to die, because they didn't see it coming the first time...'why would I see it coming the second time, you said you were all right?' um, so that ..I think that's a strong thing; you know, my children are going to die". [Rebecca. 7, 2-9]

As we saw earlier in this section therapists see the need to pay attention to the fears involved for all family members. The fear involved can immobilize parents and they can lose their ability to be effective sources of support for their children.

Comment

Jurich (2008) suggests that therapists need to pay attention to the fears involved for all family members, as much of the behaviour surrounding thoughts of suicide are generated by fear. The fear involved immobilizes parents and they lose the ability to be effective sources of support for their children. They can also be thrown into an 'existential predicament' as their child who has so much to live for in their eyes, seems to be choosing death over life. This can raise questions for parents about their own mortality.

I have found this a very useful area to explore in my own work with families particularly when there is a strong sense of hopelessness in parents and a strong element of blaming of their child who is exhibiting suicidal thoughts and

behaviours. Very often when these issues get discussed a parent will reveal feeling depressed, at times feeling suicidal and wanting to give up on life.

Summary

To summarise, the therapists drew attention to the need to address the fear that the self-harm engenders and to convey to the family that difficult and frightening issues can be discussed. The therapist acknowledges the fear and helps the family to articulate their worst fears and their belief that talking about self-harm, particularly suicidal thoughts and intentions will make things worse.

Taking the risk of talking about these issues in a direct and transparent manner creates safety and lays the foundation for creating change.

iv. *Holding hope temporarily, believing in client resourcefulness*

This Lower-level category describes how the therapists try to remain aware of the fact that families will initially find it difficult to generate hope and how the therapist will need to act as the 'holder of hope' temporarily, while working at the same time to help family members reconnect with their own resources and confidence. When people are frightened they tend to lose contact with their own resourcefulness and therefore their ability and agency in developing hope.

In the following quotes the therapists discuss having the idea that families in which a young person is feeling suicidal and who may have taken a serious overdose are families who tend to lose sight of hope, and that the therapist has to keep hope *'in the frame'*. They also discuss the need for the therapist to find ways to reconnect families with their resources and strengths, so that they can rebuild confidence which in turn helps them to begin to feel more hopeful.

"I suppose I would have a baseline hypothesis that this group of people are the people that lose sight of hope more readily, so to counter-balance that you've got to have it in the frame, even if, you know, you don't want to

bang on a drum of hope too much, its disrespectful to their despair, but you want to hold it in your backdrop of ideas behind your head.”

[Valerie. 22, 20-2 and 23, 1-2]

“...it’s very hard seeing parent’s dreams being shattered and sometimes it, it is real um, a real piece of work to hold that. To understand it with them but also to give them hope and to um, help them regain confidence.”

[Gary. 17, 23-25]

When families are burdened by the difficulties they face they can feel victimized by these burdens. Putting them in touch with their resources and thinking with them about these, and about what sustains them through difficulties, helps to open up possibilities for hope and agency.

“...to feel like it’s their resources; they’re not being told what to do, but it’s within them, that they don’t need to see me in order to carry on feeling a firm belief that that () it’s within them to solve”. [Rebecca. 16, 1-3]

Cathy described how she tries to address hope directly with the young person and with families:

“...it’s almost like (0.1) naming the hope that you as an adult have that they come through this and (), so its something about acknowledging the risk openly, acknowledging your own hopefulness”. [Cathy. 21, 23-25]

The therapists described using their belief in the possibility of change, their confidence in their ability to help families, and their overall goal and hope that the family will leave therapy believing that there is a future and being able to see a path to that future.

“...I’d have the ability to, having tried your damndest to convey that it’s...there’s possibilities here.” [Rebecca. 17, 26-27]

“They leave here feeling like they don’t need to self-harm to be heard, or that they have different ways of managing their distress and self-harming or that they have a path to the future, and that, that I think is really important, the sense that they have a future.” [Rebecca. 17, 33-36]

“I’ve said to families, sometimes I’ve said you know, as a therapist I need to hold on to the hope for change.” [Cathy. 21, 35-36]

‘Holding onto hope’ is a well-worn phrase used by both therapists and clients. Because of this it can become a ‘cliché’ and used in ways that could be construed as disrespectful or glib.

Valerie described how she tries to ‘hold the hope’ temporarily, but with the intention of the family eventually being able to ‘hold hope’ for themselves:

“I mean obviously you know [in breath] ‘cos sometimes when people come to you in a very acute and distressed situation it can be just that the, the therapist holds the hope and no family members can share that with you and you sort of hand the baton of hope over to them at some point.” [Valerie. 21, 9-10]

One of the therapists described how he never really understood hope:

“I never really understood hope to be honest (h), I mean it’s something I’ve never reall(h)y got. I know I should but I find those two other ideas more important. So being competent, being, taking one day at a time and being mindful you know.” [Phil. 47, 10-11 and 13-14]

Even though stating that he did not understand hope, Phil at the same time practiced in ways that engender hope. He described how he helps clients “*take one day at a time*” and when talking about using mindfulness, he said:

“...just sort of softening to the ideas of being, feeling hopeless, just embracing the idea, just feeling oneself into it, not trying to run away from it and just experiencing it and staying with that experience”.

[Phil. 47, 17-19]

Comment

Reflecting on Phil's view about hope, I was interested in how he seemed to distance himself from the concept of hope. It could be that he sees it as a rather 'airy fairy' notion, what Weingarten (2010) refers to as 'rainbow' hope or it could be that he was thinking about hope more as optimism, or wishful thinking.

Ludema, Wilmot and Srivastva (1997) discuss the difference between optimism and hope. They suggest that there is a moral dimension to 'hoping', and that optimism and wishing is a more superstitious idea and has more to do with luck than with human love and action. Another possibility is that for many therapists the concept of hope is too entwined with religious connotations, similar to the idea of forgiveness (Sheehan, 2007).

These thoughts have also led me to notice that none of the therapists interviewed made any references to the issue of spirituality in people's lives. It is possible that self-harm and suicidality is as much a spiritual issue as it is a psychological one. When I think about spirituality I am not necessarily seeing this as a religious concept but more about how people give meaning to their lives connecting their existence with some higher order values.

The therapists highlighted the importance of putting families in touch with their own resources. Madsen (1999) suggests resources are not internal qualities that families either have, or do not have, but are generated in collaboration with the therapist and with each other in, and through the therapeutic conversation. Conversation that seeks to find the 'noble intention' behind behaviour, conversation that elicits stories of competence and achievement, skills and abilities, hopes and dreams helps to connect

family members in new ways and can lead to the beginning steps of family members acting in more hopeful ways.

Summary

To summarise, this Lower-level category *Holding hope temporarily, believing in client resourcefulness*, describes the therapists' ideas about how families in which a young person has seriously self-harmed will be feeling hopeless and lacking confidence in themselves as to how to proceed and what to do. The therapists are concerned with trying to generate the family's own sense of hope and hopefulness and do this through temporarily 'holding hope' for them: using their own belief that the future for the young person and the family can be different and re-connecting family members with their own resources and strengths. Even Phil's dissenting voice seemed to understand families' learning to sit and tolerate hopelessness as a possible first step to feeling something different.

v. *Challenges faced in relating with vulnerable clients*

Despite valuing the importance of building a working relationship with clients and trying to engage in ways that take account of how vulnerable they feel, the path is not always a smooth one and the therapists described some of the constraints they experienced. Chief among these was the experience of not feeling able to 'trust' the word of the young person and the knowledge that often a young person will hide how suicidal they feel because they know the therapist will act to prevent them harming themselves. Most of the therapists gave accounts of experiences they had of not feeling able to trust when the young person gave verbal reassurance that they would not harm themselves, and would seek support if feeling suicidal. Some of the therapists had the experience of asking the 'right' questions and then later learning that the young person had taken a serious overdose.

"Um, I think because she...hid things quite well; like her parents had no idea what she'd been thinking of but she had, she'd been saving up

tablets...she'd actually taken an overdose of 40 Paracetamol two weeks before the one [that got her admitted to hospital] and she hadn't told anyone, she was just...and in school that day she um, it seemed, apparently laughing happy and a sort of sophisticated front, so I think I always had difficulty getting a measure of, if she was really distressed, would she, would she still, would she be able to talk to her parents or did she feel more supported or able to say that she wasn't coping, so I think for quite some time, I think I definitely felt that." [Marilyn. 12, 27-45]

Marilyn clearly points out the difficulty she experienced in knowing how to judge the level of distress in the young person and whether or not she would use her (the therapist) or the parents of the young person as resources to help her cope. This presents the therapist with a dilemma about how to proceed and what to do with the underlying worry that you can't quite trust what is being said. Valerie, when discussing this issue said:

"Well it probably reduces my trust in the therapeutic alliance and makes me more watchful." [Valerie. 3, 17-18]

The therapist can be caught between erring on the side of caution or going with statements that they don't quite believe, and therefore carrying all of the anxiety and responsibility for the young person's safety. Marilyn described how she manages this dilemma.

"...and raising that discussion with her. Um, (0.4) in our session with her mother, um (0.1) checking that communication out whether she...where she felt really, how...but at least putting it on the agenda to be discussed". [Marilyn. 13, 4-6]

Trying to work with a young person who does not wish to engage makes the building of a working relationship difficult to achieve in any situation, however trying to do this in the context of risk of suicide is extremely difficult. The therapists described feeling that they had to keep going and were not free to end the relationship because of the issue of risk.

“...and having to be very flexible (0.3) um (0.1) and working with adolescents, um maybe I’ve become too flexible (h). Yes but then that’s, and and sometimes trying to reach out and sometimes that’s not always good...but um, er, realizing the limitations because I suppose when there’s risk one wants to make sure that people are safe...” [Marilyn 25, 20-26]

There is a sense I think from this therapist that she really feels unhappy about what she can achieve sometimes and that in order to ensure safety she is working in a way that doesn’t really fit well with her, she finds herself being ‘too flexible’. This perhaps is about the tendency when doing this work for the therapist to take on too much responsibility. There was a similar theme in the following extract.

“...and I was surprised that her mother actually dropped her off and left her...and I had anticipated that the mother would be there. So that wasn’t an ideal sort of setting, because for me I’d always prefer to start off with the young person and the parents... So already I felt somewhat wrong-footed in that situation...and I often find you have to work with what you’ve got”. [Marliyn. 4, 32-39]

The ability to feel and convey empathy for clients and connect to the other’s experience is a fundamental component of the therapeutic relationship. Finding oneself in a position where this is difficult to do, poses a serious challenge for a therapist. Valerie discussed this in the interview. She described finding it hard to work with self-harm because it is something she could never imagine doing and has never experienced.

“...of things that the families that I work with um, I might have experienced in my own life. Those kind of things I could say well I’ve, I know what that’s like and I can [in-breath] draw on personal experience of loss, bereavement. There are lots of things in my life that I think I could connect with my client group with, but never with self-harm”. [Valerie. 8, 1-8]

At the same she felt that not ever having had a similar experience helped her remain '*dispassionate*' and allowed her to stay calm. It's an interesting issue in that on the one hand, having had similar experiences to clients certainly can give a therapist helpful insights, it could equally serve to 'blind' the therapist to other understandings outside of their specific experience. It would also mean that therapists could only have the possibility of connecting to other's pain and distress if they themselves had experienced the same problem.

Comment

The findings presented above prompted the following thoughts and connections with literature and personal professional experience.

Marilyn's dilemma of how to work with a young person who is difficult to engage, and who is also presenting with serious suicidal risk, has also been commented on by Boston et al. (2011) who discuss how a clinician's response to risk needs to be carefully balanced, as an inadequate response is potentially lethal and an overly active response can jeopardize the therapeutic relationship. Pentecost and McNab (2007) describing their work with depressed children, linked perseverance and 'stick-ability' with a failure to keep hope alive and thought that it resulted in therapists overworking, doubling efforts and taking too much responsibility for change.

Weingarten (2010) talks about how providing witnessing is a key component of creating reasonable hope with clients. In order to witness therapists have to resist indifference. Therapists are at risk of indifference when they feel overwhelmed or inadequate. She describes therapists as often being in a witness position, in which one is aware but uncertain what to do, or the clinician is lacking the resources to act as she wishes, and when this happens it saps a clinician's energy, enthusiasm and resolve.

While Weingarten uses the concept of witnessing in relation to violence, I think when working with clients who are difficult to engage and who are at risk of self-harm, being aware of one's witnessing position can be helpful. It helps one to

do something to change your position. There is a danger that in remaining unaware of one's position, or too overwhelmed to have the energy to think about your position, the therapist risks becoming numb and disconnected and unable to help clients feel empowered and enact reasonable hope.

Summary

To summarise, this Lower-level category *Challenges faced in working with vulnerable clients*, describes some of the dilemmas faced by therapists when working with this client group. Their main concern centred on how to work effectively in situations where they do not feel they can rely on the word of the young person not to self-harm and where they thought they had assessed the situation correctly, but later learnt that the young person had taken a serious overdose. The therapists also highlighted the difficulty in working with young people who reject help, finding themselves too concerned about risk of suicide to end the therapy, but at the same time feeling that they are not achieving anything. The danger of slipping into unawareness and numbness is discussed, and the difficulty of trying to empathize with young people who self-harm.

The Sub-category, *Relating with Vulnerable People in a Helpful Way* describes the main activities engaged in by the therapists in creating a working alliance with families. It involved being open to and acknowledging the vulnerability experienced by families when involved in the mental health system. The therapists were mindful of the fear of blame, the stigma and shame that families can experience. They described how useful ideas about positive connotation and externalizing were in reducing the impact of blame amongst family members.

Creating a conversational space in which difficult emotional experiences could be talked about safely and being willing to be with families in times of despair were highlighted. Being transparent was seen as important in creating a relationship of trust through which therapeutic risks could be taken. The therapists sought to create a context in which the 'unspeakable' could be articulated, and family members' worst fears shared. The therapists described

how they tried to hold hope for families who were feeling hopeless but with a view to working with them to create a hopeful perspective. The therapists also discussed some of the dilemmas they faced in building a therapeutic alliance and discussed their own relationship to the act of self-harm.

2. Making Sense and Meaning

This Sub-category describes how the participants went about the task of trying to help clients make sense of their situation in ways that did not oppress them further, but hopefully liberated them so that they had a greater sense of agency and belief in their ability to make change.

In trying to co-create hope with clients, therapists will be involved in helping clients make sense of their situation and prepare them for what lies ahead. This way of understanding the task of co-creating hope ensures that the present is active and not just about waiting and hoping for change.

This Sub-category has five Lower-level categories:

- i. *Having ideas and remaining open to ideas*
- ii. *Co-ordinating meaning*
- iii. *Articulating the meaning of the self-harming act and creating a relational understanding*
- iv. *Unpacking the self-harming event, listening for openings to develop meaning*
- v. *Moving between different 'domains'.*

i. *Having ideas and remaining open to ideas*

While striving to hold useful and different hypotheses to those of the family, the therapists at the same time tried to work collaboratively, by not allowing their hypotheses to dominate the conversation with the family. They tried to straddle the task of having and holding ideas, while also trying to remain open to the

family's own ideas and hypotheses. The therapists used the stance of curiosity to help them explore different perspectives and remain open to new ideas as they evolve in the conversation with the family.

"...I do try and remain curious, rather than saying um, oh this is one of those types of interactions. So I...so perhaps that's why...although I might have ideas, I also try to suspend them and hope to understand..."

[Rebecca. 7, 31-37]

Cathy, when talking about having expert knowledge, described how she tries to share her ideas in a way that families could adapt and use. The therapists' 'offerings' need to make sense to the family and be 'usable'. Cathy described how she thinks about the system of the family and the therapist as being like two different cultures. She used an interesting analogy to describe how she tries to get 'alongside' families so that the family can recognize her ideas, see the connections with their own ideas, and at the same time she can offer them something new.

"It's a bit like um, a submarine going into a m(h) mother-ship, you have to get alongside enough to the () and then you have to kind of go along for a while and then you come to the mother-ship and it has to be, it has to have a different...the difference that makes a difference so it's seen differently, so families can use it as a new initiative; so it needs to be new enough for them to see it as different, but not so far away that it feels alien." [Cathy. 3, 24-33]

Comment

Reflecting on Cathy's quote above, I was reminded of Bertrando's (2007, p.61) view in which he describes the systemic therapist as someone who tries to make sense of an 'alien' world which has unknown premises and rules. The therapist in order to create change has to be both open and respectful but also 'opinionated'.

Summary

In summary this Lower-level category describes how the therapists try to steer a course between both having knowledge and expertise while not allowing that knowledge to close down the conversation with the family. The therapist is involved in trying to create change, helping the family to develop new ideas and behaviours; not imposing their own ideas on them but rather sharing views and opinions in ways that the family can connect with.

ii. *Co-ordinating meaning*

The therapists described how they tried to pay attention to the feedback from the family so that they could decide what's possible to explore and what seems to be relevant for the family, and or young person. Following feedback involves the therapist in being mindful of the impact their enquiry is having on the family and young person, and how their behaviour is being construed through the 'lense' of the client's belief system.

“So sometimes thinking of ideas that um, she could feel that anything I said to her was quite disturbing or persecuting (0.2). So it made me think about how, I suppose in, in that sense I was thinking psychoanalytically, was also thinking like self-reflexivity and thinking about how she was construing me, how...although I didn't intend to have an effect on her in particular way, she was always seeing me in a certain light.”

[Marilyn. 2, 25-37]

Therapists are involved in making sense at two levels, on one level they are trying to create a new 'story' that explains and gives meaning to the situation that the family are in. They are also involved in making sense of, and giving meaning to, the family's responses to them. Creating meaning therefore is the task of co-ordination between different meaning systems.

iii. *Articulating the meaning of the self-harming act and creating a relational understanding*

If change is to happen the family will need to begin to adopt a more relational understanding of the self-harming behaviour. In describing their perspective on self-harm, all of the therapists focused on the idea that self-harm is an action, a non-verbal way of communicating distress and unhappiness. One essential part of the therapeutic task for them was to help the young person articulate the meaning of their self-harming behaviour, by putting it into words. The therapists described the kind of questions they might ask, to sow the seed that the self-harming is an act of communication and is connected to how the young person perceives their relationships with family members.

Valerie, when discussing this issue said:

“I want this young person to talk to their mother, or talk to their father, or talk to their peers and say, ‘I feel so low’,...can you reach out to your near ones and dear ones and say, ‘I need comfort, I can’t cope without some help’, so its trying to get it relational, that’s what I would be emphasizing.”
[Valerie. 9, 10-14]

“...always is to help people put things into words rather than action and it’s very much an action mode”. [Valerie. 8, 15-17]

Valerie described the kind of relational questions she asks:

“...did it [self-harm] have the effect you wanted, what was the effect,...how did it affect your relationships, what do you think other people thought of you having done that?” [Valerie. 10, 1-4]

Cathy echoed a similar idea and described her approach as:

“...general relationship ideas around who comforts, who do you go to, who do you talk to?” [Cathy. 2, 11-12]

Valerie cautioned against asking the kind of questions that focus attention inwards, for example asking a young person:

“...‘what made you feel so low?’, cause that’s more going inward and inward, it would be more, making it more relational”. [Valerie. 9,14-15]

For Rebecca, a central task of the work was about helping the family to begin to see how they, as a family, could change and to see their part in the situation and begin to develop an understanding of the meaning of the self-harming behaviour.

“...to language things in relational ways as a family, so its shifted from the young person to, ‘what are we going...what have we been doing?’, you know ‘what are we going to do to get?’ () you know that they’ve really been able to understand what’s been happening to them...I think some people come in so distressed and so anxious, that that’s what goes, they get frozen out from each other. So that they’ve regained a sense of being able to understand and speak of it”. [Rebecca. 17, 39-45]

Summary

In summary, this Lower-level category, *Articulating the meaning of the self-harming act and creating a relational understanding* represents the therapists’ ideas concerning the core of systemic work: creating connections between ‘parts’ of the system, between family members, their beliefs and behaviour, so that family members begin to see how their behaviour effects each other and is effected by others.

When working with young people who self-harm the therapist is trying to understand the meaning of the self-harming behaviour in terms of the family relationships, and in turn help the family to begin to see their ‘part’ so that they can respond differently.

Making behaviour understandable and meaningful is a key task of therapy. Family members will feel most hopeless when they are unable to make sense of or understand the problem behaviour. Being able to make sense of each other's behaviour allows for the possibility for new thinking and new action, and a renewal of hopeful perspectives.

iv. *Unpacking the self-harming event, listening for openings to develop meaning*

Beginning the exploration of meaning involves 'unpacking' the self-harming event. The therapists favoured asking the young person about factual information as a way of engaging them, reducing their anxiety before beginning an exploration of the meaning of the event. As the story unfolds the therapist can then listen for possible openings that would allow for meaning to be explored and also take steps to widen the conversation into other areas.

"...the way I work with that, people do it differently, is to start with a very careful analysis of what happened and not get too quickly into the reason why". [Phil. 53, 15-16]

"I'll allow the meaning to emerge from...from a behavioural description...my theory would be is if people can tell the story about what happened in detail, 'I went to the mother's cabinet, I took my mum's tablets...I knew she had Valium, then...I can then ask other questions.'" [Phil. 54, 2-8]

As well as unpacking the self-harming event and looking for openings to generate new meaning, the therapist will also move beyond the self-harm and broaden the conversation in order to access new understandings.

Trying to create innovative understandings is key in all therapy situations, however in a situation where a young person has self-harmed, the self-harm itself can become a kind of magnet that draws everyone's attention and this can

make it difficult for the therapist to widen the family's focus and open possibilities for change.

“...so I think there's something about widening out the context. That's really important I think. You know, if you can kind of see self-harm as being maybe the core in the middle that everyone wants to talk about at the moment and widening that out into lots of different layers, then you have a lot more possibilities about how to address it”.

[Rebecca. 13, 41-46 and 14, 1-2]

Comment

Jurich (2008) suggests that an advantage to a careful unpacking of what happened in the self-harming episode is that incongruities and ambivalences may surface, which will give important information about relationships. He particularly attends to accounts in which there is incongruence between the content and process of the communication between family members as adolescents find this kind of communication very difficult to handle.

Summary

To summarise, this Lower-level category, *Unpacking the self-harming event, listening for openings to develop meaning* describes how the therapist talks to the young person about the self-harm by focusing on the detail and the facts, to make it easier for the young person to talk about what happened. The therapist at the same time listens for possible openings that would allow for an exploration of the relational meaning of the act and is alert to the magnetizing pull that the self-harm seems to exert on family members, which could prevent wider and more complex exploration and discussion.

v. *Moving between different 'domains'*

'Keeping it safe' and 'being useful' were key phrases used by the therapists and a short-hand way of describing the dual therapeutic task that working with self-

harm involves. Deciding when the situation is safe enough to allow the balance of the work to move towards the domain of therapy has to be carefully judged, as ensuring the adolescent's safety will continue to be of central concern to the therapist throughout the course of the therapy.

The therapists described how they always keep their eyes on risk and will consider their actions in the light of the impact on risk. The therapists also described how risk will at times be fore-grounded in the conversation and at other times will take a more background position. Rebecca described how she always has risk in her mind:

"I always have one eye on the risk, I don't take my eye off that ever even in the long term work you know, and you wouldn't do that."

[Rebecca 3, 7-11]

Phil described how he thinks about how his actions will impact on risk:

"I'm not going to be digging up, you know skeletons in the cupboard, unless I'm convinced it's going to increase safety." [Phil. 41, 7-8]

At times it will be possible for risk and safety to remain in the background of the therapist's mind while other issues are pursued, while at other times it will need to take centre stage. Trying to keep a focus on both tasks is difficult and the therapists described how they manage it, what they look out for. They described how they needed to be alert to subtle changes in body language, as well as more obvious signs of distress, as potential risk of further self-harm.

"Well I think that's what I'm saying in terms of body language or whether one of my questions that I'm asking starts making me more curious about risk and suicidality, so if something, some response, or some sort of body language triggers an alarm-bell then I'll start exploring something in a different way. Now, you know who's to know if I didn't follow that pattern, but actually, you know followed um a different way, in terms of meaning, what difference that would make, I don't know, but I suppose I feel just

because, I guess because of my job, I just, I have to, at times follow the risk; you know, follow...an assessment of risk really..."

[Lucy. 9, 20-46 and 10, 2-3]

What the therapists seemed to be saying is that judging this move requires a combination of experience, careful attention to both verbal and non-verbal responses in the young person and paying attention to and trusting your own 'gut' feeling and using your own level of anxiety as a gauge.

Some of the therapists felt it was helpful to think about this issue as moving between domains (Lang et al., 1990). They found it useful to think about whether at any point in the therapy they were in the domain of 'production' and therefore needed to prioritize safety, or whether they were in the domain of 'explanation' and free to continue to explore meaning. Valerie, drawing on her experience of work with child sexual abuse said:

"...there is a domain (0.2) shift that you have to take account of, and it's very, you could see it as a similar manoeuvre, that you are in the domain of therapy and then all of a sudden you're challenged to think, [I've] now got to go into the domain of production and make something happen and so I'm not free to just explore..." [Valerie. 13, 8-10]

Lucy also drew on her experience of working with child protection issues:

"...and also, you know, which domain I'm moving into, I suppose it's like...Arnold Bentovin did the um, some stuff at one point on Trauma Organized Systems, at what point do you move in Child Protection to a domain of protection, out of the therapy domain, and I think you have to think about that with suicidality, at what point...do you stop being, you know, or does your curiosity become so strong you have to say (h) 'you're going to kill yourself', that sort of thing". [Lucy. 10, 38-45]

Managing the issue of risk in the context of therapy could be best understood as always involving movement between constraint and autonomy. Valerie describes her way of thinking about these twin issues:

“...and it’s on a continuum, at one end is autonomy and the other is constraint and I love this idea, I just found it so simple; [in-breath] that when you’re with a family or an individual and they’re talking to you about [in-breath] (0.2) issues of life choice that they want to explore in a different way, and you’ve got all the autonomy between you that you can handle (), you move away, away from the autonomy end of the conversation up to the constraint end of the conversation and you have to be honest with them and say, ‘when you talk to me about these topics, when you bring this topic into our conversation, I become constrained in how I can think with you about the way we understand the content of our conversation. So I am now constrained to think about how I can keep you safe, what I need to do to keep you and your family safe, who I need to involve? (0.1) ()’. [Valerie. 16, 12-23]

Comment

Jurich (2008) suggests that therapists who work with suicidal adolescents should be aware that at any stage during therapy, the adolescent could become actively suicidal and that the therapist needs to have a crisis intervention plan in place. With such a plan in place the therapist will find it easier to decide when to shift into ‘intervention mode’ and when to shift into ‘therapeutic mode’, as without this he argues that the therapist could be thrown off balance and overact in response to the adolescent’s suicidal ideation as a an ‘immanent suicidal event’ (Jurich, 2008, p. 87).

This Lower-level category *Moving between different ‘domains’* describes how the therapists maintain a focus on risk while also exploring meaning and how they find the concept of ‘domains’ (Lang et al., 1990) helpful in managing the movement between these two aspects of the work and in seeing the therapeutic conversation as lying on a continuum between autonomy and constraint.

Summary

To summarise, the Sub-category Making Sense and Meaning, describes how the therapists went about the task of developing new and different meanings of the presenting problem of self-harm. They described how they try to work collaboratively with families in developing new hypotheses and trying not to allow their hypotheses to dominate. They paid attention to feedback and to how they were being construed by family members. They worked to help family members understand self-harm as a relational phenomenon and also to see that the non-verbal communication involved was articulated. They described how when unpacking the self-harming event they were listening for openings that would allow them to explore meaning and how they work to widen the focus of the conversation away from self-harm into other areas of family life and concerns. They also described how working in the area of self-harm involves therapists in having to work both in the domain of therapy but also being ready to switch to the domain of action when issues of risk arise and need to take centre stage.

3. Focusing on Communication

Creating the kind of communication that will allow the adolescent to articulate their distress to their parents and seek their support in finding alternative ways of managing distress was a key theme in the interviews with the therapists. This Sub-category describes how the therapists worked to improve the communication between family members. In particular, they placed emphasis on trying to work with parents to help them understand what their child is trying to communicate through the act of self-harm. The participants described how they focussed on reducing anger and hostility and on creating greater emotional connection. The therapists also described focussing on the hierarchical organization of the family and on how they work to realign boundaries.

In their work with families the therapists drew on hypotheses about self-harm that positioned self-harm as a clue to unsatisfactory family relationships.

“I would have a generic hypothesis that the girl is self-harming because there’s something she’s not getting from her mother.” [Phil. 61, 9-10]

“...and what the gap was but there seemed to be some gap between...she was feeling presumably, from what she conveyed to me, some distance from, particularly her father, that seemed to be significant”.

[Marilyn. 6, 33-37]

The therapists also include unsatisfactory relationships with peers in their thinking, but their emphasis was on understanding why it was not possible for the adolescent to turn to their parents when distressed.

The therapists described focussing on trying to improve the family communication, increasing parental understanding of what the adolescent was trying to convey, reducing anger and hostility and engendering greater emotional connection.

“I want this young person to talk to their mother, or talk to their father, or talk to their peers and say, ‘I feel so low’,...can you reach out to your near ones and dear ones and say, ‘I need comfort, I can’t cope without some help’, so its trying to get it relational, that’s what I would be emphasizing.”

[Valerie. 9, 10-14]

What came across from the accounts was a strong theme about emotional distance between the adolescent and their parents. The therapists described how they also needed to pay attention to how parents responded to their adolescent and how they tried to intervene in ways that encouraged helpful responses.

“Well I suppose what I wanted...one of the things that I wanted was for [name] to be able to talk to her mother when she was feeling distressed...and for her mother to be able to hear the distress without either over-reacting or dismissing her, really, so it was a bit about changing

their pattern of communication, I suppose that was the one thing I was trying to do in all of this.” [Lucy. 19, 39-44]

Rebecca draws attention to need for parents to be able to stand in the shoes of their adolescent.

“...if parents or carers are unable to mentalize around self-harm, (). That if they can't put themselves in the shoes of somebody who's in that much distress that's going to be very ().” [Rebecca. 3, 45-46]

In situations of high conflict and or blame, creating closer relationships was not always immediately possible and the therapists had to work to find ways of creating new connections between the adolescent and their parents. The therapists in these situations described needing to work separately with the young person and their parent/s before bringing them and other family members together. The therapists' description of what they do suggested that they acted almost like a bridge, enabling both 'sides' to come together.

Similarly to the emphasis on communication, there was an emphasis on re-aligning boundaries. The therapists described needing to attend to structural dimensions of family organization.

“Cos I would certainly...I mean...that comes across when you, you know mums and daughters say, 'we're like sisters'. That kind of conversation. Well where's your mother? Yes I suppose I do work very often around hierarchy and structurally without shame (h).” [Rebecca. 6, 2-5]

The therapist worked to ensure that parents were acting as an executive sub-system, working together as a parenting team to keep their child safe, and not abdicating responsibility. They implied that self-harming behaviour is often a feature in families in which a young person feels out of control or is overwhelmed by caring for their parent, and that focusing on these aspects of family organization creates a containing context for the adolescent.

“And when they’re out of control er, it can be very reassuring that parents can work together, very reassuring...even if they disagree with [you] at the time, my experience is they often settle....um (0.7) I think that it may make a more containing context for the young person.” [Marilyn. 28. 3-11]

“...or whether or not your mum or your parent or your carer is, er, is er, prepared for it, willing to contain it, willing to think about what they can do or say to us I don’t know what to do, I’m profoundly unable to cope with this, help me out...so it’s a very difficult context”. [Rebecca. 3, 39-42]

Comment

Reflecting on the findings presented above triggered the following thoughts and connections with the literature.

What came across from the accounts was a strong theme about emotional distance between the adolescent and their parents. Given that isolation and lack of connection with others encourages feelings of hopelessness and therefore increases the risk of self-harm, the emphasis on this area seems to be crucial part of the work. Weingarten (2010, p.11) writing about hopelessness states, ‘hopelessness correlates more strongly with suicide and predicts it better than depression’.

Aldridge and Dallos (1985) link suicidal behaviour in adolescents with an escalation in conflict and negative connotation of the young person who then feels he/she can do nothing right. Asen (1998) highlights how important it is that parents acknowledge the distress that is underlying their child’s suicidal behaviour. When parents fail to do this, he contends that suicidal behaviour can escalate.

It would seem that from the findings presented above that the therapists, in deciding to work separately with parents and the young person, were trying to allow space to work with parents so that they were able to adopt a non-blaming

attitude and also to help parents to understand and acknowledge the distress that is being communicated through the act of self-harm.

Summary

This Sub-category, Focusing on Communication describes the therapists' emphasis on working with families to improve communication and to re-align generational boundaries. The therapists stressed the need to help parents respond with empathy to their child's distress, and to try to think about and understand what their adolescent was trying to communicate.

The therapists paid attention to levels of conflict and blame and worked with parents initially to help them understand and process their own reactions, so that they can be in a more receptive state to receive their child's communication. The overall aim of the therapists' intervention is to reduce levels of blame and conflict and increase emotional communication and understanding; creating a context in which the adolescent can express vulnerable emotions and turn to their parents for comfort, understanding and acceptance.

4. Making Change Manageable

This Sub-category describes the therapists' ideas about how they try to make change more manageable. The therapists talked about breaking change down into small steps, discussing and sharing a model of how change happens, exploring aspirations, intervening when there is catastrophic thinking and helping families to plan for and predict set-backs. Making change manageable for families also involved helping family members to clarify hopes and expectations of the future, setting achievable goals and being able to see a way towards achieving what they want to get.

The therapists described needing to address both hope and hopelessness in the work, being aware also not to over-emphasize hope at the expense of not

attending to the despair that clients experience when it is difficult for them to see a way out of their situation.

This Sub-category has four Lower-level categories:

- i. *Introducing a model of change that takes account of the 'up and down' nature of change*
- ii. *Adjusting hopes and expectations to what is possible*
- iii. *Walking between hope and despair*
- iv. *Keeping hope on the agenda.*

- i. *Introducing a model of change that takes account of the 'up and down' nature of change*

Phil described working with a model which does not portray change as something that happens in a smooth upward direction, but instead depicts the path of change as a process of taking 'one step forward' and 'two steps back'. He uses this model as a way of preparing clients for when change gets difficult and helping them to manage set-backs without losing sight of some of the changes they have made.

"I find another useful mid-range model for me is the curling snake going upward, () but it's it's um, it's about er thinking about the, the, that things aren't necessarily going to get better . They get worse and better, better worse, so forth. But generally the direction is up." [Phil. 46, 17-21]

"...so, its sort of like putting it into manageable proportions and think through what are the alternatives and I think that's very important for families". [Gary. 28, 26-27]

Comment

The above findings prompt the following thoughts and connections with the literature. Weingarten (2010) drawing on Gergen (1988) talks about how

people generally see hope as a progressive narrative, going upward from current to better circumstances. However, a reasonable hope narrative does not necessarily go in a straight line.

I think families find this way of thinking about change very useful, it gives them a realistic picture of what to expect, it helps them from falling into hopelessness when there is a reoccurrence of self-harming behaviour, and allows for planning about how to cope and respond when things go wrong. Planning and predicting set-backs is an important part of the work of preventing a reoccurrence of self-harming behaviour. Marsden (1999) suggests that part of the work is to help family members to notice early warning signs and have contingency plans in place. These kinds of conversations can help reduce anxiety and create reassurance particularly at the point where therapy is coming to a close.

Therapists have a key role in helping to make change manageable for their clients and finds ways that enable agency to develop and furthermore, to give family members an experience of success in making change. White (2007, p.275) describes how the therapist needs to help the client to 'traverse the zone of proximal development'. This refers to the territory that the client has to traverse from what is known and familiar to them to what is possible, from narratives about themselves that are oppressive and limiting, to narratives that are enriching and enabling. White (2007) proposes that therapists 'scaffold' the journey through the kind of conversations that they have with clients, so that steps needed to make change are experienced as being more manageable.

ii. *Adjusting hopes and expectations to what is possible*

In addition to having a model of how change occurs, the therapists also paid attention to helping families adjust their expectations of change into something more realistic. This sometimes involved the therapists having to adjust their own hopes and expectations for the family and working with what's possible.

“...when you work with a family and you realize that maybe the changes you, you think the family needs to make...in order to help the son or daughter, they are not able to make that, that change to that degree. So then you need to readjust and think okay, ‘what do we think is, is possible for you to, for them to do?’...and we can support them to get there, so it sometime has got something to do with us”. [Gary. 30,9-13]

iii. *Walking between hope and despair*

When families are finding it difficult to make change, and alternative thinking and possibilities seem blocked, it is often because they cannot see a way forward, they may have an idea of where they want to get to but cannot envisage the path that will take them there. This Lower-level category describes how the therapists try to respond to the families’ despair and how they pay attention and monitor their own reactions and avoid slipping into despair themselves.

Valerie shared her perspective on managing hope and hopelessness in the therapeutic conversation. She felt it was important for therapists to be respectful of the feelings of despair felt by family members. She also believed that the therapist needed to move between both hope and despair, keeping both in the frame. She also drew attention to the danger of therapists becoming despairing themselves and losing sight of hope.

“...you don’t want to bang a drum of hope too much, it’s disrespectful to their despair”. [Valerie. 21, 24 and 22, 1]

“...but if you get too stuck in the despair with them you just lose sight of hope yourself and you’re no longer more use to them than if they stayed at home”. [Valerie. 23,12-13]

Phil also addressed these issues. He described how he manages the task of both staying with despair and moving the client towards hope. He tries to help

clients not to be afraid of their despair, not to battle against it and at the same time he seeds an idea that tomorrow may be different:

“...that it may be different tomorrow, and just to take one day at a [time] and, and that [in-breath], there’s something for me in hopefulness, it’s about boundaries, and when I was [personal disclosure]...I remember thinking that the, that, that what I found the most useful idea was mindfulness and about just coping with the moment and (0.1) coping with fear in the moment and just getting,...not trying to wish it away but just being with it, staying with it, and out of that staying with something, that seeing it as a useful process, in the moment, just the moment, you can generate hopefulness”. [Phil. 45, 20-27]

Phil also discussed how, in sessions when he begins to feel depressed, he tries to restore his hope through using the concept of “*projective processes*”.

Comment

Reflecting on the above findings, the following thoughts and connections with the literature were evoked.

The therapists suggested that one needed to be respectful of family members who were feeling hopeless, not to ignore these feelings but to instead stay with them. Therefore, it would seem that focussing on feelings of despair is part of work of generating hopefulness. Flaskas (2007b, p.26) argues that hope and hopelessness are not either/or experiences but co-exist in a complex relationship and that the therapists needs to engage in conversation about the balance between these two experiences. Flaskas also suggests that therapists should explore how both hope and despair are distributed among family members, rather than thinking about the family as having either too little hope or too much hopelessness. She believes that therapists when working with families should value and attend to their own engagement with both hope and hopelessness.

Losing sight of hope is one way that therapists are affected when confronted by situations in which there is an overall strong feeling of hopelessness. Another response is to latch on to moments of humour or light-heartedness and treat these as an indication of change. In these situations family members can feel that the therapist does not really appreciate the depth of despair and may consider that the therapist is being flippant. Pentecost and McNab (2007) talk about the need for therapists to ensure that any interventions that focus on the positives are firmly anchored in an in-session experience of hope or change. They also suggest that when therapists find themselves focusing on moments of jollity and 'false hope', it is then that the therapist needs to think about their relationship to hopelessness and the impact that the family's hopelessness is having on them.

It would seem that from the above findings that Phil was influenced by psycho-analytical concepts when managing his emotional experiences in the course of the therapeutic conversation. How therapists use their emotional experiences in a session can be a bridge to understanding their client's emotional world. Flaskas (2002) when discussing the usefulness of analytic ideas such as transference, counter-transference and projective identification puts forward the idea that when these are used outside of an analytic frame they offer the systemic therapist useful ideas in 'offering understandings about the therapeutic relationship, the therapist's experience, in strengthening empathy and allowing a different kind of therapeutic connectedness' (Flaskas 2002, p.152). Other family therapists have offered ideas about how family therapists can utilize their interactional experience of their relationship with family members. Rober (1999, 2010) introduced the idea of the 'inner conversation' of the therapist, Cecchin et al. (1994), use the frame of 'cybernetics of prejudices' and proposes that therapists should examine the 'reverences' they bring to the therapeutic encounter and how this shapes the therapeutic encounter.

Summary

In summary, this Lower-level category, *Walking between hope and despair*, describes how the therapists recognize the need to attend to family members' experiences of both hopefulness and hopelessness and try to keep 'both in the

frame'. The therapists described trying not to over-emphasize hope at the expense of risking a family member feeling that his or her experience of hopelessness or despair was being de-valued. The therapists suggested helping clients not to feel afraid of their despair and not to battle against it incorporating ideas from mindfulness and Compassion Focused Therapy (Gilbert, 2009). When working with families in which there is a strong experience of hopelessness, therapists need to be able to monitor their own responses and incorporate practices that help a therapist notice and utilize their own emotional reactions.

iv. *Keeping hope on the agenda*

The therapists described needing to work to generate hope, consciously looking for small signs and building on these to nurture hopefulness.

“Um, (0.1) but I think I would be looking for hopeful signs a lot more vigilantly, and also looking out for small signs of () you know green shoots of hope, () you’d probably want to keep it on the agenda more determinedly.” [Valerie. 21,12-15]

“...um [0.5] because I suppose I would have a baseline hypothesis that this group are the people that lose sight of hope more readily, so to counter balance that you’ve got to have it in the frame”. [Valerie. 21, 20-23]

Comment

In reflecting on the findings presented above, the therapists’ ideas seemed to echo those of Weingarten (2010) who writes about ‘registering reasonable hope’. She suggests that therapists need to train themselves to see and hear signs of reasonable hope. Pentecost et al. (2007) talk about ‘sparkling moments’, and cheering on small changes. It would seem that noticing small changes helps to motivate clients by giving them evidence that they can change and therefore that their desired goal is achievable which in turn increases levels

of hope. Marsden (1999, p.119) describes how often hope and agency exist 'only as faint glimmers that are extremely difficult to detect' and that the therapist has to nurture the glimmer by focusing on the 'little that is'.

Summary

To summarize this Sub-category, Making Change Manageable, describes how the therapists went about making the process of change for family members more manageable and in so doing enabling family members to experience a sense of competency, agency and belief that change was achievable and within their grasp. Through this family members can see a way forward and begin to imagine a different future.

The practices described by the therapists included: sharing a model of change that incorporated the variable nature of change; exploring family members' hopes and dreams for the future; intervening when catastrophic thinking is present; helping family members to adjust their vision of the future where appropriate; and create new and more achievable goals and envisioning the path towards these. This Sub-category also described how the participants had to be mindful about how both hope and hopelessness can live side by side; how over-emphasizing hopefulness can make clients feel that the therapist is ignoring the very strong feelings of despair that they experience when they cannot see a way forward, and how their experience of the present shapes their perspective that the future will not be any different.

5. Therapist's Relationship to Hope

The relationship that therapists have to hope and hopelessness influences their interactions with clients. It has an impact on what they bring to the therapeutic relationship and how they engage with what the family presents in terms of the family's feelings of hope and hopelessness. Noticing one's own reaction and engagement with these issues is an important component of the work with families and adolescents who self-harm.

This Sub-category describes the therapists' perspectives on what sustained them and kept their hopefulness alive.

"I've found it, you know, enormously enriching and I think I've been very lucky to find an area of work that's been so um, renewing and enriching and varied and if I hadn't had lots of experience of hope being born out in practice, I don't think I would have carried on with it." [Valerie. 24, 11-14]

Commitment and belief in what they did and in the process of therapy were the most significant factors for sustaining the participant's hope. A therapist's belief in what they do can act as a source of motivation and therefore a source of hope for clients.

"...there is life after [name of unit] and there are er, (0.2) all reasons to, [0.1] to be hopeful, you know, but I think you basically have to believe it yourself". [Gary. 23, 19-22]

The participants described how their own commitment acted as a resource when they found themselves in situations that were not ideal. In these situations the therapists were able to hold onto the 'bigger picture' and were helped when they were able to step back and view the session within the overall course of the therapy.

"It's not a bed of roses but um, I think yeah, I think I, I still believe very much in what we do,...where I can think about, well this was a very difficult patch but then that happened, you know being able to think separately from the event and step away from the emotion, the emotional drain, that's the immediate thing after a difficult session." [Valerie. 24, 18-24]

The therapists also talked about how they needed to ensure that they took opportunities to nurture their own hopefulness, particularly after a difficult day.

“...of course there are some days when you’ll feel more despairing yourself because you’ve had a bad day or you’ve had six really rough families and you haven’t much hope left”. [Valerie. 23, 18-21]

A relational view of hope positions it as something that happens through connection with others. The therapists described how one of their main resources for maintaining their own hope was their relationship with colleagues, supportive colleagues they could talk to about their experience with a family.

“These are moments when I think it’s important to have a team, to have colleagues to talk about it, to talk to about it, it is about not working in isolation.” [Gary. 3, 14-15]

“Well I think, I think through, through just talking about how I am feeling you know, with... either with supervisors or others.” [Phil. 49, 14-16]

The therapists described the need to have the support of colleagues to help them think, reflect and off-load. Gary also described how the commitment of other team members is important to him together with “*just ordinary good*” relationships with colleagues. This is part of what keeps him going and sustains his hope.

“Well I mean () I, I find it comes back to the relationship, () what is nice here is I think the team, the team is very committed [0.1] um there are times of really high stress and sometimes of tension, but I think the, the bottom line is we, we can have a good laugh and we can have a good moan and we can have a good Christmas party.” [Gary. 21, 11-15]

Ward and Wampler (2010) discuss how connection to other human beings and with a higher power leads to increased hope in clients and it would seem that for the therapists this is also true; their connection with colleagues was also clearly part of what sustained their hope.

When the therapists experienced a sense of hopelessness in themselves following a difficult session they also refreshed themselves by recalling previous times when they had felt hopeless and reminded themselves how it very often proved to be a temporary experience. They described how having experiences of success in their work sustained their hope. Without experiences of success one of the therapists said she would not have been able to have carried on. Gary described how being able to accompany families through difficult times and seeing them pull through sustained him.

“And I, I just remember I had a family in this room where the son was er, is on the spectrum and er all the father, the father was talking about was Autism, and Asperger’s an [h]d [h] and I was sitting there and it was very interesting. I saw on the Metro, on the underground there was an article one day, two pages on people who were diagnosed with Asperger’s, sometimes [0.4] in hindsight. Like Einstein and people like that so...with pictures and art and it was beautifully [in-breath] presented, so I took the paper, and bought it and I said, ‘look you are in very good company and there is your hope, Einstein [h] is calling’, and I tell you, suddenly the blanket lifted. So simple, because it put it into a context or Stephen Fry with bi-polar. I said look at him [h] and and (0.1) when you asked me what keeps me going, that’s what keeps me going, that hop(e)...that that (0.4) um, (0.2) when I see that, that you can give people hope, that you can carry people, families and young people through really dark times and you see them pulling through”. [Gary. 18, 1-15]

Therapists need to have the resources and back-up to help them regain hopefulness when they begin to feel despondent about their work and hopeless about their efforts at helping the family to change. Lucy’s words I think speak to our experience as therapists when we work to the best of our abilities, and still are unsuccessful in our efforts to help clients.

*“...you can’t imagine the amount of work we’ve put into this kid, including external supervision...and nothing changed, nothing”.
[Lucy. 27, 46 and 28, 1]*

Comment

Reflecting on the above findings it would seem that the therapist's confidence in, and belief that change can happen, is a key factor in creating a hopeful therapeutic context. Selekman (2006) states that he will confidently convey to the family that change will happen and it is only a matter of *when* it will happen. Duncan and Miller (2000) suggest that the therapist's ability to instill hope contributes to the success of treatment.

Ward and Wampler (2010) discuss the importance for therapists to protect their own hope through taking care of themselves in order to avoid burn-out. In their Study, which explored hope in couple's therapy, they found that a therapist's sense of hope was essential when helping clients move up the 'continuum of hope' (Ward and Wampler, 2010). Weingarten (2010) suggests that it is essential for therapists to identify activities that support them as they 'do reasonable hope' with clients.

Summary

In summary this Sub-category, Therapist's Relationship To Hope, describes how the therapists sustained their own hopefulness. The participants described how their commitment to their work and to the process of therapy kept their hope alive. A key factor for helping therapists to maintain a hopeful outlook was their relationship with colleagues. What helped, was having good team relationships, but also having people to turn to at moments of difficulty. The therapist's sense of hope is also sustained by experiences of successful outcomes and experiences of being able to help family members see something in a new way, one that opened up new opportunities and possibilities.

When therapists are well supported they are safe-guarded from losing empathy and compassion, are less likely to develop burn-out and more likely to retain the ability to respond effectively. The next category describes some of the team and organizational processes that the participants found supportive.

6.4 MAIN CATEGORY 3: Team And Organizational Processes

This Main Category describes the therapists' perspectives on the kind of relational context that best supports them in their work with self-harming adolescents and their families and the kind of context that is not supportive. All of the therapists interviewed pointed to the need for good team relationships, clear structures of accountability, good supervision and a compassionate and supportive management structure that would enable them to feel safe and do this work. Bickerton (2007) suggests that therapists need to feel safe in order to create safety in others.

The main Sub-categories identified were:

1. Atmosphere of Mutual Trust
2. Here And Now Supervision and Consultation
3. Valuing Diversity and Difference
4. Role of Leadership
5. Emotional Impact on the Therapist and the Composition of the Team.

1. Atmosphere of Mutual Trust

*"A good relationship with colleagues [with] whom you can compare ideas."
[Valerie. 1, 3-4]*

Hopelessness and despair can be about not feeling connected to others. All of the therapists I interviewed in one way or another pointed to the need for good relationships within teams and organizations in order for them to feel resilient enough when working in situations of risk of suicide; situations in which creating hope and avoiding the pull to hopelessness is an essential part of the work.

This Sub-category describes the therapists' views about the need for risk to be held as a team responsibility rather than by an individual therapist, and that the

team needed to be able to come together and discuss how the risk will be managed. Supportive teams are teams that are prepared to think together, reflect, and try to reach an understanding as to the meaning of the self-harming behaviour. Therapists pointed to the need for good relationships with psychiatry colleagues and also for awareness as to how the relationship is influenced by the power differential, which in-turn affects what information is shared and the quality of the decision reached.

When assessing risk, the therapists felt that it was important that 'holding' risk was a team responsibility and not just the responsibility of an individual therapist; that those responsible for the decision needed to be able to come together and discuss how the risk would be managed.

"...that the significant group of people would come together and think well this is how we're going to manage the risk". [Valerie. 6,8-9]

However, teams in which colleagues expressed unhelpful attitudes towards self-harm, were not supportive and were sources of stress for the therapists.

"...when you are thinking about self-harm, you want an atmosphere in which people aren't going to simply say 'Oh, he's a self-harmer', um as though it's one thing or as though it's something histrionic, demonstrative but doesn't really mean very much, ...you want it (self harm) thought about, you know in each instance, what does it mean, what kind of communication is this?" [Valerie. 5, 2-9]

Good communication between colleagues was named as essential, particularly between a therapist and psychiatry colleagues.

"I think what's crucial for a therapist to manage risk is a very good relationship, communication etc...I'm trying to think of the word – loop...with the consultant, I think it's crucial." [Gary. 2, 14-15]

One therapist spoke about how the whole discussion about risk assessment and management is influenced by the hierarchical nature of relationships in teams. Less experienced colleagues may feel “*tongue-tied*” when in discussion with a supervisor or consultant psychiatrist.

“...so we have to have the kind of relationship, that enables you to give the kind of information that enables you to help me, so if I’m tongue-tied in your presence I’m not going to be able to do that”. [Phil. 19, 8-10]

The therapist believed that the person in the position of greater power needed to be aware of the impact of the power differential so that information that needed to be shared could be shared and therefore a better clinical decision made more possible.

“...if the supervisor underestimates their own power...sometimes the junior is not able to get out what they want because they’re trepidatious.” [Phil. 19, 22, and 20, 1-2]

Summary

In summary, when making decisions about risk, the quality of both the assessment of risk and the decisions about management of risk are influenced by the relational context in which they occur.

2. Here And Now Supervision and Consultation

“I’m not a great believer in dealing with risk in retrospective supervision.” [Phil. 20, 11-12]

Discussions and conversation about risk need to be “*timely*” and “*in the moment*”. In the therapists’ views, retrospective supervision is not enough on its own. The therapists believed that when working with risk they needed to be able to talk over their concerns, at the time when they experience concerns.

And further, they need others, for example supervisors and team leaders, to make themselves available for discussion about their concerns.

“...you’ve got to give people time, its no use saying, ‘sorry, I’ve got to do this...’. They need to be able to come into your room and talk”.

[Phil. 21, 6-9]

The therapists believed when sharing concerns, the kind of culture that most supports them is one in which they feel able to share feelings of doubt and seek reassurance; where the act of needing to seek another’s perspective is considered a sign of strength and not an indication of incompetence. Gary expressed this view as follows,

“I think in order to do this work in a team and to use, er, use a team as a support, you have to have the feeling that you’re not being, you’re not being incompetent or come across as incompetent when you say, ‘look I’m not sure, I’m worried, I’m concerned.” [Gary. 3, 22-25]

Gary further suggests that being able to do this requires the kind of relationships that are safe and trusting, and that allow for uncertainty and doubt.

“That we feel it’s okay to be in doubt, not sure, want a second opinion.” [Gary. 4, 12-13]

Summary

In summary, this Sub-category, Here And Now Supervision and Consultation, describes the participants’ perspectives on how supervision and consultation in situations of risk need to be available ‘in the moment’. Retrospective supervision as the only form of supervision was not considered to be sufficient for therapists to feel supported. Most importantly, the culture needs to be one in which the sharing of doubts and the seeking of a ‘second opinion’ is considered good practice, and not treated as a sign of incompetence.

3. Valuing Diversity and Difference

When teams get together to discuss a family or a young person the quality and outcome of that conversation will be influenced by the nature of the relationships the conversation is embedded in. Interpersonal tensions and conflict will affect the outcome. Clinical teams need to be able to voice their opinions in a way that is non-blaming and that invites the sharing of different and diverse views in a way that does not close down conversation. Teams that don't encourage alternative perspectives – in order to preserve conflict-free relationship – or teams that don't allow for diverse views to be shared in order to avoid making relationships worse than they are, are 'dangerous'.

In my experience, teams tend to veer towards these extreme positions, unless there is a conscious attempt to create something different by those in leadership positions. However, individual team members are not free of responsibility and have to play their part in taking responsibility for how their position affects others.

The participants in this research described how team discussions needed to be lively and passionate; where people could feel free to speak out.

“It's like that old northern expression, 'better out than in', I think that's the task get it out and get it.” [Phil. 17, 15-18]

“It needs to be a bit like a New York police station, in the sense that it needs to be pretty lively.” [Phil. 17, 22]

Conflict should be expected and encouraged provided that it occurs in a spirit of respect and in the interest of sharing different perspectives without damning other's views and perspectives.

“...disagree about what behaviour might mean and bounce ideas off each other in such a way that it's not that somebody's right and somebody else is wrong”. [Valerie. 6, 22-23]

An atmosphere in which no-one felt able to speak their minds was highlighted as being of particular concern. Of course interestingly, this is also often a feature of families in which a young person has self-harmed and therefore could be viewed as important information about the family dynamic. However, it needs a team who can stop and pay attention to their own interactions.

“...if everybody’s sitting on their hands and there’s kind of [an] atmosphere of egg-shelling, it..., then you’re really in trouble”. [Phil. 17, 26-29]

“You want to create an organizational culture where people can speak out and make mistakes.” [Phil. 13, 3-5]

Comment

The above findings about the importance of team functioning, links with the work of Lencioni (1998) who describes dysfunctional teams as being characterized by an absence of trust and a fear of conflict. Donnellan (1996) describes one of the characteristics of strong teams as one that recognizes that conflict is inevitable and desirable. The “*egg-shelling*” atmosphere referred to by Phil is a feature of teams in which conflict is avoided and driven underground (Kegan and Lahey, 2001).

O’Brien, (2003) when discussing family therapists working collaboratively with colleagues from other traditions, states that teams need space for dialogue, and a thoughtful work culture where time is set aside for relationship and story is seen as ‘core business’ and not as a luxury.

Selekman (2006) suggests that well-functioning teams display the ability to self-reflect and step outside of themselves and gain a meta-perspective. While I agree that this ability should be present in teams, it is difficult to achieve and in my experience is best achieved with the help of an external consultant who can structure questions and exercises that help a team move to a meta-position.

Summary

In summary this Sub-category, Valuing Diversity and Difference, describes the participants' perspectives on the kind of team culture and atmosphere that they find is supportive of them. In particular, the findings suggest that they need to be able to work in a non-blaming atmosphere where different opinions and views are welcomed and are shared from a position of respect and 'authoritative doubt' (Mason, 1993). Teams where conflict is driven underground and where the atmosphere is tense and uncommunicative are not supportive, and are not encouraging of the sharing of doubts or concerns that therapists may hold about the direction of treatment decisions.

4. Role of Leadership

This Sub-category describes the participants' perspectives on the role of team leaders in creating a safe context. Team leaders and managers have a central role in encouraging the sharing of diverse views; they lead the way, asking meta-questions of the group, encouraging team members to share unstated worries and concerns and their internal debates, and at the same time ensure that decisions are reached, clearly clarifying responsibilities and the basis of the decision.

"...so to me, the, the leaders of clinical teams who deal with risk have to set a context where they ask lots of meta questions to the group, like, um 'is there any other opinions that people ought to s...s...feel they ought to say but, but are not saying? Is there anything that people are (not) saying now that...looking back in the future, from the future, they might think that they...[0.1] i...if there was an enquiry tomorrow is there anything that we would really...you know?" [Phil. 16, 20-26]

The kind of culture that supports staff does not happen of its own accord, it needs to be shaped and consciously thought about and it needs to be led from the top down with those in senior positions leading the way through their own behaviour and interaction with others; in other words 'walking the talk'.

“But I think it always for me starts with the top. It goes top down from the consultant, er, through the management team.” [Gary. 22, 2-3]

It was also considered vital that those in positions of leadership and management needed to appreciate what it is that motivates clinicians and also show that they appreciate the complexity of the task involved. Phil expressed his view about this as follows:

“I think management of risk is all about understanding good people getting involved passionately with trying to care for people.” [Phil.28, 8-9]

“...they need to be understood as well that it’s a complex task they are undertakingotherwise people will run away from it. They won’t get involved...I mean lots of the cases we deal with are very complex...it isn’t clear what to do that’s why they are at tier 3 or 4”.

[Phil. 30, 22-26 and 31,1-2]

I think essentially what this therapist was trying to convey was how vital it was for those in positions of leadership, to recognize that the central motivator for those involved in caring for others, whether they are therapists or other healthcare staff, is their compassion for others, and it is this quality that is essential to nurture and encourage. Interestingly, Phil when describing his colleagues whom he considered to be the ones who were good at managing risk said:

“You know often it’s the square pegs actually as a...as a manager, the square pegs in the organization are very good at handling crisis and risk cases...so it’s the pains in the ass...the ones who are cross grained...they don’t take fools gladly and they’ll, they’ll always have a challenging position.” [Phil. 28, 11-14]

Here, Phil seems to point to the need for managers and team leaders to recognize and facilitate the contributions of those who seem contrary, as very often the ‘contrariness’ arises out of passion. ‘Awkward’ people make important

contributions, as their contrariness is very often rooted in compassion in that they have allowed themselves to feel and to be touched by others. If this isn't recognized there is a danger of becoming cynical.

Comment

The above findings echo Ballott and Campling (2011) who discuss how very little attention has been given to understanding and promoting what is central to the NHS as a whole, which they consider to be the issue of kinship and compassionate relationships. They argue that when we fail to attend to these issues we neglect a key dimension of what makes people 'do well for others'.

Summary

In summary this Sub-category the Role of Leadership, describes how safe and supportive cultures do not happen of their own accord but need to be nurtured and 'grown'. Team leaders and managers have a specific responsibility in creating the culture and in leading the way. They need to be able to facilitate the sharing of diverse views and encourage the sharing of doubts or concerns held by team members. Managers of teams need to show that they appreciate what it is essentially that motivates staff, ensuring that they create a context in which compassion and 'kindness' (Ballott and Campling, 2011) is nurtured and encouraged.

5. The Emotional Impact on the Therapist and the Composition of The Team

Working in situations which involve issues of risk and safety requires clinicians to remain responsive and compassionate. There is the potential danger that, in order to cope with the anxiety and stress involved, clinicians could become 'blasé' about risk, overly anxious or uncompassionate. Remaining compassionate depends on the ability to remain empathic, the ability to stand back, think and reflect (Cole-King and Gilbert, 2011). This Sub-category describes the emotional impact of the work on the therapists and how they understand and manage the range of emotions experienced.

“Mm, I suppose a bit of anger (h) () um, you know...there’s always a bit, you know cos it sort of sometime(h)mes particularly, if you don’t know a kid well maybe and you ask them and they say yes and your heart sin(h)ks, (you) thinks ‘oh God, I had to ask the question but why did I ask it ? (h)...so there’s always this ..you know, there has to be some, with anxiety there’s always, must be a bit sort of anger or pissed off-ness or whatever, you know, sort of um, well I don’t know that I completely feel compassion as I might with another child about something, you know if a child’s sad I might feel sad with them or compassionate, I don’t know, I, I think...you know with self-harm or with suicidality I’m more likely to feel in the range of emotions an irritability because of the anxiety...as opposed to an ‘oh dear’ that sort of thing really.” [Lucy. 24,14-30]

For most therapists doing this work is emotionally challenging. Lucy in the above quote is talking about the range of emotions she experiences. She describes how unlike other presentations she finds it difficult to access her compassion when faced with a young person who is self-harming.

Experiencing strong emotions like fear, irritation, vulnerability, anxiety and anger that arise in the course of the work is difficult and challenging for the therapist. These feelings are part of the territory of therapy and should not be avoided, but rather used in the service of creating therapeutic change. Negative emotional feelings are experienced by all therapists and are not a sign of incompetence or inexperience (Rober, 2010). However, they are difficult to manage and can be a barrier to creating a good working alliance. These difficult emotions can paralyse therapists, raising doubts about their competence and professionalism. Steve, I think, is alluding to this when he describes his work with a family in which self-harm is part of the presentation.

“You know maybe just sort of thinking, ‘oh God, you know what am I going to do with this family?’” [Steve. 7, 17-18]

Lucy and Valerie expressed something very similar to Steve, both refer to a feeling of incompetence or lack of confidence.

“...and then I also think you know you’ve got to hang onto the parents of course, ‘cos I...some parents of course get really wound up and distressed and then you’ve got to manage theirs and again you can get this irritability because the parent then wants to put things on you in terms of the expert and then you’re sort of feeling ‘ooh I don’t know what to do, this sort of thing”. [Lucy. 24, 31-35]

“[if] I find out a young person that I’ve been working with has been self-harming during the time I’ve been working with them and that I was unaware, it kind of wrong-foots you and makes you feel a little bit um, (0.1) kind of (0.3) not exactly foolish, but um () I think that kind of tests your confidence...” [Valerie. 12, 8-12]

When Steve was trying to make sense of some of his experiences, particularly when clients end therapy abruptly, he said:

“So there’s things that get played out that to...(0.6) you almost get a bit like...what have I done that’s so wrong?...the therapist paranoia comes in (h)...So my state of...is, what, what have I done, why am I so crap?, or you know, yeah.” [Steve. 12, 35-46 and 13, 2]

Steve seems to be referring to some really difficult experiences in which he felt very helpless and useless, but also it seemed that he did not know what to do with these feelings and how to use them in the therapeutic dialogue. Rober (2010) when considering the issue of managing difficult emotions, suggests that if therapists have no way of managing and processing their in-session emotional experiences, this can lead to the ruptures in the therapeutic alliance.

Valerie also described finding self-harm a difficult area in which to work. For her this was because she found it hard to empathize with the act of self-harm, as it was not something she could ever imagine doing herself. She said working with self-harm was not something she had ever “warmed to” and that she finds the work “really hard”. She felt that she would probably avoid having a caseload that was too heavily loaded with young people who self-harm.

“I mean I think I can cope with two or three within a mixed caseload of a dozen, but I wouldn’t want it to be more than half.” [Valerie. 10,14-15]

Anxiety and stress were also frequently referred to by the therapists. Anxiety was linked to the level of risk involved.

“I’d rather take the lower end [of level of risk] than the higher, you know (h) well. () and if I do and I do have ones that start off low and of course then go to high risk but that...it does make me anxious, you know I am going to be anxious about those...” [Lucy. 23, 44-45 and 24, 1-5]

For Valerie it was the crisis created that left her feeling stressed.

“That if somebody is [0.1] um, responding to their own stress by self-harming or overdosing, that’s gonna generate crisis in the work which I find quite stressful.” [Valerie. 10, 21-23]

The therapists highlighted the need for this work to be done by those with experience. Lucy said that when self-harm cases are referred to her service that she tries to take them on rather than having them go to someone who is less experienced, as she felt that therapists who are less experienced would become:

“too anxious at too early a stage and not be productive with the case” [Lucy. 23, 30-31].

Phil had a similar view, and stated that being able to tolerate anxiety came with experience, as experienced people had *“been there before”*. It is interesting to consider who is best suited for working with this client group. Clearly the therapists I interviewed thought that the experience level of the therapist was a key issue. Most of the therapists I interviewed found the work challenging, some were clearly feeling discouraged and finding it hard to continue working with some families because of the lack of progress.

“...but actually you know I’ve known them(h) year (h) plus and I’ve just, counting up, sort of twenty-three sessions later you know and it’s still the tendency for it to be kind of dead flat, dead-less, if not depressed”.

[Jade. 19, 43-45]

Those who came across as more enthusiastic were working in inpatient units in which they felt supported by the team.

“I mean I can go home and I know there’s a team.” [Gary. 6, 13]

Only one of the therapists, who worked in an outpatient setting expressed enthusiasm for the work.

“I love it, maybe it’s my background.” [Phil. 23, 13]

However, in his capacity as a manager he had the experience of trying to put together a team to work with self-harm and he found that many of his colleagues did not want to do this kind of work.

“When we increased the um, pool of people who were doing the deliberate self-harm rota so that everybody from child psychotherapy to family therapy had to go and assess young women on our paediatric unit, um () all to do with self-harm, it caused enormous anxiety. So we decided to open it out so that everybody had to do it and ...that’s when we realized a lot of people didn’t want to do it.” [Phil. 3, 23-24 and 4,1-4]

The outcome of this ‘experiment’ was that a decision was taken to go back to a dedicated team doing the work.

Comment

The findings presented above show that the therapists experience this work as anxiety-provoking and stressful, and believe that it is best done by experienced clinicians. This is echoed in the literature, for example Toth et al. (2007, p.1)

state that suicide is one of the topics that almost 'universally triggers anxiety and apprehension in clinicians, both novice and seasoned practitioners'.

In adult psychiatry, Stone (1993) when writing about working with adults who were borderline and suicidal, had a number of ideas as to what kind of therapists' attitudes and 'traits' were helpful. He mentions having firstly a faith in one's profession and professional ability. In addition, he believed that being able to face the possibility of a patient's death without losing confidence in your own ability or profession was vital. He also suggests that the therapist should be someone who is not timid or excessively concerned about their self-image, has a healthy tolerance for uncertainty, an ability to accept risk, and the ability to act decisively when there is suicidal intent.

Selekman (2008) suggests that therapists are intimidated by the unpredictability of young people who self-harm and also by how difficult it is to 'read' them. He also holds the view that mental health professionals will often try to avoid working with young people who self-harm. Ougrin (2010, p.87) based on the evidence of effective interventions, believes that the work should be done by 'dedicated teams, consisting of therapists with low caseloads who have a mutual support structure'.

The Sub-category, The Emotional Impact on the Therapist and the Composition of The Team, describes the range of emotions that therapists experience when involved in working with self-harm. The participants described finding the work challenging. They described some of the very strong emotional reactions they experience: including anger and irritability; anxiety and feelings of incompetence; and a lack of confidence. They described how it can be very hard to feel compassionate towards the young person.

The participants thought that those working with self-harm should be experienced therapists, more able to manage the anxiety and stress involved, and that it should be recognized that not all therapists feel able to do this work and consequently, it may be best done by a dedicated team who are interested in and want to work in this area.

Summary

In summary, in this Main Category Team and Organizational Processes participants identified that this was an area of work that was difficult and stressful. The question was raised as to who should do this work; should it be expected of everyone or should it be done by a 'voluntary' team. The participants highlighted that having a good feeling of connectedness with colleagues was essential and gave them an experience of feeling supported and encouraged, and less isolated. They also highlighted that an atmosphere that is negative and blaming is unhelpful and that team leaders and managers need to consciously nurture and create contexts that are supportive and nurturing of staff, that encourage self and team reflection, that see to it that team discussions allow for the 'unspoken' to be voiced, and that take account of the impact of differentials in power on clinical decisions.

7. CHAPTER 5: DISCUSSION

Introduction

In this chapter I will consider in more detail some of the findings from this study and amplify some of the implications of the findings for clinical work in this field.

Firstly, I briefly summarise the key findings and then I address, in addition, the strengths and limitations of the study, a review of the 'quality' of the study, some self-reflective thoughts and finally offer some ideas for future research directions.

7.1 A Summary Of Key Findings

- (i) The Core Category: Cultivating The Practice Of Hope, Withstanding The Pull To Hopelessness

This study set out to describe and illuminate the experience of family therapists who work with young people who self-harm. The central concern for therapists that emerges through the analysis of nine interviews is how to stay engaged with families and young people in the face of high levels of risk of self-harm, and further, how to create change in situations where there is a strong pull towards hopelessness, both for the family and for the therapist.

The findings suggest that maintaining a stance of hopefulness is their best response and their greatest challenge.

To engage with families from a position of hope requires therapists to have a set of practices that guide their interaction with the family, as outlined in the Main Categories 1 and 2, detailed below. In situations that involve risk, often permeated by a sense of hopelessness and emotionally demanding, therapists need to be able to practice from a position of safety, in a context that is supportive and 'hope inducing' in order for their work to be most effective. Aspects of organizational and team life that are supportive of therapists as described in Main Category 3, are detailed below.

(ii) Main Category 1: Making The Situation Safe

This Category incorporated a number of processes in which the participants engaged.

First and foremost it emerged that therapists focus a lot of attention on the issue of risk and that at the core of risk assessment is the clarification as to the intention behind the self-harming act; requiring directly asking about the intention to die. Therapists were found to be well-informed about risk factors for self-harm and used this information to guide their assessment, keeping this at the forefront of their thinking and prioritizing the safety of the young person. That therapists need to be aware of risk throughout the therapeutic process and not just at the beginning stages of the work was clearly indicated in the findings.

Despite indicating that assessing risk is a key issue, the findings suggest that training family therapists in the assessment of risk is inadequate and overly focussed on facts. Many Family therapists were considered to be ill-equipped for the task, with a tendency to 'miss' the critical requirement to make a decision. A focus on the decision-making aspect of the risk assessment process, with clear recordings of reasons for actions on the part of the therapist was clearly indicated as being crucial. It was proposed that therapists would benefit from having a decision framework; knowing the key questions to ask in order to reach a decision and being able to justify and record the decisions taken. A decision-making 'tree' was suggested as a tool to assist them in this.

Findings also indicated that when clinical teams focus on risk, this can be at the expense of reflection on the meaning of the act of self-harm, and a prioritizing of action only.

The analysis revealed that systemic therapists prioritize creating a safe context in which issues of risk and safety can be addressed in discussion and collaboration with the family; who they see as having a central role in creating a safe context for the adolescent. They involve family members in creating a safety plan, engaging them in taking responsibility for their child's safety. Addressing parental anxieties and fears is an important component of the work, particularly the fear that the self-harm could be repeated and, or could be fatal.

Incorporating separate meetings with the young person and with their parents as part of the therapeutic process was found to be a preferred way of working. A primary aim was to help the young person communicate their distress to their parents. Meanwhile, in the separate sessions with parents, they worked to help them respond to their adolescent in ways that conveyed they had heard and understood their distress and were taking the situation seriously. The findings suggest that in the early stage of the work, the therapists prioritized the building of a working relationship, laying a firm foundation for therapeutic change.

That the unpredictable and uncertain nature of this work can create anxiety for the therapist was clearly indicated in the findings. Experiencing frequent anxiety was seen as 'part and parcel' of the work: created by uncertainty, not being able to trust the word of the young person and the experience of a young person having taken a serious overdose despite therapists having followed good practice guidelines. The level of anxiety was found to influence the therapists' ability to manage risk. Therapists were mindful of a focus on safety, not just for their client but also for themselves, and were diligent about maintaining records.

The findings indicate that therapists are supported in their work by techniques drawn from different theoretical models rather than relying on a single model. Ease of access to psychiatric colleagues was also seen as key resource for therapists when assessing and managing risk, and equally the key need for good cross-service collaboration in order to maximize safety for the young person.

(iii) Main Category 2: Conversing Therapeutically – The Practice of Hope

This Category describes the stances and activities engaged in by the therapists in co-creating a 'conversational space' (Weingarten, 2010, p.14) in which hopefulness is co-created and change can take place.

Practising from a position of hopefulness involves the therapist in a range of therapeutic activities.

It was found that therapists gave centre stage to creating a strong working alliance with families. An appreciation of the sense of vulnerability felt by family members when having to place themselves in a help-seeking relationship was central to this belief. Exploring the meanings of attending a mental health service, focussing on lifting the burden of blame and shame, and attempting to convey a sense of acceptance and openness with the family, was found to be central in the work. The normalisation of the family's experience through re-casting the young person's difficulties within a developmental frame, using self-disclosure and relating 'stories' about other families' experiences, using positive connotation and externalizing techniques to help reduce blame were an integral part of the work. That it was important to communicate to family members their belief that the process of therapy could be helpful and that a hopeful outcome was possible, was clearly indicated in therapist responses.

The findings suggest that the therapists' collaborated with families to create a conversational space that would allow for frightening and difficult issues to be spoken about, with therapists working to convey their position as capable and confident therapists to the family, open to hearing whatever needed to be shared. Therapists clearly recognized how fearful and frightened family members can feel when dealing with self-harm, particularly where their child could have died and that feeling confident in the therapists' abilities helps to reduce their anxiety. Being as transparent as possible about their thinking helps to build trust and safety, laying the foundation for taking therapeutic risks. The therapists accounts of their therapeutic practice indicates that family members tend to believe that talking about self-harm will trigger further episodes, and further that the young person was often 'at pains' to convince their parents that this was a one-off episode. The findings show that the therapists thought it was important to challenge parents' beliefs about this by being able to talk about self-harm and the risks and fears involved.

The findings illustrate that therapists in the early stages of working with adolescents who self-harm needed to act as the 'holders of hope' for the family, with the intention to enable them to access their own hopefulness. That self-harm can have the effect of leaving families feeling inadequate and unable to access their own resources was indicated. Therapists worked from a position of

seeing families as essentially resourceful, focusing their therapeutic activity on reconnecting family members to their capabilities, strengths and competencies with the aim of creating a sense of agency and a belief that change was possible.

The challenges faced by therapists in the work were highlighted. The most common challenge was the tendency to become overly responsible for change, particularly in the face of adolescents who are high risk and who do not wish to engage in therapy. Therapists felt challenged by the difficulty of not being able to trust the word of the young adolescent, which resulted in being overly careful and cautious, with the tendency to carry all of the responsibility for the young person's safety. The findings indicate that when the therapists experienced impasse in the work and when a young person was not engaging, they felt obliged to keep trying despite lack of progress, because of the risk involved. In addition the therapists were challenged when they experienced difficulties in feeling empathic towards the young person, which in turn impacted on the therapeutic relationship.

The findings suggest that the therapists worked to create a 'story' that made sense of the young person's self-harming behaviour. To achieve this they try to have their own hypotheses while also trying to remain open to the family's hypotheses, paying attention to the feedback from the family and thinking about how their own actions may be construed by the family. The therapists primarily viewed self-harm as a communication about family relationships. They emphasized encouraging the young person to talk to their parents about their distress, using relational questioning to help family members begin to see the connectedness between the self-harm and family relationships, and working towards a situation in which family members began to use the language of 'we' rather than 'you'.

It was clear that the therapists are mindful of the magnetic draw that self-harm can exert and therefore always work to widen out the conversation to increase possibilities for change. Allowing meaning to emerge from a careful unpacking of the self-harming event, where questions are initially fact based and aimed at

exploring the different steps taken by young person in the lead-up to the self-harming act, was clearly indicated.

That the therapists also needed to be very risk aware throughout the course of the work, and being prepared for the potential for the level of risk to change in the course of therapy was clearly indicated in the data. They were helped by holding in mind the dual task of needing to focus on risk and safety while also exploring meaning, and the concept of 'domains' (Lang et al., 1990) was found to be useful in managing this. Therapists tried to remain alert to changes in the young person's body language and mood, additionally using their own 'gut-feelings' to guide them in relation to changes in the level of risk. At times they found it necessary work in the domain of production, prioritizing safety, sometimes necessitating a more directive therapeutic style. The findings suggest that when issues of risk are managed safely the therapist is then free to work in the domain of aesthetics prioritizing meaning and exploration.

It was found that the therapists focused on the emotional communication between family members, and stepped in when emotions threatened to overwhelm. They intervened to reduce conflict and hostility, prioritized increasing the emotional connection between the adolescent and their parents, focused on helping parents to 'stand in the shoes' of their adolescent and, where necessary, intervened to create clearer generational boundaries. The therapists tried to make change feel manageable by exploring aspirations and hopes for the future, by helping family members set realistic goals and by intervening when there was a tendency towards catastrophizing. They explored the family's model of change and shared their own, highlighting that the path of change did not proceed in a smooth upward direction. They also coached family members in noticing early warning signs of relapse and adjusted their hopes for the family in line with what was deemed achievable.

The therapist tried to walk between hope and despair, keeping both in the frame and ensuring family members' despairing feelings were understood, respected and acknowledged. The findings suggest that the therapists believe it is important to monitor their own feelings of despair and withstand joining the family in feeling hopeless, with the need to be vigilant about consciously looking

for small signs of hope, and expanding on these. That the therapists' own relationship to hope is an important resource was strongly indicated. Participant therapists were sustained in the work by their belief and commitment in what they did, by experiences of success, and through having good working and supportive relationships with colleagues.

The findings suggest that when therapists feel disillusioned and hopeless they need to take action, and seek the help of colleagues through both off-loading and processing their experience and through discussion and exploration in supervision. This suggests that therapists have to be mindful of the importance of the need to take care of, and nurture, their own sense of hope.

(iv) Main Category 3: Team And Organizational Processes: Supporting Therapists

This Category describes aspects of team and organizational processes and structures that are supportive of therapists and some that are unsupportive.

The findings suggests that therapists engaged in this work need to work in a context that is supportive and makes them feel safe, and that good relationships with colleagues is essential. The data suggests that when there is concern about risk, the team needs to come together to discuss how the risk will be managed and become a team responsibility rather than being the sole responsibility of an individual therapist. When the team prioritizes reflection and understanding of the meaning of the self-harming behaviour therapists thus feel supported, feeling unsupported when colleagues portray 'blasé' attitudes towards risk, or conversely when colleagues are overly anxious. That therapists feel supported when they have a good relationship with psychiatry colleagues was clearly indicated, and further that power differentials between clinicians affect the information shared, which in turn impacts on the quality of assessment of risk and decisions about risk management.

The importance of supervision is another key finding: that when it comes to issues of risk, retrospective supervision is not sufficient. Clinicians need to be able to share their concerns 'in the moment' and therefore team leaders,

consultants and managers need to make themselves available. The culture of the team needs to be one in which the sharing of doubts and concerns and seeking another's opinion are encouraged and treated as a sign of competence rather than as a sign of incompetence.

The findings suggest that the quality and outcome of clinical decisions is influenced by the nature of the relationships the conversation is embedded in. Clinicians feel supported when the team is one in which it is encouraged to share diverse views and opinions in a way that does not close down conversation. The atmosphere of team discussions needs to be lively and passionate, with team members encouraged to speak out. Creating an environment in which conflict is expected and encouraged, provided it takes place in a spirit of respect and in the interest of sharing different perspectives and enriching the discussion is essential. The findings indicate that teams in which conflict is buried are experienced as unsupportive, and that therapists need a thoughtful work culture where the nourishing of good relationships is seen as a priority and part of the core business.

The role of leadership is kernel in the creation of a supportive work culture. The findings suggest that leaders and those in positions of authority need to lead the way: encouraging the sharing of different perspectives; asking meta-questions of the team and encouraging members to share unvoiced concerns and 'inner' debates; and needing to 'walk the talk', modelling the kind of attitudes and behaviours they want to inspire in others.

That supportive cultures do not happen of their own accord, but have to be 'grown' was clearly indicated, and those in positions of leadership have a key role and responsibility in this task. Therapists feel supported when managers appreciate what it is that really motivates them, seeking to create a culture in which compassionate relationships between staff and clients are supported and mirrored by compassionate relationships across the whole organization.

The findings clearly illustrates that the work is emotionally demanding and that therapists often mirror the same emotions as the family; often feeling anxious, overwhelmed, helpless, angry, vulnerable and hopeless, at times doubting their competence and professionalism. While noting their emotional responses, it

appeared that many of the participants did not seem to have a clear approach as to how to manage their emotional experience, and while they referenced ideas such as transference and self-reflexivity these seemed to be more academic references rather than examples of models or techniques applied in their actual practice. This suggests that the therapists may have been working in teams where the sharing of the emotional experience of the work was not encouraged, or did not assist them adequately in processing and making sense of this aspect of the work.

Conclusions from the data indicate that ideally the work should be done by experienced therapists who are part of a dedicated team who are interested in, and want to, work with this client group.

The next part of this chapter on the discussion will be devoted to elaborating on some of the key findings.

7.2 Elaboration of Some Key Findings

This part of the Discussion Chapter will expand on some of the findings that struck me as especially interesting and valuable. Specifically, the discussion will focus on the issue of hope and therapy, the emotional experience of the therapists and the 'use of the self' of the therapist. It will also focus on the findings regarding team and organizational processes and structures that are supportive of therapists involved in working with self-harming adolescents at risk of suicide, and nourishing of their practice of hope.

The main finding or core category of this study was concerned with how therapists maintain hope in the face of situations that can be characterized by feelings of hopelessness and despair. This was an unexpected outcome of the study and was not something that had been anticipated. It had not been part of the research question or sub-questions. As a result, it can be considered as 'news of difference'. Given that the concept of creating and sustaining hope constituted a finding in this study, it was not included in the main Literature Review (Chapter 1). However, a Literature Review on Hope has now been included and can be found in Appendix 6. This Literature Review includes an overview of the family therapy literature on hope and additionally a brief overview of hope in different academic traditions.

Here I will focus on relating the findings about hope to elements of the Literature Review.

A review of the literature on hope shows that the practice of hope is primarily discussed within the context of situations of trauma, loss and illness (McGoldrick and Moore Hines, 2007; Weingarten, 2010), in situations of chronicity and in situations of therapeutic impasse (Flaskas, 2007b). Tomm and Govier (2007) state that hopefulness can be sustained in mutual supportive relationships, but when people experience disappointment, conflict, traumatic events and interpersonal stress they become vulnerable to despair.

I would suggest that most of these scenarios are present in the clients that family therapists work with particularly in the context of CAMHS teams and in inpatient settings. While self-harm is not explicitly mentioned by most of the

above authors, many of the families presenting with an adolescent who has self-harmed will have experienced the kind of trauma and distress described. This was evident in the case descriptions used by the participants in this study when they described their work with adolescents who self-harm and their families.

Flaskas (2007b) is probably the only author who explicitly discusses the practice of hope in relation to self-harm. She gives an example from her practice, of an eight year-old boy who had tried to kill himself. Flaskas describes his suicidal act as an 'act of despair' but she comments on how his aunt was the one who was 'doing hope' for him at a point when he had not learnt to do it for himself. She highlights an important aspect of her work with this boy and his family involved the building of a network that would act as a resource. This network included members of the boy's family, members of his community, his school, his teacher and family therapy.

(i) Explicit and Implicit Practices of Hope

The findings of this study suggest that the participants practiced from a position of hope and that their practice incorporated both implicit and explicit ways of co-creating hope with families. Flaskas, McCarthy and Sheehan (2007) suggests psychotherapy itself is an act of hope and that therapy is about creating possibilities for change. Echoing Weingarten (2010) and Hoffman (2007) Flaska states that there is very little family therapy literature explicitly addressing hope but that in her view, themes relating to hope and despair are implicitly present in the writings of family therapists and in their discussions. She considers that family therapists implicitly place hope at the centre of their work through practices that focus on the strengths and resiliencies of clients, and further she considers that influences from narrative, solution-focused and post-Milan model of therapy add to therapists' attempts to put hope at the centre of their practice. The point raised by Flaskas and echoed by Weingarten and Hoffman, as to why the issue of hope has remained largely implicit in the talk and thinking of therapists is worth consideration. It seems to me, that focusing on hope explicitly may feel perhaps overly philosophical, and or theological, or

fanciful. Present day family therapists may feel cautious about the use of language that has religious overtones.

I have a strong personal feeling that it may be more productive to leave it as an implicit practice. I can recall having seen colleagues, keen to use the language of hope explicitly, come across to parents as unrealistic, foolish and unappreciative of the real pain and disappointment they experience. In order to be hopeful there must be space given to sitting with hopelessness. This aspect of working with hope will be addressed later in this chapter. I also think that there is a question of categories involved, in the sense that you don't tell a person to be hopeful, but you act in specific ways and enact specific practices out of which hopefulness is generated.

Co-ordinating Hope

The participants in this study identified several ways in which they try to co-create hope with their clients. They described how they try to make change manageable by setting realistic and achievable goals.

In the literature, Beaver's and Kaslow (1981) refer to developing hope through translating it into 'bite-sized' goals and Snyder (2000) conceptualizes hope as having two components, the ability to plan pathways to desired goals and the motivation to use these pathways.

The therapists in this study highlighted how at times they need to adjust their hopes for a family, in line with what is achievable for them, highlighting that setting goals from a systemic perspective involves co-ordination and collaboration between therapist and family. In order to achieve this, the therapist needs to monitor and moderate their own hopes for the family. I would suggest that the therapist therefore needs to be prepared to handle disappointment. How the therapist handles disappointment will have an impact and will require the therapist to be careful not to mirror the family's lunge towards hopelessness, while still acknowledging that set-backs and disappointments have occurred. Other practices that I like to use and find helpful include exploring exceptions, asking questions about differences and re-

framing. In this study there were several examples in which the therapists referred to these practices and while not explicitly linking them with hope, these practices increase options for families, and help to develop more hopeful perspectives (Hof, 1993; Ward and Wampler, 2010).

Introducing the Family to a Realistic Model of Change

Families will often come to therapy with an unrealistic understanding of change; indeed they often seem to see therapy as offering a sort of magical solution. They therefore need to be helped to understand that change is not progressive and problem-free, but often involves two steps forward and one step back in terms of progress. This prepares families for set-backs. This resonates with the findings of Ward and Wampler (2010, p.221) who describe how therapists increase clients' hopefulness by helping them to 'get over the hump' and navigate their way through 'stuck' situations. In this study one of the ways that therapists enabled families to think about hope, was through talking with them about the nature of change.

In my experience, adolescents who repeat self-harm and their parents, will view the reoccurrence as a failure and a return to old ways, when it may be a stage on the road of change. The challenge for the therapist is to both acknowledge the disappointment and intervene to disrupt catastrophic thinking. By focusing on what had helped in previous relapses and recovery from these, family members have evidence that they can recover, which in turn reinstates confidence and hopefulness.

Looking for Signs of Hope

The therapists in this study described the need to actively watch for signs of hope then build on, and amplify these. This finding resonates with Weingarten (2007, 2010) who suggests that therapists need to train themselves to see and hear signs of 'reasonable hope'. This involves very careful listening, for the aspirations in people's actions.

Alertness to the Absent but Implicit

Carey (Carey et al., 2009, p.321) suggest that therapists tune themselves to hear not just the problem presented but also what the 'problem is not' – to hear what is 'absent but implicit'.

Small Triumphs and a Sense of Agency

Beavers and Kaslow (1981) suggest that therapists should notice 'small triumphs' and explore how these were achieved. They suggest that this leads to greater awareness and develops a sense of being able to shape 'one's environment and relationships'. It helps to change the client's perspective of themselves as helpless, which in turn increases their sense of hopefulness. Cooper et al. (2003, p.7) suggest that the 'cornerstone of hope is the ability to participate and influence the daily course of one's life'.

It's the Journey that Matters Not the Destination

The above has emphasized the importance of leading the young person and their family through change by taking on 'bite-sized' goals: by the therapist moderating and managing their own hope; reflecting on theirs and the family's relationship to disappointment; acknowledging set-backs and addressing catastrophic thinking; consciously looking for signs of hope; building on and amplifying these; listening for what's 'absent but implicit' and creating a sense agency.

To my mind, these ideas are usefully balanced by the view that it is the journey, the pursuit of the goal that is important, not necessarily reaching the actual goal itself. In the act of travelling unexplained things happen, new directions evolve. It is a little like White's idea of scaffolding (White, 2007) in which a therapist creates a structure that supports a person in accomplishing something new.

Weingarten (2010) emphasizes that it is the process of a reaching a goal that is important, not achieving the goal itself. She argues that reasonable hope is not about accomplishing a goal, but about aiming towards it: 'it's the journey not the arrival that matters'.

Hope and Hopelessness

The therapists in this study described how they needed to be careful not to over-emphasize hope at the expense of ignoring a family members' feelings of despair. They expressed that they needed to be careful not to join the family and take on their hopeless feelings, thus becoming overwhelmed and ineffective.

Flaskas (2007b) when writing about hope, emphasizes the need to consider hope in its relationship to despair or hopelessness. She suggests that the relationship is a complex one, and that hope and hopelessness can live side by side, that clients can feel both hopeful and hopeless at the same time. Weingarten (2010) discusses how one of the most important practices in co-creating reasonable hope is for the therapist to understand their witness position. Weingarten emphasizes that therapists must take care when exposed to a client's despair so that they stay empowered. She does not give any specific ideas as to how therapists can empower themselves. However, it would seem that when therapists become aware of their clients' feelings of despair, acknowledge these, try to understand the source of the despair and its effects, and convey this understanding to clients, that this would be a way to resist becoming apathetic or indifferent. It would also allow for the doubt and despair that is part of the landscape of hope to surface.

I find a lot that is attractive in Flaskas and Weingarten's ideas, and many of these are reflected in the findings of this study. I think their ideas offer some very important insights about the need to hold both despair and hope in the same frame.

I use their ideas in my clinical practice and these ideas make a contribution, but I am aware they are not a panacea. In working with clients I have often been

struck by the thought that putting the ideas of Weingarten and Flaskas into practice is more easily 'said than done'. How do you sit with people's expressions of despair and hopelessness when your experience tells you that this can lead to the person becoming more entrenched in their hopelessness? Sometimes I have found 'diversion' helps. I try to use my 'inner conversation' (Rober, 2008) as a resource, and say to the person, something along the lines of 'the more we talk about this, the more down-hearted you seem to get, without wishing to be insensitive or disrespectful could we – for five or ten minutes – think together about what's going well in your life, what things are you grateful for, what have been the achievements in your life, what makes getting up in the morning worthwhile?' Alternatively, I sometimes try to help the person take a meta-position. Drawing on White's (1990) concept of externalizing, I ask them to reflect on their hopelessness; treating it as something external to themselves that is holding them in captivity.

Hope and the Therapeutic Relationship

The 'therapeutic relationship' has been identified as a very significant component of creating change (Sprenkle et al., 2009). The components of the therapeutic relationship or alliance include the emotional connection with the therapist, engagement in the therapeutic process, safety within the therapeutic system and a shared sense of purpose within the family (Friedlander et al., 2006).

While not specifically naming the therapeutic relationship or connecting it explicitly with hope, it was clear from the accounts of their work that the therapists in this study, placed a lot of emphasis on building a strong therapeutic alliance with the families. They spoke about needing to create a 'safe therapeutic space'. They were mindful of how vulnerable family members feel when placed in a help-requesting position. They were sensitive to the issue of blame, both the family's expectation of being blamed by the therapist and the ways in which family members blame each other. They worked to create a setting in which family members felt safe discussing their fears and worries. They described how important it was to convey an attitude of acceptance,

understanding, and respect for their clients. They spoke about the importance of engaging with families and finding ways to 'join' them. I would suggest that in paying attention to the creation of a strong therapeutic alliance the therapist is also creating a context in which hope can flourish. In my experience people who are hopeless tend to avoid contact and connection with others, and become increasingly isolated. The forming of a good therapeutic connection validates the person, normalizes, and shows that their experiences are worthy of attention.

Supporting Echoes

There are many who support the ideas expressed by the therapists in this study. Weingarten (2010) and Cooper et al. (2003) believe that hope is a shared experience and further that hopelessness flourishes when people feel isolated and alone. Building a strong therapeutic relationship with a family is one way in which family members can begin to feel less isolated and more connected. Ward and Wampler (2010) consider a strong therapeutic relationship as central to generating client hope; an essential part of the work of creating a 'hopeful environment'. Cutliffe (2004) suggests that hope and the therapeutic relationship are inseparable from each other. Beavers and Kaslow (1981, p.121) state that one of the ways a therapist develops 'genuine' hope is by 'hearing, acknowledging and empathizing with clients in a non-judgemental framework, so that clients experience authentic concern, interest and caring'.

A Different Vocabulary

Weingarten (2010) when discussing practices that help co-create hope, does not name the therapeutic relationship as such, but she does describe clinicians as being in a 'relationship of love' with their clients. The kind of love she refers to is the love one has for friends, or a neighbour. Weingarten suggests that the lapses in rapport that occur in the relationship between a client and a therapist need to be addressed, and that failure to acknowledge and address them is anti-therapeutic.

There is a lot of emphasis on the importance of the therapeutic relationship and I subscribe to this, but I find myself very drawn to the language used by Weingarten as expressed above. Firstly I believe it introduces a different way of talking, which jogs one and creates a jolt. It leaves me with a stronger sense of responsibility. The language of 'building a therapeutic relationship' and a 'working alliance', may have lost their impact through over-use and familiarity. For me, Weingarten's language brings home more acutely that one is involved in co-carrying the burden of the other, which is a very sobering thought: it suggests a commitment of the heart.

One Size Doesn't Fit All

In my clinical practice I often have the experience of working with families where one parent is very hopeful and the other very hopeless. Sometimes, when I feel it is appropriate and when I have a good relationship with the parents, I venture to introduce with some humour the idea that they are a little bit like ministers in government – carrying different portfolios, one being the minister of hope, the other the minister of hopelessness, and in so doing get them to think about the pros and cons of their respective positions.

Flaskas (2007a) discusses how the therapist when engaging with family members needs to be aware that different family members will orient differently to both hope and hopelessness and that they come to therapy with different levels of hope for the therapy itself. Equally, therapists come with different relationships to hope and hopelessness, and in turn this affects the engagement with family members.

Holding Hope for Others

Closely linked to the building of a strong therapeutic relationship and a hopeful environment is the therapist's hope, which Ward and Wampler (2010) suggest acts as a source of motivation for clients. Beavers and Kaslow (1981, p.121) speak about clients identifying in the initial stages of therapy, with the therapist's

'affect and mood', and through this they 'borrow hope'. Cooper et al. (2003, p.2) suggest that the idea, 'that positive change is possible and that therapy can improve clients' lives is the 'raison d'être of therapeutic practice'.

The participants in this study described how they try to 'hold hope' temporarily for the family, while they work to reconnect family members to sources of resilience and to their strengths. They described how the therapist's belief in the possibility of change and in the family's possibilities is part of the task of co-creating hope. Cooper et al. (2003) suggest that asking about client's lives in an appreciative way implies that there is something valuable in the client's life. Walsh (2002, 2003) writes about how resilience benefits families when facing challenges and set-backs in life. She suggests that affirming family strengths in the midst of difficulties, helps families to 'counter a sense of helplessness, failure and blame and reinforces pride and confidence' (Walsh, 2003, p.8).

The idea of holding onto hope for others is a popular idea and was used by the therapists I interviewed, but I have an in-built caution towards the use of this in a session. When I hear colleagues say that they are holding hope, I find it 'cringe-producing', and I have noticed that families don't respond well to it. While I think it is an important idea, it doesn't need to be stated. The holding of hope for the sake of the client is not a technique: it is an ethical position.

In my view, Walsh's ideas of exploring the strengths and resiliencies in the history of the family especially as they encountered adversity is really important.

The Spiritual Dimension

Spiritual and religious beliefs are one of the key sources of resilience for families. (Walsh, 2003). It was interesting that the participants in this study did not refer to this aspect of families' lives, despite the fact that suicidal behaviour in a young person can be a statement about not valuing life.

Jurich (2008) talks about how parents can be thrown into an existential predicament when their child self-harms – their child who, in their minds, has so much to live for tries to end their life. This can shake a parent's foundational

beliefs and create a crisis of meaning. Jurich suggests that some parents can begin to fear their own ability to choose life over death. McGoldrick and Moore Hines (2007) argue that our clinical job as therapists in relation to hope is to help clients connect with their own spiritual resources, their own sources of hope that will help them to keep going when they feel despair.

Walsh (2003) suggests that resilient families value transcendence and spirituality and that they have a purpose and connection to something beyond themselves. This can be through a connection with religious beliefs and or through other sources of connection with wider realities, for example art, music and nature, politics and movements for the betterment of the world. Walsh suggests that through seeing themselves as part of something bigger, clients are able to take a wider perspective of the crisis they are in, which can lead to a heightened sense of purpose.

In my view this would seem to suggest that a key area for therapists to focus on when working with self-harm is the spiritual aspect of family members' lives. This could include both a focus on formal religious beliefs where appropriate, and on what it is that gives meaning and purpose to family members' lives, and further, how the act of self-harm has impacted on the spiritual aspect of the family's life.

I believe that when faced with a crisis, particularly a crisis in which family members experience a sense of shame or feel blamed, they often withdraw from sources of support, isolating themselves from friends, family and community. The therapist will therefore need to enquire about this and try to find ways that re-build connections and community with others. The more resilient family members are, the more they will be able to manage and respond to the distress of their child, consequently decreasing the likelihood of further risk and increasing safety. Walsh (2002, p.2) suggests that when therapists affirm a family's strengths and, or help them discover untapped resources and skills in the midst of difficulties, they 'counter a sense of helplessness, failure and despair'.

(ii) The Emotional Experience of the Therapists and Therapist's 'Use of Self'

The participants in this study reported on the emotional impact of working with self-harm. They described at times feeling anxious, overwhelmed, helpless, angry, vulnerable and hopeless, doubting of their competence and professional skills. Their emotional experience seemed to mirror closely that of the families they were working with. Bickerton et al. (2003) discuss how professionals can get drawn into the family's dynamic and exhibit similar behaviour such as confusion, secrecy and conflict. Boston et al. (2011) describe how their team discussions were characterized by powerful emotions and how they worked to contain anxiety and resist over-reacting. The therapists in this study described families as feeling overwhelmed, lacking in confidence, feeling like a failure, hopeless and helpless, frozen, angry and fearful. Jurich (2008) similarly describes families in which a young person has self-harmed as experiencing fear, helplessness, hopelessness and anger. I was curious about this mirroring between the therapists and the families' experience and began to reflect on its significance.

Initially I wondered if this close mirroring between therapist and family meant that the therapists were overly close to the families, and that they were unable to keep their professional boundaries. This seemed a rather negative understanding of the therapists' experiences. On reflection, and after having read Rober (2010), I reviewed my perception of the therapists' experiences. I now understood it as the therapists being very attuned to the emotional experience of the family.

The findings suggest that the participants in this study noticed, and were aware of their emotional responses, however they did not appear to have a way of managing their emotional experience and use it for therapeutic benefit. It seemed that they found the emotional impact overwhelming and challenging, which often led to a feeling of stuckness and therapeutic impasse. One understanding of this is that the therapists were experiencing what could be described as negative emotions, for example, hopelessness, anger, irritation, fear and worthlessness, and that they viewed these feelings and related thoughts as not being very productive. Both Rober (2010) and Bertrando and

Arcelloni (2009) refer to how these more negative emotions are a usual part of the process of therapy and are not indications of a being a 'bad' therapist. However, they also acknowledge that these emotions are difficult for a therapist to manage, and present a challenge. Rober (2008, 2010) discusses how these emotions can act as barriers to the development of a therapeutic relationship and that therapists may sometimes feel paralysed when they feel strong emotions towards a client in the session. This leaves the therapist feeling powerless, unable to know how to help the client and how to use their negative feelings constructively for the benefit of the client.

Everything experienced by therapist in the therapy room – the feelings and images, thoughts and ideas, what Rober (2010) refers to as their 'inner conversation' – can be used as a therapeutic tool to further the work with the family (Flaskas 2002, Real 1990).

However, it is not enough for a therapist to be aware of their experience, they have to be able to reflect on their experience, notice how it is organizing their interaction with the family and translating their reflections into a theme or an idea that can be introduced into the therapeutic dialogue. This process can be applied to all of the therapist's emotions, both negative and positive. Rather than censoring negative emotions, therapists need to be able to acknowledge them and to speak about them, even those that a therapist might feel ashamed of, otherwise they threaten to derail the therapeutic relationship. This leaves the therapist feeling incompetent and losing faith in their ability, and in the possibility of achieving change.

(iii) Team and Organizational Processes: Supporting Therapists

I have already entered into some discussion in the findings about how team and organizational structures need to be configured in a way that supports therapists in their practice of hope. There was a very clear message from the participants that working with self-harm and suicidality is demanding and complex work. Briggs (2002) and Bickerton et al. (2007) echo this finding when writing about working with self-harm. The findings from this study indicate that

the culture of the team and organization within which therapists practice; the attitudes and structures, are key factors in supporting therapists in doing their job effectively and safely and in supporting them in the practice of hope.

Messages from the Participants

The reader will recall that the participants in this study highlighted the following: the need for beneficial relationships with their colleagues; the need to feel safe; the need to feel that they could rely on colleagues; offloading when overwhelmed and consulting with them when concerned or in doubt. The therapists believed that risk needs to be held by a team rather than by an individual, and that the team needed to come together and discuss what to do.

They stressed the importance of the availability of supervisors and managers that they could go to and share concerns and worries. The availability of 'in the moment' supervision as distinct from retrospective supervision was stressed. The therapists felt supported when the team was one in which members were encouraged to express their views in ways that opened up discussion rather than closing it down. Teams in which conflict was buried were considered unsupportive.

The role of leadership in nurturing and tending to the culture, and the role of team leaders in enabling the sharing of different perspectives through asking meta-questions of the team was stressed. Supportive cultures were those in which expressing doubts is not seen as a sign of incompetence.

From a personal point of view, I was very taken by these findings as they resonated with my own experience and they also resonate with the literature.

Personal Experience

My career has been largely spent working in residential and inpatient settings. I first became aware of the idea that an environment could be shaped in such a way as to benefit both clients and staff when I was introduced to the work of

Bettleheim (1974) and Redl (1951,1952). Prior to this I had worked in a hospital as a student nurse. It was in this setting that I had my first 'taste' of the negative impact of institutions on staff welfare and well-being. The culture was one in which student nurses experience very high levels of stress and anxiety. They regularly found themselves attending to tasks beyond their competence and were later blamed for mistakes that occurred. The hospital culture was not one in which admitting to being unable to undertake a task was considered acceptable, nor one where mistakes were readily admitted. Staff were at times humiliated by senior and consultant staff and made little of in front of patients and colleagues; not a climate that was conducive to learning or openness or transparency. Along the way there were casualties: people I was close to either left to try other career paths; or left due to emotional breakdown. I survived and continued with my training, qualified, and then vowed never to work in a hospital again.

Subsequently I worked for 12 years in a residential treatment setting, first as a staff member, eventually as team leader. In this setting my experiences were very different. This was a culture in which mistakes were seen as stepping-stones to learning. The value of staff learning was greatly emphasized and every effort was made to see that no-one was placed in situations beyond their competence. This setting was marked by strongly shared beliefs, and by an intense sense of 'being in it together' and being 'there' for each other' as staff members. In my role as team leader, I worked to maintain these values and paid particular attention to the induction of new staff members and their on-going formation. I placed a strong emphasis on the experience that staff members had from their interaction with residents, with each other and with management. I was very strongly committed to giving staff a sense of agency by involving them appropriately in the management of the organization.

I have worked in five other mental health settings, one a CAMHS team, the other four being inpatient units. It is not possible here to detail my experiences in each of these settings, but all were different and each had important affordances and constraints. With reflection I see the importance of the values that each of these settings promoted and also their downsides, which I will comment on later.

As part of the work of this research project, I have been particularly interested in the literature that relates to the findings and experiences of the participants and my own experience. What follows is a very brief summary of what I think are significant ideas.

Views from the Literature

Kahn (2005) writes about creating resilient care-giving organizations. He suggests that resilient cultures are strengthened by shared beliefs. These beliefs hold members together and help them face both daily stresses and more unexpected events. He defines resilience as a 'property of the collective and found in the work relationships created between people in organizations' (Kahn, p.xi). He also holds the view that resilient cultures are cultures in which members move towards one another for support when stress or anxiety is experienced, as opposed to moving away from each other. In resilient cultures there is a sense of 'being in it together', and of not being left alone to face difficulties.

Kahn suggests that resilient cultures are cultures that invite and encourage open expression of emotion, not only those emotions experienced in interactions with clients, but also amongst the team. Resilient cultures hold the belief that attending to the emotional life of the team or organization enables them to create the kind of relationships that help survive and meet the challenges of the work. He also believes that a resilient culture is one in which the members can have an influence, can exert some control over events in the organization and have a sense of agency. This, he suggests, prevents feelings of helplessness and powerlessness.

Bickerton et al. (2007, p.123) argue that, when working with high-risk populations, that 'only safe clinicians can assist clients in keeping safe'. Bickerton also argues that in order to promote safety for clinicians working with high-risk young people, the work environment needs to set up strict guidelines on providing help, in order to protect the clinician as well as the client. This includes clear assessment protocols and having structured case discussions at

every team meeting. The authors highlight that professionals are at risk of being drawn into interactions around the distressed young person and their family that are characterized by confusion, secrecy, conflict and chaos.

Lencioni (1998) looks at the hallmarks of dysfunctional teams rather than those of functional teams. Dysfunctional teams are characterized by an absence of trust, where members are on their guard, afraid to raise issues for fear of conflict. The result is a culture of blame with lack of accountability, in which members are uncommitted to decisions taken.

Ballatt and Campling (2011) drawing on Haigh (2004) describe effective cultures as cultures in which staff have a sense of belonging and a sense of safety. They are cultures in which staff feel supported, looked after, and cared about within the team. They are cultures in which difficulties and conflict can be voiced, and where staff have a reflective attitude to their work. These are learning cultures where team members appreciate and value each other's contributions and in which staff have a sense of agency and empowerment.

Aggett et al. (2013, p.9) suggest that in 'well-functioning teams, risk is continually and openly discussed in ways that enhance rather than restrain relationships'. In addition, Aggett et al. (2013) discuss the importance of the role of team leaders in conducting clinical meetings in a way that allows for real dialogue to take place, this includes ensuring that members feel able to raise issues about each other's practice without giving offence. It also involves team leaders in asking questions that allow team members to share views and opinions that they fear might cause conflict.

Reflection

In reflecting on the above, I am aware of how much the ideas and thoughts of the interviewees have resonated with my own experience and also with the literature as summarized. The combination of these could organize one into the belief that the organizational culture is a very key factor in creating hope and defending against hopelessness for both therapists and families and is one that I espouse. However on further reflection, I also feel it needs to be embraced

with caution, as there are some additional aspects that need to be taken into consideration. Team and organizational culture while being 'a' key value is not 'the' key value.

The first aspect that I would like to consider is about the idea of effective cultures as having shared values, a sense of the collective, of 'being in it' together. I believe that this is a highly valued and important factor in building an effective culture and one that for staff, can be a wonderful experience. However cultures like this are 'expensive' in terms of time and effort.

At one point in my career, I worked in an inpatient unit in which great value was placed on shared beliefs and in the collective. A number of practices contributed to the building of this culture. One was the calling of meetings. Any member of the community could call a meeting to discuss a concern. These meetings were very effective and created safety and cohesion, but they were also very time-consuming and one consequence was that at the end of the day many essential tasks, such as phoning a family or writing up notes had not been done and required staff to work unpaid overtime in order to catch up. There was also a strong commitment to the 'all being in it together' dimension of effective cultures. This required staff to be more flexible and inter-changeable in their roles, which sometimes lead to confusion and lack of clarity. Both these dimensions could lead to increased 'wear-and-tear' on staff and eventually to burn-out.

Another aspect that needs to be taken on board is that traumatic and upsetting things happen no matter how 'good' the culture of a service is. Services experience traumatic events such as a near fatal suicide attempt or an actual suicide. When these events occur there is a tremendous sense of sadness, and a loss of confidence, belief and hope, raising the question: 'What did we miss?' A highly cohesive 'we are in this together' culture cannot therefore provide a guarantee against events like this happening. There is, in my experience, an un-articulated idea or unconscious belief that we can move towards a position where all the variables of treatment can be under our control, when in fact I don't believe this to be possible. If one can control all the

variables and therefore predict, there is no need for hope because one has certainty. Hope dwells and needs to be nourished in contexts of uncertainty.

Linked with the above point, it must be realized that teams and organizations don't exist as separate entities but exist within wider macro cultures. In my own experience, in the literature and the participants of this study, give great value to the idea of getting the culture right. However, our services are not hermetically sealed: what occurs in the macro culture within which a service is situated impacts on the service. The macro culture is neither cohesive nor coherent; there are different agendas, power struggles and vested interests. The dynamics, political, social and economics of the macro culture, all impact on the service. Efforts to work with the population of interest to this research, not only require an appropriate micro culture but also need to take account of issues in the macro culture within which it is situated.

The value of openness and transparency in teams was a key issue raised by the interviewees and again one that I would be in support of. However, I also think the idea of open expression between team members needs to be positioned alongside other realities, including issues of power differences, and issues of authority, and above all an understanding of how to give feedback that opens options for people rather than turning them towards defensiveness. In a previous work setting, I have experienced meetings intended to be supportive of staff, meetings in which all were invited to be open and share their experience, but often when this happened the result was staff felt hurt and misunderstood. Those who were particularly vulnerable were those who were younger or in a lower position in the hierarchy, or from an ethnic minority group, or because they had made a mistake and felt persecuted.

For many years I have been involved in teaching family therapy in Romania and in this context I used to be very taken by how chaotic meetings were, meetings that were supposed to be open, and free, and supportive. Having puzzled about this, I eventually introduced some rules for giving feedback, rules that I had learnt from the teaching of the late David Campbell and Gianfranco Cecchin. Later, when these rules had made a difference, and the group felt very relieved, they explained that under communism, groups working together

were expected to practise group self-criticism. When participating in these groups, members 'scored' points when they 'shredded' other members of the group. These experiences have led me to the conviction that the conventional wisdom for groups to be open and transparent with each other, needs to be carefully nuanced.

Finally, another aspect that needs to be kept in mind is that when teams and organizations strive for coherence and shared beliefs, this is often achieved at the expense of diversity and change. It is interesting to consider the parallel here with resilience in families. Walsh (2003) suggests that resilient families are families that are cohesive, but also they are families that respect differences and support each other's individuation. Applying this thought to services and groups, there is a need for vigilance in services and groups that espouse the values of shared beliefs, because eventually, services like this lose energy, become reluctant to change and can eventually die.

Individual Responsibility

I have focussed a good deal on the value of specific aspects of a team and organizational culture that can be supportive of therapists. I am not forgetting that individuals also have a responsibility to look after themselves and nurture their own hopefulness. The findings of this study show that the therapists had individual and personal beliefs, ideas and practices that supported them in their work, their belief in and commitment to therapy being primary sources of support.

In my own professional life, my hope is sustained by reading, by attending workshops and conferences, by keeping in contact with colleagues, by talking things over with colleagues and through regular supervision. Weingarten (2010, p.18) believes that it is important for therapists to 'identify activities that support them while doing reasonable hope with clients'. She suggests that it is likely that the activities that support therapists in doing reasonable hope will also sustain hope in clients.

I believe that all therapists, but particularly those working in taxing situations, have an obligation to take steps to do what is nourishing of them and to guard against losing contact and practicing in isolation.

7.3 CLINICAL IMPLICATIONS

On the basis of the findings of this research study, a number of clinical implications are proposed. They fall into the areas of training, therapeutic practice, and organizational structure.

1. Training of Family Therapists

In the area of training, I think this research highlights the need to ensure that family therapists need to receive formal training in risk assessment. In addition, the training needs to be conducted by a family therapist experienced in working with risk of suicide in adolescents so that the trainees can benefit from the 'wisdom' gleaned through experience and practice. The training would also need to be experiential so that opportunity is given to trainees to role-play asking about suicidal intent using a direct approach.

I would also suggest that the training needs to include a discussion about how self-harm and suicide impact on therapists, and further to create opportunity for discussion and exploration of beliefs and attitudes to self-harm. This should include the thoughts and feelings it evokes. This part of the training would also be suitable for qualified family therapists working with adolescents who self-harm.

A further implication concerns the fact that there is very little guidance for therapists working with self-harm. The participants in the study were familiar with research identifying those most at risk, including family factors. However, they seemed unfamiliar with the research into outcome studies identifying evidence-based treatments and interventions that seem to be effective, for example, Diamond (2010). This may be to do with the fact that identifying risk

factors has preoccupied research into self-harm and it is only in the last few years that research into family therapy for self-harm has been addressed.

The findings of this study draw attention to the need for regular supervision, but also point to the need to have someone available within the team who is able to provide 'in the moment' supervision and consultation. In addition, family therapists and teams working with self-harming adolescents should be given regular opportunity to reflect on their practice in the company of others working with self-harm. This reflection should include a focus on the emotional impact of the work on the therapist and on the team and reflection on how the emotional experience can be used for therapeutic benefit. A family therapist will benefit from reflecting on this in individual supervision. However, discussing the emotional impact of the work with others who experience similar feelings and reactions would be additionally beneficial. It would help to 'normalize' the therapist's experience. It would create a sense of connection and it may provide an opportunity for something creative to evolve.

2. Therapeutic Practice

At the level of therapeutic practice, the findings highlight the centrality of the engagement process and the building of a strong therapeutic relationship. Research on self-harm shows that young people who self-harm are difficult to engage (Ougrin, 2010b). As part of the engagement some time could be spent exploring the young person's and their parents' experiences of other services they have been involved with – for example accident and emergency departments or hospital wards – and how these have impacted on them.

In addition, this study would indicate that it is helpful to focus on strengths and resilience in families, so that families can get connected to a sense of pride and confidence in themselves, and in their ability to face adversity. This would include exploration and discussion of the family's spiritual resources and an emphasis on building community and family relationships so that the pull to isolation or withdrawal are countered.

Focusing on a family's strengths and resources is part of the work of co-creating hope, and has been discussed earlier is an implicit way of creating hope. However, it may also be helpful to families for therapists to ask explicitly about hope, and therapists may need to build a repertoire of questions, depending on their preferred model that would directly address this, for example: 'How has hope sustained you in the past; how hopeful are you about finding a way forward; what is it about you as a family that gives you hope; what stands in the way of you feeling more hopeful?'

It may also be that family therapy for self-harm should be augmented by the addition of support groups for parents, helping them to feel less isolated and putting them in touch with other parents experiencing similar difficulties. In my experience a parent's level of hope is often sustained through hearing other parents speak about their struggles and experiences and about what helped them to keep going etcetera.

3. Organizational Structures

At the level of organizational structure, the study identified that where possible, it is best to develop teams that want to do this work, that a clear approach which all team members can subscribe to is developed, that team and individual supervision is given priority, that regular team discussion and reflection on cases is prioritized and time allowed to process the emotional impact of the work, and where the centrality of relationships between team members is considered to be at the heart of the work. Teams working with young people who self-harm need themselves to feel safe in their relationships and in the structures surrounding them, so that they can focus on the safety of the young person.

As has been discussed before, those in positions of leadership need to concentrate and pay attention to building and nurturing those aspects of organizational and team life that result in a resilient culture and resilient workers.

7.4 Strengths and Limitations of the Study

Strengths

This study endeavoured to explore the experience of working with adolescents who self-harm and their families from the perspective of family therapists.

One of the strengths of this study is that it is grounded in the day-to-day experiences of family therapists working with self-harm. At the initiation of this research study there were no research studies reporting on systemic work with self-harming adolescents and very little clinical literature. This study identified a gap in the field and has tried to illuminate how therapists approach this work, what they prioritize, how they intervene to create change and the dilemmas they face.

An additional strength of this study was the use of grounded theory to analyse the data. While it is a laborious method, it does allow the researcher to stay close to the experience of the participants and through this for ideas to surface. I also thought it was beneficial that two sets of interviews were conducted. Deciding to interview the second group of therapists allowed me to explore ideas and themes from the first group of interviews in greater depth.

Further, the study included an emphasis on the emotional impact of the work which so far, has not been a feature of research into family therapy for self-harm. I believe that another strength of the study is that it considered the effect of the organizational and team context in which therapy takes place and how this context can act as a resource for therapists facing challenging and difficult work. This study also identified the practice of hope as being central when working with self-harm and that therapists could usefully augment their practice by both an implicit and explicit focus on hope. In addition the study drew attention to the issue of therapist anxiety as a possible risk factor, which has not been part of the research on identifying risk factors.

And finally, this study makes a contribution towards articulating a framework for working with self-harming adolescents and their families, and introduces a new vocabulary in the context of working with self-harm – the language of hope and hopelessness.

Limitations

Limitations of the study were that it only focussed on the perspective of the therapist. Had it been possible it would also have been illuminating to hear the family's perspective. Further, the research was limited by reliance on therapists' verbal accounts of their practices; a research design that included access to observation of clinical sessions would have provided an insight into therapists' actual practice as distinct from their reporting of their practice.

I believe that a further limitation of the study was that it tried to achieve too much. On reflection, a narrower focus may have been beneficial; a study that focused solely on, for example the therapeutic relationship in the context of working with self-harm, or one that focused solely on the emotional experience of the therapist.

7.5 Assessing the Quality of the Research Study

In conducting this study the researcher endeavoured to follow the criteria on which the quality of qualitative research is evaluated by drawing on both Elliott et al. (1999) and Tracey (2011). In the chapter on the Method (Chapter 2), this criteria is set out under the headings of (i) Reflexivity, (ii) Situating the sample, (iii) Grounding in examples, (iv) Providing credibility checks, (v) Coherence, (vi) Accomplishing both general versus specific research tasks, and (vii) Resonating with readers. Under each heading I indicated how these criteria would be put into practice. The task now is to review the stated intentions.

(i) Reflexivity

I have introduced reflexive comments in both the account of the data-analysis and in the chapter on Method, and also in this chapter. In doing this I have tried to be transparent about my interest and experience of working with self-harm, so that the reader can consider how this may have influenced the choice of research question, the decisions taken and the interpretations made of the data.

(ii) Situating the sample

I have described the participants' details relevant to the research so that the reader knows something of the participants' contexts and can therefore make sense of their statements and allow the reader to assess the relevance and applicability of the findings.

(iii) Grounding in examples

I have given many examples from the transcripts, in Chapter 4, on the Findings, so that the reader is able to see the connection between the data and the researcher's understanding of the data.

(iv) Providing credibility checks

Throughout the data analysis process I consulted colleagues and supervisors regarding possible interpretations of the data in the transcribed interviews.

I also gave copies of the transcripts to my supervisor showing initial open codes and how these built towards the categories and eventually the Core Category and Main Categories.

I also included quotes from the interviews of sufficient length that would permit readers to make their own judgement as to the meaning of the participants' statements.

(v) Coherence

When considering the criteria of coherence, I included a purpose statement setting out the intentions of the research.

I tried to be as transparent as possible about the steps taken in the different stages of the data analysis process, so that how I arrived at the Core Category made sense and was coherent. I also included tables to visually demonstrate how the Lower-level categories built towards the Sub-categories and how these in turn built towards the Main Categories and then to the Core category.

(vi) Accomplishing both general versus specific research tasks

While the research findings cannot be generalized to working with all families presenting with an adolescent who has self-harmed, it is hoped that a family therapist reading the report would find useful ideas for their practice that could be adjusted to fit the particular family or context that they work in.

(vii) Resonating with readers

Finally, in addressing issues of resonance it is hoped that a family therapist working with self-harm would, having read the report, find it to be credible and relevant to their practice, and that those new to working with adolescents who self-harm would feel that they had some guidance and a framework. This would help to give direction and focus in the conversation with the family, and some knowledge as to the potential challenges that may arise.

7.6 Self-Reflections

Beginning with the choice of subject area for this study, the reader may recall that, as explained in the introduction, this was very much driven by my own clinical experience. When I initially had the idea for the project I was new to working with self-harming adolescents and felt I needed some ideas and guidance. I was very disappointed in my search for ideas and very surprised by the scarcity of family therapy writings on the subject. The few articles that had been written seemed to originate from the earlier phase (first cybernetic) of family therapy development. I found some of the hypotheses of the authors useful but thought about why there were such a limited set of writings on the issue of self-harm at that time as the situation has changed somewhat since then.

Based on my own experience I think it is possible that this area of work was considered to be the domain of psychiatry professionals, probably because of the issue of risk of suicide. Thinking back, before I started to work with adolescents who were at serious risk of self-harm, I had worked for 12 years in a CAMHS service. The practice at that time was that young people who self-harmed were seen at A&E by the psychiatrist on call. If further work was indicated they would continue to work with the young person, and as such the young person never actually appeared on the general waiting list from which I drew my caseload. This experience was probably the 'norm', and family therapists were, generally speaking, not working with this population; which would explain why they were not writing about it. Of course, this explanation may only be relevant in the context of the U.K: I don't know whether it would have applied to other countries. Additionally, when I was trying to recruit family therapists for the study, quite a number of them declined because they had no experience of working with this population, explaining that the work was being done in specialist adolescent clinics, rather than in generic CAMHS teams.

Because my interest in researching this area was driven by my clinical experience, I was aware that when compiling the interview schedule that my own hypotheses and ideas would be of value in indicating areas that I could focus my enquiry on. However, while using my own experience, I was concerned that it could dominate the conversation with the participants and therefore not allow for anything new or surprising to emerge. To create some balance to off-set my own experience, I took opportunity to engage colleagues and supervisors informally about their experiences. I also availed of the experiences of my fellow doctoral students when presenting my research work at The Tavistock. I invited the group to brainstorm around what areas they would chose to focus on and identify as key if interviewing family therapists about working with self-harm. As I described in the Method chapter, I observed a video-taped interview of a first session with a family (conducted by a colleague) in which the adolescent had seriously self-harmed. I also used observations from this to augment the interview schedules. All of this helped to broaden my thinking and incorporate ideas and hypotheses from others.

When interviewing the participants, I wanted to have the kind of conversations that would allow them to share their 'real' experience, thoughts and dilemmas. By this I do not mean that I thought they would fabricate ideas, but I wanted to act in a way that would encourage them to share their actual experience, 'warts' and wisdoms. I was also aware that they might feel exposed or put under scrutiny. I was careful therefore to name some of these issues at the beginning of the interviews when explaining the project. I generally tried to do this with a 'light touch' and an invitation to the therapist to include ways of working, whether or not they fitted with accepted and current practice. I think this was helpful in that one of the participants, when describing what she did in a session, jokingly said that she worked "*structurally without shame*". In the actual interviews, I found it difficult at times to strike a balance between trying to follow lines of enquiry that were opening up mid-conversation and sticking to the specific areas of interest to this study.

When it came to analysing the data, I had already decided that the methodology would be grounded theory. I chose grounded theory because it seemed to offer a 'model' or set of practices that one could follow, and furthermore the model as espoused by Charmaz (2006) fitted with my therapeutic orientation, in that it allowed for the interpretation of the data to be viewed as one possible understanding among many. The decision to conduct a second set of interviews was helpful because it allowed me to pursue areas that I had become interested in. Having analysed the first six interviews, I was very struck by how difficult and complex the task of working therapeutically with this client group was. Conducting the second set of interviews allowed me to focus on the question of: 'given the complexity and difficulty involved, how does a therapist keep going, what sustains him or her?'

I experienced a feeling of protectiveness towards the therapists. I was very appreciative of how exposing it can be to speak about your practice and I felt I had a duty to protect the therapists from criticism or ridicule. In conversation with them, their ideas and descriptions made sense, however very often when reading back over the transcripts, I noticed many 'false starts' and many 'trailing's off', as the therapists attempted to articulate their experience. Consequently, some passages required careful re-reads and review. I found it

easier to get a sense of the meaning by reading the passage aloud. Initially I felt irritated by the 'false starts' and 'trailing's off', but on reflection, I realized that perhaps I had been hoping for or had assumed clearly articulated ideas when actually 'false start's and 'trailing's off' are a feature of how communication and conversation occurs. A further thought is that there is no over-arching framework about how to work with self-harm and the 'false starts', represent the therapists' struggle to put words on their experience. Through the findings of this study I have introduced a new vocabulary in which to talk about the work and hope that this will contribute to the articulation of a framework.

In reflecting on the findings, I was surprised by the level of focus on the issue of risk and over the period of the research came to fully appreciate how much of a concern it was for the participants, particularly for those working in outreach and outpatient settings. I am aware how different it is in my current work context in an inpatient unit, where assessing risk is very much the domain of medical staff, and where additionally in this setting, should I became concerned about a young person's safety during a family therapy session, I am able to have immediate access to psychiatry colleagues.

As I have stated previously I was surprised by the findings about hope and its centrality in this work. I have become increasingly interested in the issue of hope within my own clinical practice. I believe that the effort involved in doing this research has been beneficial to my work. In my clinical practice prior to this study I may have been vaguely conscious of the idea of hope, however I do not think I ever gave it serious attention. I probably unthinkingly saw it as a static entity, something you either had or did not have. I would have considered myself a hopeful person but I am not sure I would have seen this aspect of myself as having such potential and influence in the practice of therapy.

This finding has also prompted me to reflect on something I have noticed but not really thought about in my own family experience. I have always been aware that in my own family, there is little or no emphasis on the past and on family history. I grew up not knowing and not thinking it was odd, that I did not know for example the names of my grandparents, either maternal or paternal. Obviously, when training as a family therapist this lack of knowledge and

information about my history has been commented on. Over the years I have tried gently to know more of my family's history. My father's often stated refrain comes to mind – *'Why would you want to go dragging up the past?'* It was not until doing the reading about hope that I came to the realization that from the little that I do know about my family story, there is a strong history of tragic loss and trauma and of course experiences of loss and trauma are strongly linked with families who lose hope. Clearly my family have dealt with their history of loss, and experience of loss by always focusing on and looking to the future, and not dwelling on the past. While it may be that my family have been unable to integrate the past, this has nevertheless served to gift me with a future orientation.

7.7 Future Research Recommendations

Several directions for further research have emerged based on completing this research project.

1. I think a study explicitly devoted to the issue of hope in therapy would be useful. The research could focus on identifying therapist's beliefs and attitudes to hope, how they understand hope and how they practice it. The research design could include both interviews with therapists and the use of video, or audio-taped examples of practice, with therapists explaining why what they presented was an example of hope in practice. A grounded theory analysis would be appropriate.
2. This study focused on the perspective of the therapist. Future studies could include the perspective of the family in identifying aspects of the therapeutic encounter that they felt contributed to the creation of their hope. The 'significant moments' (Elliott et al., 1994) research method could be used, inviting family members to choose from a recorded session, those moments or episodes that they thought were significant and helpful to them in feeling more hopeful about their situation.
3. A further research study could focus on the role of leadership in organizations and teams working with risk. The study could explore

through the use of semi-structured interviews with both leaders and with those whom they lead, aspects of leadership that may be of particular significance in these kinds of working environments.

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APPENDIX 1

INTERVIEW SCHEDULE 1

APPENDIX 1

INTERVIEW SCHEDULE 1

Opening / Introduction

- The interviews opened with an introduction and a description of and explanation about the research
- Time was given to answering questions or concerns about the process.

Prompts

- i) *Can you tell me more about that?*
- ii) *How did you bring that idea/thought etcetera into the work?*
- iii) *Tell me more about how you used that idea in the work with the family?*
- iv) *Did you think it was a fruitful direction to go in?*
- v) *How, in what way did it help/not help?*
- vi) *How important or central did you think it was to the work?*
- vii) *What did it offer in your work with the family?*
- viii) *What problem or issue or dilemma did it solve?*

Interview Questions

1. Can you tell me about your work context?
2. How much of your caseload would include adolescents who self-harm?
3. What have been the main theoretical influences on your work as a family therapist?
4. What ideas and people influence you?
5. Do you use these ideas with all families?
6. Do you think working with this client group is different in any way to working with other client groups?
7. If yes, what do you think is the main difference in your approach?

8. Could you think about a particular family you are currently working with or have recently worked with: you could choose from a family where you thought that the work went well or one where you thought the work did not go so well.
9. What kind of ideas did you intend or want to introduce when you were going into the session?
10. When you met the family, what were you expecting?
11. What thoughts were evoked for you in the early stages of the session?
12. What thoughts were evoked as the session unfolded?
13. How did your thoughts change over the course of this session and later sessions?
14. What did you think it was important to pay attention to?
15. What was your therapeutic agenda or what kind of possibilities were you trying to create?
16. What elements of the interaction stood out?
17. What feelings did you experience in the session?
18. Did you experience any negative feelings towards the family or young person?
19. If yes: how did you make sense of, and manage these?
20. Were there any surprises or anything unexpected in the sessions?
21. Did you experience any concerns and anxieties?
22. What therapeutic issues did you face?
23. What stances or approach did you take in relation to these?
24. What was the effect of these?
25. Did you experience a sense of impasse or 'stuckness' at any stage?
26. What was involved in this? What were the tensions?
27. How did you address these?
28. With what effect?
29. Did issues related to blame or responsibility arise in the course of your work with the family?
30. If 'yes', how did you manage these issues? What dilemmas did you encounter?

31. If the therapist has named a specific therapeutic orientation and then talks about introducing another model, ask: Why did you deviate from your usual/main model; what was happening in the session that prompted this?

Engagement and the Therapeutic Relationship

1. What feelings were evoked in you prior to meeting the family, and then when you met the family for the first time, what feelings were evoked for you?
2. Did these change over time, if so in what way?
3. How did you account for the change?
4. How did you experience trying to engage the family?
5. What, if any dilemmas did you face?
6. What kind of relationship were you trying to create with the family?
7. What stances did you adopt in trying to bring this about, or what did you do to try to bring this about?
8. Did you encounter any difficulties?
9. How did you understand these and how did you respond?
10. What did you want to convey about yourself to the family and to the young person?
11. How did you go about this?
12. What was the minimum you would want the family to say you did for them, what was the maximum?

Risk

1. Do you think there are any specific responsibilities attached to working with this client group?
2. Are there specific issues that arise; can you give an example in your work with this family and say how you approached the issue/s?
3. When you take on a new family in which there are concerns about risk of suicide, what is your usual reaction?
4. What feelings do you experience?
5. How do you relate to the issue of risk?
6. What issues arise about risk during the course of therapy?

7. How do you manage when issues of risk arise?
8. How do you manage both risk and trying to create change?

Closing Questions

1. If you were talking to colleagues about their work with young people who self-harm, what issues/experiences would you be interested in asking them about?
2. In this interview, was there any area that you would have liked me to have enquired about or discussed?
3. Are there any comments or feedback you would like to give?

APPENDIX 2

INTERVIEW SCHEDULE 2

APPENDIX 2

INTERVIEW SCHEDULE 2

Opening / Introduction

- The interviews opened with an introduction and description of and explanation about the research
- Time was given to answering questions or concerns about the process.

Prompts

- i) Can you tell me more about that?*
- ii) Could you expand on that?*
- iii) How important or central did you think it was to the work?*
- iv) How, in what way?*

Interview Questions

32. Can you tell me about your work context?
33. How much of your caseload would include adolescents who self-harm?

Support

1. I'd like to hear your thoughts about what you think supports therapists in doing this kind of work?

Prompts

- i) Organizational structures*
- ii) Accountability*
- iii) Leadership*
- iv) Policies and procedures*
- v) Shared framework/model*

2. What aspects of organisational structures/processes are important /helpful?

Prompts

- i) *Team Culture*
- ii) *Team atmosphere*
- iii) *Relationship with colleagues*
- iv) *Team Meetings*

1. What kind of relationships are supportive of you in doing this kind of work?
2. Could you describe the kind of conversational style you think works best in team meetings?
3. What are its elements?
4. What processes help create this kind of conversation?
5. How is this helpful in a team, what does it help to create?
6. How do you think the quality of relationships affects risk management? If yes how?
7. What kind of relationships support good clinical decision-making in situations of risk?
8. How is clinical decision-making in a context of risk best enhanced?

Safety

1. How are therapists best helped to feel safe when doing this kind of work?
2. What helps you to feel safe?

Impact of the Work on The Therapist

1. What keeps you going?
2. What makes it feel worthwhile?
3. What engages you?
4. What are the benefits /opportunities and pleasures in doing this work?
5. What do you think is the impact on you and on your family therapy colleagues of doing this kind of work?

Prompts

Stress/Anxiety:

1. How do you think this should be managed, what helps?
2. What resources do you draw on?

Hopefulness:

1. What helps maintain your hopefulness? (See questions on Hope.)

Confidence:

1. How do you think your confidence is affected?
2. What about your colleagues, how is their confidence affected?
3. How do you think therapists are best enabled to feel confident in doing this work?
4. How do you think confidence to do this work is best developed?
5. What do you think creates confidence in therapists?

Theory

1. Do you think you have a set of ideas that enable you to do this work?
2. Do you think systemic theory is sufficient?
3. If not, what additional theories do you draw on?
4. How does this help, what does it help you address?
5. What guides you to know what you are doing is worthwhile – is it moment to moment events in the session, or something more over-arching?

Constraints

1. From talking to other therapists I have picked up a feeling of caution/constraint when doing this kind of work, is that your experience?
2. How do you think that feeling comes about, what creates it?
3. Do you think the work is worthy of caution?

4. What would you find yourself doing or not doing that you would regularly do with other families?
5. Do you think you act differently? If yes, how are you different – in yourself, in your interactions, in what you attend to?

Prompts

- i) *Use of Self – humour*
 - ii) *Self-disclosure*
 - iii) *Creativity / taking therapeutic risks*
6. If the Department of Health issued a directive that no blame would adhere to therapists in relation to the suicide of a patient, how would you react?
 7. What impact would this have?
 8. Would this make a difference to how you would work?

Hope – Families

1. Is hope a category that comes into your thinking in this kind of work?
(engendering hope, sustaining hope)
2. If it is part of your practice – if so, why?
3. Do you consciously and explicitly try to engender hope, or is it more implicit?
4. If yes, how do you do go about engendering hope/how do you practice 'doing' hope?
5. How do you help families connect to sources of hope?
6. What sources of hope do you try to connect them to?

Hope – Therapists

1. How would you describe your relationship to hope?
2. When working in this area what supports you to maintain a sense of hopefulness when you feel discouraged/and or when the situation feels hopeless?

3. Do you/have you experienced times (in the context of working with self-harm) when you felt a sense of hopelessness?
4. What kind of situations engender feelings of hopelessness in you?
5. How have you continued to feel useful in hopeless situations?
6. How do you recognise when you have lost hope?
7. How do you restore the loss of hope in yourself?

Core Task

1. What do you see as being the core or central task/s of the work?
2. How do you conceptualise the work?

Therapists' Emotions

1. How are you affected emotionally when doing this work?
2. What kind of emotions tend to surface?
3. Have you experienced having very strong emotional reactions?
4. How do you understand this?
5. How do you manage strong emotions in a session?
6. How does your emotional reaction affect how you respond to family members?
7. Do you find some emotions more difficult to deal with both in yourself and in family members?
8. Do you think there is a connection between these emotional reactions and the issue of risk/self-harm?

Closing Questions

4. If you were talking to colleagues about working with young people who self-harm, what issues/experiences would you be interested in asking them about?
5. In this interview, was there any area that you would have liked me to enquire about?
6. Are there any comments or feedback you would like to give?

APPENDIX 3

RESEARCH STUDY PARTICIPANT INFORMATION SHEET (Therapists)

APPENDIX 3

RESEARCH STUDY PARTICIPANT INFORMATION SHEET (Therapists)

Title of Project: Family Therapists' Experiences of Working with Adolescents who Self-harm and their Families

Name of Researcher: Colette Richardson

Introduction

You are being invited to take part in a research study. To help you make a decision about taking part, I have outlined the purpose of the study and what taking part will involve. I will also be available to meet with you, prior to the research interview to discuss any questions or concerns you may have.

The Study and its Purpose

This study will be an exploratory qualitative study of family therapists' experiences of working with adolescents who self-harm and their families. The purpose of the study is to generate clinically useful information for working with this client group.

Who are the Participants?

Family therapists who are engaged in therapy with families of young people who self-harm and for whom there is a concern about risk of suicide.

What does Participation Involve?

Participating therapists will be invited to an interview with the researcher. It is anticipated that the research interview will take up to one and a half hours. The research interview will take place at a location convenient to the participant. Permission will be sought to make an audio recording of the interview and following the interview, the audio-taped interviews will be transcribed for the purposes of data analysis.

Confidentiality

All of the information pertaining to this study will be kept in a safe and secure place. Participants' identities will be protected through the use of a coding system, for example each participant will be given a number. No identifying information or details will be used. When writing up the research the researcher will refer to the participant as 'the therapist' and will be given a pseudonym.

The study is part of a doctoral programme, the final report therefore will be kept in the University Library and at the Tavistock Clinic. The findings may also be published in a scientific journal. In order to make the findings transparent, I intend to use direct quotes from the participants, so on reading the research report you may recognise something you have said. However, your name or other identifying features will not be used.

The Researcher

This research is being conducted by Colette Richardson MSc. Systemic Therapy, who is currently involved in studies towards a Doctorate in Systemic Therapy at the Tavistock Clinic and University of East London. The study is being supervised by Dr. Bernadette Wren, Consultant Clinical Psychologist and Family Therapist at the Tavistock Clinic.

Ethical Review

This study has been given a favourable ethical opinion for conduct in the NHS by the Barnet, Enfield & Haringey Research Ethics Committee.

Contact Details:

Colette Richardson
Northgate Clinic
Edgware Community Hospital
London.
Ph. 020 8732 6400

APPENDIX 4

CONSENT FORM (Therapists)

APPENDIX 4

CONSENT FORM (Therapists)

Title of Project: Family Therapists' Experiences of Working with Adolescents who Self-harm and their Families
Name of Researcher: Colette Richardson

Please initial box

I confirm that I have read and understood the information sheet dated 17.06.2008 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason.

I confirm my consent for audio taping of my interview with the researcher. I understand that these audiotapes will be erased on completion of the research project.

I understand that verbatim quotes may be used in the research report and that these will not be identifiable.

I agree to participate in the above study.

Name Date Signature

Researcher Date Signature

APPENDIX 5

TRANSCRIPTION NOTATION

APPENDIX 5

Transcription Notation Used:

As adapted from The Jefferson Transcription System (Jefferson, 2004).

- | | |
|--------------|---|
| (.) | A full stop inside a bracket denotes a micro pause, a notable pause but of no significant length |
| (0.2) | A number inside a bracket denotes a timed pause. This is a pause long enough to time and subsequently show in transcription |
| () | Where there is a space between brackets, this denotes that the words spoken here were too unclear to transcribe |
| <u>Under</u> | When a word or part of a word is underlined it denotes a raise in volume or emphasis |
| CAPITALS | Where capital letters appear it denotes that something was said loudly |
| Hum(h)our | When a bracket 'h' appears it means there was laughter with the talk |
| ... | Indicates when speech trails off. |

APPENDIX 6

LITERATURE REVIEW ON HOPE

APPENDIX 6

LITERATURE REVIEW ON HOPE

Hope has long been a focus of academic disciplines. Initially it was the province of theology and philosophy, later becoming a focus of study in medicine, nursing and psychology.

In Greek mythology, hope is linked to the story of the first woman on earth – Pandora. Pandora was given a box as a gift by Zeus, with instructions not to open it. The box contained all the evils of the world, but included one blessing – hope. However, Pandora's curiosity, gifted to her by the Gods, resulted in her opening the box and in so doing the entire contents were released, with the exception of hope itself. There have been many interpretations of this myth. One understanding is that this was a story told to explain why evil exists in the world, and that Zeus included hope in the box to act as a comfort for mankind in facing the hardships of life.

Hope lies at the centre of Judeo-Christian thinking. Hope in these traditions is based on the concept of promise in the relationship between man and God. God promised to be with His chosen people and bring them to the 'Promised Land'. In return the people were to worship God and observe His laws. They lived in the hope that God would fulfil his promise. In Christianity hope is built on the resurrection; the resurrection of Christ from the dead represented the fundamental idea that pain and suffering could be overcome. That life is not limited to, or by our past and present, but instead holds the promise of the future is a foundational principle held within the story of the resurrection. As such, in both Judaism and Christianity hope is based on the concept of promise. Moltmann, one of the most significant Christian theologians of the 20th Century (O'Hara, 2013), argued that God is a 'God with future as his essential nature' (Moltmann, 1993, p.16). In his view, Christianity is a hope-based religion, with

hope founded on God's promise. Hope as promise conveys the idea of living in the present while anticipating the future, which is yet to be revealed.

Marcel, an existential philosopher, positioned hope as 'essential to the life of the soul' implying that life without hope is meaningless (Elliott, 2005). Marcel believed that the self is best understood as an entity in relationship with others. He developed two concepts, *disponibilité* and *indisponibilité* (Marcel, 1951). Marcel proposed that the self will develop best when in relationship with others who are fully available and present. *Disponibilité* is best understood as a hope in the good intentions of others towards us, and because it is not always easy to maintain positive expectations in others, Marcel proposed the concept of fidelity; meaning a commitment to maintain relationships (O'Hara, 2013). Hope, according to Marcel, provides the strength not to despair. He argued that hope was more than a general optimism about a positive future outcome, and is better understood as an 'attitude of positive expectancy without knowing how the future will reveal itself' (O'Hara, 2013, p.36).

In the field of medicine, hope was first identified as integral to the psychiatric profession, by Menninger (1959). In an address to the American Psychiatric Association, he argued that doctors were 'duty bound' to speak up about the validity of hope. Hope as construed by Menninger (1959, p.482) was a 'resource that could be exhausted', however with appropriate training young doctors could be enabled to 'light a candle of hope' for their patients. Doctors were seen as capable of influencing a patient's hope and to some extent be responsible for it. It was something that could be passed from doctor to patient and from teacher to student. Menninger drew on religious, psychological and existential ideas (Elliott, 2005). Elliott (2005) contends that following the impetus created by Menninger's Address, hope became a growth industry in medicine and nursing.

In the 1970's hope became a focus for the nursing profession with an emphasis on the role of the nurse in inspiring hope in patients. Vaillot (1970, p.272) wrote that to 'fail to inspire hope was *ipso facto* to fail in a duty of care, and it thus by implication would be contributing to the client's demise'. Nursing research on hope has focused both on defining the dimensions of hope (Miller, 1983;

Dufault and Martocchio, 1985; Morse and Doberneck, 1995) and on identifying strategies that inspire and foster hope (Herth, 1993; Cutcliffe 2004, 2006a, 2006b).

Another development in the 1970's was the move towards studying the psychometric properties of hope, making hope an individual variable that could be measured. The first hope scale was developed by Gottschalk (1974) and then later developed by Snyder (2000). Snyder developed a model of hope in which hope is defined as having two components. These are the ability to plan pathways to desired goals despite obstacles, and agency or motivation to use these pathways to reach the desired goal (Carr, 2004b). The positive psychology movement (Seligman, 2002) dominated psychology from the 1990's, with this development heralding a shift in psychology from a deficit model to one that focuses on the study of human strengths (Carr, 2004b). Within the positive psychology movement, research has focused on how and why people take a positive perspective on life. Seligman focused on optimism as an explanatory style rather than a personality trait (Carr, 2004b). Optimism and hope are seen as closely related constructs in the positive psychology tradition.

Hope therefore has been understood as comfort to help mankind face the ills of life, as a promise of fulfilment in the future, as an attitude of positive expectancy and as a resource that could be exhausted. Hope was also construed as something that could be passed from one person to another; it could be inspired and fostered in others. Hope was construed as an individual characteristic that could be measured. It was defined as the ability to plan a path towards one's goals, and having the motivation to use that path.

Hope in Family Therapy Literature

Since the birth of family therapy in the 1950's hope has not been a concept that family therapists have written about. It appeared for the first time in an article by Beavers and Kaslow in 1981. The lack of a focus on hope seems surprising. (Flaskas, Mc Carthy and Sheehan, 2007). Hope is considered one of the

common factors, accounting for positive outcomes in therapy (Hubble et al., 1999; Sprenkle and Blow, 2004).

The reasons for the lack of focus on hope has been discussed by a number of family therapists. In the last few years several authors have commented on this (Hoffman, 2007; Flaskas et al., 2007; Weingarten, 2007, 2010). Hoffman suggests that hope and its opposite despair, may be considered 'out of bounds in writing about therapy because of their frank moral nature' (Hoffman, 2007 p.xii). Similar to the development of forgiveness in the theory and practice of family therapy, therapists may consider that the concept of hope is too connected to religion, given that hope is one of the cornerstones of Christianity (Sheehan, 2007). Weingarten (2010, p.6) suggests that the reason for the neglect is that it may be seen as the 'province of theology and philosophy and is more a moral than a psychological construct'. In addition, Weingarten (2010) suggests that hope may also have not been attended to by early family therapists because in the 1950's it was considered to be the domain of the medical profession, and further that family therapist's may have found the construal of hope as too individualistic. Weingarten (2010) further suggests that family therapists, with their interest in the social and political, would not have considered hope an appealing area to focus on given its position within a biological framework.

Flaskas et al. (2007, p.2) while agreeing that hope has been a neglected area in family therapy also states that hope and despair are, 'nonetheless deeply embedded in our discussions in far more extensive though non-explicit ways and our sense here is that this is precisely because of the centrality of the experience of hope and hopelessness in everyday practice'. She also suggests that the move to a strength's-based approach with a focus on resilience, is one of the ways in which family therapists have tried to place hope more at the centre of their practice. Weingarten (2007) considers that family therapists 'know' that hope is beneficial, but that few have written about it and about why it is advantageous.

Family therapists who have written explicitly about hope have included Beavers and Kaslow (1981); Hof (1993); Cooper, Darmody and Dolan (2003); Flaskas,

(2007); Flaskas et al. (2007); Ingram and Perlesz (2007); McGoldrick and Moore Hines (2007); Tomm (2007); Weingarten (2007, 2010); Ward and Wampler (2010).

Beavers and Kaslow (1981) suggest that demoralisation characterizes those who seek help, with couples and families presenting as despairing that life can get better; feeling incompetent, helpless and a failure. They look to the therapist as a source of hope to combat these feelings. Beavers and Kaslow suggest that they borrow hope from the therapist through identification with his affect and mood, which may evolve into the couple or family developing confidence and new skills, with realistic hope 'flowing from' these new skills. They suggest that more positive family experiences encourage breaking through isolation and loneliness. Through borrowing the therapist's hope, patients may re-capture a sense of trust and an optimistic belief that life has value and meaning. They take the position that hope does not exist in a vacuum but in shared experiences with others.

Beavers and Kaslow suggest nine elements which contribute to the development of hope, and which a therapist should focus on. These include (i) Non-judgemental listening, (ii) Translating hopes into 'bite sized' achievable goals (iii) Attending to how achievements were attained and helping family members in their ability to be observers of themselves and their interactions, (iv) Helping family members to develop better interpersonal skills, (v) Developing a trusting relationship between therapist and client, (vi) Noticing small triumphs and discussing future hopes and dreams, (vii) Inviting patients to collaborate and share responsibility for defining and meeting goals, (viii) Developing relationship skills that encourage people to risk and deepen ties with others, and (ix) lastly they suggest that having a 'transcendent belief system', a belief in the larger human enterprise, encourages community, purpose and meaning.

Hoff (1993) identified barriers to hope from his work with couples and suggests several strategies for instilling hope. Barriers to hope include a history of negative interactions, blaming and cognitive distortions. Strategies for instilling hope include creating an environment in which clients feel appreciated, understood and accepted; helping clients to understand the dynamics of

change, 'so that they can trust that there are some predictable and universal aspects to change' (Hof, 1993 p.223). Re-labelling and re-framing negative views, noticing and affirming client strengths, helping clients identify and use their spiritual resources and using humour and absurdity to release energy and creativity are likewise suggested for instilling hope.

Weingarten (2007, 2010), states that when family therapists work to restore hope in families their ideas about hope and how to promote it tend to be implicit in their practice rather than explicit. Weingarten tries to address this position by articulating and making explicit her perspective and practice of hope. Quoting Cheavens et al. (2005) she considers that hope is a very significant concept, that it confers many advantages for both individuals and societies. For example, individuals who are hopeful perform better at problem-solving, at managing challenging situations and when coping with illness and disability (Snyder et al., 1999). She suggests that it is really important to work with hope, that research on hope confirms that it confers survival advantages (Groopman, 2004), that hopelessness confers risk and that hopelessness correlates more strongly with suicide and predicts it better than depression (Grewal and Porter, 2007). She offers the 'construct of reasonable hope, a variant of hope' as she believes that this variant of hope 'fits with how family therapists think and act' (Weingarten, 2010, p.6).

When describing 'reasonable hope', she distinguishes it from 'rainbow hope'. Reasonable hope is about what is within reach and achievable, rather than that which is desirable but unachievable. With reasonable hope, Weingarten argues that we are less likely to be disappointed than with rainbow hope. This is true for both therapist and client. She suggests that therapists need a way of thinking about hope that does not leave them vulnerable to feeling hopeless (Weingarten, 2010).

She describes reasonable hope as having five characteristics, (i) Reasonable hope is relational, (ii) Reasonable hope is a practice, (iii) Reasonable hope maintains that the future is open, uncertain and influenceable, (iv) Reasonable hope seeks goals and pathways to these, (v) Reasonable hope accommodates doubt, contradictions and despair. Weingarten (2010) believes that a systemic

therapist practicing reasonable hope does not give hope or instil hope in others but creates a conversational space in which hope rather than hopelessness can arise.

Weingarten suggests several ways in which clinicians can co-create reasonable hope with clients: (i) Understand your witness position, (ii) Assess for and work with trauma, (iii) Co-create conversational hope spaces, (iv) Interview for resilience, (v) Use questions that activate reasonable hope, (vi) Identify barriers and supports for reasonable hope, and (vii) Assess for and remove obstructions to love. She believes that the first two – understanding your witness position and assessing for and working with trauma are the most important, without which it is difficult to succeed at the practice of reasonable hope.

Weingarten (2010) also argues that it is important for clinicians to identify activities that support them in doing reasonable hope and she gives another list of activities that help bolster morale and support therapists in doing reasonable hope. Her list includes believing that the small is not trivial, that therapists should accept proxy measures of success, that they should train themselves to see and hear signs of reasonable hope, that therapists should allow themselves experience joy and see it as a resource, that they should enjoy vicarious hope and allow themselves be influenced by the hope that others express, and that in their work with clients they should recognize unfairness and injustice and help clients pursue what is just.

Flaskas (2007b) writes about hope and hopelessness in terms of the individual and the family's experience and also about the therapist's engagement with their clients' experience. She sets out four ideas about hope and hopelessness in the context of therapy. The first concerns the co-existence of hope and hopelessness, the second, how hope is 'a layered experience of emotion, meaning and behaviour', the third concerns the relational and social context of hope and hopelessness. The fourth considers the therapeutic relationship and the therapeutic use of self. Flaskas building on Perlesz (1999), suggests that hope and hopelessness need to be considered as existing in relation to each other; that they can co-exist in the same person, and/or in the family. She argues that hope and hopelessness are not either/or positions and that when

hope is high, hopelessness is not necessarily low. She states that this may be particularly so when facing abuse, trauma and tragedy.

Flaskas (2007b) discusses how we should not underestimate the emotional power of hope and hopelessness, neither should we only orient to it as an individual feeling, but also an action or behaviour, and a belief. She considers that hope and hopelessness are communicated through emotion, meaning and behaviour. Quoting Weingarten (2000) she takes the position that 'one can do hope even when you can't feel hope'.

Flaskas also discusses how the relational context of hope, both family and community can support the doing of hope. In agreement with Weingarten (2007, 2010), she takes the position that hope is something you do with others. She suggests that in some situations where an individual family member is in a place of hopelessness, other family members can 'do hope' on their behalf. She also considers how in families different family members can hold different positions in relation to hope and hopelessness. Sometimes the pattern is fixed; for example the same parent holds the position of hope while the other holds the hopelessness, while in other situations the pattern can be more fluid. She also discusses how family members can feel hopelessness and at the same time do hope for another family member as in the case of a mother of a child with a serious illness. She reminds us that families also carry the legacy of previous generations in relation to hope and hopelessness. She believes that involvement in community membership is another source of hope and a resource for families. Flaskas also discusses how situations of poverty, stigma and racism can make it much harder for families to hold a balance between hope and hopelessness.

Flaskas (2007b, p.30) focuses on the therapeutic relationships and the therapeutic use of self. She states that 'the research on generic factors associated with positive outcomes in therapy suggests that of the factors associated with positive outcomes what we as therapists have to offer in therapy, the therapeutic relationship continues to be the single most important ingredient'. She discusses how therapists may react to the family's relationship to hope and hopelessness. Sometimes a therapist can find understanding one

person's expressions of hope and hopelessness more easily than others. At other times a therapist can feel critical of what 'appears to be an overbalance of hope in a family where there are very serious issues at stake' (p.31). This makes it difficult for a therapist to remain curious and empathic. In other situations families can present with an over balance of hopelessness in proportion to the description of their struggles, and she suggests that it can be hard for a therapist to resist either covertly or directly trying to talk the family out of their hopelessness.

Flaskas also believes 'that the most challenging time for therapists is often at periods of impasse. At these times the fear and expectation of failure can set-in for both the family and the therapist'. Flaskas (2005) discusses how at points of impasse, feelings of despair, anger, blame and shame often trigger anti-therapeutic sequences in the therapeutic relationship, undermining the capacity for the family and the therapist to hope for something better. She argues that it can be important at times like this to hold hope for the family, including the hope that the feelings of hopelessness and the fear of failure will become more bearable.

She suggests that because therapists have their own personal relationship to hope and hopelessness and also hold particular hopes for the family, the task involves 'holding on to a therapeutic position that stays other-focused while using our "self" as fully as possible as a resource' (Flaskas, 2007b, p.32). Flaskas suggests the task involves 'inner conversations' (Rober, 1999) about the family and the therapeutic process as well as 'outer conversations' with colleagues, in supervision and with the family.

Flaskas (2007b, p.33) lists and summarises eight practice orientations: (i) Attend to the experience of hope and hopelessness, especially in situations of chronicity, and when there are serious outcomes at stake and also attend to our own experience of hope and hopelessness as therapists in the therapeutic relationship in these same situations and in critical periods of engagement and impasse. (ii) Directly invite conversations with families about their experience of hope and hopelessness. (iii) Move beyond the language of having too much or too little hope and instead pitch language towards the balance of hope and

hopelessness or the distribution of hope. (iv) Be attuned to the co-existence of strong hope and strong hopelessness especially in experiences of abuse, trauma, loss and tragedy, as this allows therapists to stay open to witnessing the realness of a client's experience. (v) Know that in some situations deep hopelessness cannot be cured or talked away; knowing this will allow the therapist to stay more connected to a client's experience and will also allow the therapists to hold hope about the way in which hopelessness may come to be experienced more tolerably over time. Deep hopelessness can be helped through strengthening hope even if the hopelessness itself stays just as strong. (vi) Use the different ways in which family members might feel, think and do hope to make more visible the labour of doing hope that is being undertaken in the family; doing this can open up different ways that the labour can be shared both within and beyond the family. (vii) Holding a conversation about the distribution of hope and hopelessness can heighten awareness of the effect of this distribution on different family members. (viii) It is useful to consider the power of the broader social and historical context, and to know the limits of therapy as well as its capabilities.

McGoldrick and Moore Hines (2007) also take the position that hope can not be given to clients by therapists and that instead hope requires action in order to help transform lives. Hope on its own is not enough; it needs to be anchored in practice. They distinguish hope from optimism and see hope as being crucial for human survival, and having the ability to transform the future by mobilizing people to act. McGoldrick and Moore Hines (2007, p.51) suggest that hope at its core is 'a spiritual belief in belonging to something larger than ourselves, a belief that whatever trauma we experience at present or carry forward from the past can be transformed into possibilities for the future'. They describe hopelessness as a 'loss of will', which is necessary in order to pursue possibilities.

McGoldrick and Moore Hines argue that our clinical job in relation to hope is to help clients connect with their own spiritual resources; their own sources of hope that will keep them going when they feel despair. They do this by reminding their clients that they are a part of something bigger, helping them to see themselves as belonging in many different contexts. The task of therapy is

to support a client's hope and resilience and healing through developing their sense of belonging and connection.

They suggest that discussing clients' religious and spiritual beliefs is very important in helping clients explore their own values and in connecting them to sources of hope. They consider that it is essential for people to have a sense of being part of what went before and what will be in the future in order to maintain their hope. They suggest exploring the client's experience in ways which link their past, present, and potential future. They suggest a series of questions that are helpful when exploring the connection between beliefs and hope, for example, they suggest asking clients: 'What were the beliefs you were taught when growing up that were meant to give you hope? What is your relationship to those beliefs now?'

McGoldrick and Moore Hines consider the importance of hope in helping people make changes that could enhance their quality of life in situations where there may be no concrete resolution, for instance in bereavement or physical deterioration.

Ingram and Perlesz (2007) created an archive of clients' 'wisdom narratives', clients' stories of reconnecting to hope and well-being after traumatic and problem-saturated experiences. They developed a research project to see what the effects on their clients would be to have access to a collection of 'wisdom narratives'.

They defined wisdom as 'understanding that arises out of experience and supports and prepares one for future related experiences through on-going reflection and learning' (p.75). They believe that the 'wisdoms project' provided a way to bring forward through mutual co-creation and compassionate witnessing, unheard stories and knowledges which engendered hope. The process of writing a story that others would hear and learn from provided a healing experience and a sense of hope for both clients and therapists. They suggest that the writing and telling of the person's story engendered a sense of belief or faith in the person's own abilities, and sense of self-worth, which invited the potential for on-going change.

The authors found that when the clients' own story was read back to them it had the effect of fostering self-compassion which flowed out to others in the person's family and community. Ingram and Perlesz suggest that hearing one's own story as an externalized narrative in the first or third person may enable a person to separate enough so that they can see themselves as they would another in the same position; in this way becoming a compassionate witness to themselves and helping them to let go of a negative self-image.

Ingram and Perlesz (2007, p.85) consider that the 'experience of self-compassion created through telling, writing and reading, listening to and bearing witness to one's own and others' stories' are similar to experiences reported by clients and therapists involved in multiple family groups, reflecting teams, and outsider witness groups. The experience of listening to, or reading another's story, about their struggle creates an experience of not being alone and of being heard.

Karl Tomm (2007) suggests that when people live in mutually supportive relationships they have a solid base for on-going hopefulness. However, when relationships deteriorate through disappointments, trauma and interpersonal stress and conflict that hope may be eroded, leaving people vulnerable to despair. Tomm introduces the practice of acknowledgement as a 'behavioural competency' that helps to rebuild and maintain hope. He regards processes of acknowledgement as central for enabling reconciliation and also for generating and maintaining well-being (Tomm, 2002).

Tomm (2007) describes acknowledgement as an explicit expression of something already known which is communicated to another person and sometimes to a whole community. For example, in interpersonal conflict acknowledgment of an act of wrongdoing is usually a crucial first step towards reconciliation. Tomm considers that when one person has wronged another and is not willing to acknowledge it, the person harmed will be fearful that the wrongs could be committed again and will be unable to trust and work towards an improved relationship.

Ward and Wampler (2010, p.216) conducted a study on hope in couple therapy. They defined hope as a 'belief and a feeling that a desired outcome is possible'. They identified four processes that help to nurture hope:

- (i) **Creating a Context of Hope.** The authors suggest that a strong therapeutic relationship increases hope by establishing a sense of connection between therapist and clients. Therapist hope was identified as a key component because it helps to motivate clients and is reflected in clients. Therapist hope provides a sense of options for clients and evidence that they can improve their relationship. Therapist belief in the process of therapy also contributed to creating a hopeful context. In addition, their findings suggest that where spirituality is a source of hope for clients it should be incorporated into the therapeutic process.
- (ii) **Cutting the Engine on the Freight Train.** This refers to processes that stop negative interaction patterns. The processes include setting a time frame, acknowledging and validating experiences, normalizing problems and providing a statement of hope. These interventions increase hope because they give people options and the possibility to act. They provide evidence that others have successfully navigated difficult relationships. Other strategies that increase hope are: a) Finding exceptions – this increases options and evidence that people have the ability to act differently; b) Reframing – this involves changing clients' perspectives and framing problems in ways that are hopeful. Through re-framing clients can be helped to consider possibilities and options that they had not previously considered; c) Rewarding Interaction, for example asking clients to spend time together that is not about delving into the issues that brought them to therapy; this builds hope through providing evidence that change is possible; and lastly d) Celebrating steps. This involves recognizing and celebrating positive events throughout the therapeutic process.
- (iii) **Getting over the Hump.** This process is about helping clients to address and navigate difficult issues and conversations that have caused them to become 'stuck'. This can involve getting things to happen differently in the session which gives a sense of hope that they can do things differently. 'Getting over the hump' is achieved through helping the couple to

empathize or understand their partner's perspective and through enabling the couple to stand outside their normal interaction and observe it from a distance. A further finding of Ward and Wampler's research was that the therapists reported needing to protect their own hope to avoid burnout.

Cooper et al., (2003, p.2) describe how they cultivate 'hope eliciting' conversations in their practice. They suggest that the concept of hope and its development is essential to therapeutic practice and that the 'idea that positive change is possible; that therapy can improve people's lives, is in essence the 'raison d'être of therapy'. Further, they consider that the therapist's task is to identify what clients are hopeful about and try to tap into that resource.

They discuss how, from a narrative therapy perspective, hopelessness develops when people evaluate themselves against societal norms and expectations and judge themselves as having failed. The authors discuss different therapeutic options that may help to cultivate hope.

They suggest that asking questions about what it is that gives clients a reason to keep going, and asking questions that allow people to evaluate their lives in a 'way that frees them from normalizing judgement of self' create a context for 'hope to nestle in'. In addition they suggest that when therapists ask about people's lives in an appreciative way, that this in itself is a 'hope implicit act' because the therapist's appreciative questions imply that there is something valuable in the person's life. Asking about the future is also a way to create hope. Through asking about the client's desires and preferences for the future, the therapist implies that there is at least the possibility of things getting better. Through these questions the therapist implicitly communicates that there is a future and that the therapist has faith that the client will find a way to survive the current situation.

Cooper et al., (2003, p.8) also suggest that 'hope follows action, rather than the other way round. Helping clients become aware that what they are all doing, even if it is "merely" coping and "just" getting by can be the first step in rebuilding a sense of their own agency and control'. They also suggest that hope is fostered and strengthened by empowerment, being able to influence

and or taking control of one's life. Identifying with clients actions they can take to keep going, enables clients to participate in and influence their life.

Cooper et al. (2003) argue that there may something implicit in the therapist's style that is hope-eliciting, for example conveying warmth, safety, concern, empathy and faith that things will improve. They also suggest that hope grows more easily in 'a context that involves relating to someone beyond oneself and acting somehow on that relationship' (p.16). Enquiry and attention regarding a client's connection to a hope-friendly environment can counter hopelessness, isolation and disconnection. One of the authors discusses that what keeps her going as a therapist is the knowledge that she is not alone. Her hope is invigorated by being part of the psychotherapy community; where help and support can be accessed.

APPENDIX 7
ETHICS APPROVAL

Ms Collette Richardson

Flat 5
36 Boundary Road
London
NW8 0HG

16 June 2014

Dear Ms Richardson

**University of East London/The Tavistock and Portman NHS Foundation
Trust: research ethics**

**Study Title: Exploring systemic therapy in families where a young person
has deliberately self-harmed,**

I am writing to inform you that the University Research Ethics Committee (UREC) has received NHS documentation regarding the above study, which was submitted to the Chair of UREC, Professor Neville Punchard. Please take this letter as written confirmation that UREC acknowledges you had NHS ethical approval for your study, and had you applied for ethical clearance from our UREC at the appropriate time; it is likely it would have been noted. However, this does not place you in exactly the same position you would have been in had clearance been obtained in advance. Therefore, when responding to any questioning regarding the ethical aspects of your research, you must of course make reference to and explain these matters in an open and transparent way.

For the avoidance of any doubt, or misunderstanding, please note that the content of this letter extends only to those matters relating to the granting of ethical clearance. If there are any other outstanding procedural matters, which need resolution, they will be dealt with separately as they fall entirely outside the remit of our University Research Ethics Committee.

If you are in any doubt about whether, or not, there are any other outstanding procedural matters you should contact Mr William Bannister at the Tavistock and Portman NHS Foundation Trust (e-mail WBannister@tavi-port.nhs.uk).

Yours sincerely



pp: Catherine Fieulleateau

Ethics Integrity Manager
For and on behalf of
Professor Neville Punchard
Chair of the University Research Ethics Committee (UREC)

Tel.: 020 8223 6683 (direct line)

E-mail: c.fieulleteau@uel.ac.uk

c.c. Mr Malcolm Allen, Dean of Postgraduate Studies, Tavistock and Portman
NHS Foundation Trust
Mr Will Bannister, Associate Director, Education and Training, Tavistock
and Portman NHS Foundation Trust
Professor John J Joughin, Vice-Chancellor, University of East London
Professor Neville Punchard, Chair of the University of East London
Research Ethics Committee
Dr Alan White, Director of the Graduate School, University of East
London
Mr David G Woodhouse, Associate Head of Governance and Legal
Services