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YOUNG PEOPLES' VIEWS ABOUT THEIR DELIBERATE SELF-HARMING BEHAVIOURS – AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

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This section consists of five essays, focusing on the critical appraisal of theory and practice in clinical psychology. Four essays are relevant to the four core placements completed in year 1 and 2. The final essay relates to the paediatric specialist placement completed in year 3. The essays are presented in the order in which they were undertaken, which hopefully illustrates the development of my academic ability.
ADULT MENTAL HEALTH ESSAY

Both behaviour therapists and cognitive therapists may use behavioural techniques in the treatment of anxiety disorders and depression. However, the underlying theoretical rationale for the use of these behavioural techniques differ.

Critically evaluate these different theoretical rationales by drawing on the literature from anxiety and depression.

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INTRODUCTION

Both behaviour therapists and cognitive therapists "share a pragmatic interest in effecting and demonstrating behaviour change in the treatment of psychopathology" (Reitman & Drabman, 1997:419). In fact, as the title suggests, both therapists may use very similar 'behavioural' methods in the treatment of anxiety disorders and depression and effecting change. However the behaviour therapist and the cognitive therapist will differ significantly with respect to how behaviour change is explained and the processes that lead to the change. As we shall see in this essay, each therapist conceptualises the psychological disorder in accordance with different underlying theory, therefore the focus and rationale for using behavioural strategies differ. Fundamentally the behaviour therapist conceptualises and treats psychological problems in terms of the overt, conditioning environment. Therapy is underpinned by the theoretical principles of classical and operant conditioning, which stems from learning theories. In contrast the cognitive therapist will be focusing on internal processes, such as identifying, modifying and challenging cognition's and underlying schema, whilst using behavioural strategies. Therapy is underpinned by cognitive theories, postulated by the likes of Beck (1976) and Ellis (1962). This essay sets out to critically evaluate each theory and thus the theoretical rationale behind the use of behavioural techniques in treating anxiety and depression. This will entail a critical evaluation of the foundations, experimental evidence and assumptions upon which these theories are based and ask whether the theory is adequate in explaining psychopathology and therapeutic effects.

Why is it important to evaluate the underlying theory?

Scientific theory informs the clinical practice of the clinical psychologist in treating psychological disorders. With increasing pressure for clinicians within the National Health Service to advocate and carry out evidence based practice, it is vital that clinical psychologists are not only working to ascertain the efficacy of treatment approaches but also advocating empirical evidence to support the validity of the theory underlying the treatment approaches. Failing to question the validity of underlying theories may lead clinicians to explain therapeutic change in inaccurate means, which would be "a significant disservice" (Corrigan, 1990:141) to the patient, the service and the profession. It is hoped that such evidence will contribute to our
understanding of therapeutic effects, thus promoting our understanding of the underlying mechanisms. This will help clinicians in determining the appropriateness of treatment approaches and possibly lead to the development of new, more effective interventions (Clark and Steer, 1996).

Focus of the essay
There is not a single, unified cognitive theory/therapy for the treatment of anxiety disorders and depression. Cognitive theories may differ in the extent that they use behavioural techniques, the range of clinical applications and the extent of empirical evidence to support the efficacy of treatment (Clark & Beck, 1989). For example Ellis' Rational Emotive Therapy may use very few behavioural methods, focusing almost exclusively on verbal methods in challenging beliefs and thoughts (Ellis, 1962 cited in Rachman, 1997). However cognitive therapies do share a common cognitive orientation, including Beck's (1976) Cognitive therapy, Ellis' (1962, cited in Rachman, 1997) Rational Emotive Therapy (R.E. T.) and Meichenbaum's (1975, cited in Hawton, Salkovskis, Kirk & Clark, 1989) Self Instructional Training. This essay will focus on the work of Beck's Cognitive Therapy, as it has become the most widely used/referenced cognitive model in therapy, is supported by considerable experimental and self-report research, (Wells, 1997; Clark & Beck, 1989) and promotes the use of behavioural strategies in treatment packages.

This essay will draw on the literature on depression. Also attention will concentrate on specific phobias, which was the main focus of early behavioural experimental theory and panic disorder, which has developed a well-documented cognitive model (Clark, 1986). Depression, panic disorders and specific phobias are defined within the DSM-IV and affect a high proportion of patients seeking treatment in today's N.H.S. In fact, an estimated 75% of psychiatric hospitalisations are due to depression (Fennell, 1989).

What are behavioural techniques?
Behavioural techniques were first used in behaviour therapy and broadly focus on the manipulation of overt behaviour for a specific aim, i.e. re-conditioning or to test out cognitions. Examples of behavioural techniques include exposure, activity scheduling/
monitoring and desensitisation. Some behavioural techniques (or modified techniques) are specific to cognitive and to behavioural models of anxiety disorders and depression.

**BEHAVIOUR THERAPY**

Conditioning and other learning theories, which underpin behaviour therapy, were originally developed from the findings of laboratory animal experiments, which focused heavily on the induction of experimental neurosis in animals (Rachman, 1997). Two broad processes of learning were identified and generalised to the acquisition and maintenance of human behaviours; (1) classical conditioning, developed from the work of Pavlov, Watson, Wolpe (cited in Rachman, 1997) and (2) operant conditioning, which developed from the work of Skinner (cited in Rachman, 1997). In general, psychological problems were seen as a product of faulty learning or "unfortunate conditioning events" (Rachman, 1997:7), and were therefore susceptible to re-learning, via the manipulation of the conditioning environment. Behaviour therapy became an accepted treatment for many psychological disorders, specifically the use of in-vivo exposure with phobias and obsessional behaviour and operant/goal setting techniques in rehabilitation (Hawton, Salkovskis, Kirk and Clark, 1998).

Eysenck (1960 cited in Rachman, 1997) claimed that behaviour therapy was important as it took the first steps toward providing scientific experimental evidence on which to base the theory, unlike what Eysenck referred to as the seemingly unfalsifiable psychoanalytic and psychodynamic approaches of the time. Indeed Williams (1992) states that behavioural accounts of depression did much to 'break the mould' of traditional explanations, i.e. biological verse psychodynamic theories. Behaviour therapy provided a commitment to the use of strict scientific standards, a focus upon outcome studies and according to Rachman (1997) was a "major factor in the advancement of the profession of clinical psychology, which had formerly been restricted to measurement and assessment" (1997:11). This new wave of empiricism became central to developing theory such as Beck's.

However the experimental research behind the behavioural learning theories has its
limitations. It appears that the greatest scepticism around conditioning and learning theories questions the validity and generalisability of animal experimentation i.e. the use of relatively primitive animal behaviour without language in order to understand complex human behaviour. Breger and McGaugh (1965 cited in Gelder, 1997) stated that "the behaviourists have traditionally assumed that principles established under highly controlled conditions usually with animal subjects, form a scientific foundation for a psychology of learning. Yet when we come to apply these principles of human learning situations the transition is typically bridged by rather flimsy analogies," (Breger and McGaugh, 1965 cited in Gelder, 1997:27). The extremely limited human research (Watson & Rayner, 1920 cited in Davey, 1992) became hugely over-generalised. Little consideration was given to the possible experimenter bias and the influence of confounding variables that, according to Rachman (1977), undermined such experimentation.

**Behavioural therapy for anxiety disorders**

One of the most popular behavioural formulations of the acquisition and maintenance of human phobias is Mowrer's (1960) two-factor learning theory (cited in Foa, Rothbaum & Kozak, 1989). In the first stage, classical conditioning principles are applied to explain how fears are acquired. For example, during human experience associations can occur between a neutral stimulus and an unconditioned stimulus that provokes fear/discomfort. This association leads to the neutral stimulus acquiring aversive properties and thus becoming the conditioned stimulus for the conditioned fear response. In the second stage, operant conditioning is applied to explain the maintenance of phobias, through the development of learned responses, e.g. avoidance/escape. Such responses act as negative reinforcers e.g. the reduction of anxiety. The addition of the second stage was helpful for behaviour therapists in understanding the maintenance of such disorders as agoraphobia.

From this two-factor theory, behavioural techniques were developed with the specific rationale of reducing the association between the conditioned stimulus and the conditioned response (fear/anxiety) and overcoming the reinforcing avoidant behaviours. For example, Wolpe (1958) proposed that gradual exposure to the feared situation whilst inhibiting the fear response with an incompatible affect (such as
relaxation) was an effective treatment for phobias/fears. Wolpe referred to this process as reciprocal inhibition (relaxation inhibits the feared response) and is evident in current day behavioural strategies in treating phobias and anxiety disorders.

Specific evidence for this model came from clinical observations, such as patients recalling a traumatic experience(s) prior to the fear developing (Lautch, 1971), the severe anxiety states observed in combat soldiers (Gillespies, 1945; Lewis and Engle, 1954, both cited in Rachman, 1977), plus a limited number of studies which looked at the effects of laboratory conditioned fear induction in humans (Sanderson et al, 1963 cited in Rachman, 1977).

Critical evaluation of the behavioural account of phobias
1. The failure to develop phobias following a traumatic experience
Although of interest, evidence from combat situations represented an extreme and uncommon set of circumstances, which Rachman (1977) warns against overgeneralising. Additionally he suggests that such evidence suffered from selection bias and was not always subjectively interpreted. It is also of interest to consider that one assumes not all soldiers who experience the traumatic combat develop phobias. Similarly Lautch's (1971) study of dental phobia, found that not all subjects experiencing painful treatment at the dentists went on to develop any signs of dental phobia. Not all people who reported having a traumatic flying accident went on to develop a fear of flying (Aitkin, Lister & Main, 1981 cited in Davey, 1992). It appears that conditioning theory failed to explain the conditions in which phobias do not develop, despite exposure (even repeated) to traumatic events. It would appear that there are significant individual differences in our susceptibility to acquire phobias, which is not explained by Wolpe's theoretical rationale.

Davey (1988 cited in Davey, 1992) suggests that 'latent inhibition' might explain findings such as Lautch (1971). He reported that subjects who did not develop dental phobia, experienced their first painful treatment much later than those who did develop dental anxieties. Consistent with latent inhibition, these subjects would have had repeated exposure to the dentist (the conditioned stimulus) alone, before the pairing of the conditioned stimulus with the painful treatment. Additionally Davey
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(1992) suggests that the extent of the conditioned response is dependent on how the individual evaluates and perceives the traumatic experience. Therefore if the individual were able to 'devalue' the traumatic experience, a phobia would not automatically occur (Davey, 1992). This implies the acceptance of more contemporary conditioning theories that internal processes of evaluation and perception can influence the conditioned learning i.e. the development of phobias.

2. **Development of phobias without an obvious traumatic experience**

A further problem with conditioning theories is that they fail to explain all human fears/ anxieties, such as the patient who presents with a phobia that appears to have emerged without any identifiable conditioning experience (Rachman, 1977; Emmelkamp, 1982 cited in Davey, 1992). Davey (1992) advocates the need for more research into this area as he reports that conditioning experience may be very subtle and less obvious (refer to White & Davey, 1989 cited in Davey, 1992). However in such circumstances it is quite difficult to use conditioning theory principles to guide treatment such as when therapist and patient are unable to identify the original conditioned fear.

It appears that the behavioural rationale/ theory behind the use of techniques such as systematic desensitisation provides only partial explanation for therapeutic effects in anxiety disorders i.e. why are some people more susceptible to development of phobia then others (Rosenhan & Seligman, 1989). Further research such as that by White and Davey (1989 cited in Davey, 1992) are required to answer whether contemporary conditioning models can provide fuller explanations. Behavioural techniques using the conditioning rationale have however been found extremely effective with certain populations such as children and people with learning disability.

**Behaviour Theory and Therapy of Depression**

One of the most prominent, early behavioural theories on depression was proposed by Lewinsohn, (1974, 1975 cited in Rehm, 1989), who based much of this approach on clinical and research evidence. In general, behavioural therapists claim that depressive symptoms result from the person failing to receive adequate or sufficient positive reinforcement from their environment. Lewinsohn and Hoberman (1982 cited in
Emmelkamp, 1994) proposed that inadequate social skills might be the prior condition that leads to low rates of positive reinforcement. In addition Lewinsohn (1974 cited in Rehm, 1989) proposed depressed individuals were not able to experience pleasure from available reinforcement due to the interference of social anxieties. Therefore the rationale behind behavioural methods for the treatment of depression such as activity scheduling, social skills training and desensitisation is to: - (1) provide an environment where more adaptive behaviour can be learned by ensuring such behaviour receives optimum reinforcement; (2) enhance the individuals social ability to elicit positive reinforcement from his/her environment; and (3) desensitise the individual to social situations to reduce the interfering anxiety.

Critical evaluation of behavioural account of depression

1. Inability to demonstrate a direct causal relationship between factors

Although a number of studies do suggest an association between depression and inadequate social skills (Coyne, 1976; Lewinsohn, Mischel, Chaplin & Barton, 1980; Youngren & Lewinsohn, 1980; all cited in Emmelkamp, 1994) this does not necessitate a casual relationship. For example the depression may be responsible for the lack of subsequent social skills (Emmelkamp, 1994). Additionally Williams (1992) argues that evidence to suggest a relationship between depression and inadequate social skills were themselves flawed as lacking validity (i.e. used role plays rather then real life situations), were reliant on subjective ratings of social skills and are largely without control comparisons. Research using independent raters of social performance did not find such a relationship (Youngren & Lewinsohn, 1980 cited in Williams, 1992).

It appears that much of the behavioural model is based upon purely correlational research evidence, from which causal relationships cannot be assumed (Williams, 1992); for example between depression and lack of positive reinforcement or depression and inadequate social skills, especially in the light of contrary evidence. For example, Wilson (1982 cited in Emmelkamp, 1994) found that improvements in depression were not related to an increase in enjoyable activities, where one would expect to achieve higher levels of positive reinforcement.
2. **Failure to provide a full explanation of depressive symptoms**

Many argued that the behavioural model of depression failed to do justice to the variety and severity of symptoms present in clinical depression (Williams, 1992). Indeed Williams (1992) argues that the behavioural models "were not expressed sufficiently precisely to generate testable experimental or clinical predictions" (1992:15). Champion (1992) argued that behavioural models of depression failed to account for all types of depression and many have come to view behavioural accounts just far too limited an explanation of depression.

Hawton et al. (1989) reported that the failure of behaviour therapy to treat depression during the early 1970s lead to increasing scepticism about the extent of the behavioural explanations. Many purely behavioural accounts of depression moved toward the inclusion of some cognitive element such as Seligman's (1974) Learned Helplessness Theory reformulated to include a cognitive component in explaining depression (Abramson et al., 1978 cited in Williams, 1992).

**COGNITIVE THERAPY**

Cognitive theories of psychopathology, in particular depression, were well received by many (Rachman, 1997) due in part to:- (1) an increased awareness of the inability of behavioural accounts to treat depression; (2) the possibly reassuring presence of behavioural components in the treatment programme; and (3) the publication of early successes in treatment of clinical depression (Beck, Rush, Shaw and Emery, 1979).

Beck’s cognitive theory was based upon the information processing perspective (Beck, 1987 cited in Clark & Steer, 1996). Rather then dysfunctional learning, "distortions in thinking" (Wells, 1997:2) were seen to play an integral role in the emergence and maintenance of anxiety disorders and depression (Clark & Steer, 1996). Beck's cognitive theory assumes that humans actively construct reality (Clark & Beck, 1989) unlike traditional conditioning theories, which see human learning as an unconscious, automatic procedure. Due to faulty processing, maladaptive schemata may develop during our formative years, which can be extremely rigid and concrete. The content of such schemata differ, reflecting each disorder. For example, in
depressed patients schema/ underlying beliefs are more likely to reflect the negative cognitive triad proposed by Beck i.e. negative view of self, future and world. In anxiety disorders underlying schemata will indicate a tendency to perceive danger/threat of danger in the environment.

During depression or anxiety disorders, these underlying schemata come out of a latent state and are evident in the patient’s verbalised negative automatic thoughts. The themes of such thoughts reflect the different disorders. Patients with anxiety disorders are more likely to have thoughts about perceived immediate danger and a negative self-view of their ability to cope. Depressed patients verbalised thoughts will reflect loss and hopelessness.

Despite some confusion (Haaga, Dyck & Ernst, 1991) Beck's theory does not assume that his explanation i.e. biased information processing and cognitions are the sole cause of psychopathology (Clark & Beck, 1989). Beck acknowledged that other factors such as genetics, developmental, hormonal and physical factors may be involved in the aetiology of psychopathology (Clark & Beck, 1989).

Applying Cognitive Theory to Cognitive Therapy

The focus of cognitive therapy is to "identify, reality test and correct distorted conceptualisation and the dysfunctional beliefs (schemas) underlying these cognitions," (Beck, 1974:4).

Behavioural techniques that can be verified within the patient’s case conceptualisation, are viewed by cognitive therapists as the "most powerful means of cognitive change" (Wells, 1997: 78). They provide concrete evidence to challenge negative automatic thoughts and in some cases underlying beliefs.

Behavioural techniques in cognitive therapy include exposure experiments, self monitoring, mini-surveys, activity scheduling, manipulation of safety behaviours and symptom induction (Wells, 1997). They are used in line with cognitive theory to:- (1) enable the patient to learn about the cognitive model and maximise patient participation in therapy; (2) to modify affect; and (3) to identify and challenge
maladaptive beliefs and negative automatic thoughts (Wells, 1997) and to help
develop and believe in alternatives way of thinking. For example, according to the
Clark's cognitive model, panic disorder patients experience panic attacks because they
catastrophise the anxiety symptoms i.e. "If I have a panic attack, I will faint and I will
die". A cognitive therapist would set up a behavioural experiment to challenge this
belief. This might entail inducing the symptoms of panic via a hyperventilation
exercise, to provide visible evidence that the patient will not faint when in panic and
opportunity to re-attribute bodily sensations to less threatening causes.

Cognitive therapists accept that behavioural techniques such as relaxation and
distraction can be helpful in initially modifying the severe symptoms directly.
However such methods are short-term measures, as they do not allow the patient to
challenge/ disconfirm their automatic thoughts or underlying belief. For example
teaching distraction techniques to a patient with panic disorder, may initially reduce
anxiety symptoms. However panic attacks are likely to continue as the patient
attributes the non-occurrence to the distraction, rather then any change in his/ her
negative automatic thoughts i.e. "If I go to the shopping mall, I will have a panic
attack and faint" (Wells, 1997). The patient remains vulnerable to panic attacks,
especially when he/she is prevented from practising the distraction techniques.

**Critical Evaluation of Cognitive theory**

Interestingly the call for the scientific foundations of cognitive theory came after the
approaches were generally accepted within psychology, unlike the behavioural
approaches (Gelder, 1992). Much of the earlier cognitive theory was based upon
clinical observations rather then experimental findings. This focus, on depressed
patients, may have been the reason for cognitive therapists early successes in treating
depression, rather then relying on generalising animal experimentation or non-clinical
samples as behavioural accounts had done. Indeed Rachman (1997) states that
"cognitive concepts have widened the explanatory range of behaviour therapy and
helped fill in the picture" (1997:18).

Although there has been considerable evidence to suggest the efficacy of cognitive
therapy (Dobson 1989 cited in Haaga, Dyck & Ernst, 1991), Haaga et al. (1991) argue
that: "there has been less consensus on the validity of cognitive theory" (1991:215).
Cognitive theory is actually very difficult to prove or disprove, in part due to the internal mechanisms referred to in the theory and the subsequent methodological issues this raises, i.e. measuring schemata. This problem is one of the main criticisms levied by behaviour therapist (Lee, 1992). Gelder (1997) and Haaga et al. (1991) suggests that it is possible to break down the theory into a number of testable hypotheses and prediction about depression and anxiety disorders such as panic, some of which will now be critically evaluated. The hypotheses investigate the extent that maladaptive thoughts play a central role in the maintenance of emotional disorders and look at cognitions as a 'product' i.e. verbalised thoughts, and at a 'process' level i.e. bias information processing (Clark & Steer, 1996).

1. Depressed patients are more negative in their thoughts than non-depressed people
There is clinical evidence to suggest that depressed patients do report more negative thinking then either non-depressed people or previously depressed patients (Blackthorn, Jones & Lewin, 1986 cited in Haaga et al., 1991). During remission of depression, cognitive theory assumes that the maladaptive schemata would return to a latent state and therefore negative thinking would not be evident. Blackthorn et al. (1986) results are consistent with this hypothesis. However although differences have been reported, Coyne and Gotlib (1983) argue that such difference have not been as consistent as Beck's model might assume.

2. All depressed patients think more negatively about themselves, the world and the future - The cognitive triad
Haaga et al. (1991) refer to numerous empirical evidence to support the presence of the cognitive triad in depressed patients. Depressed patients viewed themselves much more negatively and were more hopeless about the future (Blackburn et al., 1986; Myers et al., 1989 both cited in Haaga et al., 1991) then they were during remission. However Haaga et al. (1991) point out that the present evidence defines 'the future and the world' in relational terms i.e. the patients future and the pressure the world puts on the patient, rather then the future and the world at large. Indeed evidence suggests that depressed patients are only negative about their own performance not other peoples,
(Garber & Hollon, 1977 cited in Beidel & Turner, 1986). Perhaps this 'personal' emphasis needs to be incorporated into the triad. Haaga et al. (1991) suggest reducing the triad to a single dimension i.e. negative view of self, to be in keeping with the research findings.

3 **Differing cognitive content of thoughts in depression and anxiety disorders - The Cognitive Content Specificity Hypothesis**

The theory hypothesizes that depressed patients' thoughts will be characterised by themes of personal loss or deprivation, whilst patients with, for example, panic disorders will be characterised by the appraisal of immediate threat/ danger. Clark and Steer (1996) refer to this as the cognitive content-specificity hypothesis. They report that this is central to the cognitive model as it distinguishes psychopathology and thus justifies focusing upon cognitions in treatment. These themes should be reflected in the patient's verbalised thoughts, which has often been measured in studies by using tools such as the Automatic Thought Questionnaire (Hollon & Kendall, 1980 cited in Haaga et al., 1991) and Crandell Cognitions Inventory (Crandell & Chambless, 1986 cited in Haaga et al., 1991). Depressed patients have scored significantly higher on these measures then non-depressed psychiatric controls (Dobson & Shaw, 1986 cited in Haaga et al., 1991; Beck et al., 1987 cited in Clark & Beck 1989). Some might question the validity of these tools in accurately accessing internal, unobservable cognitions. However clinical observation studies provide support for the hypothesis (Beck, 1967 cited in Clark & Beck, 1989).

There is less research on the cognitive content of patients with anxiety disorder (Clark & Beck, 1989). Clinical observations have indicated that generalised anxiety disorder patients report fear of physical or psychological threat to themselves (Beck, Laude, & Bohnert, 1974; Hibbert, 1984 both cited in Clark & Beck, 1989) and this is supported by self-report measures i.e. the Anxious Self-Statement Questionnaire (Kendall & Hollon, 1987 cited in Clark & Beck, 1989).

4 **Patients with depression and anxiety disorder process information in a biased manner**

Clark and Beck (1989) conclude from the research evidence that there is "strong
empirical evidence that a depressive mood state does bias one's perception against positive self referent information" (1989:387).

In explaining the less consistent evidence regarding biases over negative material, they suggest that only more severe depressed patients having a tendency to become biased toward negative material (Beck & Clark, 1988 cited in Clark & Beck, 1989).

Some question the extent that this bias in depressed individual’s thinking is 'irrational' or 'prone to logical thinking errors' (Power & Champion, 1986:210). Indeed Lewinsohn et al. (1980 cited in Emmelkamp, 1994) found that depressed patients were more realistic in their perception of situations then non-depressed. To this extent, Layne (1983) argued that depressed patients were merely less optimistic, which does not necessarily reflect faulty information processing. This questions how a cognitive therapist might challenge the depressed patients cognitions i.e. should not assume that the patients thoughts are illogical.

There is considerable evidence to support the hypothesis that patients with anxiety disorders have an attention bias toward threatening stimuli in the environment (MacLeod, Mathews & Tata, 1986). Butler and Mathews (1983) found that patients with generalised anxiety disorder report a tendency to interpret ambiguous stimuli in a threatening manner (Clark & Beck, 1989). Therefore a patient with anxiety disorders is more likely to attend and perceive danger in their environment then non-anxious people.

5. Panic occurs in patients with panic disorder when the 'threat' cognition is activated

Behavioural theory might assume that exposure to the feared object would provoke some degree of anxiety and possibly panic. However cognitive theory is able to explain what happens when panic does not occur. Using carbon dioxide inhalation or lactate infusions as the trigger for the panic reaction, patients did not react in panic when they were either: (1) re-assured that the arousal was normal, transient and non harmful (Rapee et al., 1986 cited in Gelder, 1997); (2) when they believed they had control over the amount inhaled when actually they did not (Sanderson et al., 1989)
cited Gelder, 1997); and (3) when they were told their reaction would be pleasant excitement (Van der Molen et al., 1985 cited in Gelder, 1997). This evidence demonstrates how powerful the manipulation of the patient's expectations, and thus cognitions, can be in reducing the panic reaction.

In an effort to directly activate the cognition, by providing false heart rate information, Ehlers et al. (1988 cited in Gelder, 1997) was able to induce a panic attack in patients. Such evidence does support the primacy hypothesis of cognitions in panic disorders proposed by Beck (1976) i.e. that cognitions are not causal as previously stated but "first among equals" (Haaga et al. 1991: 215) in the development of anxiety disorders such as panic disorders. In a review of cognitive therapy and panic, Wolpe (1989) agreed that catastrophic misinterpretations are common in panic and act to increase the severity of the panic response. However he cites evidence that such misattributions occur after the first panic attack (Wolpe & Rowan, 1988 cited in Wolpe, 1989), which implies that the first panic for some people will be an unconditioned fear response. This evidence suggests that both behavioural and cognitive theories have something to contribute to our understanding of the genesis and maintenance of panic disorder.

Some studies have looked at mood induction in activating depressed cognitions; however there are extensive methodological flaws in such evidence (Beidel & Turner, 1986).

**Specific criticisms to Beck's cognitive theory**

There are a number of articles which report critically of cognitive theories (Lee, 1992; Beidel & Turner, 1986) and deny the contribution that cognitive theory/therapy has made in the treatment of depression and anxiety disorders, over that made by behavioural therapies (Giles, 1983; Wolpe, 1989; Sweet & Loizeaux, 1991). Lee (1992) argues that cognitive theories are "intrinsically unscientific" (1992:268) and are no more then metaphorical accounts, which rely on untestable assumptions and unmeasurable variables. Indeed there are still concerns over the ability to measure cognitions, especially underlying maladaptive schemata. This essay has illustrated efforts to test out the assumptions of the cognitive theories and on the whole this
evidence is supportive of the presence of certain ways of thinking and bias in information processing in emotional disorders, which can explain the therapeutic effects in cognitive therapy. Beidal and Turner (1986) specify that such evidence, i.e. the differences in cognitions found between depressed and non-depressed patients does not constitute evidence of the causality of cognitions in psychopathology. They suggest that cognitions may simply accompany or result from the disordered state. Testing out the causality question is thwart with methodological problems, for example measuring underlying schemata, plus the fact that such schemata are in a latent state until a critical event. This may be a reason why Beck's theory has moved away from the previous rhetoric purporting cognition as causal in the genesis of psychopathology.

**Cognitive therapy is no more effective then other treatments**

Teasdale (1993 cited in Rachman, 1997) argues that cognitive therapy is no more effective then other treatments that do not focus directly on negative thoughts. Rachman (1997) concludes that negative cognitions can reduce as a consequence of direct or indirect methods. Indeed Margraf (1995 cited in Rachman, 1997) found that pure exposure treatment without any manipulation of cognitions was as effective as pure cognitive therapy without exposure in reducing negative cognitions. Rachman (1997) questions why more direct attacks upon negative cognitions were not more significantly effective then indirect attacks. This may be due to the exclusion of exposure in the direct cognitive therapy. As previously identified some form of behavioural experiment is the best means of creating cognitive change. It may be possible that behaviour therapists are inadvertently being effective at indirectly challenging cognitions.

**The vagueness of terminology**

Terms such as schemata, beliefs and attitudes are used interchangeable within cognitive theory/therapy and this has lead to some confusion. Power and Champion (1986) argue that the terms are too vague and need to be distinguished from everyday concepts. Some efforts have been made to clarify terminology such as schemata (Mandler, 1984 cited in Power & Champion, 1986). Such clarification will be helpful to testing out the validity of the theory. Power and Champion (1986) argue that
schema theories, such as Beck's, "stop too soon" (1986:205) and that further work should look at higher level representations of mental processing.

**DRAWING CONCLUSIONS FROM THE CRITICAL EVALUATION**

The evidence cited in this essay is far from exhaustive. The well-fuelled debate over the validity of theories, which underlie cognitive and behaviour therapy, is extensive and well documented. However efforts have been made to address some of the main criticisms and flaws levied against each theory in the available literature. Also attention was given to strengths of each theory.

This essay has identified that cognitive therapists and behaviour therapists use very similar behavioural techniques in treating psychopathology. Both therapists' views behaviour techniques as vital in promoting change, either at a cognitive or a conditioning level. Although each therapist is driven by different theoretical rationales, this fact alone makes identifying the mechanism of change in therapy very difficult (Beidel & Turner, 1986). This is why this essay has focused on the validity of the underlying theory rather then looking at the efficacy of treatment interventions.

Theories, which inform behaviour therapy, were vital in focusing attention on empirical evidence and outcome studies within clinical psychology. However the conditioning theories, although successful with certain populations, were not found to be fully adequate in explaining phobia, depression and therapeutic change in some circumstances. For example conditioning theory could not be applied to explain phobic reactions without an identifiable traumatic experience. This lead to difficulties applying conditioning theory to clinical practice. Efforts to overcome this difficult have been reflected in more contemporary conditioning theories which accept the role of some internal process i.e. perception in emotional disorders. Future researchers might address how conditioning principles and cognitive processes might interact to influence the genesis and maintenance of psychopathology.

The theoretical rationale behind cognitive therapy has been shown to have empirical evidence to support the hypothesis that negative thoughts and an attentional bias toward negative material play a role in maintaining depression. Evidence is available
to support the hypothesis that verbalised thoughts reflect some underlying perception (or schemata) consistent with the disorder. The impact of cognitions on our behaviour is evident in research of panic disordered patients (Ehlers et al., 1988 cited in Gelder, 1997). What remains to be agreed upon, within psychology, is the centrality of cognitions in emotional disorders and thus the extent that cognitions should be the focus of behavioural interventions. The main flaw in being able to critically evaluate cognitive theory is the conceptual and methodological difficulties inherent in measuring internal processes that are not directly observable. Indeed Clark and Beck (1989) identified that at a theoretical level further research is required specifically for this purpose i.e. finding appropriate experimental methods for assessing schemata. This will require better operationalisation of the concepts involved.

With regard to the clinical implications of this essay, one may conclude that all the theories discussed have contributed to clinicians understanding of emotional disorders to varying degrees. It is unlikely that any one factor alone accounts for the genesis and/or maintenance of emotional disorders and the debate between theories and the contradictory evidence illustrates this. Indeed what causes and maintains a depressive episode/ phobia in one person might be different to that experienced by another person. This evidence does suggest the need for eclectic initial assessments in clinical practice, so that the clinician can identify key areas specific to the individual patient, such as cognitions, conditioned behaviour plus other areas not considered in this essay such as biology and possibly systemic influences to inform therapy. In addition clinicians need to be aware that their intervention techniques, regardless of their theoretical stance may effect the patient’s conditioned learning, cognitions and/or other variables. This consideration is vital in furthering our understanding of psychopathology and consequently our ability to treat psychopathology.
REFERENCES


WHAT IS THE IMPACT OF OTHERS’ EXPECTATIONS ON THE COMMUNICATIVE ABILITIES OF PEOPLE WITH LEARNING DISABILITIES AND HOW MIGHT A CLINICAL PSYCHOLOGIST WORK WITH THESE ISSUES?

Year 1

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INTRODUCTION
Effective communication is vital in enabling our needs to be met and is therefore crucial to our quality of life (Van der Gaag, 1998). Yet many people with learning disabilities (PLD) have difficulties communicating. Indeed they are often labelled as different/disabled on the basis of this difficulty (Leudar, 1997; Keman & Sabsay, 1997). This essay sets out to illustrate how such difficulties are not merely a product of a primary, internal delay or deviance in the development of communication in PLD. In fact, external factors within their communicative environment, specifically others’ expectations and behaviour, impacts on the communicative abilities of PLD. We shall examine systemically how inaccurate or inappropriate expectations can produce secondary handicaps for PLD, and lead to a vicious cycle of communication breakdown and frustration. First, the communicative environment experienced by PLD will be examined. Secondly, attention will focus on identifying other peoples’ expectations of PLD, how these expectations have changed and possible reasons why these expectations may be inappropriate. This essay will consider the views and expectations of society in general, carers, Clinical Psychologists and the views of the learning disabled person themselves. Thirdly, the impact of other peoples’ expectations will be addressed, which include challenging behaviour, withdrawal, acquiescence, social isolation, low self-esteem and a failure to meet the needs and rights of PLD. Finally, ways in which the Clinical Psychologist can work with these issues will be reviewed including functional analysis, cognitive behaviour therapy, staff training and further research. Such work is vital if we are to provide an adequate quality of life for PLD.

LEARNING DISABILITY AND COMMUNICATION PROBLEMS
Learning disability - definition and prevalence
The associated characteristics of PLD are: “significantly sub average intellectual functioning (defined as below 70 IQ points) resulting in or associated with concurrent impairments in adaptive behaviour and manifested during the developmental period (birth to 18 years of age)” (Grossman, 1983:11). This definition illustrates that
intellectual abilities alone are not adequate for the classification of PLD and that it is to some extent socially constructed (Hatton, 1998). Learning disabilities range from mild, between 50 and 70 IQ points, to profound learning disabilities, below 20 IQ points, (ICD-10 classification cited in Hatton, 1998). Approximately 75-85% of PLD have mild learning disabilities (Keman & Sabsay, 1997).

Communication - definition
Kenefick (1988) defines communication as “the exchange of messages between two or more individuals in direct relationship through the use of oral language, symbols, signs and behaviour, when the meaning of these symbols is understood by all participants in this exchange” (1988:189). Two important points are made. Firstly, that communication is not only achieved through verbal language, thus an individual’s communicative ability may also include non-verbal means and behaviour. Many people (not only PLD) use signs, symbols and gestures to communicate to others. A considerable amount of research from speech and language therapists has recently been devoted to developing facilitated communication systems for PLD (van der Gaag, 1993). Secondly, communication involves more than one person and both must understand the means of communication, the signs or symbols etc. Considering communication as a two-way process it is therefore vital to look not only at the individual but also the ‘system’ in which it occurs, i.e. the communicative environment and the impact of this.

The importance of communication
Communicative ability affects all areas of life. An inability to communicate effectively may lead to dependency, isolation, frustration, restricted activity and ultimately our physical, social and emotional needs not being met. Remington (1997) questions whether O’Brien’s (1987) five accomplishments could be met without effective communication: community presence, promoting choice, respect for others, encouraging valid social roles and community participation. Such accomplishments underpin the philosophy of many services for PLD.
Communication difficulties in PLD

Communication difficulties can be characteristic of all levels of learning disability. Enderby and Davies’ (1989) cross-sectional survey estimate that 50% of the learning disabled population in the UK have some communication difficulty. Regional surveys suggest even higher figures (Budd, 1981; Noble, 1990 both cited in Van der Gaag, 1998). Varying prevalence rates regarding the pervasiveness and severity of such problems reflect the heterogeneous nature of learning disability.

Leudar (1981) suggests that there has been a tendency in the past to place the cause of the communication problem within the person with learning disabilities, focusing upon their lack of skills. He reports that this is inappropriate and un-desirable. One should not ignore the varying lack of skills apparent in PLD, but one also needs to consider a more systemic focus e.g. the quality and quantity of opportunities to communicate and the impact of the ‘other’ communicative partner. Indeed Leudar proposed that people react to poorly skilled PLD to actually create a “non-standard communicative world” (1981:276) and that it is this environment that influences the communicative abilities of the learning disabled person in addition to the original poor discourse skills, leading to secondary handicaps.

THE COMMUNICATIVE ENVIRONMENT

Leudar (1981) proposes that the communicative environment (and opportunities) experienced by the learning disabled person differs from that experienced by the non-learning disabled person. Studies of communication development in children support this argument.

Hodapp (1997 cited in Rondal & Edwards, 1997) identifies that mothers style of interaction is more didactic, directive and possibly even intrusive to their learning disabled child in comparison to mothers of non-learning disabled children. Debates exist over the appropriateness of this style and the direction of causality e.g. whether this style of communicating is caused by the child’s lack of attentiveness or feedback, or being unable to initiate conversation (Field, 1987; Clark & Seifer, 1983 both cited
in Nind & Hewitt, 1994) or whether this lack of responsiveness by the child is a result of the adults style of communicating. Beveridge (1989 cited in Leudar, 1997) suggests that such a directive style may have a negative impact on the child’s communicative abilities as this style of communication does not necessarily change as the learning disabled child’s communicative competence grows. This didactic communicative style to PLD appears to continues into adult life from others’ in general (Vogel, 1987 cited in Rondal & Edwards, 1997).

Van der Gaag (1989) found that the pragmatic (rather than linguistic) communicative competence of PLD i.e. their ability to use language, was influenced significantly by whether they lived in a hospital or in the community. Although direct causality could not be assumed, they hypothesised that those living in the community had greater opportunity to communicate and were therefore using their communication skills more. The greater pragmatic competence meant that they were “more likely to initiate a conversation, describe recent events, ask and respond to questions, and give information.... maintain interest in a topic of conversation, take turns and use non-verbal communication skills more effectively” (1989:225).

This initial discussion suggests that others’ may provide a different communicative environment for PLD, which can impact on their communicative abilities. How might others’ expectations of PLD contribute to this?

WHAT ARE PEOPLE’S EXPECTATIONS OF PLD AND WHAT IS THE POTENTIAL IMPACT ON THE COMMUNICATIVE ABILITIES OF PLD?

“The expectations of non-handicapped individuals can have an important influence on the communication skills that the handicapped person actually uses” (Van der Gaag, 1989:222). Purcell, Morris and McConkey (1999) suggest that carers perceptions of PLD impacts on the communicative environment of PLD. We shall now see how inaccurate expectations/ perceptions of PLD, lead to carers failing to adjust their ways of communicating to maximise their partners communicative abilities; thus reducing communicative opportunities for PLD.
Unfortunately relatively little specific research or literature on what ‘others’ think of (or expect from) PLD exist (Hodgkinson, 1998). This is despite the growing awareness of the importance of the external environment on the communicative abilities of PLD (van der Gaag, 1993). Efforts to infer others’ expectations may be drawn from areas such as: government policies for PLD, principles such as normalisation, theories of communication development and observational studies of PLD.

**Changing attitudes and expectations in policy**

Within legislation we can see changing expectations of PLD. Gradually we have moved away from the belief that PLD are untrainable, needing to be protected from the larger world. The impact of this earlier view was that PLD were de-valued and segregated from society, which according to Wolfensberger’s principle of normalisation may have lead the original disability to be exacerbated. Indeed research at that time found hospitalisation a waste of a ‘persons potential’ (Clarke & Clarke, 1958) limiting their opportunities for communicative interaction.

Growing evidence in the 1950s about the potential of all levels of learning disability (Clarke & Clarke, 1958) plus enquires into the poor state of mental hospitals (Morris, 1969) led to a view that community care was more advantageous for PLD rather then segregation and hospitalisation. The Community Care Act (1990) emphasised the rights of PLD, that they should have greater say in their life planning and the input of services. PLD were beginning to be asked their views, reflecting an expectation that PLD are able to communicate their needs and that they are able to lead ‘normal’, functional lives within society.

**Theory of ‘normalisation’ and its misconception**

Principles of normalisation, expanded by Wolfensberger, were defined as “making available to the mentally subnormal, patterns and conditions of everyday life which are as close as possible to the norms and patterns of mainstream society” (Nirje, 1970:62)
The principles of normalisation, which is likely to have informed changing government policy has, however, been frequently misconceived. For example: some might expect that it is just about ‘making people normal’ and place too much importance on making PLD look normal and have a normal image (Brechin & Swain, 1988). Such misconceptions can lose sight of the individual’s special needs as a learning disabled person and may lead people to hold inaccurate or inappropriate expectations of PLD, to negative effect.

Strategies, such as ‘passing for normal’, reflect such misconceptions. ‘Passing’ was an attempt at impression management to make PLD appear competent, to create a positive image via controlling the content of interactions with others to make them as safe as possible (Goffman, 1963 cited in Edgerton, 1993). For example, only talking about things which the learning-disabled person felt safe with. Szivos and Griffiths (1992) argue that such strategies deny the reality of having a learning disability and advocate that PLD (and others) need to recognise their ability/ disability. In fact evidence suggests that when PLD try overly to present an image of competency, that they may well communicate less effectively (Kerman & Sabsay, 1997).

Bartlett and Bunning (1997) suggest that normalisation may be specifically misconceived as the “normalising of communication acts to adults with learning disabilities, even though it may involve an overestimation of their skills” (1997:149-150). They suggest that this may effectively create tension for carers who want to communicate age appropriately yet also support the learning-disabled persons efforts to communicate.

Misconceived, there is a danger of over-estimating the abilities of PLD, placing too much anxiety on the individual to appear competent and failing to recognise his/her individual needs.

**Expectations of carers**

Observed language variations in different syndromes suggest that there can be differences in the receptive and expressive communication skills of PLD. Chapman
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(1995 cited in Warren & Yoder, 1997) reported that children with Down's syndrome have much weaker expressive language skills, and strengths in receptive language and pragmatics and later vocabulary. People often rely heavily upon verbal abilities and may judge a learning disabled person's general capabilities on the basis of this, which may be inaccurate. For example, others may expect someone with Down's syndrome to have limited verbal comprehension on the basis of their limited expressive ability.

Many PLD can be quite adaptive, using external cues to understand verbal language from carers, and thus to some extent conceal their disabilities. For example, "we are going to the park now" is responded to not because of the words used but because the carer is pointing at the coat belonging to the person with learning disabilities. This may reflect the stage of communication development of the learning disabled person. In this example the individual has situational understanding (i.e. understands words, the intonation of voices in context) but has not acquired full verbal comprehension (Cooper, Moodley & Reynell, 1978). One can see how easy it may be for carers to begin to over-estimate the clients level of understanding, especially if carers are not sensitive to their own style of communicating i.e. their use of gestures, which according to McConkey, Morris and Purcell (1998 cited in Purcell, Morris and McConkey, 1999) they often are not. Verbal comprehension develops in stages, from situational understanding like this, to an understanding of key words in a phrase, to understanding some words out of context and so on. A learning disabled person may be at any one of these stages (Cooper et al., 1978).

The impact of high expectations of PLD and a failure to account for the special needs of PLD is illustrated in Keman and Sabsay's (1997) ethnographic study of adults with mild learning disabilities. Only on close examination and over time do others become aware of the incompleteness, and contradictions apparent in one clients (Carl's) seemingly articulate and interesting style of communication. Others might expect Carl to be much more able then he actually is, which leads to a pattern of miscommunication, anger and frustration in his communicative experience, negatively impacting on his self-esteem.
Expectations held by PLD

Although PLD have quite diverse experiences (Atkinson & Williams, 1990 cited in Van der Gaag, 1993) research suggests that they frequently share common, negative experiences, which may shape their own expectations about their ability to communicate and specifically their desire to interact and communicate (Van der Gaag, 1993). Experiences include rejection, broken attachments, victimisation and a lack of choice, opportunities and continuity in social support and relations. Van der Gaag (1993) suggests that a number of short term broken attachments may lead the individual to withdraw from forming new attachments or conversely to displaying over compensating, clingy behaviour, whereby the individual will put inappropriate amounts of energy into his/ her effort to communicate. Each of these strategies may be quite disruptive to the individual’s social interaction.

PLD have higher expectations of failure then the general population and have a tendency to internalise this failure, often giving up on communication when their listener does not understand (Loumides & Hills, 1997). Frequently, listeners will repeat what the learning disabled person has said, even when not necessary (Leudar, 1980) perhaps due to their expectation that they will not understand. This implies that what PLD say requires validation, which ultimately contributes to the individual’s poor self-esteem, motivation and confidence in their ability to communicate.

From a psychodynamic perspective, Stokes and Sinason (1992) suggest that PLD may exaggerate their handicap as a defence, to mask their anger and frustration. For example, Sinason (1986) refers to a client who exaggerated his ‘handicap’ so that people could hardly hear him. Rather then be the victim of his handicap, others where made to feel handicapped as they were not able to understand him; thus he regained some control. However Strokes and Sinason (1992) advocate that this type of secondary handicap may ultimately impede the development of the learning disabled person and mitigate against their needs being met (apart perhaps from their need to feel in control). Similarly Leudar, Fraser and Jeeves (1987) suggest that some PLD may withdraw as a means of gaining some control and ‘autonomy’ over a restrictive
environment. However, their efforts often lead them to be viewed by carers as behaviourally difficult, which deepen the communication problem further.

**Expectations of Clinical Psychologists**

Clinical Psychologist may continue to focus attention on changing the behaviour of the client, rather than looking at the problem as part of the system. The impact of this may be inappropriate and misguided interventions and poorer outcomes.

Clinical Psychologists' expectations of PLD are changing alongside those of society in general. Greater emphasis is being placed upon the expansion of therapies available to PLD to mirror mainstream culture e.g. the provision of psychotherapy (Stokes & Sinason, 1992; Beail & Warden, 1996) and Cognitive Behaviour Therapy (Kushlick, Trower & Dagnan, 1997) to PLD, reflecting our increased expectations of PLD to engage in therapy and benefit from it.

**SUMMARISING THE IMPACT OF OTHERS' EXPECTATIONS ON THE COMMUNICATIVE ABILITIES OF PLD?**

We have seen that others' expectations, which may impact on the communicative abilities of PLD can be influenced by misconceived principles, an inaccurate understanding of the individual's true abilities, a lack of awareness of one's own style of communicating and/or of the experiences of the learning disabled person.

Bartlett and Bunning (1997) refer to O'Brien's (1981) vicious cycle to explain the impact of these inaccurate expectations on the communicative abilities of PLD (Figure 1 and 2). Both too low and too high expectations lead to a reduction in the learning-disabled person's opportunity to communicate. For example carers' belief in 'a normal adult life' for PLD may lead to high expectations of the learning-disabled persons abilities. Opportunities provided by carers to engage in communication may be unrealistic, increasing the chance of the learning-disabled person experiencing failure in their communication. Bartlett and Bunning suggest that this leads to a restriction in the usage of communication by the learning disabled person, i.e.
withdrawal, but it may also increase the use of alternative communication methods that are less socially appropriate such as challenging behaviour. The result is the continued exclusion of PLD from an appropriate communicative environment, and ultimately a failure to meet the needs of the learning disabled person. This impact may be considered a secondary handicap for the learning disabled person.

**Illustrating the vicious circle of communication breakdown**

![Figure 1](attachment:image.png)
Purcell (1999) states that helping carers and others to adjust their expectations of PLD will help them to modify the nature and style of interacting with their clients.

**Interviewing PLD**

The impact of others on the communicative abilities of PLD also has implications for interviewing PLD, both within a legal and a therapeutic context.

**Legal Interviews**

It appears that PLD are often “victims of, witnesses to, and suspected of various crimes” (Bull, 1995:247). PLD are at a high risk of sexual and physical abuse (Turk & Brown, 1992) and in addition are over-represented within the population of those detained by police for questioning (Gudjonsson, Clare, Rutter & Pearce, 1993 cited in Bull, 1995). Although the Police and Criminal Evidence Act in 1984 acknowledged the need for special care when interviewing PLD, Irving and McKenzie (1993 cited in Bull 1995) cited the limited understanding within the police force about what learning disability actually means. In light of this, it is highly unlikely that they are aware of
the effect they may have upon the communicative abilities of their learning disabled interviewees.

Singh and Gudjonsson (1984) and Gudjonsson (1991) found that if PLD also feel incompetent or, importantly, if this is communicated to them during the interview, then he/ she may be more open to suggestive questioning. This may be equally compounded by the apparent power differential between the police and the learning disabled interviewee (Gudjonsson & Lister, 1984). Cahill, Grebler, Baker and Tully (1988 cited in Bull, 1995) investigated police interviews with PLD and found hazardous questioning which involved leading questions, police often upgraded the incomplete/ unclear response given by the learning disabled person and then asking if this upgraded version was right. PLD are highly likely to acquiesce. For example, they are likely to agree if a question is not fully understood, if they are unsure of the ‘correct’ way to answer but also as a means of seeking social approval (Shaw & Budd, 1982 cited in Leudar, 1997) or as an attempt to disguise their incompetence (Keman & Sabsay, 1997).

The impact of expecting PLD to interview in the same as individuals without a learning disability fails to attend to the special needs of the learning disabled interviewee. This may lead to considerable problems, such as false confessions, inaccurate or contradictory recall of information, high suggestibility on the part of the learning disabled person and potentially to continued abuse. Perlman, Ericson, Esses and Isacs (1994) states “perhaps the most important factor affecting vulnerability of developmentally handicapped (PLD) to abuse is that perpetrators perceive them to be less able to report abuse” (Perlman et al., 1994:172). Fundamentally this infringes on the legal rights of the learning disabled person.

Therapeutic Interviews

Interviewing PLD within a therapeutic/ assessment context can also be difficult, especially when we consider that many PLD have difficulty describing subjective feelings and emotions (Prosser & Bromley, 1998) plus the possibilities that their emotions may have been previously invalidated or not talked about. The impact of
not interviewing PLD may contribute to undermine/ disempower PLD. PLD may be able to provide useful insight into the cause of their behaviour not possible from carer’s information alone. The consequence of this may be inappropriate intervention, poor compliance from the learning disabled person and poor client satisfaction (Prosser & Bromley, 1998).

HOW CAN A CLINICAL PSYCHOLOGIST WORK WITH THESE ISSUES?

Working with challenging behaviour
Challenging behaviour is not a diagnostic term but refers to “behaviour of such intensity, frequency or duration, that the physical safety of the person or others is placed in serious jeopardy, or behaviour which is likely to seriously limit, or deny access to and use of ordinary community facilities” (Emerson, Cummings, Barrett, Hughes, McCool & Toogood, 1988:16). Three major forms of challenging behaviour exist, including aggressive/ destructive behaviour, self-injurious behaviour and stereotypy (Hastings & Remington, 1994). This essay will not focus upon specific forms, rather on challenging behaviour in general. Challenging behaviour presents serious challenges to service providers (Emerson, McGill & Mansell, 1994; Dept of Health, 1995) and is a frequently cited reasons for placement breakdown.

Theory of challenging behaviour as communication - explanation and evidence
One school of thought on challenging behaviour proposes that it has a communicative function, occurring when more acceptable means of expression fail (Durand, 1990), either because they are beyond the individual’s abilities or due to a lack of opportunity or external response/ reinforcement in his/ her environment (as considered earlier). Theories on challenging behaviour suggest that it is functionally equivalent to a verbal request (Donnellan, Mirenda, Mesaros & Fassbender, 1984) and may be referred to as ‘communicative behaviour’ rather then challenging behaviour (Chamberlain, Chung & Jenner, 1993). Research supports this theory, providing evidence that poor communication skills are linked with higher reports of problem behaviour and physical aggression (Bott, Farmer & Rohde, 1997; Gould, 1977). Challenging behaviour has been found to be more prevalent in severe and profound learning-
disabled people (Wing, 1989 cited in Chamberlain et al, 1993) where one might expect to find greater communication problems, although it is not exclusive to this level of disability.

Based upon the principles of positive and negative reinforcement, theories of challenging behaviour also suggest that it may be behaviourally maintained (Carr, 1977). Hastings and Remington (1994) report a number of intervention studies and empirical work to support the impact that others’ behaviour (specifically carers) may have on the development and maintenance of challenging behaviour of PLD, reporting that carers’ responses to challenging behaviour may be counter-habilitative. Such responses and limited or poor communicative interactions between carers and cared contributes to what McGill (1993) refers to the ‘challenging environment’.

Interestingly Beveridge and Hurrell (1980) found that over 50% of clients efforts to communicate were not responded to by carer; other studies found even higher figures (Cullen, Burton, Watts & Thomas, 1983).

Supporting these models, Derby, Wacker, Sasso, Steege, Northup,Cogrand and Asmus’ (1992 cited in Hasting & Remington, 1994) study found that the majority of clients’ challenging behaviour was maintained by serving some social function e.g. attention or escape.

Functional analysis of challenging behaviour
On the basis of this theory, a Clinical Psychologist may employ functional analysis to identify the function of this ‘communicative behaviour’ and to identify how this behaviour may have developed or is being maintained within the ‘system’. Possible communicative functions include access to desired events, escape from or avoidance of aversive situations/ events. There may not be a direct relationship between the topographical form of challenging behaviour and its functions, therefore the Clinical Psychologist must individualise the functional assessment and consider the possible multi-functional role of the behaviour (Toogood & Timlin, 1996). The Clinical Psychologist also needs to identify how other means of communication are failing in his/ her current communicative environment and also what conditions are associated
with low rates of challenging behaviour. Toogood and Timlin (1996) advocate the use of multiple assessment formats to obtain accurate information to guide intervention.

The functional analysis informs the intervention programme, which may involve the functional displacement of challenging behaviour, the modification of the environment to reduce the motivational bases for these behaviours and increase the motivational basis for alternative, appropriate behaviours. Achieving the latter often requires staff training.

Staff training
Clinical Psychologists need to be aware of possible mitigating factors within the system when designing the intervention. Emerson (1998) states “in many ways, teaching a functionally equivalent response to a service user may be considerably easier then ensuring that care staff continue to listen to and act upon alternative methods of communicating” (1998:149).

Weiner’s attributional theory of helping behaviour (1980) suggests that carers are more likely to take on board intervention programmes when they perceive that the client is not responsible or is not able to control their behaviour. However carers have a tendency to attribute the challenging behaviour as a problem within the client rather then see their own behaviours playing a role (Heyman, Swain, & Gillman, 1998). Fenwick (1995) suggests the need to address carers’ feelings and stressed the need for debriefing after displays of serious challenging behaviour.

Carers find dealing with challenging behaviour very stressful (Bromley & Emerson, 1995) and report experiencing a considerable amount of negative affect in dealing with such behaviour (Hastings, 1993 cited in Hastings & Remington, 1995). Considering the potential lack of support received by carers, which can lead to further stress and time constraints on communicative interactions (Bicknell, 1997 cited in Purcell et al., 1999) one needs to be sensitive and build rapport with carers and clients.
Applying cognitive behaviour therapy to carers may be beneficial in helping carers examine their own feelings and beliefs about clients and to learn about their own style of communication (Kushlick, Trower & Dagnan, 1997). Fundamentally trying to challenge beliefs that communication problems reside within the client alone to influence their interactional style with clients. In addition, staff training may help carers learn more effective ways to respond to early signs of communication and to create more positive opportunities for communication for the benefit of themselves and clients. This may benefit from Speech and Language Therapy (SALT) input i.e. in assisting carers in using signs/ symbols in a meaningful way and promoting consistency in their communication (Thurman, 1997). Kushlick et al. (1997) advocate the need to provide follow up support and/ or supervision to carers to prevent ‘new learners’ from giving up before they see the benefits of their new behaviour. Purcell et al. (1999) also advocates on-going monitoring.

**Multi-disciplinary approach**

Van der Gaag (1998) recommends a co-ordinated, multi-disciplinary approach to addressing the communicative needs of PLD. Specifically Clinical Psychologists and Speech and Language Therapists may work jointly when dealing with challenging behaviour. The role of the Speech and Language Therapist may not only be to provide the means to communicate but also to provide an accurate assessment profile of the communicative abilities of PLD, so that others get an accurate picture of the intrinsic skills of the individual and their strengths and weaknesses. This would contribute to more realistic carers expectations of PLD in an effort to reduce the mismatch between carer’s behaviour and client’s abilities.

**How effective are intervention programmes?**

As intervention should be aimed at the system, evaluation should not rely solely upon a reduction in the frequency and severity of the challenging behaviour. In addition, evaluation should identify the level of engagement between the client and carers and the client’s community involvement (Emerson et al, 1994). This way the Clinical Psychologist can determine whether there has been a change in the communicative
environment that may have contributed to the development or maintenance of the challenging behaviour.

There is no single explanation for challenging behaviour and hence there is no single approach (Thurman, 1997). It is important to note that sudden onset of challenging behaviour has often been linked to organic or psychiatric problems (Blunden & Allen, 1987 cited in Chamberlain et al, 1993), which should be ruled out when conducting the functional analysis. Other psychological interventions include: (1) Cognitive Behavioural Therapy, applied more to milder learning disabled clients often with mental health problems, or, as we have seen, with carers (Stenfort Kroese, Dagnan & Loumidis, 1997; Kushlick et al, 1997) and (2) Psychodynamic approaches (Stokes & Sinason, 1992). Although there is less literature regarding the latter in its application to challenging behaviour and learning disability, it can provide useful insight into the impact of their life experiences to aid psychological formulation (Bicknell, 1997 cited in Purcell et al., 1999).

Working with withdrawal
An approach that has focused heavily on changing the expectations and behaviour of carers to elicit communication from PLD is Intensive Interaction (Nind & Hewett, 1994). It is aimed at a very specific client group, namely severe to profound learning-disabled people who are pre-verbal and have withdrawn from social communication and interaction. Nind and Hewett (1994) developed intensive interaction after their personal lack of success and high carer turn over after applying more behavioural techniques with this client group. Intensive interaction is based on knowledge of the fundamentals of communication in infancy, aiming to identify the optimal parent-infant interaction style for development and learning and applying this to teachers’ interaction with PLD. The focus was the on ‘process’ by which communication and interaction was achieved rather then the physical outcome.

What is most notable from this approach is the focus upon influencing the quality of carer-client interactions by helping carer and others to adapt their “interpersonal behaviour to become more sensitive to subtle cues” (Nind & Hewitt, 1994:8) given by
clients. Thus the carer became responsible in essence for providing an environment where the individual feels safe and motivated to communicate and to positively reinforce the client’s subtle cues to “initiate, maintain or terminate interaction” (Nind & Hewitt, 1994:8). This approach helps carers promote clients in communicating and in valuing their efforts to do so.

**Critique of Intensive Interaction**

Intensive interaction may reflect a gentle teaching approach, which also focuses significantly upon the bonding process. Unfortunately controlled studies fail to suggest significant benefits from this approach, although it may be a useful adjunct to more structured interventions (Cullin & Mappin, 1998).

**Interviewing PLD**

Psychologists have worked with the police force to find the best methods to interview witnesses with learning disabilities (Bull & Cullen, 1993) alongside legislative changes such as videotaped interviews. Emphasis is placed upon educating the police about what learning disabilities are, challenging expectations that the learning disabled person is an unreliable witness and focusing on how the police can change their behaviour to help the communicative abilities of PLD. Tully (1988 cited in Bull, 1995) lists a number of hazards to avoid when interviewing PLD including acquiescence, confabulation, premature upgrading, overlooking information given and to avoid repeating questions after a response is given. Much research into this area is limited however due to small sample size, therefore we are unable to generalise findings e.g. the use of pictorial aids for children with mild learning disabilities (Seligman, Budd, Spanhel & Sehoenrock, 1981).

There is a spuracity of direct research concerning interviewing PLD. Clinical Psychologists could contribute to further research in collaboration with the police. Bull (1995) states that “clearly what is required is increased research on the skills needed by those who interview people with a learning disability” (1995:256). Research is also needed to help Clinical Psychologists conduct clinical interviews with PLD. Although some efforts have been made to develop new instruments to assess
emotional states in PLD (Matson, 1988 cited in Benson & Ivins, 1992) or adapt non-learning disabled norm-referenced questionnaires (Lindsay & Michie, 1988) further efforts are needed in this area to devise tools with relevant norms (Benson & Ivins, 1992).

**Working with the low expectations of the learning disabled person**

Although limited, some evidence does suggest that we cannot expect to change the communicative abilities of PLD without first addressing the communicative environment i.e. changing the expectations/behaviour of carers or primary communicative partners (Cullen, 1988). From this interactionist perspective, it is hoped that improving the communicative environment will have a long term knock on effect of increasing their success in communicative interactions, improving both communicative partners motivation to communicate and increasing self esteem and confidence of PLD. The ultimate aim would be to help PLD communicate their needs and equally enable carers to get more positive affect from their interaction with clients (e.g. reduction in challenging behaviour).

Brumfit (1985 cited in Van der Gaag, 1993) emphasised the importance of considering the emotional aspect of communication. Clinical Psychologists need to consider not only how the system currently contributes to the communicative abilities of PLD but also how past systems/ experiences have made an impact on the individual. Providing psychological formulations to carers may help them, for example attribute the clients challenging behaviour to external factors, rather than as within the clients control, increasing chance of helping behaviour/ commitment to intervention.

Many PLD do successfully engage in a variety of communicative interactions, maintaining friendships and relationships with family (Kernan & Sabsay, 1997). Many learning disabled people are “vibrant and highly motivated communicators” (Beveridge, 1997:143). Perhaps further research should try and identify factors of the communicative environment and the expectations of significant others where communication problems do not exist to help us inform psychological intervention where they do.
CONCLUSION

This essay has illustrated that effective communication is not the sole responsibility of the individual with a learning disability. We have seen how the communicative environment can influence the extent to which PLD use their communication skills. Others' behaviour, driven by inaccurate expectations, may reduce the opportunity for PLD to engage in communication, it may increase the chances of PLD failing in their communicative attempts and ultimately make us unable to meet the needs of PLD. At worst, it may lead to challenging behaviour, withdrawal or the continued abuse of PLD. Clinical Psychologists have a role, alongside other health professionals (such as SALT) to investigate and increase awareness of the impact other people have upon the communicative abilities of PLD, especially with management/ carers and the police. In addition, Clinical Psychologists have a distinct role including: - (1) providing functional analyses and interventions aimed at promoting a healthier communication environment i.e. to reduce challenging behaviour, increase carer/community- client interaction; (2) holistic evaluations of such interventions on the ‘system’; (3) staff training (CBT); and (4) researching best ways of interviewing PLD within a therapeutic and legal context.
REFERENCES


CHILD, ADOLESCENT AND FAMILY ESSAY

CRITICALLY EVALUATE PSYCHOLOGICAL THEORIES OF CHILD ABUSE AND THEIR CONTRIBUTION TO CLINICAL PRACTICE

December 2000

Year 2
INTRODUCTION

Since the recognition of child abuse as a social problem in the 1960s there have been numerous theories proposed to explain its aetiology. These theories guide clinical practice in terms of prevention/ intervention strategies and also influence social policy. This essay critically evaluates some of the major psychological theories of child abuse, including social learning/ cognition theory, attribution theory, and attachment theory and multi-factorial models of child abuse. The essay illustrates how theories of child abuse are moving away from a unitary focus, toward an understanding of child abuse as multiply determined and that both risk and compensatory aetiological factors require consideration. Strengths and weaknesses of each theory will be considered in turn, including their contribution to clinical practice in the prevention and intervention of abuse. Prevention strategies will be considered at each level: primary (societal changes), secondary (screened high risk families) and tertiary prevention (after abuse has occurred). Definitional and methodological difficulties in researching child abuse will also be discussed.

The importance of critically evaluating theory
Theories of child abuse need to be critically evaluated so that clinicians can be confident about intervention efforts. Newberger, Newberger and Hampton (1983) stated that: "an insufficient theory base may contribute more to the failure of programs to treat child abuse than the lack of intervention resources" (1983: 265). In addition uncritical acceptance of certain theories/ hypotheses has been highly detrimental in recent years. For example, uncritical acceptance of the intergenerational transmission of abuse lead one judge to refuse a mother custody of her child once it was known that she had been the victim of child abuse herself (Kaufman and Zigler, 1989 cited in Mash and Wolfe, 1991).

What makes a good theory?
According to Newberger, Newberger and Hampton (1983) a good theory must make sense, account for a significant part of the data available on child abuse and it must be useful i.e. guide future research and prevention/ intervention strategies.
Focus of the essay
Due to word limitation, this essay will focus upon theories of intrafamilial child physical abuse and also child neglect. An important point to make is that victims of child abuse are rarely subjected to only one form of abuse (Browne, 1988). For example, both physical and sexual abuse is accompanied by emotional abuse. Also many theories fail to distinguish between physical abuse and neglect.

Although the public and many professionals often use the term abuse, a review of the literature reveals that researchers frequently use 'child maltreatment', as illustrated in this essay. Maltreatment reduces the emotional impact of the term 'abuse' (Crittenden, 1988) and reflects the growing evidence that this issue includes several different conditions (Giovannoni and Becerra, 1979 cited in Crittenden, 1988).

DEFINITIONS, INCIDENCE AND GROWING AWARENESS OF CHILD ABUSE
Growing awareness of child abuse
Kempe, Silverman, Steele, Droegemueller and Silver (1962 cited in Buchanan, 1996) are credited with 'rediscovering' child abuse in a landmark paper, which led to the recognition of intentional physical abuse upon children as a social problem: 'the Battered Child Syndrome'. Lynch (1985 cited in Erickson, Egeland and Pianta, 1989) reported that papers on child abuse were written before this time, yet where not widely published or acknowledged. She suggested that society may not have been ready to accept the problem of child abuse existed.

It took a number of years before other forms of abuse were similarly recognised; firstly physical abuse (Kempe et al., 1962), then sexual abuse (Finkelhor, 1979) and then emotional abuse (Garbarino and Gillian, 1980 all cited in Browne, 1988). Initially, the consequences of abuse focused upon observable, physical effects. Only recently has attention turned to the serious psychological effects of abuse, including impairments to the sense of self and security, to social, emotional and cognitive functioning (Erickson, Egeland and Pianta, 1989). Garbarino and Vondra (1987 cited in Erickson et al., 1989), however, state that it is specifically these consequences that
characterise all forms of abuse. Clinicians working with children and families need to be aware how and why forms of abuse can be damaging to an individual’s growth and development and how abuse impacts upon their functioning throughout their life.

**Definitions of child abuse and the extent of the problem**

Researchers and practitioners in this field have long been 'dogged' by difficulties in defining child abuse (Buchanan, 1996). One of the main difficulties is illustrated by Giovannoni (1989) who considers how professional bodies define child abuse differently due to different purposes i.e. legal definitions, medical definitions, and researchers definitions. In addition the consequences of child abuse cannot always be seen and therefore is not easily quantified for definition purposes. Giovannoni (1989) advocates the need for more child-centred definitions and states: "a broken bone due to a physical attack may be a useful operational definition of child abuse, but from the standpoint of children, the consequences may be far more extensive, just as the experience itself, in its totality, reaches far beyond the broken arm," (1989:34).

The Department of Health (2000) provides definitions of child abuse as criteria for child protection registration in England and Wales (appendix 1). Physical abuse and neglect are defined as:

Physical injury - "Actual or likely physical injury to a child, or failure to prevent physical injury (or suffering) to a child, including deliberate poisoning, suffocation and Munchausen’s syndrome by proxy."

Neglect - "The persistent or severe neglect of a child or the failure to protect a child from exposure to any kind of danger, including cold and starvation or extreme failure to carry out important aspects of care, resulting in the significant impairment of the child’s health or development, including non-organic failure to thrive."

The lack of consensus over the definition of types of child abuse has lead to varying estimates of prevalence (Browne, 1998). To give an example of the extent of the problem, at least one to two children die each week due to child abuse in the UK (Central statistics office, 1994 cited in Browne and Herbert, 1997).
Health provide figures from investigating agencies that 4 in 1000 children are abused in the UK (1995 cited in Browne and Herbert, 1997). Such figures are considered the 'tip of the iceberg' as many cases of abuse go unreported (Audit Commission, 1994; Knutson and Selner, 1994).

**METHODOLOGICAL DIFFICULTIES IN CHILD MALTREATMENT STUDIES**

Child maltreatment research is a highly controversial area and as we have seen even fundamental questions have lead to methodological difficulties i.e. estimating the extent/ prevalence of the problem. Mash and Wolfe (1991) review methodological difficulties in child maltreatment research and highlight theoretical and definitional concerns, research designs issues, sampling considerations (bias and representativeness) and measurement difficulties. Additionally Mash and Wolfe (1991) highlight the difficulties putting theory into practice given the different agendas and requirements of professionals involved i.e. social services, the law, policy makers and health clinicians.

However Belsky (1993) advocates that criticisms of research into the aetiology of child maltreatment should be considered within the context of the difficult nature of the problem under investigation. Belsky states: "this field of inquiry is not concerned with easy-to-recruit, highly motivated, middle class families with well-organised lives who find it convenient and enjoyable to disclose much about themselves and their children. Rather, researchers in this area must rely on the co-operation of community and social welfare agencies, as well as the troubled and often highly defensive, transient and disorganised families that are most at risk for maltreating their offspring" (1993:414).

It is important that professionals are aware of different aetiological theories but also of their research base and consider their limitations due to methodological flaws such as that highlighted by Mash and Wolfe (1991).
THE 'INTERGENERATIONAL TRANSMISSION OF ABUSE WITHIN THE FAMILY' HYPOTHESIS

Psychological theories have frequently focused upon explaining the intergenerational hypothesis. Unequivocal support was originally attributed to this hypothesis regarding the intergenerational transmission of abuse i.e. that maltreated children are likely to become abusive parents (Steele and Pollock, 1968 cited in Kaufman and Zigler, 1989). However researchers have increasingly questioned the validity of these findings proposing sampling bias and lack of controls (Potts et al., 1979 cited in Herzberger, 1983), the use of non-representative samples and the use of observers who were not blind to the parents’ maltreatment history (Kaufman and Zigler, 1989) plus an over-reliance on retrospective reports (Belsky, 1993).

Kaufman and Zigler (1987, 1989) undertook prospective studies to investigate this hypothesis. Although Belsky (1993) argues that they failed to take into account the developmental age of the child or future external stressors, the study did provide evidence that two thirds of parents, maltreated themselves as children, did not abuse their child by aged 1. The intergenerational transmission of abuse is possible but far from inevitable. Kaufman and Zigler (1989) state that "being maltreated as a child puts one at risk of becoming abusive, but the path between these two points is far from direct or inevitable" (1989: 129). This essay will illustrate how psychological theories have adapted to explain the child abuse data and possible mechanisms of transmission of child abuse across generations.

EARLY PSYCHOLOGICAL THEORIES

Early psychological models presumed child abusers to be in some way 'deviant' (psycho-biological perspective) and much attention was paid to identifying the characteristics of the abuser, which made him/her different from the rest of the non-abusing society (Crittenden and Ainsworth, 1989) such as suffering from mental illness (Melnick and Hurley, 1969). Buchanan (1996) suggests that such attempts to pathologise and marginalise abusers may be quite an instinctive societal reaction to an event, which conflicts with the romanticised view of parent-child relationship.
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Societies adversity to child maltreatment is perhaps reflected by societies failure to acknowledge the problem for so many years.

Crittenden and Ainsworth (1989) state that as the incidence of child maltreatment grew, there was growing realisation that abusers were not easily distinguishable from non-abusers. This process of investigation may, however, have contributed to clinical practice by breaking down societal stereotypes of abuse and abusers. Whilst not condoning maltreatment, Browne and Herbert (1997) stress the importance of keeping a balanced perspective when dealing with child maltreatment. They state that pathologising the abuser “blinds us to their individuality and the essential normality (in the sense being commonplace) of some of their predicaments” (1997:42).

Main criticisms levied at such early approaches, in addition to the contradictory research evidence, was the lack of consideration of the actual social and family environment in which the maltreatment occurs.

SOCIAL LEARNING THEORY AND SOCIAL COGNITION
One of the most frequently cited mechanisms to explain child maltreatment and specifically the intergenerational transmission of child maltreatment comes from social learning theory (Bandura, 1977). Feshbach (1974 cited in Kaufman and Zigler, 1989) and Herzberger (1983) hypothesise that abusive behaviour and parenting may be transmitted by teaching the child that aggression is appropriate, via social learning principles including observation/ modelling, direct reinforcement, coercion training etc. (Belsky, 1993). Central to this theory is the belief that children learn rules that support the use of aggression and that the child is active and unique in perceiving abusive behaviour. Herzberger (1983) identified factors that increased the likelihood of a child learning such rules that included if the parent’s abusive behaviour was perceived as 'normal' i.e. if the abuse follows actual wrongdoing, or if accompanied by verbal rationalisations that substantiate the parent’s actions.

Evidence to support this theory comes from Kempe and Kempe (1976 cited in Herzberger, 1983). Clinical interviews highlighted that children who had been
physically abused reported their abusive care as proper and 'normal', blaming themselves for what they saw as punishment. In addition, Herzberger and Tennen (1983 cited in Herzberger, 1983) also found college students who reported being physically abused as children, perceived the abusive treatment of case presentations as less severe, appropriate and more reflective of the child's misbehaviour, than students who did not report physically abusive childhoods.

Such evidence needs to be considered tentatively however as it relies on students retrospective reports of their childhood treatment. Also this theory ignores the possibility that rationalising previous abusive experience from primary caregivers in childhood may in some way serve a function for the child such as a coping/ defence mechanism for the child. This theory does offer one explanation why so many children do not disclose parental abuse.

Herzberger (1983) concludes that a social cognition theory of child abuse needs further empirical investigation, especially possible compensatory factors. For example Herzberger (1983) advocates the need to consider further the impact of the child's exposure to other styles of discipline. Herzberger acknowledges that social cognitions are not the sole determinant of abusive practices and calls for further research to consider its place within the current literature i.e. other theories.

Strength of Herzberger's theory (1983) is that it considers the impact of the wider system not only the family. She suggests that societies attitudes to physically disciplining children may lead to 'consensual validation' of abusive practices. This theory advocates for the primary prevention of child abuse through challenging societies acceptance of violence and the justification of its uses (Feshbach, 1980 cited in Herzberger, 1983).

Further family interventions informed by this theory may be aimed at the secondary level (screened high risk families) or the tertiary level (after the child has been maltreated) of abuse prevention. Such interventions assume that children and parents "can be taught to eliminate their maladaptive behaviours by changing external contingencies and by challenging their irrational beliefs and faulty logic; also by
encouraging them to instruct themselves in certain ways" (Browne and Herbert, 1997:155). Clinical interventions include self-control procedures (Meichenbaum, 1985) and anger management programmes (Novaco, 1975). This theoretical framework has contributed much to the Webster-Stratton parenting groups, which utilises a collaborative approach to help prevent abusive practices in high-risk families such as when the child has conduct disorder (Webster-Stratton and Herbert, 1994).

**ATTRIBUTION THEORY**

To fully understand the parental process that may contribute to child maltreatment, Newberger and White (1989) considers the "cognitive dimensions of influence on the development of parental care" (1989:303) specifically parents beliefs, attitudes, attribution and expectations of the child. Rather then focus upon the behaviour of the child or the characteristics and abilities of the parent, Newberger and White (1989) considers how the parent perceives the child's behaviour.

Newberger and White (1989) hypothesise that abusive parents will ascribe negative attributions to their child’s behaviour more so then non-abusing parents i.e. abusive parents will attribute child breaking something due to badness rather then tiredness. This may be due to the child having more health problems, eating or sleep disturbances (Browne and Herbert, 1997) or as a result of parents holding unrealistic expectations of the child (Rosenberg and Reppucci, 1983 cited in Newberger and White, 1989) or a mixture of both.

Browne and Saqi (1987) provide evidence to support Newberger and White's hypothesis. They found mothers under stress required some degree of negative attributional style toward their child before becoming abusive. Such research however fails to consider fathers. Newberger and White (1989) provide further mixed evidence supporting this hypothesis (Siracusa, 1985 cited in Newberger and White, 1989) and against this hypothesis (Rosenberg and Reppucci, 1983 cited in Newberger and White, 1989). They argue that the latter research may have failed to find significant differences due to the differing nature of the control group, which included non-abusive mothers but who had been receiving help in controlling their child’s
behaviour. This may illustrate that a negative attributional style is not 'enough' to explain child maltreatment but perhaps merely indicates parenting difficulties.

Nevertheless parental causal attributions have been considered one of the important early indicators of potential child maltreatment practices (Weihe, 1987 cited in Newberger and White, 1989) and should be an important part of the clinician's initial assessment of the parent-child relationship (Browne and Herbert, 1997). By assessing deeper levels of cognitions, clinicians may be able to learn about how the parent interprets the child's behaviour, enabling the clinicians to have a better understanding of the underlying reasoning for parental decisions and consider the likelihood of abusive practices occurring (Newberger and White, 1989). In addition, Browne and Saqi (1987) suggested that positive perceptions held by parents might act as protective factors in preventing abuse, despite the presence of risk factors.

Newberger and White (1989) stresses that a cognitive approach merely aims to elaborate a 'critical dimension' of parental functioning or dysfunction, which has implications for parental care. Similar to Herzberger (1983), they advocate that their focus is just one part of the broader picture, which needs to be integrated into the knowledge base of child abuse.

ATTACHMENT THEORY
Developed out of psychoanalytic thinking, attachment theory originates from the work of Bowlby (1953, 1979, 1984 all cited in Buchanan, 1996). The assumption that children are predisposed to form attachments during infancy has considerable importance to the study of child abuse (Browne and Herbert, 1997). The early attachment relationship between infant and primary carer-giver functions as an innate survival mechanism from which the infant interacts and learns about his/her world and others (Ainsworth, 1967 cited in Crittenden and Ainsworth, 1989). Early attachments are viewed as crucial to the child's social, language and cognitive development (Crittenden and Ainsworth, 1989). This view contributes to understanding the wide-ranging consequences, which have been reported after parental child maltreatment (Erickson, Egeland and Pianta, 1989).
From this early attachment, the child develops unconscious inner working models which influences the child's sense of self and significant others, and is fundamental in creating the child's expectations about future relationships. This early attachment experience provides a model for future relationships (Crittenden and Ainsworth, 1989) as the inner working model tends to become a "self fulfilling prophecy as others react to the child's expectations of how they will behave" (Howe, Brandon, Hinings and Schofield, 1999:26) and the child assimilates new relationships to fit his/her inner model (Zeanah and Anders, 1987 cited in Buchanan, 1996). Sroufe (1993 cited in Buchanan, 1996) provided evidence to support this assumption. Previously identified securely and anxiously attached infants re-created relationships with teachers in line with their early child-caregiver attachment experience. Of interest were the fundamental differences that were evident in the expectations children brought to new relationships who were abused or neglected. Abused children expected others to be 'rejecting, hostile and unavailable', whilst neglected children expected others to be 'unresponsive, unavailable and unwilling to meet his/her needs'. Unlike other theories of child maltreatment, attachment theory does distinguish between child abuse and child neglect.

Attachment theory hypothesises that an unsatisfactory early relationship and a failure to form a secure attachment is a critical concept in understanding child abuse and its intergenerational transmission (Crittenden and Ainsworth, 1989; Bowlby, 1984). Egeland, Jacobvitz and Sroufe (1988) state that “infants whose needs have not been appropriately met develop expectations that care is not available and others cannot be trusted and, as adults, are more likely to have difficulty entering into supportive relationships with others and providing adequate care for their offspring” (1988:1080).

Thus Crittenden and Ainsworth (1989) argue that anxious attachments, as critical concepts for understanding child maltreatment, are sufficiently focused to inform clinical practice, unlike multi-factorial and ecological theories (discussed later). Rather than focus upon the poor social conditions, which may precipitate child maltreatment, Crittenden (1984, cited in Buchanan, 1996) states that by knowing
about the nature of family attachments, clinicians might be better placed to identify those most vulnerable to external stresses.

There is considerable evidence that physically abused children are anxiously attached to their parents (Crittenden, 1985). Further evidence to support this hypothesis comes from investigations using Ainsworth's 'strange situation' (Crittenden, 1985) and non-laboratory evidence (Crittenden, 1983 cited in Crittenden and Ainsworth, 1989). However there is also evidence to suggest that despite abuse, some abused children can be resilient to this experience and are securely attached (Browne and Saqi, 1988).

To incorporate this data, attachment theory proposes that certain experiences may influence or modify 'inner working model' to enable more secure attachments being made and breaking the intergenerational transmission of abuse. Such experiences include a relationship with a supportive, non-abusing adult during childhood, therapy and/or an emotionally supportive partner in adulthood (Egeland, Jacobvitz and Sroufe, 1988). Also the notion of resolving past abusive experience was found important in breaking the cycle of abuse (Egelando et al., 1988; Hunter and Kilstrom, 1979). Of clinical interest, Egeland et al. (1988) highlighted that abusive mothers who had been abused as children, had a tendency to dissociate their feelings from their memories of their own abuse. This splitting (Sullivan, 1953 cited in Egeland et al., 1988) may be a crucial concept in the intergenerational transmission of abuse and has considerable implications for clinical practice in terms of the need for psychotherapy for individuals who are victims of abuse and who have not experienced compensatory factors considered by attachment theory. This concept undoubtedly requires further empirical research.

In acknowledging that attachments are dynamic and changeable and that compensatory factors can influence the 'inner working model', attachment theory provides an explanation for the conditions and mechanisms under which child abuse may or may not be transmitted from one generation to the next. Belsky (1993) advocated this as the main strength of attachment theory, considering both risk and compensatory factors.
Crittenden and Ainsworth (1989) advocate the advantages of attachment theory in explaining child abuse, including: (1) it enables current knowledge to be integrated around a single concept to inform intervention; (2) it distinguishes between child abuse and neglect; (3) as a developmental theory, it is sensitive to the "differences in the nature and effect of anxious attachments at different stages of development, which is vital to the development of appropriate diagnostic and treatment procedures" (1989:330); (4) it is not an exclusive, static concept but enables the family perspective and environmental factors to be considered in influencing the ongoing development of attachments; (5) attachment theory produces specific hypotheses that be empirically tested; and (6) it provides a rationale for explaining intergenerational transmission of maltreatment and how this cycle can be prevented with intervention. The concept of attachment and its importance to child maltreatment is illustrated in its presence in government policies i.e. Quality Protects Programme (1998).

In terms of its contribution to clinical practice, attachment theory advocates the early detection of attachment disorders in parents and children, the assessment of poor attachments in high-risk families and intervention with abusive families to support the development of more secure attachments (DeLozier, 1982). Buchanan (1996) states that "reworking of existing poor quality models of attachment relationships would appear important for preventing the intergenerational transmission of child maltreatment. The establishment of un-idealised reflections for their early experience would appear to be a pre-requisite for the creation of future positive relationships," (1996:102). In contrast to social learning theories, attachment theory advocates the need to address early childhood issues rather than focus purely on the here and now. Children and parents who have been victims of abuse may benefit from psychotherapy to help them resolve their experiences and prevent splitting, especially in the absence of compensatory factors i.e. significant supportive relationship with at least one adult in childhood and/or emotionally supportive adult relationship.

Main criticisms of attachment theory is its failure to consider wider contextual issues (Buchanan, 1996) such as the influence of societal attitudes. Crittenden and Ainsworth (1989) argue, however, that accepting attachment as an ongoing developmental task
that may sustain transformations allows for the influence of external factors. However, further investigation may be necessary in determining the impact of such factors on the ongoing development of attachments in childhood and adulthood. Further criticisms of attachment theory is that it focusing too heavily upon mother-child attachments and does not considering father-child and sibling attachments and their relative importance.

RECOGNITION OF CHILD ABUSE AS MULTIPLY DETERMINED – MOVE TOWARD MULTI-FOCUS MODELS

There has been growing acknowledgement in recent years that single-focus psychological models may not adequately explain the available data on child abuse. Indeed Browne and Herbert (1997) suggest that simple explanations of child abuse make the solution to this pervasive and complex problem appear too easy. Through out this essay, it has been demonstrated how psychological theories of child abuse acknowledge the contribution of 'other' risk and compensatory factors. For example, attachment theories consider compensatory factors that may enable the individual to re-model their inner working model to break the cycle of abuse. Belsky (1993) argues that focusing upon specific factors in the aetiology of child maltreatment as 'main effects' is perhaps the cause of the sporadic findings in the literature. Instead Belsky (1993) argues that the focus should be upon the transactional process involving characteristics of the child, parents and the family and wider context.

According to Belsky (1993) acknowledging that abuse is actually multiply determined (although disappointing for predictive purposes), is vital for clinical practice as it acknowledges there is no single solution to child abuse. Many targets may be appropriate to focus intervention but in addition it highlights how directing clinical efforts at a single target is not likely to be successful in the long term (Belsky, 1993). Belsky gives the example of providing parenting training without consideration of the very poor economic and socially isolated conditions in which the family live is unlikely to prevent maltreatment in the long term (Belsky, 1993). His theory suggests that intervention efforts should be multiply targeted before success may be evident.
(Belsky, 1993); this would require a multi-disciplinary approach and social policy initiatives.

There has been a gradual recognition also at a legislative level that the approach to child maltreatment needs to be much broader and recent initiatives of professional agencies turned to 'joined up thinking' and collaborative work i.e. Quality Protects Programme (1998).

A multi-focus model
In an effort to integrate the divergent aetiological viewpoints from psychology and other fields, Belsky (1980) devised an ecological model of child maltreatment. Other models that have attempted this include Garbarino (1979) and Frude (1989 cited in Browne and Herbert, 1997).

Drawing heavily upon the work of Bronfenbrenners (1977 cited in Belsky, 1980) model of the ecology of human development, Belsky's (1980) integrative model considers four levels of analysis which: "subsume almost all of the factors and explanations that have been posited in efforts to account for the aetiology of child abuse and neglect" (1980:321). Belsky advocates that understanding and predicting child maltreatment will only be possible when the dynamic process through which it occurs in practice is detailed explicitly. Belsky four level of analysis are listed in table 1.

Table 1 Belsky's (1980) levels of analysis of child abuse

<table>
<thead>
<tr>
<th>Level</th>
<th>Consideration at this level</th>
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<tbody>
<tr>
<td>1. Ontogenic development</td>
<td>What the individual, abusive parents bring to the family setting and development parenting role</td>
</tr>
<tr>
<td>2. Microsystem</td>
<td>The immediate family setting in which the abuse takes place</td>
</tr>
<tr>
<td>3. Exosystem</td>
<td>The larger social system beyond the family but in which it is embedded</td>
</tr>
<tr>
<td>4. Macrosystem</td>
<td>Societies attitude toward violence and children</td>
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Belsky's (1980) model was effective in drawing together a considerable amount of research and literature into child maltreatment into an integrated, comprehensive model and demonstrating how factors both within and outside the family may interact and lead to child maltreatment (Buchanan, 1996). He argued that the integrated model might help guide future research and investigation. For example, Belsky did not believe that the current research base was sufficient to detail the necessary and sufficient conditions for child maltreatment, but that this model provided a "variety of testable predictions concerning the dynamic process through which child maltreatment occurs," (1980:330). Belsky admits however the statistical difficulties in the type of research required for this analysis.

In terms of its contribution to clinical practice it highlights some of the crucial aspects for consideration for risk assessment and may help clinicians organise the complex information they receive in clinical practice (Newberger, Newberger and Hampton, 1983). Clinically formulating child maltreatment multi-factorially may provide a constructive, less stigmatised approach to intervention i.e. not one focus of blame.

Olds (1978 cited in Belsky, 1980) and Olds and Henderson (1989) addressed the usefulness of the ecological model in the primary prevention of child maltreatment. Olds and Henderson (1989) researched the effectiveness of a programme which entailed specially trained nurses intervening in the initial 3 levels suggested by Belsky's (1980) model. The role of the nurse is quite vast and potentially unboundaried, varying from educational, recruiting family members to support the mother, promoting informal social supports and maximising social services support and liaising between the family and formal and informal support.

Of interest is the Ontogenic development level is used as the identifying factor for targeting prevention strategies/ intervention. In this sense care must be taken not to stigmatise or marginalize certain groups within society i.e. single mothers and the poor as 'potential abusers'. Also of concern is the inclusion of moral judgements in such programmes i.e. Olds (1978 cited in Belsky, 1980) advocated the role of the nurse in helping the mother to give up smoking, drinking and maintaining healthy eating.
In its practicality Olds and Henderson's (1989) research highlighted the usefulness of the home visitation in prevention programmes. If done properly it facilitated reaching vulnerable parents who may lack self-confidence or trust in formal agencies. In addition, home visitations enable a more thorough understanding and assessment of the home environment and social support system. To be achieved, this requires a considerable amount of interpersonal skills on behalf of the clinician involved and legally very clear boundaries with the parents regarding confidentiality i.e. if parents disclose harming their children.

Crittenden and Ainsworth (1989) criticise multi-focus models such as Belsky's (1980) as 'infinitely complex' to the extent that it makes its applicability to clinical practice 'unrealistic'. Indeed Buchanan (1996) states that due to the size and complexity of the model, the model and any intervention it initiates is difficult to test empirically. However it does highlight the varying levels of influence in child maltreatment and possible levels of prevention and intervention and thus the need for a multi-disciplinary, broad approach including legislation.

OTHER THEORIES WHICH PROVIDE HELP IN UNDERSTANDING CHILD ABUSE

Although more sociological in its perspective, the feminist theory of child abuse makes a significant contribution to clinical practice in considering the role of unequal power between the abuser and the child and the helplessness of the victim, other family members and barriers to disclosure. Clinicians need to consider the perceived and actual power differentials within the abusive family when conducting assessments/ interventions.

Criticisms to this theory include its minimisation of psychological and motivational contributory factors. In addition, it does not allow the child who feels abandoned and betrayed by his/her parents or significant other to express such feelings in therapy and may also deny the fact that many children are highly resilient and courageous in
surviving abuse (demonstrating power). The feminist perceptive may actually contribute to the stereotype of viewing women as powerless.

FUTURE AREAS OF RESEARCH IN CHILD MALTREATMENT

Buchanan (1996) critiques current research into child maltreatment and argues that too much current research relies on post-abuse families, therefore suffering from sampling bias (only representative of those abusive families that come to the attention of professional agencies). Despite efforts such as Olds and Henderson (1989), she argues that too little research has focused upon primary and secondary preventative strategies. She advocates that one of the future research challenges may be to identify those at risk, improve ways of mediating risk and promoting protective mechanisms and developing improved methods for evaluating outcome of preventive approaches. Although Belsky (1993) questions whether society, in general, is ready to undertake such initiatives. In addition, Buchanan (1996) argues that research has neglected the role of fathers and the majority of research originates from the west, therefore may not be generalisable to other cultures.

EFFECTIVENESS OF THEORY DRIVEN INITIATIVES

Although beyond the scope of this essay further consideration may be given to the efficacy of theoretically driven treatment initiatives provided by Psychologists and other clinicians. Difficulties at this level of enquiry are that many psychological interventions are not driven by one theory. For example one of the dominant treatment initiatives provided by Psychologists, the Webster-Stratton Parenting group, although founded in social learning/cognition theory, also draws upon other theoretical influences. For example, it emphasises efforts to change parents attributions of the child's past and current behaviour (attribution theory) and also advocates the therapist provide a supportive relationship with the parents to heighten the parents' sense of security (attachment theory). Given the criticisms to single focused theories of child abuse, this tendency is not surprising.
CONCLUSIONS

The contribution of the Clinical Psychologist and consideration of theories of child abuse

The Department of Health (2000) identified the role of the Psychologist in contributing to the core assessment of families and to offer a range of support services to both children in need and their families. Psychologists appear to contribute most to secondary and predominantly tertiary levels of prevention. However some theories can contribute to focusing primary prevention efforts i.e. social cognition theory and ecological models. In summary, this essay concludes that psychologists need to be holistic in their assessment and intervention to consider early experiences, early and current attachments, parental attributional style, cognitions and compensatory, protective factors in both screening and intervention stages. Also Psychologists need to be sensitive to unequal power differentials within families, consider factors that may prevent disclosure of maltreatment and their legal responsibilities within the therapeutic relationship.

Critical evaluation of theories of child abuse

This essay has considered some of the main psychological theories of child abuse. It has illustrated that no theory alone currently provides an empirically validated, adequate explanation of child abuse. Attachment theory as a developmental theory may provide a degree of explanation regarding the current data on child abuse in the sense that it can theoretically account for the transmission and non-transmission of abuse across generations. Yet this requires further research. Crittenden and Ainsworth (1989) state the need to test out a range of attachment theory derived hypotheses, not to prove attachment theory but to determine whether it is any more effective then other theories in explaining child abuse.

Difficulties drawing conclusions from this essay and difficulties researching this field illustrate the complexity of the problem itself. It appears that recognising child abuse as a multiply determined social problem is the first step in recognising the complexity, recognising there are no easy solutions and recognising the need for multiply targeted prevention strategies at a number of levels. Ecological models may go some way in integrating diverse theoretical points of view and viewing child abuse as multiply
determined but its intervention strategies are too broad for empirical validation. Some of the most clinically useful ideas have come from theories, which have advocated protective and compensatory factors in the prevention of child maltreatment. A major step forward clinically will be when vulnerable parents can ask and receive help before being labelled abusive. Buchanan (1996) states this is a challenge for all clinicians working in this field.

In conclusion, clinicians currently need to address child maltreatment from the individual, interactional and environmental level and to develop strategies which are relevant to each case drawing upon a variety of frameworks available but taking into consideration theoretical and research strengths and weaknesses. The main conclusions are the need for more research and for clinicians to remain aware of gaps in our knowledge base. Further research is required on protective and compensatory factors in child maltreatment in both the short and long term, research on fathers, other cultures and the different types of maltreatment.
REFERENCES


APPENDIX 1

Definition of different types of child maltreatment

Definition of child abuse for child protection registration (Department of Health, Education and Science, the Home office and Welsh Office, 1991). Taken from the joint document 'Working together under the Children Act" cited in Browne and Herbert (1997:114)

Neglect
"The persistent or severe neglect of a child or the failure to protect a child from exposure to any kind of danger, including cold and starvation or extreme failure to carry out important aspects of care, resulting in the significant impairment of the child's health or development, including non-organic failure to thrive."

Physical injury
"Actual or likely physical injury to a child, or failure to prevent physical injury (or suffering) to a child, including deliberate poisoning, suffocation and Munchausen's syndrome by proxy."

Sexual abuse
"Actual or likely sexual exploitation of a child or adolescent. The child may be dependent and/or developmentally immature', where 'sexual exploitation' represents the involvement of dependent, developmentally immature child and adolescents in sexual activities they do not truly comprehend, to which they are unable to give informed consent or that violates social taboos of family roles," (Kempe and Kempe, 1978 cited in Browne and Herbert, 1997).

Emotional abuse
"Actual or likely severe adverse effect on the emotional and behavioural development of a child caused by persistent or severe emotional ill-treatment or rejection." All abuse involves some emotional ill treatment. This category is used where it is the main or sole form of abuse.
OLDER ADULT ESSAY

DISCUSS THE USE AND EFFECTIVENESS OF CBT FOR EMOTIONAL DISORDERS IN PEOPLE WITH DEMENTIA

Year 2

June 2001
Academic Dossier - Older Adults Essay

INTRODUCTION
Cognitive behaviour therapy (CBT), developed from Beck's (1967, 1976) cognitive model of depression, is a well-established, evidence-based, psychological treatment for emotional disorders. Yet there remains very little research or written accounts of the application of this approach with older adults (over 65 years), nor specifically in treating older adults with co-existing emotional disorders and a dementia. With increasing emphasis on a person-centred approach within dementia care (Kitwood, 1997; Cheston, 1998) there is a growing interest in the emotional needs of people with a dementia and how psychotherapeutic approaches, such as CBT, can be applied to reduce the distress and additional disability caused by the emotional disorder. This essay examines the application of CBT with people with co-existing dementia and emotional disorder (Teri and Gallagher, 1991; Thompson, Wagner, Zeiss and Gallagher, 1990; Grant and Casey, 1995) and considers how CBT has been modified to compensate for cognitive impairment and how the clinician might address 'realistic' negative thoughts (Moorey, 1996). In light of the need for evidence-based practice, advocated by the recent National Service Framework for older adults (2001), the research evidence for using CBT with this client group will also be examined.

Although other emotional disorders, such as anxiety, may also co-exist with dementia (Koder, 1998), most of the literature focuses upon the prevalence, impact and treatment of depression in dementia. For this reason, this essay will focus upon the application of CBT for depression.

WHAT IS DEMENTIA?
Dementia is an irreversible and degenerative illness, currently with no known aetiology or cure. According to DSM-IV, a dementia is progressive in nature and is characterised by memory loss and a persistent impairment of two or more psychological functions, such as: language, visuo-spatial skills, judgement, abstract thinking or personality (Cummings and Benson, 1992 cited in Kaszniak and Christenson, 1997). There are numerous causes of dementia including: (1) Degenerative illnesses such as Alzheimer's disease, Parkinson's disease, Lewy body dementia; (2) Vascular causes such as multi-infarct dementia; and (3) Infective causes
such as AIDS and Creutzfeldt-Jakob disease. Morris (1999) states that the profile of decline, in terms of cognitive, behaviour and personality changes, may differ not only between illnesses but also within an illness, such as Alzheimer’s disease. This illustrates that people with a dementia do not necessarily present as a homogenous group. Therefore individual assessment and treatment planning is vital to meet the individual’s needs.

Prevalence of dementia
According to the Alzheimer’s disease society (1996 cited in Woods, 1996), there is an estimated 700 000 people in the UK suffering from a recognised dementia. Alzheimer’s disease is the most common form of dementia in older adults, found in about 5% of those aged over 65 years and 20% of those aged over 80 years (Cross and Gurland, 1986 cited in Teri and Wagner, 1992). As life expectancies increases in Western society, the prevalence of dementia and associated difficulties is likely to rise, which poses significant challenges for older adult services and the need for effective treatment initiatives with this population.

Prevalence of emotional disorders in older adults with a dementia
Teri and Wagner (1992) state that historically, dementia and depression have been viewed as ‘mutually exclusive’ and attention has focused upon differentiating them. Although such distinctions are crucial it is important to acknowledge that depression and dementia may co-exist. Depression may occur as a secondary condition to the dementia or as a recurrence of a depressive episode that predates the dementia (Warrington, 1997). Teri and Reifler (1987) estimated that as many as 30% of people with Alzheimer’s disease also meet the DSM-III criteria for major depression. The prevalence of depression in a dementing population has been found to be greater than the prevalence of depression in: (1) a non-dementing older adult population (Wragg and Jeste, 1989 cited in Murphy, 1986); and (2) medically ill, older adult, outpatient population (Rovner, Broadhead, Spencer, Carson and Folstein, 1989). Consequently, depression is a significant problem for many people with dementia and this provides a strong argument for the development and utilisation of treatment approaches, such as CBT.
Difficulties diagnosing depression in someone with a dementia
Difficulties arise in diagnosing depression in people with a dementia due to the shared symptomatology of the two conditions. Loss of motivation and energy, changes in sleep and appetite, agitation and poor concentration may be features of both disorders (Warrington, 1997). This makes the use of clinical inventories, often useful for screening purposes, contentious. Teri and Wagner (1992) state that “existent measures can identify the presence of specific symptomatology, but they cannot clarify its cause” (1992:381) i.e. whether the symptom is a product of the primary disease, the dementia or whether it is a result of a co-existing depression. The use of psychometric measures is also questionable because of the lack of normative information on the use of such measures with an older adult, dementing population. In an effort to address this, some measures of depression have been specifically designed for this client group, such as the Cornell Scale for Depression in Dementia (Alexopoulos, Abrams, Young and Shamoian, 1988). However, Kasznick and Christenson (1997) state that the clinical interview remains the main tool in diagnosing depression in people with a dementing illness. Warrington (1997) advocates the importance of a multi-disciplinary, holistic assessment to obtain information about the onset and nature of possible depressive symptoms.

A further difficulty in the diagnosis of depression in older adults is that older adults tend to report more somatic complaints that dysphoric mood (Benedict and Nacoste 1990). Kaszniak and Christenson (1997) argue that this pre-occupation may result in depression being overlooked.

The nature and impact of co-existing depression and dementia
Kaszniak and Christenson (1997) state “the failure to diagnose and treat depression in an Alzheimer’s disease patient may result in un-necessary emotional, physical and/ or social discomfort,” (1997:84). Depression in people with a dementing illness has been found to cause excess disability, that is, disability beyond that, which can be explained by the primary disease (Kahn, 1975 cited in Teri and Wagner, 1992). Clients with co-existing dementia and depression may experience excess disability in terms of additional behavioural and functional difficulties. For example, Rovner et al. (1989)
found dementing patients who suffered depression were more cognitively impaired and more disabled, in terms of self-care, than dementing patients who did not suffer depression. Research suggests that dementing clients with depression present a greater risk to themselves due to increased risk of falling (Reifler, Larson and Teri, 1987) and increased suicidal ideation (Teri, Baer and Reifler, 1993) and are more likely to be dependent upon carers/services due to greater impairments in daily living skills (Pearson, Ross, Lohr, Rovner, Chase and Folstein, 1990) than non-depressed, dementing clients.

In addition, depression in dementia patients has been found to have a significant, negative impact upon the well being of their carers. Carers are more distressed by their patients' emotional symptoms such as crying and depression (Greene, Smith, Gardiner and Tombury, 1982 cited in Teri and Wagner, 1992) than any other behaviour, including increasing impairments in daily living skills.

Thompson et al. (1990) argues that if patients with coexisting depression and dementia can “achieve relief from psychological problems, they might function at a more optimal level for a longer time, which would probably increase quality of life for both the patient and the family” (1990:385).

**Treatment interventions for depression in older adults with dementing illness**

So far, it has been illustrated that a significant number of people with a dementia suffer from depression and this depression leads to excess disability. Yet despite the need for effective treatment, there are very few studies on the treatment of depression in people who have a dementia (Teri and Wagner, 1992).

*Pharmacological treatment of depression for people with a dementia*

Anti-depressant medication has been shown to be beneficial in the treatment of depression in people with dementia, improving mood, functional abilities and even cognitive functioning (Greenwald, Kramer-Ginsberg, Marin et al., 1989; Reifler, Larson, Teri and Poulson, 1986 both cited in Kasznick and Christenson, 1997). Kasznick and Christenson (1997) argue however that the evidence for the use of
pharmacological treatments is largely based on uncontrolled clinical trials and thus the efficacy of this approach remains to be shown. In the only controlled study, antidepressant medication did improve levels of depression in people with co-existing depression and dementia, but this improvement was not greater than the placebo control (Reifler, Teri, Raskind, Veith, Barnes and White, 1989).

Of additional concern is that some anti-depressant medication may be contraindicated for some dementing clients as they have an anti-cholinergic effect, which might further exacerbate cognitive impairments (Thompson et al., 1990). Although newer drugs have fewer side effects (Warrington, 1997), the lack of empirical evidence and the possible side effects of pharmacological treatments suggest that alternative treatments need to be considered.

**Barriers to older adults receiving/accessing psychotherapy**

Historically older adults have under-utilised mental health services (Emery, 1981). Possible reasons why psychotherapy, such as CBT has been applied less to this population include: (1) Assuming that older adults would not find therapy 'acceptable'; and (2) assuming older adults lack the pre-requisite skills needed to use therapy meaningfully.

Grant and Casey (1995) state that older adults have often been viewed as 'poor psychotherapy candidates'. It is likely that this view stems from Freud, who argued that people over the age of 50 did not have the 'elasticity of mental processes' and were too rigid in their thinking to be able to benefit from psychotherapy. Grant and Casey (1995) argue that as a result of Freud’s comments, the psychotherapeutic treatment of older adults has received little attention within the literature or research.

Zeiss and Breckenbridge (1997) consider the impact of the 'professions' assumption that: (1) any form of therapy would be less acceptable to older adults; (2) that seeking psychological therapy would be stigmatising for older adults; and (3) that older adults prefer medication to therapy in treating depression. These assumptions are unsubstantiated in light of research undertaken by Rokke and Scogin (1995 cited in
Zeiss and Breckenbridge, 1997), which specifically investigated older adults attitudes to different forms of treatment. They found that older adults were less concerned about stigma associated with seeking help from mental health services than younger adults. In addition, older adults also rated therapies as significantly more credible and acceptable than medication treatments. Rokke and Scogin (1995, cited in Zeiss and Breckenridge, 1997) state “the belief that older adults are less interested in….the more cognitively demanding and discursive types of treatment may reflect a subtle form of ageism that has worked its way into our clinical lore” (1995:225). Indeed Emery (1981) suggests that clinicians need to be able to identify and challenge any dysfunctional thoughts or belief they might hold about working with this client group such as “old people can’t learn new behaviours” or “the elderly need care, not treatment”.

The recently published National Service Framework (2001) for older adults, which aims to improve the quality and accessibility of physical and mental health care for older adults within the National Health Service (NHS), draws attention to the need to reduce ageism in service provision. It proposes that the NHS needs to ensure that decisions about treatment are based upon clinical need, not age. CBT has evidence to suggest it is an effective treatment for emotional disorders in younger adults (Dobson, 1989). It therefore seems appropriate to consider the applicability of this approach with older adults.

APPLYING BECK'S COGNITIVE MODEL TO UNDERSTAND DEPRESSION IN OLDER ADULTS WITH A DEMENTIA

Beck’s cognitive model of depression

The application of CBT for clinically depressed clients with dementia is based upon the cognitive model of depression proposed by Beck (1967, 1976). Beck’s work was based on non-dementing, depressed adults. In brief, Beck’s cognitive model proposes that depression is maintained by a bias in information processing, whereby the individual has an over-riding negative view of himself/herself, the world and their future (Moorey, 1996). Beck (1967) called this the cognitive triad. Negative automatic thoughts and cognitive distortions, such as ‘all or nothing’ thinking and
overgeneralizations, lead to other symptoms of depression including withdrawal, reduced activity levels and interest, low mood, poor concentration and physical symptoms, such as loss of appetite and sleep. These symptoms contribute to a vicious cycle of depression by increasing negative automatic thoughts further. CBT aims to help the client learn about the cycle of depression, learn to identify their negative automatic thoughts and the distortions in their information processing and challenge these thoughts.

Applying a cognitive model to understand depression in older adults with a dementia
Teri and Gallagher (1991) argue that Beck's model can be applied to help understand the depression of a client in the early stages of dementia. They state that: “if patients realise their memory and level of functioning are impaired, they may focus on the negative to the exclusion of the positive, exaggerating their deficits” (1991:413). Some argue that automatic negative thoughts and cognitive distortions may occur more readily in people with cognitive impairment, evident in dementia sufferers, due to the compounded effect of their poor reasoning, judgement and memory (Thompson et al., 1990).

Difficulties applying a Cognitive model with dementing older adults
In applying Beck’s cognitive model to understand depression in dementia sufferers, there are some important questions that need to be addressed, including: (1) Is depression merely an understandable reaction to the loss associated with dementia? (2) Does the depression merely reflect a period of difficult adjustment? (3) Due to the progressive nature of dementia, sufferers will undoubtedly face reduced capabilities and losses, to the extent that some of their negative automatic thoughts are likely to be accurate appraisals of events – how can CBT challenge ‘realistic’ negative thoughts?

Is depression merely an understandable reaction to the losses associated with dementia?
Some might argue that depression is an ‘understandable reaction’ to the loss associated with dementia. Indeed Thompson, Wagner, Zeiss and Gallagher (1990)
state that both depression and anxiety are “quite common in patients who are beginning to sense a loss in their cognitive and functional abilities” (1990:383). Dementia has been referred to as a form of bereavement, as it means facing “two kinds of loss simultaneously, the loss of mental powers, and the loss of a familiar way of life” (Kitwood, 1997:29).

Reifler, Larson and Hanley (1982) state, however, that it is not adequate to view depression merely as ‘a universal feature of early dementia’ due to the patient’s awareness of his/her loss of abilities/ functioning. Indeed prevalence rates inform us that many people who have a dementia do not suffer from depression. Warrington (1997) argues that treatment should not be denied on the basis that the depression is understandable. She argues that although understanding is important in promoting empathy; depression, which reflects a significant worsening in the individual’s presentation, requires treatment. This point was also made in the National Service Framework for older people (2001).

A cognitive model of depression suggests that the difference between those who do and do not develop depression during dementia is the way in which they think about their stressful situation. Indeed a cognitive model is useful in that it differentiates between ‘normal’ grieving and sadness in reaction to adverse life circumstances and depression. Although Moorey (1996) does not specifically talk about dementia sufferers, his examples can be adopted to illustrate the different reactions to dementia. For example, a client with dementia who is increasingly forgetful might think: “I can no longer remember things as well as I used to”. This would reflect an accurate appraisal and would lead to feelings of sadness and loss. However if this client thought “I will never enjoy anything again” or “I can’t do anything now, I am useless and unlovable”, this would reflect depression as his/her thoughts include overgeneralizations and arbitrary inferences. It appears that the identification of overgeneralizations and cognitive distortions would be important in the diagnosis of clinical depression in someone with a dementia and would distinguish depression from an adjustment disorder.
The role of CBT in adjustments disorders

Moorey (1996) suggests that a high proportion of the emotional distress experienced by people in adverse life circumstances is 'part of a process of adjustment' (1996:456). If this process of adjustment is ongoing, Moorey (1996) suggests that formal cognitive behavioural therapy may be inappropriate, as it inappropriately pathologises the problem. To facilitate adjustment, Moorey (1996) advocates that a more humanistic approach in which principally a supportive relationship enables the client to vent their feelings. However he does see a role for CBT in this process of adjustment. Specifically: - (1) to address excessive distorted thinking such as self blame, guilt and (2) helping the client become aware of and challenge maladaptive beliefs which may impede on the adjustment process i.e. "I must always be seen to be coping" and "It is a sign of weakness to express my feelings".

How can CBT challenge 'realistic' negative thoughts?

Clients with dementia will face loses and their negative automatic thoughts might be a realistic interpretation of events, at least to some extent. Indeed Moorey (1996) states that "cognitive therapy is not so straightforward when the patient has objectively negative surroundings" (1996:467). Grant and Casey (1995) state that such negative experiences (i.e. when the patient has physical evidence of his/her reduced abilities) are "an opportunity for the therapist to encourage persistence and to reframe the negative experience as a problem to be addressed rather than as a reflection of personal inadequacy" (1995:568). Grant and Casey (1995) advocate that the therapist is required to provide much of the energy to the process of supportive CBT. More specifically Moorey (1996) suggests that when faced with 'realistic' negative thoughts, the clinician must be able to explore the underlying, personal meaning of these thoughts. In doing so, the clinician explores what on the surface might appear understandable distress, to try and identify possible distortions in how the individual views themselves, their situation and their future.

Addressing 'realistic' negative thoughts requires much sensitivity and a good therapeutic relationship with the client. Moorey (1996) advocates that the
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collaborative nature of CBT provides an ideal method for this process to occur as it allows the client to feel empathy and understanding but also to be proactive in working together to overcome problems.

Grant and Casey (1995) suggest more existential CBT for clients who, due to depression, are less able to realistically evaluate their lives in what Butler (1963) refers to as a 'life review', the final developmental task of ageing. CBT is applied to help the client 'develop a less negative life appraisal', as a means of helping the client feel self-worth and a sense of achievement.

How CBT has been applied to older adults with co-existing depression and dementia?
Teri and Gallagher (1991) propose the aims of CBT, with depressed clients at the early stages of dementia are: (1) to challenge negative automatic thoughts, thus reducing cognitive distortions and helping the client consider more helpful ways of viewing specific situations, and (2) to help the client feel more in control of his or her mood and daily situation. Grant and Casey (1995) suggest that CBT may provide a supportive framework in which people can learn to resolve practical concerns and test out distorted views of themselves. In line with standard CBT techniques, clients are given homework assignments, which entails testing out their predictions about their ability to participate in certain activities through behavioural experiments. Grant and Casey advocate such tasks with clients with a “try it and see” approach. According to the cognitive model of depression, positive outcomes may have a positive effect on mood, increase motivation to engage in activities and consequently break the cycle of depression. Reinforcement is crucial when clients demonstrate learning of cognitive techniques to encourage more positive thoughts about their own abilities, in spite of the diagnosis (Teri and Gallagher, 1991).

Thompson et al. (1990) argues that CBT would be a suitable treatment for dementing, older adults because: - (1) it is short-term; (2) it is a problem solving approach which focuses upon current difficulties; and (3) it is multi-modal to facilitate learning.
The challenge of using CBT with cognitively impaired older adults

Suitability for CBT relies on the presence of pre-requisite skills including the ability to work collaboratively, to learn new information/skills and to be open to a cognitive model (Fennell, 1998). It seems accepted in the literature that severe cognitive impairment, more obvious in the later stages of dementia, acts as a contra-indication for CBT, as the individual is unable to learn or retain new information and thus unable to use therapy meaningfully.

Not all cognitive abilities are impaired by dementia, especially during the early stages when depressive symptoms are most frequently observed (Reifler, Larson and Hanley, 1982). Morris (1999) argues that preserved abilities ‘can be harnessed in the development of strategies for the management and rehabilitation of patients’ (1999:112). It is during the early stages of dementia that Teri and Gallagher-Thompson (1991) Thompson et al. (1990) and Grant and Casey (1995) have considered CBT in the treatment of depression. They provide some suggestions on how CBT needs to be modified for older adults suffering from a dementia. These suggestions are based on clinical experience, rather than empirical evidence.

General considerations when working with older adults

The clinician needs to consider practical issues with this client group such as transport, mobility (i.e. is the client physically able to sit for therapy session?), sensory deficits, physical health issues plus any barriers to treatment. Barriers might include a preoccupation with somatic complaints, which might prevent acceptance of a psychological approach or model. Such issues are pertinent to working with older adults as evidence suggests older adults do focus more readily upon somatic complaints than report dysphoric mood (Benedict and Nacoste, 1990). In light of this, the suitability of a cognitive approach should be considered and the older adults might require more time in socialising to the cognitive model.

Modifying CBT for cognitive impairments

Table 1 lists the proposed modifications of CBT by Thompson et al. (1990), Koder (1998) Teri and Gallagher (1991) and Casey and Grant (1995). These modifications
are aimed primarily at compensating for poor concentration, distractibility, impaired abstraction and to prompt memory.

Table 1 Possible modifications to CBT to compensate for cognitive impairments in dementia in order to maximise therapeutic gains

1. Scheduling briefer, more frequent sessions
2. Ensuring the repetition of work undertaken
3. Recording sessions on audio-tape for the client to listen to between sessions
4. Encouraging the use of external prompts and cues such as diaries, cue cards and other memory aids
5. Continually monitoring the clients understanding of therapy and set tasks.
6. Therapist needs to take a more didactic, directive role
7. Use clients language, terminology and images
8. Simple language with the minimisation of jargon
9. Agenda’s remain brief
10. Therapeutic goals should be kept simple and attainable

The literature stresses the importance of the clinician having an accurate understanding of the client’s current cognitive abilities (Thompson et al., 1990; Teri and Gallagher, 1991). This helps guide the treatment regime, by identifying which components of treatment programme might require modification and helps the clinician pitch their communication with the client. Thompson et al. (1990) also argue that a neuro-psychological assessment helps the clinician “judge whether a particular negative thought or self-appraisal is accurate (i.e. reflects true deficits) or a distortion” (1990:389).

Thompson et al. (1990) advocate the importance of structure and the setting of specific agenda’s within sessions. The rationale they propose for this is given in both behavioural and cognitive terms. Behaviourally, structured sessions provide an
opportunity to model problem solving skills, which entails deconstructing the problem into less overwhelming tasks. Thompson et al. (1990) state that “the way time is used and the way problems are approached in the therapy session provide a model that the patient can follow at home, as well as after therapy has concluded,” (1990:390). In line with a more cognitive model, Thompson et al. (1990) state that structured sessions provide opportunities for the client to succeed and promote more positive expectancies, which consequently provides evidence to challenge negative automatic thoughts or distorted cognitions about their “ability to function and participate adequately in relationships” (1990:390).

The involvement of family members and/or carers is also encouraged to help generalise therapy to home situations and promote learning i.e. problem solving, the use of prompting and structure. Carers might also provide help in identifying and challenging negative automatic thoughts. Others have suggested the involvement of carers as co-therapists can be beneficial and may act as a ‘memory prosthesis’ (Koder, 1998). It is important that the involvement of carers in treatment be undertaken with the consent of the client.

**Effectiveness of using CBT in the treatment of emotional disorders in people with a dementia**

Although the literature states that interest in the application of CBT in treating depression in patients with a dementia is growing, (Thompson et al., 1990) there remains very few controlled empirical studies into its efficacy with this population. It is important to be aware that some early references to the use of CBT with this population, such as Teri and Uomoto (1991 cited in Scogin and McElreath, 1994) actually refer to interventions based on behavioural theory and the principles of conditioning (Skinner, 1953) rather than Beck’s cognitive model.

**Evidence for the use of CBT with older adults**

Thompson et al. (1990) suggest that, in light of the lack of direct evidence regarding the efficacy of CBT with emotional disorders in dementia, indirect evidence comes from research into the use of CBT with older adults in general. The usefulness of such
Evidence is debatable given that: (1) a client with a dementia presents with a degenerative, irreversible disease and (2) it is contentious to assume that the cognitive, behavioural and personality changes in dementia reflects a 'speeding up' of normal ageing.

Much of the evidence from older adults in general, advocate CBT as an effective intervention for depressed older adults (Koder, Brodaty and Anstey, 1996; Steur, Mintz, Hammen and Hill, 1984). In a meta-analysis of comparison studies that looked at the efficacy of psychosocial treatment for depression in older adults, including CBT, Scogin and McElreath (1994) found that CBT had a greater effect size than when other therapies were used. However, due to the lack of control groups, the research remains unable to explain the mechanism that accounts for this efficacy.

Evidence for the use of CBT specifically with clients with a dementia
Teri and Gallagher-Thompson (1991) reported that with time, dementing older adults are able to learn skills of CBT and that, post-treatment, clients reported that intervention was useful. Such anecdotal evidence remains highly subjective and open to demand characteristics. The lack of standardised, evaluative measures makes it difficult to quantify the efficacy of CBT, or any other intervention, in treating this client group. Controlled outcome studies are needed to identify whether treatment changes are due to the intervention, yet the ethical difficulties of using controls makes such studies difficult.

Indirect evidence for the use of CBT as an effective, supportive therapy for helping people adjust to diagnoses, comes from Moorey and Greer (1989 cited in Moorey, 1996). They found that supportive CBT produced more changes than non-directive counselling, in fighting spirit, hopelessness, anxiety and coping in patients diagnosed with cancer. This suggests that CBT may be more helpful to the adjustment process of a diagnosis of dementia than just a supportive relationship, although this warrants research.
The need of future research

In order to provide evidence-based practice and meet the standards set out in the recent National Service Framework for older people (2001), more empirical research is needed into the aetiology and treatment of depression in clients with co-morbid dementia. Anecdotal evidence suggests that CBT can be useful in treating depression in older adults, there is now a need for more controlled studies to illustrate its usefulness in a modified form. In order to find out which treatments are the most effective in the alleviation of depression in people with a dementia, further research is needed also in finding more effective methods of accurately assessing depression in clients with a dementing illness (Thompson et al., 1990). Dick, Gallagher-Thompson and Thompson (1996) also suggest that the efficacy of using psychotherapies, such as CBT with older adults from various racial and ethnic minorities needs consideration.

A RE-CONCEPTUALISATION OF THE EXPERIENCE OF DISTRESS WITHIN DEMENTIA

James (1999) re-formulates the experience of distress with dementia to help guide clinicians working with this client group by incorporating Kitwood’s notion of personhood into Beck’s cognitive model. This draws together a cognitive model with the more subjective experience of suffering from dementia and considers also the impact of carers’ reactions to the client’s level of distress. This re-conceptualisation may be helpful for clinician’s formulating about clients with co-existing dementia and depression and guide future CBT.

Depression in more severely impaired dementing person

During the later stages of the dementing process, it is often assumed that clients are less conscious of their cognitive deterioration and consequently less prone to emotional disorders. Although they acknowledge the difficulties in diagnosis, Demuth and Rand (1980) argue that depression can occur in the severely demented person. Greater emphasis on behavioural interventions, based upon work by Lewinsohn and his colleagues (1984 cited in Teri and Gallagher, 1991) may be more suitable for clients with more moderate to severe cognitive impairment, who are unable to cope with more cognitively demanding therapy (Teri and Gallagher, 1991). Behavioural approaches
focus upon “altering the contingencies that maintain depressive behaviours and by introducing new contingencies to stimulate and maintain non-depressive behaviours” (Teri and Gallagher, 1991:413).

Other therapeutic strategies have been developed for use with people with dementia at all stages of the disease. Although not specifically developed for treating depression and distress, James (1999) suggests that clinicians need to be open to incorporating such approaches with dementing clients as the approaches can address client’s distress. Strategies include reality orientation, reminiscence groups, validation therapy, environmental modification and Snoezlens (for a review see Droes, 1997).

Considerations for the clinician when working with people with a dementing illness

It is important that clinicians are aware of the difficulties working with this client group, not only in the models they use to formulate, or the techniques they use in therapy, but also the fact that clients with dementia, will never fully recover or return to optimal functioning. Cheston (1998) states that “while working with dementia sufferers can be a rewarding experience for the therapist, an awareness of the existential terror of a loss of being is an inevitable accompaniment of this work” (Cheston, 1998:213). Thompson et al. (1990) stresses that clinicians need to seek consultation and support appropriately when working with this client group and be aware of and address any personal cognitive distortions or negative automatic thoughts they might hold during the course of intervention.

Isolation is particularly relevant to some older adults and clinicians must be aware of potential dependency (Wilkinson, 1997). To compensate for possible dependency, Wilkinson (1997) suggests that the clinician must ensure the client attributes their therapeutic improvements to him or herself rather than to the clinician. Teri and Gallagher (1991) suggest that ending therapy requires ‘frank’ discussion at intervals, 1-2 months prior to the therapy terminating. Dependency on the therapist, relapse prevention and the usefulness of booster sessions needs to be considered at that time.
People with dementia are likely to present with complex difficulties, of an interdisciplinary nature. Therefore they require a co-ordinated, multi-disciplinary approach.

CONCLUSIONS
Prevalence rates have illustrated that depression represents a substantive problem for many people with a dementia. This depression can lead to excess disability for the individual, impair their quality of life further and increase carer distress. This essay has illustrated that depression is not merely an understandable reaction to the losses associated with dementia, and that it requires treatment. The recent National Service Framework (2001) has highlighted the need to provide older adults with mental health problems effective diagnosis and treatment. As a well-established treatment approach for younger adults, CBT is gradually being applied and modified for older adults with co-morbid depression and early stages of dementia (Thompson et al., 1990; Teri and Gallagher, 1991; Casey and Grant, 1995). Beck’s cognitive model, which underlies CBT, does provide a model in which depression can be distinguished from adjustment disorders, in terms of cognitive distortions. In addition, CBT proposes that even ‘realistic’ negative automatic thoughts can be addressed by considering the underlying meaning of an individual’s fears and thoughts. However, evidence for this approach with this population remains anecdotal, and modifications of this approach to compensate for cognitive impairments are based upon clinical experience rather than empirical evidence. There is considerable need for further research to find more adequate measures of depression in dementia and for controlled, empirical studies to identify the impact of treatments. In the mean time, clinicians are advised to work multi-disciplinarily in order to meet the complex needs of people with a dementia.
REFERENCES


"CHILDREN WHO HAVE A PARENT WITH HIV OR HAVE A DIAGNOSIS OF HIV THEMSELVES SHOULD BE OLD."

DISCUSS THE ISSUES AROUND THE DISCLOSURE OF HIV IN FAMILIES WITH AN HIV INFECTED MEMBER AND CONSIDER HOW A CLINICAL PSYCHOLOGIST MIGHT WORK WITH THESE FAMILIES.

Year 3

December 2001
INTRODUCTION
The disclosure of the diagnosis of human immunodeficiency syndrome (HIV) or acquired immunodeficiency syndrome (AIDS) to a child is a contentious and emotionally charged issue. The question of how and when to tell children about their diagnosis, or their parents', has become more pertinent as the incidence of HIV within families has slowly risen (Unlinked anonymous survey steering group, 2001) and with medical advancements in combination drug therapies, which are enabling children and adults with HIV to live longer, relatively symptom-free lives. The disclosure of HIV/ AIDS presents challenging issues for parents and health professional alike. Although the prevailing view in paediatric care is that children benefit from being told about life threatening illnesses, such as cancer, there are specific cultural and social considerations which complicate the process of disclosing HIV and AIDS (Lipson, 1994). This essay sets out to examine whether children should be told their own or their parents' diagnosis of HIV and consider factors that act as barriers to the disclosure of HIV/ AIDS to children. In addition, this essay discusses the numerous ways in which a Clinical Psychologist might work with families with an HIV infected member and contribute to the complex issue of children and HIV/ AIDS.

Prevalence of HIV/ AIDS
Worldwide the incidence of HIV/ AIDS is rising. It affects all cultures, classes and ages (Lwin and Duggan, 1996) and its impact is severe. Indeed in America, HIV/ AIDS has become the leading cause of death in young adults aged between 25 and 44 (Centre of disease control, 1996 cited in Weiner, Battles, Heilman, Sigelman and Pizzo, 1996) and in Africa, where the main route of transmission is now heterosexual contact, the prevalence of HIV/ AIDS is so great it threatens entire communities. Although in comparison the prevalence of HIV/ AIDS in the UK is relatively small, incidence levels are rising (Unlinked anonymous survey steering group, 2001).

There is growing recognition that those infected do not form a homogenous group. HIV/ AIDS is no longer solely associated with certain risk groups such as intravenous drugs users and gay men. Specifically, health professionals in paediatric care are becoming increasingly aware of a small, but rising population of families affected by HIV/ AIDS. HIV/ AIDS can significantly impact on the whole family and has been
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termed a 'family disease' due to the transmission risks between partners, from mother to baby and consequently the possibility of multiple losses in a family (Melvin, 1996; Giaquinto, Giacomet and Pagliaro, 1992). The majority of children with HIV in the UK are infected by vertical transmission either during pregnancy, labour or through breast-feeding. This essay, therefore, focuses on the issues raised for these children and their families. Other routes of transmission include intravenous drug usage in older children and contaminated blood transfusions (although the latter is quite rare nowadays). It is, however, important to note that different routes of transmission can provoke different issues for the families affected.

In addition to the growing number of children who are actually infected with HIV, there are also many more children who are significantly affected by the impact of the disease on their family (Weiner et al., 1996). More than 9 000 HIV negative children were reported to have lost their mother or both their parents to HIV/AIDS in Western Europe (UNAIDS, 1998, cited in Melvin, 1996). Melvin (1996) argues that the psychological and care needs uninfected children, whose parent(s) are HIV infected, might be just as great as those who are directly infected.

HIV/AIDS has become an important and challenging issue within paediatric care, for Clinical Psychologists and other health professionals.

**Increasing survival rates**

Paediatric HIV/AIDS used to be viewed as 'universal and quickly fatal' (Lipson, 1994). Yet with medical advancement in combination drug therapy in the 1990s, children with HIV are now living longer and going to school. The emphasis in paediatric HIV management has therefore shifted from approaching paediatric HIV as a terminal illness to approaching it as a 'chronic, manageable disease' (Meyers and Weitzman, 1991; Boland, 2000). Now that children with HIV/AIDS are living longer, the issue of disclosing the diagnosis to the child and the child's right to be involved in decisions relating to their illness have become increasingly pertinent. This essay will illustrate that balancing the rights of the child and the wishes of the parents presents unique challenges for health professionals.
THE DISCLOSURE OF SERIOUS ILLNESS TO CHILDREN

Health professionals within paediatric care tend to advocate the early disclosure of serious illnesses to children (Lipson, 1994). Lipson (1994) suggests a number of factors that have contributed to this stance, including the increasing recognition of the rights of children (UN Convention on the rights of the child, 1989, cited in Waugh, 2001) and the benefits of enlisting the child in the fight against the illness, promoting treatment compliance. Developments in psychological research have also been informative. Often children were perceived as lacking the cognitive maturity to understand or cope with the facts of a serious illness and needed protection from the emotional burden of the illness. Research illustrated that children as young as 6 years have the cognitive capacity to conceptualise and understand illness and death at an appropriate level (Bibace and Walsh, 1980). Bibace and Walsh (1980, 1991) related children's understanding of HIV/AIDS and other illnesses to Piaget's developmental stages (Bibace and Walsh, 1980, 1991). This conceptualisation has been useful in informing educational and therapeutic interventions with children with chronic and life threatening illnesses.

Not only were children found to have the cognitive capacity to understand illness and death, but also research, which interviewed children who knew their diagnosis, found that most wanted to know more about their illness, their treatment and even their prognosis (Ellis and Leventhal, 1993). Furthermore, potential positive effects of disclosure were documented within the research. Children who had been told about their cancer diagnosis were better adjusted and coped better in the long term than those who were not told (Slavin, O'Malley, Koocher and Foster, 1982; Spinetta and Maloney, 1978).

FACTORS HINDERING THE DISCLOSURE OF HIV/AIDS TO CHILDREN

Current trends of non-disclosure in families infected/affected with HIV/AIDS

Despite the general trend in paediatrics for early disclosure, research suggests that when parents become aware of their own diagnosis or their child's, their initial reaction is to conceal the diagnosis (Weiner et al., 1996). Although the rate of disclosure within families affected by HIV has varied between studies (Weiner et al., 1996),
Funck-Brentano, Costagliola, Seibel, Straub, Tardieu and Blanche (1997) found that only 6 out of 35 HIV positive, school aged children were fully aware of their diagnosis, according to their parents’ reports. Even with older children, many remain unaware of the diagnosis (Thorne, Newell and Peckham, 2000; Grubman, Gross and Leiner-Weiss, 1995). Similarly many uninfected children are not aware of their parent’s diagnosis. In a UK study, Mok and Cooper (1997) found that only 5 out of 101 HIV positive mothers (5%) had disclosed their diagnosis to their uninfected children.

**Reasons for non-disclosure in families affected/infected with HIV/AIDS**

Many reasons, for not disclosing HIV status to children, are similar to those given by families affected by other serious illness, such as concerns that the child is too young to understand, fear of distressing the child and the possible impact of this emotional distress on the disease itself (Weiner et al., 1996, Weiner, Battles and Heilman, 1998). Parents may also fear that they are not equipped to contain their child’s anxieties and answer difficult questions about the future (Waugh, 2001).

There are concerns, however, that are unique to the disclosure of HIV/AIDS. These include the simultaneous disclosure of maternal status, fears that the child will not be able to conceal the diagnosis, which in turns leads to fears of further disclosure and fear of experiencing discrimination and stigma associated with HIV/AIDS (Weiner et al., 1996; Lipson, 1994; AAP, 1999; Courville, Blum, Gunchin and Brunell, 1992 cited in Bor, Miller and Goldman, 1993). It is important that health professionals are sensitive to these concerns and are aware that disclosing HIV/AIDS to children may be as stressful for parents as learning about the diagnosis itself (Weiner et al., 1998).

**Stigmatisation associated with HIV/AIDS**

The stigma associated with HIV/AIDS is frequently cited as a barrier to disclosure (Lipson, 1994; Bor, Miller and Goldman, 1993). This stigma can be highly detrimental, as adults have reported losing friends, feeling rejected and even harassment after disclosing their HIV status (Powell-Cope and Brown, 1992; Lipson, 1994). Indeed HIV/AIDS has been termed the most controversial disease in modern history (Powell-Cope and Brown, 1992). Much of the stigma associated with the
disease might be maintained by: (1) the association of the disease with ‘socially unacceptable’ behaviours such as intravenous drug use, sexual promiscuity and homosexuality; (2) the frequent misperception that HIV/AIDS can only be transmitted by these ‘socially unacceptable’ behaviours; and (3) the assumption that people had control over engaging in the behaviours that led to their infection and the resulting stigma. Weiner, Perry and Magnusson (1988) found that perceiving stigma as controllable influenced the way subjects responded to people with these conditions, which was generally with more anger, less liking and less helping behaviour than other conditions perceived as less controllable such as cancer. Theoretically paediatric HIV should be viewed as an uncontrollable stigma, due to the vertical mode of transmission. Yet research illustrates how uninfected caregivers can share the stigma of HIV/AIDS and experience similar discrimination (Powell-Cope and Brown, 1992). Therefore even uninfected children may indirectly experience stigma associated with HIV if parents disclose their illness.

Stigma theory argues that the extent an individual feels stigmatised will depend upon how obvious his/her condition is (Goffman, 1968 cited in Weiner et al., 1996). Weiner et al. (1996) argues that it is possible to live with HIV for many years, relatively symptom free and thus without any visible signs of the condition. Non-disclosure may thus serve to reduce the feeling of stigma.

Possibility of dual/further disclosure

Disclosing the child’s diagnosis is likely to lead to the simultaneous disclosure of the parents’ diagnosis, which impacts further on the child. Furthermore, disclosure to the child may lead to difficult questions regarding the mode of transmission. This may lead parents to reveal other family secrets, such as infidelity or intravenous drug usage (Bar et al., 1993). Most children who are infected acquired HIV perinatally (Melvin and Sherr, 1993) which can cause parents to feel quite disabling feelings of shame, guilt, responsibility and sadness. These factors make disclosure difficult. Indeed Lipson (1994) states that: “parents resist disclosure of diagnosis to children in part because they seek to avoid consciously confronting their own contribution to the child’s infection and illness” (1994:63).
**Cultural issues**

90% of paediatric HIV occurs in minority families, including immigrants and refugees particularly from African countries (Walker, 1991 cited in Lipson, 1994). Minority families are often already marginalized within society and may have experienced racial discrimination, poverty and stigmatisation. Many families may view disclosure as increasing the risk of further discrimination and lowered status (Lipson, 1994).

Cultural issues may impact upon disclosure and it is important that health professionals are aware of how each family generally manages information and how the family perceives the child’s role within the family (Boyd-Franklin 1989). Some cultures would not deem it appropriate to share sensitive information with children, and that children should accept adults’ decisions without question (Melvin, 1999; Boyd-Franklin, 1989). Melvin (1996) stresses that health professionals need to be aware of the cultural and religious beliefs of those affected by HIV, and the possible impact of these on childrearing practices, the sharing of information within the family and the families ability to use or access formal support services.

**WHAT DOES CURRENT RESEARCH SAY ABOUT THE DISCLOSURE AND NON-DISCLOSURE OF HIV/ AIDS TO CHILDREN?**

**The experience of parents who have disclosed**

There are very few studies that examine specifically the impact of disclosure of HIV on children. Weiner and her colleagues, in the United States, have examined the experience of parents disclosing their HIV status to their children (Weiner, Battles and Heilman, 1998) and factors associated with parents disclosing their child’s diagnosis with HIV/ AIDS (Weiner et al., 1996). They found that on average parents waited 2 ½ years before disclosing their HIV status to their children. Parents often ended up disclosing their own diagnosis because of their child’s diagnosis, which implies that parents with uninfected children may put off disclosure longer than parents with infected children. This causes concern given the need to plan for the child’s future care (whether infected or not) prior to the advanced stages of the disease (Mok and Cooper, 1997).
The main reason for non-disclosure remained similar to what one might expect from families affected by other illnesses, including fear of causing distress to the child and thinking the child was too young to understand. It is possible that the studies were insufficiently sensitive to tease out other factors more specific to the disclosure of HIV/AIDS.

Weiner et al. (1996, 1998) found that the impact on the parent and the child after disclosure was varied. Some parents reported feeling more withdrawn and rejected after disclosing their HIV status to their uninfected children, whilst others felt their lives had changed for the better due to the release from secrecy. Relief was also a dominant theme for parents who disclosed the child's HIV diagnosis. The progress of children after they had learnt about their diagnosis of HIV was also varied. 60% felt their lives had changed for the better or stayed the same, whilst the remainder felt their lives had got worse (Weiner et al., 1998). Further research is warranted to investigate what factors might account for the positive and negative reactions of parents and children to disclosure such as differences in the disclosure process.

Research has also tried to identify factors that increase the likelihood that parents will disclose. Ledlie (1999) found no difference in the age of the child or the stage of the disease between children who had been told their diagnosis and those who had not. She found the main variable that increased the likelihood of children being told their diagnosis was when the child lived with caregivers who were unrelated to them. This implies that the parent's infection and the route of transmission may be important variables in hindering the disclosure of HIV/AIDS. Ledlie (1999) acknowledged that there are a number of explanations for her findings, including the need for parents to feel ready to disclose and to have come to terms with their own diagnosis.

The impact of non-disclosure

Hardy, Routh, Armstrong, Albrecht and Davis (1995) found that children who did not know their diagnosis were more likely to place dolls (who represented family and medical staff) with their backs to a model of the child's bed, than children who knew their diagnosis. They interpreted this as illustrating how the child might perceive communication around them as quite closed and isolating. Although the findings
should be treated with caution, given that they were based on subjective interpretations, this study does raise questions about the possible negative consequences of keeping secrets from a child, especially in their presence.

Weiner et al. (1996) hypothesised that many of the children in their study were actually already aware, to varying extents, of their diagnosis prior to disclosure. They argued this on the basis that 45% of children in their study were not surprised by the diagnosis and only a third reported feelings of sadness or anxiety after disclosure. Without formal explanations, children may invent their own explanations for the difficulties observed, such as self-blame, which can be detrimental to the child’s self-esteem (Melvin, 1996; Stuber, 1989). A policy of non-disclosure risks the child learning about the diagnosis by accident. In such instances, children may feel distrustful of their parents and fear they are keeping others secrets from them (Weiner et al., 1996).

Weiner et al. (1996) found that a quarter of the children in their study were not allowed to tell anyone else about the diagnosis. If the child is unable to tell others about their or their parent’s diagnosis, the child may become isolated from potential sources of support (AAP, 1999), which may be important to the adjustment process. Continued secrecy reduces the child’s opportunity of expressing their emotions and fears, which, in some cases, may heighten their anxiety around the illness. Bar et al. (1993) argued that this might impact upon the child’s ability to adjust to the illness and the prospect of losing their parent or of their own death. Maintaining secrecy can cause considerable stress and reduce support opportunities for parents also. It may lead to personal distress and loneliness (Tasker, 1992) and has been hypothesised as contributing to the higher rates of depression observed in non-disclosing parents (Weiner et al., 1996, 1998). Sharing information about chronic illness, such as cancer and cystic fibrosis, with friends and family has been found to have a positive impact on parents and their children in the process of adjustment (Eiser, 1990). Specifically being able to talk to friends and relatives about their emotions and the problems associated with HIV/ AIDS has been found to reduce the amount of depressed and helpless thoughts in adults with HIV (Ostrow, Monjan, Joseph and van Raden, 1989).
The assumption that non-disclosure protects the child from distress is not supported by research with children with cancer. Clafin and Barbarin (1991) found no difference in the distress and disruption reported by children who did or did not know they diagnosis. They conclude that, although in the short term non-disclosure might reduce emotional distress, over time children cannot be shielded from the contextual experience of serious illness and seeing their parents’ distress. Indeed they state that: - “illness symptoms and treatments may convey much more powerfully the seriousness of the situation to the child than any words adults convey or conceal” (Clafin and Barbarin, 1991:187).

Although maintaining secrecy may reduce the social stigma experienced by family members, it is not yet clear whether this benefit outweighs the cost of maintaining secrecy, in terms of the isolation and impact on relationships.

WHAT IS THE ROLE OF A CLINICAL PSYCHOLOGIST IN HELPING FAMILIES WITH AN HIV INFECTED MEMBER?
Clinical Psychologists have an important role in helping families with an HIV infected member. This role may be focused at an individual level, such as in helping families through the disclosure process and in adjusting to a terminal illness, or this role may be much broader, in terms of improving our understanding of HIV/ AIDS through research and in the evaluation of preventative strategies (Olson et al., 1989).

Individual work with families affected by HIV/ AIDS, most notably counselling, may be undertaken by health professionals best placed to provide this input, such as nurses or paediatricians, who already have established rapports with the families. However psychologists might contribute indirectly to this input by providing consultation, debriefing and support to these health professionals. Indeed this team approach to working with families affected by HIV/ AIDS is advocated within the literature (Lwin and Duggan, 1996; Stuber 1989).
Helping parents and other health professionals learn about the disclosure process and providing support and consultation with the disclosure process

The psychologist has an important role in sharing information and findings from the recent research in helping families to make an informed decision about if, when and how to disclose. Olson et al. (1989) stress that parents also need to be aware of the limitations of the current research base and what we do not know, such as whether the child will be able to maintain the secrecy of the diagnosis, what psychological effects disclosure may have on the child or the reaction of the wider system.

Helping parents periodically consider the relevant advantages and disadvantages of disclosure and how these factors might change over time is an integral part of helping parents move along the process of disclosing. Parents might need help in viewing disclosure not as a discrete event but a process of steps that occurs over time, at a pace that is acceptable for parent and child (Melvin, 1996), and linked to the child’s cognitive developmental level. Partial disclosure can be as helpful as full disclosure to the child’s emotional well-being and adjustment (Funck-Bretano et al., 1997). Indeed full disclosure of the diagnosis itself may be far less important to the child than giving them information to help them make sense of their experiences related to the illness (Melvin, 1996; Waugh, 2001).

This ‘continuing dialogue’ about disclosure also aims to contain parents’ anxieties around disclosure, help the family identify and utilise coping mechanisms and supports and reduce the families sense of isolation (Melvin, 1999; Lwin and Duggan, 1996). To promote engagement, health professionals working with HIV affected families need to respect parents’ personal style and attitudes (Melvin, 1999) and “acknowledge the need for families to find their own time and space to involve the children,” (Mok and Cooper, 1997:486). This refers to Ledlie’s notion of developing “perceived personal readiness” (Ledlie, 1999:148), whereby the parents’ feel the child is ready to know and feels able to provide emotional support to the child after disclosure. Therefore health professionals need to acknowledge the possible function of non-disclosure during the initial stages, e.g. time for parents to adjust to the diagnosis (Holt, Court, Vedhara, Nott, Holmes and Snow, 1998). Forcing parents to disclose when they are not ready to provide support for the child after disclosure, or
allow the child to disclose to others, may not be in the child’s best interest (Stuber, 1989; AAP, 1999; Lwin and Duggan, 1996) and is likely to lead to families disengaging with services (Lwin and Duggan, 1996). Rather than focus on early disclosure, health professionals need to assess individual families circumstances in advising what is best for the child, which remains the primary objective (AAP, 1999).

Once the child learns about the HIV diagnosis, it is important to identify and address the child’s fears, misperceptions or distorted cognitions around the illness, their situation and their future. It is important to be aware that children will often demonstrate emotional distress through behavioural changes. A Clinical Psychologist may have an important role in helping children and significant others understand such behaviours and in adjusting to chronic illness (Moorey, 1996).

Lipson (1994) suggests that parents and children may benefit from sharing their experiences with peers in similar situations. Psychologists may have a role in developing, advising or running support groups for parents and children infected or affected by HIV/ AIDS. Support groups aim to reduce isolation, ameliorate guilt and shame around HIV infection and transmission and enhance the self-esteem of parents and their children (Spiegel and Mayers, 1991). Waugh and Donaghy (2001) found that parents who had attended a support group, reported feeling better prepared to discuss illness more openly with their children. Further research is warranted to discover whether such groups positively impact on child’s/ families mental health, adjustment to chronic illness and adherence to treatment.

**Monitoring cognitive and neurological development**

Paediatric psychologists have a role in monitoring the developmental functioning of children infected with HIV, through the use of psychometric measures. This may help professionals better understand the impact of HIV and drug therapies on normal cognitive development. Monitoring allows for deficits or difficulties to be detected early and intervention offered to inform educational needs and placements. Sharing such information to schools may not be possible, however, if parents refuse to disclose the diagnosis to the school. Nevertheless monitoring may highlight progress and thus
provides vital feedback for parents and “tangible proof that their efforts to promote the child’s well being have been of benefit” (Melvin, 1999:79).

**Counselling and psychological interventions**

There is growing recognition for the need for support and counselling services for those families affected by HIV/AIDS, in preparing children and their families for loss, coping with bereavement (Lwin and Duggan, 1996) and adjusting to alternative care (Mok and Cooper, 1997).

Lwin and Duggan (1996) recognised that although counselling may be provided to all families affected by HIV (such as pre-test counselling), psychological therapy is more specific and should not always be assumed as appropriate or necessary. They stress the importance of recognising families personal resources and strengths before making a referral for psychological intervention. Failure to do so may lead to too much support too early and the family losing their identity to the HIV/AIDS. Niebuhr, Hughes and Pollard (1993) found that many health professionals referred parents with HIV to Paediatric Psychology, to discuss their children’s emotional needs, only for the families to not attend. This may be due to a number of factors, such as: (1) health professionals assuming that the parents and children need help due to their HIV; (2) parents not needing help or failing to recognise their child’s emotional needs and their need for support; and/ or (3) health professionals being unable to tolerate or contain distress. For the latter, psychologists play an important role in developing support services for staff, including debriefing and supervision. Stuber (1989) recognises the emotional burden of working with families affected by HIV/AIDS, especially in light of the difficult ethical issues that are raised and the multiple losses and bereavements that may occur in one family. She stresses the importance of working collaboratively within teams to reduce the emotional strain and the examination of possible counter-transference issues, such as the reluctance to bond with a dying patient or an unconscious tendency to blame certain family members for the child’s infection, when working therapeutically with these families.

Pertinent difficulties for this population, which might warrant a referral to a Clinical Psychologist might include: bereavement, anxiety, depression, behavioural
difficulties, poor adherence or fear of medical procedures and pain management. The therapeutic goal of any intervention with children affected by HIV should be to improve the child’s quality of life. Lwin and Duggan (1996) discuss a number of case examples of Clinical Psychologists working therapeutically with families affected by HIV/AIDS and raise some pertinent ethical dilemmas; for example, the clinically depressed mother who refused to have her children tested for HIV when the father was HIV positive. Lwin and Duggan (1996) stress the importance of holding child protection issues against the need to engage the family with services. They conclude that ensuring the family remains engaged with services is one of the prime objectives in ensuring the child’s best interests are achieved.

Research
A number of areas have already been discussed where further research is warranted. Indeed one of the most important ways of learning more about the complex issues presented by HIV/AIDS is to undertake more research. Much of our current understanding of HIV/AIDS is based on what we know about other terminal illnesses, such as cancer or the impact of HIV/AIDS on other populations, such as gay men. As we have illustrated HIV/AIDS presents its own unique issues for families, and thus merits specific investigation. Yet research in this field is difficult. Accessing children and families, with an HIV infected member, is difficult due to cultural and language barriers and ethical issues. Families who decide not to disclose the diagnosis to their children are unlikely to agree to participate in research investigating this process, due to fears of further disclosure. The current research on the disclosure of HIV/AIDS to children, detailed in this essay, is largely based on studies with small samples, often not controlled (i.e. includes patients infected by differing routes of transmission) which has implications for the generalisation of the findings. Bor et al (1993) states that we need to know more about when and how parents disclose a diagnosis of HIV/AIDS to their children and how different approaches to disclosure impact upon individual and family functioning, adaptation to illness and coping with illness. More qualitative research might be useful in gaining more insight into the child’s experience of disclosure, coping with HIV and/or living with a parent with a terminal, stigmatised illness and highlighting difficulties specific to HIV/AIDS disclosure.
Informing preventative strategies and educational programmes

Olson et al (1989) argue the importance of using theory practice links in developing and evaluating preventative programs, such as reducing high risk behaviours and promoting preventative behaviours. Psychologists, skilled in research and with knowledge of health models, might contribute to the evaluation of past preventative programmes in order to adapt psychological models and inform future programmes. The Health Belief Model (Rosenstock, 1966 cited in Olson et al., 1989) is one psychological model that has been applied in this way.

CONCLUSIONS

This essay has illustrated that the question of whether or not children should be told their or their parents HIV status is not easily answered. Although early disclosure of chronic illnesses to children is advocated within paediatrics, there is growing acknowledgement of the unique difficulties presented when disclosing HIV status to children and the possible function of non-disclosure during the early stages. Non-disclosure may actually function to protect the parent, in allowing them time to adjust to the diagnosis so that they then have the emotional strength to tolerate and cope with their child’s adjustment. Yet non-disclosure can also be detrimental, especially in terms of increased sense of isolation for parent and child. Continuing dialogue with health professionals and other supports are helpful in moving parents along the process of disclosure, which should aim to help the child make sense of what is happening to them and/or their parent(s) and get them involved in decisions about their future. Clinical Psychologists have an important role working directly in addressing the psychological difficulties of families affected by HIV, indirectly in supporting other health professionals who provide counselling and more widely in terms of research and the application of psychological theories to prevention strategies. There remains considerable scope for research in helping us learn more about children and HIV.
REFERENCES


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CLINICAL DOSSIER
Summary of Clinical Dossier

This section provides an overview of my clinical experience gained on the 3-year doctorate in Clinical Psychology. Details on each of my clinical placements are provided, including the name of supervisors/ placement location and details of the range of clients seen and interventions undertaken. A summary of five case reports is also provided; four case reports relate to the core placements and the final case report relates to the Paediatric specialist placement. These case reports are submitted in full, along with full details of clinical experience (including placement contracts and log books, samples of correspondence and evaluation forms) in Volume 2 of this portfolio.

Please note that in all instances, clients’ names and identifiers have been changed to preserve confidentiality and client anonymity.
OVERVIEW OF CLINICAL EXPERIENCE GAINED WHILST TRAINING ON THE DOCTORATE IN CLINICAL PSYCHOLOGY

Core Placements
- Adult Mental Health
- Learning Disabilities
- Child, Adolescent and Families
- Older Adults

Specialist Placements
- Paediatrics
- Child Systemic/ Family Therapy
PLACEMENT SUMMARY - ADULT MENTAL HEALTH

Supervisor: Metka Shawe-Taylor, Consultant Clinical Psychologist
Location: Dorking Community Mental Health Team, Clarendon House, Dorking
Dates: 13.10.1999 – 24.03.2000

Working in a multi-disciplinary team, I saw 27 clients (age range 17 to 68; 12 male, 15 females) presenting with a range of problems/issues including: obsessive compulsive disorder, depression, phobias, panic attacks, Aspergers Syndrome, deliberate self-harm, social phobia, anger management and relationship difficulties. Dominant theoretical approach was Cognitive Behavioural therapy; subsidiary approaches included Interpersonal therapy and Psychodynamic psychotherapy. I undertook 3 cognitive assessments in consultation with a Neuro-psychologist, administering and interpreting the Wechsler Adult Intelligence Scale-third edition, the Adult Memory and Information Processing battery, the Stroop and the verbal fluency test. Psychometric measures used to inform assessments, monitor progress and evaluate interventions included: Beck’s Depression Inventory, Beck’s Anxiety Inventory, General Health Questionnaire, Social Phobia Rating Scale and Novaco’s Anger Scale. Other experiences included: running a 3-hour workshop on the assessment and treatment of anger management problems on the Cognitive Behavioural Therapy Diploma Course and attending a conference on EDMR, PTSD and hypnosis and a one-day course on managing personality disorders.
PLACEMENT SUMMARY –
PEOPLE WITH LEARNING DISABILITIES

Supervisor: Enrique Valles, Lead Clinical Psychologist
Location: Community Learning Disabilities Team, Baltic Road, Tonbridge, Kent

Working in a multi-disciplinary team, I saw 20 clients (age range 7 to 60; 11 males, 9 females) who ranged in level of disability from borderline/mild, to severe and profound learning disability. Presenting problems/issues included: physical and verbal aggressive behaviour, poor communicative environment, Autistic Spectrum Disorders, sleep disturbance, challenging behaviour, deliberate self harm, parenting assessment, adjusting to independent living and depression. Interventions often focused individually but also with families, care home staff and teachers. I set up a social skills group for young people with learning disabilities (organising parental educational letter and consent forms and evaluative strategies). Dominant theoretical models utilised on this placement included systemic, cognitive behavioural, behavioural and principles taken from psychodynamic psychotherapy. I took on one case that was supervised by a clinical psychologist specialising in psychodynamic psychotherapy with people with learning disabilities. I administered and interpreted the WAIS-III UK, the Leiter, the British Picture Vocabulary Scale and the Vineland. Other experiences included running 3 workshops (each a full day) on ‘understanding and managing difficult behaviour’ for care staff at residential homes for people with learning disabilities.
PLACEMENT SUMMARY -
CHILD, ADOLESCENT AND FAMILIES

Supervisors:  Bruce Holroyd, Consultant Clinical Psychologist
              Dr. Louise Paque, Clinical Psychologist

Location:    Child and Family Psychological Medicine, St. Peter's Hospital, Chertsey

Dates:       11.10.2000 – 23.03.2001

Working in a multi-disciplinary team, I saw 16 clients (age range 3 to 16; 6 males, 10 females), presenting with a range of difficulties/ issues including: agoraphobia, panic disorder, depression, ADHD, PTSD, suicidal ideation, autistic spectrum disorder, OCD, school refusal, diabetes, transitional issues, soiling, behavioural difficulties, insecure attachments, sleep problems and dog phobia. I developed clinical skills in applying cognitive behavioural therapy with children and young people, but also in assessing, formulating and intervening from a systemic perspective (including narrative approaches). I also attended psychodynamic supervision workshops. I observed my supervisor and the dietician run a healthy eating group (education, plus cognitive behavioural intervention). I undertook three cognitive assessments, administering and interpreting the WISC-III UK, WIPPSI, WORD, WAND, and WOLD. I also learnt to use the Connor’s in screening for ADHD. Other experiences included (1) visiting schools and special needs service; (2) attending regional interdisciplinary training day on “Autism: cause and treatment”; (3) attending educational workshops with my supervisor on child protection, educational and organisational issues and (4) attending half-day workshop on deliberate self-harm protocols.
PLACEMENT SUMMARY - OLDER ADULTS

Supervisor: Sara Turner, Consultant Clinical Psychologist
Dr. Victoria Hill, Clinical Psychologist

Location: Wandsworth Community Mental Health Team for Older People,
Springfield Hospital, Tooting, London


I saw 21 clients (aged between 70 and 90, 7 male and 14 female) from a variety of cultural, ethnic and religious backgrounds, presenting with a range of problems/issues, including: panic attacks, anxiety, suicide risk, bereavement, memory problems, suspected dementia, coping with ill partner, difficulties adjusting to nursing home or day centre, obsessional tendencies and isolation. Main theoretical model was cognitive behavioural and solution focused interventions. I planned, negotiated and ran a reminiscence group at a day centre (included 2 males, and 3 females). I undertook cognitive assessment of two cases where dementia was suspected, using MEAMS, WAIS-III UK, Doors and People test, AMIPB, Mini mental state, Crichton Names Learning tests, Verbal fluency test, WMS, Hayling and Brixton executive functioning test and Rey-Osterrich complex figure test. Efforts were made to ensure tests were carried out in accordance with hypothesis testing principles. Other psychometric measures used to monitor progress included the Hospital anxiety and depression scale (HADS). Other experiences: (1) presented on the use and effectiveness of CBT with older adults to specialty meeting; (2) involved nursing home audit, assessed care staff completion of and knowledge of care plan procedures.
SPECIALIST PLACEMENT SUMMARY - PAEDIATRICS

Supervisor: Sarah Waugh, Consultant Clinical Psychologist
Location: Paediatric Psychology Service, St. George's Hospital, London
Dates: 11.10.2001 – 22.03.2002

Working in a psychology department, I saw 21 clients (age range 2 to 16, 13 males and 8 females) presenting with a range of physical and mental health problems, including: obesity, hypersensitivity to sensation of sickness which had lead to significant weight loss, psychosomatic complaints, school refusal, constipation, soiling, bone marrow transplant, feeding difficulties, enuresis, pain, hospital phobia, seizures, panic attacks, PTSD following road traffic accident, learning difficulties and severe anxiety over medical procedures and uncontrolled diabetes. Dominant theoretical approaches on this placement included systemic, cognitive behavioural, behavioural and other strategies including motivational interviewing. I was able to learn much from my supervisor about her clinical work with children and families affected by HIV/ AIDS and her research into adherence to treatment. I interviewed two families affected by HIV/ AIDS to inform a disclosure booklet I devised for families disclosing their child’s HIV status to the child. Other experiences included: (1) joint teaching to junior doctors about bereavement and its impact on children; (2) presenting a review on the Chronic Fatigue Syndrome/ ME report at the paediatric psychology meeting; (3) spending a day on the paediatric ward and observed ward rounds; (4) meeting with a Paediatric Psychologist at Great Ormond Street; (5) attending inpatient psychosocial meetings to identify whether inpatients who might benefit from psychological input and (6) developing a booklet to help prepare a child (with a learning disability) for an operation.
SPECIALIST PLACEMENT SUMMARY – SYSTEMIC, FAMILY THERAPY WITH CHILDREN

Supervisor: Gloria Martin, Consultant Clinical Psychologist
Location: Child and Family Consultation Centre, Richmond Royal Hospital, Kew Foot Road, Richmond, Surrey.

I saw children, adolescents and their family’s presenting with a range of problems/issues including conduct disorder, Attention Deficit Hyperactivity Disorder, exclusion from school, transitional issues, bereavement, aggressive behaviour, impact of parental separation, domestic violence, school refusal, attachment issues, impact of parental depression on child and parenting, eating disorders and Autistic Spectrum Disorder. I developed my knowledge and skills in assessing, formulating and intervening from a systemic framework and was actively involved in reflecting teams for client work and team meetings. I joined 3 starter clinics, which aim to provide assessment and brief intervention for families, for the under 5s, neuro-developmental difficulties and eating disorders. I worked jointed with other professionals within the team, including the consultant psychiatrist, child psychotherapist and the family therapist. I presented to the team my major research project findings and presented to the local specialty meeting about Dialectical Behaviour Therapy, it’s evidence base and adaptation for use with young people who engage in repeated deliberate self-harm. I also spent the day with the clinical psychologist at the Youth Offending team, joining team meetings, case discussion and observed the clinical psychologist working with a client.
SUMMARY OF CLINICAL CASE REPORTS

Core Placements
• Adult Mental Health
• Learning Disabilities
• Child, Adolescent and Families
• Older Adults

Specialist Placements
• Paediatrics
Adult Mental Health Case Report

Assessment and intervention with a 31-year-old man presenting to the community mental health team with social phobia

March 2000
Year 1

Assessment: Mr E was referred by Community Mental Health nurse due to her concerns about his social anxiety. Two initial assessment sessions (hour each) with Mr E were undertaken to assess his view of the presenting problem and gain a background history (specific attention was paid to his past and current experience of interpersonal relationships with family, peers etc. and current strategies for coping with the social anxiety, which may indicate maintaining factors). Mr E completed the BDI, BAI and Social Phobia Rating scale.

Formulation: It was hypothesised that Mr E suffered from long standing social phobia, presenting as a generalised fear and avoidance of social situations, which interfered significantly with his ability to form relationships, leaving him low in mood and isolated. He had in the past used alcohol as a means of masking his fears. Mr E’s presenting difficulties were formulated using a cognitive model of social phobia.

Intervention: Research evidence for the efficacy of cognitive behavioural approaches in the treatment of social phobia are discussed. Intervention focused on: (1) socialising Mr E to this cognitive model in helping him understand his current difficulties, gain control and understand the rationale for treatment; (2) learn about how safety behaviours, self-consciousness and post-mortem behaviour may maintain his anxieties and (3) undertake behavioural experiments, in session and as homework assignments, to test out his maladaptive thoughts and the impact of dropping safety behaviours. The latter aimed to help Mr E develop more adaptive ways of thinking, provide him with evidence that he can cope in social situations and to disconfirm his worse fears. Given his history it was important to monitor his alcohol consumption and this was undertaken in liaison with the community alcohol nurse specialist.
Outcome: By the end of treatment, Mr E's general level of anxiety had reduced (according to the BAI) and he reported finding his social anxiety less distressing (according to Social Phobia Rating Scale). Mr E reported that he no longer engaged in post mortem behaviours and had found it helpful to think more positively after social encounters. Some of his safety behaviours appeared to have been modified as opposed to removed as he reported concentrating on relaxing and taking deep breathes. However given the entrenched nature of his difficulties, it was important to recognise his progress as this new strategy had helped him to re-engage with activities. It was agreed that Mr E had a break from therapy to enable him to consolidate what he had learnt and put his skills into practice. During the course of intervention, further information came to light to build a picture of Mr E's possible underlying core beliefs that may help explain his current negative automatic thoughts e.g. "If I am not liked by everyone, I am worthless". Talking through these possible underlying beliefs with Mr E helped him understand that he was behaviourally inhibited by his anxiety rather than lacking social skills.

Critical review: The impact of Mr E's social phobia on the therapeutic relationship and Mr E's resistance to carrying out behavioural experiments were discussed. On reflection, audiotaping sessions for Mr E to listen to as homework may have been useful in facilitating cognitive change and obtaining more personal rating scales may have been useful to monitor his progress.
People with Learning Disabilities Case Report

The assessment and intervention of a client with moderate learning disabilities who has difficulties expressing and managing her emotions

September 2000
Year 1

Assessment: To address Katie’s verbal and physical aggression to other residents/pupils, a holistic assessment was undertaken over 7 sessions, which included interviews with Katie, staff at her residential home and staff at her college. Particular attention was paid to helping Katie express her view of the problem, assessing her emotional vocabulary, gaining her consent throughout the assessment and intervention and obtaining baseline measures. The assessment incorporated a cognitive and behavioural element; individual sessions with Katie focused on identifying any underlying cognitions that mediated her aggressive outbursts, whilst a functional analysis was completed to ascertain whether the behaviour was being reinforced in any way.

Formulation: Katie’s aggressive behaviour was understood in terms of social learning theory (her early experiences of domestic violence were viewed as providing an inappropriate model of expressing anger to someone who already had difficulties expressing herself) and a cognitive model of anger management difficulties. Precipitating factors included the transition to living with peers in supported accommodation and the loss of her old lifestyle and physical contact with her mother, who had moved abroad. Katie’s communicative environment was also considered, as observations at her home suggested she had little opportunity to express her feelings or needs in general. Protective factors included her engagement in meaningful daytime activities at college, her ability to maintain friendships and staff and Katie’s motivation for intervention.

Intervention: Individual work with Katie concentrated on a modified cognitive behavioural approach to anger management as suggested by Black, Cullen and
Novaco (1997). This entailed learning about how it feels to be angry (early warning signs) and arousal reduction strategies (progressive muscle relaxation and self-instruction). The focus of intervention with staff was: (1) to share the formulation with staff to help them understand Katie’s difficulties within the context of her early experiences and recent losses; (2) provide them with psycho-education to learn about a cognitive model of anger and consider how insight into Katie’s underlying beliefs and thoughts help to understand her behaviour; (3) in light of these beliefs and thoughts, to develop guidelines with staff to support Katie when she was angry; and (4) consider ways of increasing Katie’s communicative opportunities to help her express emotions and adapt to living with peers e.g. daily one to one time with staff. Staff continued to monitor Katie’s behaviour using charts in order to evaluate the impact of intervention. Self-reports from Katie and staff were also used to monitor intervention efficacy. Given Katie’s recent losses, it was important to negotiate ending input.

**Outcome:** After intervention, aggressive outbursts had reduced from once a day (baseline) to less than once a fortnight (according to staff records). Katie and staff felt that she was better able to express her feelings, especially during one to one time with staff. Katie reported that she had a plan of what to do when she felt angry and that staff were supporting her to do this i.e. relaxation strategies.

**Critical review:** Further information from Katie’s mother would have been useful in learning more about her early attachment and separation experiences, however her mother had moved to Spain. Although the Speech and Language Therapist provided advise on Katie’s communicative abilities, further psychometric assessment might have been useful in identifying areas of strength and difficulty in her cognitive functioning and ability to learn.
Child, Adolescent and Families Case Report

Systemic, narrative intervention with a 14 year old adolescent and her family due to difficulties adhering to type 1 diabetes, management regime.

March 2001
Year 2

Assessment: The Consultant Paediatrician referred Sarah, aged 14, due to her difficulties managing type 1 diabetes, diagnosed when she was 11 years old. The initial assessment investigated the presenting difficulties in detail, including how Sarah and her family reacted to the diagnosis and its management, how much they knew about diabetes and its management, family members views on the cause of the management difficulties and how the family have previously attempted to resolve the difficulty. A developmental and family history was undertaken, which also assessed family relationships, parenting style and Sarah’s mood, emotional regulation and personality. The initial assessment involved one family session and 2 individual sessions with Sarah. A contract for the assessment and efforts to build rapport were discussed. Formal diabetes-related, self-report assessment instruments were completed by Sarah to inform the assessment and monitor intervention effects.

Formulation: Sarah’s difficulties managing her diabetes were understood within a systemic, narrative and developmental framework. Differences in parenting style may have restrained Sarah’s family’s ability to negotiate her transition to adolescence and independence. The impact of managing type 1 diabetes on the normal developmental transitions in adolescence were considered; the demands that managing the diabetes placed on Sarah often conflicted with her lifestyle choices as an adolescent. Problem saturated narratives within the family and their circular impact was discussed. For example, Sarah’s parents’ narrative reflected that they did not think Sarah cared about her health, and therefore felt they needed to take responsibility for reminding her to take her injections. This had the reciprocal impact however, as when her parents took more responsibility this allowed Sarah to give up responsibility. Sarah’s narrative suggested that she felt her parents did not trust her and was less likely to take...
responsibility if they ‘nagged her’. Her parents’ viewed this as further evidence that she did not care and took more responsibility; leading to a vicious cycle.

**Intervention:** Family sessions concentrated on exploring with the family their current linear view of the problem and helping them consider a circular view of causality. Through circular questioning and open communication, new information was obtained to deconstruct certain narratives within the family, such as Sarah’s view that her parents did not trust her and her parents’ view that Sarah did not care about her health. This process helped the family to be more supportive with one another and feel that they were on the ‘same side’ in overcoming the management difficulties (externalising the problem and reducing blame). Time was also spent focusing on conflict resolution within the family when considering Sarah’s desire for independence, in an effort to empower the family’s underlying problem solving abilities and increase empathy of each others’ position. Individual sessions were also undertaken with Sarah at the family’s request, which focused on facilitating more flexible, solution focused self-narratives around her independence and diabetes management. The merits of using family based interventions and efficacy of such approaches are discussed.

**Outcome:** According to Sarah’s self reports, her feeling of control over her diabetes and communication within the family had improved, whilst the emotional intensity she perceived within her family had reduced. In order to assess the impact of intervention on actual adherence, the summary of Diabetes Self-care Activities was due to be re-administered during the last session (this case report was written up prior to this date). The families reported more open communication about the diabetes and Sarah’s desire for independence, which was consider a good prognostic sign.

**Critical review:** At a theoretical level, one might argue that all interventions should have remained with the family as a unit, in order to provide the family with a model to facilitate this process at home. However individual sessions were considered important in maintaining the therapeutic alliance as it was requested by the family. Professional issues are discussed around confidentiality and the potential conflict between Sarah’s belief that she had not received advice about her diet and exercise,
despite input from a nurse specialist. The possibility of incorporating behavioural strategies, such as an age appropriate reward system for adherence and short-term goals, were considered, if difficulties persist.
Older Adults Case Report

A comprehensive neuropsychological assessment of an 81-year-old man with short term memory problems

September 2001
Year 2

Assessment: The Consultant Psychiatrist requested a neuro-psychological assessment of Mr. P’s cognitive functioning due to a significant deterioration in his memory. The initial assessment interview aimed to: (1) obtain a chronological history of the memory difficulties and their impact on daily life (both Mr. P’s view and his wife’s); (2) obtain educational and occupational history to learn about Mr. P’s pre-morbid functioning; (3) consider possible genetic and environmental aetiological factors; and (4) assess for any functional mental disorder (depression or anxiety) that may contribute or explain the current difficulties. Efforts to dispel misconceptions about the assessment process and efforts to build rapport with Mr. P and his wife were discussed.

Formulation: Preliminary hypotheses, based on the initial assessment interview and referral information, included: - (1) Mr. P’s current memory difficulties reflected a real decline in his memory capabilities, beyond that which can be explained by normal ageing and (2) given the lack of evidence of any functional mental disorder, Mr. P’s memory difficulties are the result of organic changes, such as that associated with the early stages of Dementia of the Alzheimer’s type (DAT). Neuro-psychological assessment aimed to test out these hypotheses. For example, using neuro-psychological tests with age-adjusted norms enabled the comparison of Mr. P’s performance with others his age to ascertain whether changes in his functioning could be explained by normal ageing. A neuro-psychological profile was developed in order to contribute to a differential diagnosis. This assessment provided a baseline measure of his capabilities for future comparisons to identify areas of deterioration and the rate of deterioration.
**Intervention:** Pre-morbid intellectual functioning was estimated with the National adult reading test (NART-II). Current intellectual functioning and memory was assessed using the Wechsler Adult Intelligence Scale – third edition and the Wechsler Memory Scale – third edition. Throughout the assessment process, hypotheses were further developed which informed the use of further neuro-psychological assessment tools. For example, to clarify whether Mr. P’s impairment in learning, evident in the WMS-III, was specific to auditory information, the Shapes (visual learning) subtest of the Doors and People test was administered.

**Outcome:** Specific deficits and retained strengths in Mr. P’s cognitive functioning were identified. Deficits were beyond what one might expect in normal ageing and, in the absence of any functional mental disorder, these cognitive deficits were considered to reflect organic impairment. The history of the difficulties also appeared to suggest a slow, insidious progression consistent with the onset of an organic problem. In consultation with the Consultant Psychiatrist, it was concluded that Mr. P suffered from the early stages of possible DAT and this became the working hypothesis for future interventions. The neuro-psychological assessment results were discussed with the couple and the trainee worked with Mr. P and his wife on developing memory strategies and self-cueing strategies. This intervention aimed to use Mr. P’s retained strengths in order to compensate for deficits. Mr. P attended outpatient clinic with the Consultant Psychiatrist to discuss the probable diagnosis and consider his suitability for anti-dementia medication. It was agreed that the Consultant, in his outpatient clinic, would monitor Mr. P’s progress. If there were further changes in his functioning in the future, further consultation with Clinical Psychology was agreed and the possibility of re-assessment.

**Critical review:** Limitations of neuro-psychological tools are discussed, including the lack of norms for an older sample, ceiling and flooring effects and the lack of ecological validity of tests.
Motivational interviewing with a 9 year old boy who suffers from obesity –
Helping him move from pre-contemplative to contemplative

March 2002
Year 3

Assessment: Referred by the Consultant Paediatrician, Jamie, aged 8 was significantly overweight. His obesity was affecting him physically (Jamie had recently developed gynaecomastia) and socially (Jamie was avoiding activities with peers, such as swimming). Jamie had refused to engage with input from psychological services and dieticians in the past. However Jamie consented to the current referral and was seen individually and with his mother for an initial assessment. The importance of a holistic assessment and engaging Jamie in this process were discussed. Psychometric tests were administered including the Birleson Depression Scale, Self Image Profile for Children and the Life in School Checklist.

Formulation: A combination of a hormonal imbalance, a genetic predisposition and lack of parental boundaries around food may have made Jamie vulnerable to excessive weight gain. Jamie’s mother, Ms Parker’s own use of food as a means of coping with stress may have acted as a model for Jamie, in that food is a means of comfort. Therefore, food was considered to possibly serve an important function for Jamie. Restraining Jamie from food, without this function being served by some other means, may have been detrimental to his self-esteem. Jamie did not appear to suffer from low mood or low self-esteem; it was important to monitor this, however, during intervention. The imbalance in Jamie’s intake of food and energy expenditure, are viewed as contributing to the vicious cycle of weight gain. It was hypothesised that Jamie sought help now because of increasing social discrimination and stigma of the obesity and specifically the gynaecomastia. The need to intervene in childhood obesity is discussed.
Cognitive behavioural interventions have been found to be effective in reducing weight in children suffering obesity. However, such an approach, which would focus on persuading Jamie to change his behaviour, was felt likely to increase Jamie’s resistance to therapy leading to his dis-engagement with services, given his unmotivated presentation and previous resistance to interventions. Motivational interviewing was considered a means of helping Jamie become more motivated and open to benefits from other treatment approaches, such as cognitive behavioural approaches. The use of motivational interviewing with eating disorders is discussed.

**Intervention:** Through developing a trusting, therapeutic relationship with Jamie, the trainee explored issues that concerned Jamie and tried to build and strengthen motivation to change, promoting his choice and personal control over his situation. The aim of intervention was to engage Jamie with psychological services, and to help him move from pre-contemplative to contemplative of behavioural change (specifically, to reduce his resistance to talking about his concerns around weight and acknowledge weight as a problem). Such change may mediate future input, which may be more cognitive behavioural based. Clinical skills including counter-attitudinal role-plays, talking in the third person and reflective listening were employed. Issues of consent to treatment given Jamie’s pre-contemplative state, the importance of full parental consent and the importance of a clear rationale for intervention were discussed.

**Outcome:** The initial aim of engaging Jamie with the service was achieved as he attended all sessions. He was also able to say weight was a problem, by recording it on his problem lists. By talking in the third person, Jamie was able to express the impact of his weight on him and the difficulties of changing his behaviour. Jamie’s mother reported that she had noticed Jamie had started eating healthy options, such as cereal, which implied Jamie was contemplating and even trying out change.

**Critical review:** The main criticism to this intervention is the lack of empirical evidence illustrating the efficacy of motivational interviewing with this population, specifically with children and obesity. This meant that it was vital to ensure informed
consent for treatment and that a clear rationale for the choice of treatment was given, weighing up the costs and benefits of intervention.
RESEARCH DOSSIER
Summary of the Research Dossier

This section includes three research projects. The service related research project is a small-scale project undertaken in the first year. This quantitative project was undertaken on behalf of the University of Surrey, Clinical Psychology Doctorate course team and placement committee to survey the views of clinical psychologists on what hinders and facilitates the provision of placements to trainees. The literature review was undertaken in the second year of training and critically reviews the current literature and research on treatments for young people who engage in deliberate self-harm. The final research project, undertaken during the second and third year, represents the major research project. This qualitative project aimed to gain an insider's perspective of deliberate self-harm by young people and what it means to be helped, employing an Interpretative Phenomenological Analysis.
SERVICE RELATED RESEARCH PROJECT

A CROSS SECTIONAL SURVEY OF FACTORS THAT MAY FACILITATE OR HINDER THE PROVISION OF PLACEMENTS TO TRAINEE CLINICAL PSYCHOLOGISTS – AN ANALYSIS OF CLINICAL PSYCHOLOGISTS' VIEWS.

July 2000

Year 1
ABSTRACT

In response to the growing demand for clinical psychologists, there has been an increase in the number of training places commissioned. This increase however has placed considerable strain upon the current availability of supervisors leading to placement shortages. The shortage of placements for trainee clinical psychologists has serious implications for the expansion of the profession. This study aimed to identify what qualified clinical psychologists viewed as important in hindering or facilitating them in placement provision. Personal benefits e.g. continued professional development, enjoyment were dominant facilitators for both those who did and those who did not offer placements. Workload and time were dominant hindrances. The need to advocate offering placements as part of the psychologist’s professional role was considered.

Aim: To identify the views of qualified clinical psychologists on what currently hinders or facilitates them in offering trainee clinical psychology placements.

Design: A cross sectional survey of qualified clinical psychologists views via a postal questionnaire.

Setting: 255 clinical psychologists currently working in the old South Thames region were sent the questionnaire over two mail shots. 128 responded, providing a 50.2% response rate.

Main measures: A two-part questionnaire was designed for this study. The first part ascertained characteristics of respondents and requested main reasons why respondents did or did not offer placements. Secondly respondents were asked to rank main domains and more specific statements that hindered or facilitated them in offering placements. Domains were identified via interviews with clinical psychologists and card sort tasks.
ACKNOWLEDGEMENTS

I would like to thank Linda Dowdney, Victoria Hill and Mary John for their contribution supervising my work. Also I would like to thank all those who took part in the card sort tasks and Dr Metka Shawe-Taylor for her help starting this study. Thank you also to Tara Iqbal and Claire Elphick for their help photo-coping.
1. BACKGROUND TO THE STUDY

The supervision of trainees on placement by qualified clinical psychologists plays a critical role in their training as clinical psychologists. Principally supervised placements enable the trainee to put theory into practice (Pratt, 1999). All clinical psychology trainees require core placements in adult mental health, people with learning disabilities (PLD), child and adolescent and older adults (The British Psychological Society (1995).

In response to the growing demand for qualified clinical psychologists, there has been a progressive increase in the number of training places commissioned. For example, within the South Thames region the annual number of training places has increased from 24 in 1994 to 48 in 2000. Further increases are planned; according to MacKenzie and Roth (1999) 25% increases in the number of clinical psychology trainees are planned nationally over the next 4-5 years.

The increasing number of trainees is however placing considerable strain upon the current availability of supervisors at both a regional and national level.

In addition, some propose that the proportion of psychologists who are eligible to offer supervision and those who actually do offer placements may by falling, especially in certain specialties (Gray, 1997). In fact the former South East Thames Training Advisory Group (TAG) identified extreme difficulties finding child and PLD placements, and stated that it was virtually impossible to find sufficient older adult placements (TAG, 1998 Consultation document).

The TAG proposed possible reasons for the shortage of placements including:

"the fragmentation of many departments; the lack of clear expectations that all qualified clinical psychologists undertake regular supervision; a failure to give priority to clinical psychology trainees over statement of equivalence candidates and other professional trainees who are not funded by the NHS; increased managerial responsibilities... (in)adequate resource to support
increased managerial responsibilities... (in)adequate resource to support training placements... lack of support from Trust management for supervisory activities because it is seen as reducing the supervisor's direct client contact," (TAG, 1998:1-2).

These ideas and the subsequent suggestions proposed in the TAG document are largely based upon the experiences of regional training courses who secure placements within each specialty, rather then on the views of qualified clinical psychologists who are eligible to supervise. One may thus question the representativeness of the evidence base and validity of TAG's report.

Mackenzie and Roth (1999) highlight how changes in the structure of the NHS may be placing increasing pressure and demands upon practicing clinical psychologists so they have less time to offer placements. Yet paradoxically the impact of insufficient placements would be to constrain the training system, limit the expansion of the profession and thus pressure will continue to grow. Ultimately this cycle may lead to a failure to meet the demand for the profession.

2. THE STUDY

2.1 Aim of the study
The aim of this study is to identify the views of qualified clinical psychologists on what currently hinders or facilitates them in offering trainee placements.

Such questions need to be answered to inform the Education Consortium and regional psychologists as to whether hindrances can be overcome; to promote factors that facilitate placements; or whether the profession actually needs to consider new approaches to training. In addition it was hoped that this research might increase awareness within the profession of the current shortage of placements and the impact this may have on the profession.
3. RESEARCH QUESTIONS

I. What factors do clinical psychologists regard as important in relation to facilitating or hindering placement provision?

II. Are there differences between those who do, and those who do not offer placements in terms of factors thought to facilitate or hinder placement provision?

4. METHODOLOGY

4.1 Design
A cross-sectional survey of qualified clinical psychologists views.

4.2 Sample
255 clinical psychologists currently working within the Old South West Thames region as identified by Surrey University database.

4.3 Measures
A two-part questionnaire was designed for the study. The first part ascertained the specialty of the respondent, their length of time practicing, working in their current post, and their preferred therapeutic orientation. In addition, it requested respondents to state the main reason why they did or did not currently offer placements. This produced qualitative data from which themes were later identified. 25% of questionnaire responses was analysed by an independent party to promote the reliability of these themes. 75% agreement was obtained between 2 raters' responses to the agreed themes (appendix 1).

The second part of the questionnaire listed 10 domains thought likely to facilitate (4 factors) or hinder (6 factors) placements provision (appendix 2). These domains were derived by means of a card sort procedure in which 47 statements were presented to 8 clinical psychologists. Each psychologist was asked to group the statements into domains; over 60% agreement was required between psychologists (5 out of 8
agreeing) for a set of statements to be considered a domain (see appendix 3). The statements themselves were derived from interviews with 5 current supervisors, 3 clinical psychologists who did not currently offer supervision and 2 Surrey University placement tutors.

Respondents were asked first to rank (1 = most important) both facilitating and hindering domains in order of importance to their own provision of placements. Secondly to rank in order of importance between 3 and 7 specific statements that was grouped under each domain heading. For each domain and specific statement a 'not applicable' category was also available.

4.4 Procedures
The questionnaire was posted to the sample. To improve the response rate all questionnaires ensured anonymity and a second mail shot was distributed 4 weeks after the initial mail shot.

4.5 Statistical analyses
Statistical analyses included Mann Whitney tests to identify significant differences between mean rank scores and Chi square tests to identify group differences in whether domains were considered applicable. SPSS was used for statistical analyses.

5. RESULTS

Due to the limitations of space, only domains ranked most important in facilitating or hindering placement provision will be examined further as well as domains where significant group differences are found between groups. The remaining analyses can be found in Adams et al (2002, in preparation).

5.1 Response rate: 128 questionnaires were returned, a 50.2% response rate. 91 (71.1%) of respondents currently provided placements. Of the remaining 37, 16 (12.5%) had previously offered placements, while 21 (16.4%) had never done so.
Given the small size of the latter non-placement provider groups, they were combined into one group for the purpose of analyses.

Characteristics of respondents in relation to specialty, preferred therapeutic model etc. can be found in appendix 4.

6. Results Part One: Facilitating the provision of placements

6.1 Domains that facilitate placement provision: quantitative analyses:

6.1.2 Main domains: Results are presented as mean rank scores. As can be seen from Table 3, the majority of respondents ranked all factors as applicable. The two factors that respondents regarded as most important emerged as 'ways in which the supervisor may benefit' and 'benefits the trainee contributes to the service in terms of client work'.

The bottom mean ranking related to the course domain itself. While 88% of respondents rated this factor as applicable, of these 54% ranked this as the fourth least important domain.

Table 3 Domains facilitating placement provision

<table>
<thead>
<tr>
<th>Facilitating domains</th>
<th>Mean rank</th>
<th>n</th>
<th>% recorded factor applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Ways the supervisor may benefit e.g. professional development, job satisfaction</td>
<td>1.85</td>
<td>117</td>
<td>91.4</td>
</tr>
<tr>
<td>2) Benefits trainee contributes to service in terms of client work</td>
<td>2.06</td>
<td>119</td>
<td>93.0</td>
</tr>
<tr>
<td>3) Other general benefits to team/ organisation</td>
<td>2.92</td>
<td>119</td>
<td>93.0</td>
</tr>
<tr>
<td>4) Way the course can help the supervisor</td>
<td>3.17</td>
<td>113</td>
<td>88.3</td>
</tr>
</tbody>
</table>
6.1.2 *Statements within main domains*: The five statements grouped within the domain ‘supervisors benefits’ can be seen in table 4. The majority of respondents reported these statements as applicable. Respondents ranked as most important, their enjoyment of contact with learners, closely followed by an increase in their awareness of other models and the promotion of a reflective style of working. Adding to their own status was ranked least important.

Table 4 Benefits to the supervisor - specific statements.

<table>
<thead>
<tr>
<th>‘Ways the supervisor may benefit’</th>
<th>Mean rank</th>
<th>n</th>
<th>% recorded applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoying contact with learners</td>
<td>1.72</td>
<td>123</td>
<td>96.1</td>
</tr>
<tr>
<td>Helping supervisor become more aware of their own style of working, consider other models, promote reflexive style of working</td>
<td>2.09</td>
<td>121</td>
<td>94.5</td>
</tr>
<tr>
<td>Encourage supervisor to keep up to date with theories/research</td>
<td>2.23</td>
<td>124</td>
<td>96.9</td>
</tr>
<tr>
<td>Opportunities to meet other regional clinical psychology supervisors</td>
<td>4.17</td>
<td>104</td>
<td>81.3</td>
</tr>
<tr>
<td>Adds to your status in the team - as someone who trains others</td>
<td>4.27</td>
<td>98</td>
<td>76.6</td>
</tr>
</tbody>
</table>

6.2 *Respondents who did or did not offer placements - group comparisons*

6.2.1 *Main domains*: There was no significant difference between the groups on whether respondents reported domains as applicable (appendix 5).

When comparing the two groups of responders, ‘benefits to the supervisor’ again emerged as an important domain, being ranked first by both groups. Within each
group, similar proportions of supervisors considered this the most important factor (table 5).

The only domain to emerge as significantly different between the groups was the course factor. Those not offering placements ranked this as significantly more important than those providing placements (Mann Whitney U=937.5, p<0.01).

Table 5 Domains facilitating placements provision - group comparisons

<table>
<thead>
<tr>
<th>Facilitating domains</th>
<th>Placements offered:</th>
<th>Mann Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=91)</td>
<td>No (n=37)</td>
</tr>
<tr>
<td></td>
<td>Mean rank</td>
<td>n</td>
</tr>
<tr>
<td>1) Ways the supervisor may benefit e.g. professional development, job satisfaction</td>
<td>1.82 (0.91)</td>
<td>83</td>
</tr>
<tr>
<td>2) Benefits trainee contributes to service in terms of client work</td>
<td>1.9 (0.93)</td>
<td>86</td>
</tr>
<tr>
<td>3) Other general benefits to team/ organisation</td>
<td>2.74 (0.92)</td>
<td>86</td>
</tr>
<tr>
<td>4) Way the course can help the supervisor</td>
<td>3.29 (1.00)</td>
<td>80</td>
</tr>
</tbody>
</table>

* p < 0.01

6.2.2 Specific statements within main domains: Exploration of rankings of specific statements within the course domain, revealed that although ranked in importance by both groups as the second least important facilitating domain, those not offering placements regarded the course providing them with training as significantly more important (Mann Whitney, u= 750.5, p<0.01).
### Table 6 Course - specific statements

<table>
<thead>
<tr>
<th>'Ways the course can help'</th>
<th>Placements offered:</th>
<th>Mann Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=91)</td>
<td>No (n=37)</td>
</tr>
<tr>
<td>Specific statements</td>
<td>Mean rank (standard deviation)</td>
<td>n</td>
</tr>
<tr>
<td>Receiving information on course content and trainees stage of learning</td>
<td>3.00 (1.64)</td>
<td>86</td>
</tr>
<tr>
<td>Provision of accurate information on trainees previous experience</td>
<td>3.06 (1.74)</td>
<td>87</td>
</tr>
<tr>
<td>Having open/ close communication with the course</td>
<td>3.65 (1.95)</td>
<td>83</td>
</tr>
<tr>
<td>Clear &amp; concise evaluation procedures</td>
<td>3.60 (1.57)</td>
<td>86</td>
</tr>
<tr>
<td>Clear &amp; concise contracts between trainee and supervisor</td>
<td>3.78 (3.59)</td>
<td>86</td>
</tr>
<tr>
<td>Being provided with training from the course on supervising</td>
<td>4.78 (2.10)</td>
<td>78</td>
</tr>
<tr>
<td>Being in a position to feedback to the course on the way it is run</td>
<td>5.84 (1.61)</td>
<td>81</td>
</tr>
</tbody>
</table>

* p <0.01

6.3 Respondents reasons for providing placements - qualitative analyses:

The explanation for providing placements cited by responders were grouped into themes outlined in section 4.3.

6.3.1 Current supervisors: The number of respondents whose reason for providing placements fell into each theme can be seen in table 7. Responders valued personal
and professional development and the development of the profession, and saw training as part of their professional role.

Table 7 Themes facilitating placement provision: current supervisors reasons

<table>
<thead>
<tr>
<th>Facilitating theme</th>
<th>Respondents who did offer placements (n=91)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>43</td>
</tr>
<tr>
<td>Development of profession</td>
<td>21</td>
</tr>
<tr>
<td>The role of a clinical psychologist</td>
<td>20</td>
</tr>
<tr>
<td>Support in training model</td>
<td>17</td>
</tr>
<tr>
<td>Promoting interest in specialty</td>
<td>16</td>
</tr>
<tr>
<td>Contribution to service</td>
<td>15</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Links with university</td>
<td>1</td>
</tr>
</tbody>
</table>

6.3.2 Those not currently providing placements: While personal and professional development was important for this group, the most important change that would facilitate placement provision related to job characteristics and time demands (table 8).

Table 8 Themes facilitating placement provision: those currently not providing placements

<table>
<thead>
<tr>
<th>Themes identified</th>
<th>Respondents who did not offer placements (n=37)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
</tr>
<tr>
<td>Change in job specifics/ demands/ time</td>
<td>12</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>10</td>
</tr>
<tr>
<td>Links, support &amp; training from the university</td>
<td>6</td>
</tr>
<tr>
<td>Nothing</td>
<td>6</td>
</tr>
<tr>
<td>Improved practical resources</td>
<td>4</td>
</tr>
<tr>
<td>Type of placement / supervision offered</td>
<td>3</td>
</tr>
<tr>
<td>Organisational/ departmental issues</td>
<td>1</td>
</tr>
<tr>
<td>Reported intentions to offer in the future</td>
<td>6</td>
</tr>
</tbody>
</table>
7 Results Part Two: Hindrances to Placement Provision

7.1 Domains that hinder the placement provision: quantitative analyses:

7.1.2 Main domains: The lack of time for supervision, due to other commitments was ranked as the most important domain hindering placement provision. This was closely followed by practical difficulties, see table 9. Least important was the course domain (mean rank 4.49), which only half of responders judged as applicable to them.

Table 9 Domains hindering placement provision

<table>
<thead>
<tr>
<th>Hindering domains</th>
<th>Mean rank</th>
<th>n</th>
<th>% recorded applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Not enough time due to other constraints</td>
<td>2.36</td>
<td>111</td>
<td>86.7</td>
</tr>
<tr>
<td>2) Practical difficulties</td>
<td>2.39</td>
<td>104</td>
<td>81.3</td>
</tr>
<tr>
<td>3) Lack of organisation/ team support</td>
<td>3.46</td>
<td>64</td>
<td>50.0</td>
</tr>
<tr>
<td>4) Supervisors personal situation/ difficulties</td>
<td>3.70</td>
<td>75</td>
<td>58.6</td>
</tr>
<tr>
<td>5) Difficulties with clients/ nature of work</td>
<td>3.89</td>
<td>59</td>
<td>46.1</td>
</tr>
<tr>
<td>6) Problems with the course</td>
<td>5.19</td>
<td>63</td>
<td>49.2</td>
</tr>
</tbody>
</table>

7.1.3 Specific statements within main domains: 86.7% of respondents ranked 'lack of time due to other commitments' as of greatest importance in hindering placement provision. However specific statements within this domain were endorsed by smaller percentages of respondents as applicable (table 10). For those who considered these statements applicable, increased managerial responsibilities and the supervision of others were ranked particularly important (table 10).
Table 10  Not enough time - specific statements

<table>
<thead>
<tr>
<th>Specific statements</th>
<th>Mean rank</th>
<th>n</th>
<th>% recorded applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Too little time due to increased managerial responsibilities</td>
<td>1.67</td>
<td>55</td>
<td>43.0</td>
</tr>
<tr>
<td>2) Too little time as I am supervising other staff (same profession)</td>
<td>2.00</td>
<td>53</td>
<td>41.4</td>
</tr>
<tr>
<td>3) Too little time as I am supervising other staff (different profession)</td>
<td>2.20</td>
<td>61</td>
<td>47.7</td>
</tr>
<tr>
<td>4) Too little time due to research commitments</td>
<td>2.87</td>
<td>46</td>
<td>36.0</td>
</tr>
<tr>
<td>5) Too little time as I am currently taking my conversion doctorate</td>
<td>3.21</td>
<td>14</td>
<td>10.9</td>
</tr>
<tr>
<td>6) Too little time as I am supervising statement of equivalent candidates</td>
<td>3.23</td>
<td>13</td>
<td>10.2</td>
</tr>
</tbody>
</table>

7.2  Respondents who did and did not offer placements - group comparisons

7.2.1  Main domains: There was no significant difference between the groups on whether respondents reported domains as applicable (appendix 5).

The rank ordering of the two most important hindrances to placements remained the same when providers and non-providers of placements were compared (table 11). In both groups, insufficient time due to other commitments and practical difficulties were ranked as the most important domains, and were considered applicable by the great majority of each group. However over half of those not offering placements ranked the domain 'supervisors personal situation/ difficulties' as significantly more important in hindering placement provision than those who did offer placements (Mann Whitney, u=317.0, p<0.01).
Table 11 Domains hindering placement provision - group comparison

<table>
<thead>
<tr>
<th>Hindering domains</th>
<th>Placements offered:</th>
<th>Mann Whitney U</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=91)</td>
<td>No (n=37)</td>
</tr>
<tr>
<td></td>
<td>Mean rank (standard deviation)</td>
<td>n</td>
</tr>
<tr>
<td>1) Not enough time due to other commitments</td>
<td>1.79 (1.06)</td>
<td>82</td>
</tr>
<tr>
<td>2) Practical difficulties</td>
<td>2.07 (1.13)</td>
<td>75</td>
</tr>
<tr>
<td>3) Supervisors personal situation/ difficulties</td>
<td>3.29 (1.67)</td>
<td>55</td>
</tr>
<tr>
<td>4) Lack of organisation/ team support</td>
<td>3.29 (1.16)</td>
<td>45</td>
</tr>
<tr>
<td>5) Difficulties with clients/ nature of work</td>
<td>3.55 (1.53)</td>
<td>44</td>
</tr>
<tr>
<td>6) Problems with the course</td>
<td>4.45 (1.40)</td>
<td>49</td>
</tr>
</tbody>
</table>

* p < 0.01

7.2.2 Specific statements within main domains: Both those who did and those who did not offer placements ranked increased managerial responsibilities as the main specific time limitation hindering placement provision (table 12). However a significantly lower proportion of the non-providers ranked this as applicable to them (Pearson's Chi Square 7.38, degrees of freedom = 1, p<0.01). A similar finding emerged in relation to time spent supervising others (same profession). Both groups ranked it as second in importance, but significantly fewer non-providers regarded this as applicable to them (Pearson's Chi Square 8.40, degrees of freedom = 1, p<0.01). Nearly half of the non-providers recorded 'supervision of others (different profession)' as applicable.
### Table 12 Specific statements within ‘not enough time’ domain - group comparisons

<table>
<thead>
<tr>
<th>Specific hindering statements</th>
<th>Placements offered:</th>
<th>Pearson's Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=91)</td>
<td>No (n=37)</td>
</tr>
<tr>
<td></td>
<td>Mean rank</td>
<td>n</td>
</tr>
<tr>
<td></td>
<td>(standard deviation)</td>
<td></td>
</tr>
<tr>
<td>Too little time due to increased managerial responsibilities</td>
<td>1.70</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>(1.03)</td>
<td></td>
</tr>
<tr>
<td>Too little time as I am supervising other staff (same profession)</td>
<td>2.07</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>(0.89)</td>
<td></td>
</tr>
<tr>
<td>Too little time as I am supervising other staff (different profession)</td>
<td>2.33</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>(1.21)</td>
<td></td>
</tr>
<tr>
<td>Too little time due to research commitments</td>
<td>3.00</td>
<td>39</td>
</tr>
<tr>
<td></td>
<td>(1.34)</td>
<td></td>
</tr>
<tr>
<td>Too little time as I am currently taking my conversion doctorate</td>
<td>3.30</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(2.39)</td>
<td></td>
</tr>
<tr>
<td>Too little time as I am supervising statement of equivalent candidates</td>
<td>3.25</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>(1.14)</td>
<td></td>
</tr>
</tbody>
</table>

(1) Pearson's Chi Square, degrees of freedom = 1

* p<0.01

Those who did not offer placements ranked ‘being newly qualified’ and ‘personal circumstances e.g. sickness, maternity leave, new in post’ as important specific statements to hinder offering placements (table 13). A significantly higher proportion of non-providers ranked being recently qualified as applicable to them then providers of placements (Pearson's chi square 13.16, degrees of freedom = 1, p < 0.001). Whilst a significantly greater proportion of providers reported ‘wanting to do other things not compatible with supervision’ (Pearson’s Chi Square 10.82, degrees of freedom = 1, p
= 0.001) and 'feeling burnt out by previous supervision load' (Pearson’s Chi Square 6.55, degrees of freedom = 1, p<0.01) as applicable then non-providers of placements.

Table 13 Supervisors personal situation/ difficulties - specific statements

<table>
<thead>
<tr>
<th>Specific hindering statements</th>
<th>Yes (n=91)</th>
<th>No (n=37)</th>
<th>Pearson’s Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean rank (standard deviation)</td>
<td>n</td>
<td>% recorded applicable</td>
</tr>
<tr>
<td>Newly qualified</td>
<td>4.91 (1.81)</td>
<td>11</td>
<td>12.1</td>
</tr>
<tr>
<td>Personal circumstances e.g. sickness/ maternity leave/ new in post</td>
<td>2.46 (1.63)</td>
<td>37</td>
<td>40.7</td>
</tr>
<tr>
<td>Not feeling confident enough to take on trainees</td>
<td>3.15 (1.53)</td>
<td>20</td>
<td>22.0</td>
</tr>
<tr>
<td>Feeling unable to provide a supportive role to trainee</td>
<td>2.81 (1.21)</td>
<td>36</td>
<td>39.6</td>
</tr>
<tr>
<td>Wanting to do other things not compatible with offering supervision</td>
<td>1.57 (0.78)</td>
<td>63</td>
<td>69.2</td>
</tr>
<tr>
<td>Feeling burnt out by previous supervision load</td>
<td>2.44 (1.41)</td>
<td>39</td>
<td>42.9</td>
</tr>
</tbody>
</table>

(1) Pearson’s Chi Square, degrees of freedom = 1

* p<0.01

7.3 Respondents reasons for not providing placements - qualitative analyses

Respondents reported ‘workload and time’ most frequently as the main reason to hinder placement provision, see table 14. Those offering placements recorded ‘insufficient practical resources’ as second most important hindrance. Significantly
more providers of placements recorded this as applicable (Pearson’s chi square 7.16, degrees of freedom = 1, p<0.01). Whilst those who did not offer placements identified ‘personal and professional development’ as second most important. Significantly more non-providers of placements recorded this as applicable (Pearson’s chi square 24.69, degrees of freedom = 1, p<0.001).

Table 14 Themes hindering provision of placements

<table>
<thead>
<tr>
<th>Themes identified</th>
<th>All respondents (n=128)</th>
<th>Did offer placements (n=91)</th>
<th>Did not offer placements (n=37)</th>
<th>Pearson Chi square</th>
<th>p value significance (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Applicable</td>
<td>%</td>
<td>Applicable</td>
<td>%</td>
<td>Applicable</td>
</tr>
<tr>
<td>Workload and time</td>
<td>71</td>
<td>55.5</td>
<td>54</td>
<td>59.3</td>
<td>17</td>
</tr>
<tr>
<td>Insufficient practical resources</td>
<td>35</td>
<td>27.3</td>
<td>31</td>
<td>34.1</td>
<td>4</td>
</tr>
<tr>
<td>Professional personal development</td>
<td>14</td>
<td>10.9</td>
<td>2</td>
<td>2.2</td>
<td>12</td>
</tr>
<tr>
<td>Problems with the University</td>
<td>5</td>
<td>3.9</td>
<td>4</td>
<td>4.4</td>
<td>1</td>
</tr>
<tr>
<td>Organisational issues</td>
<td>5</td>
<td>3.9</td>
<td>4</td>
<td>4.4</td>
<td>1</td>
</tr>
<tr>
<td>Appropriateness of supervisors work/work setting</td>
<td>5</td>
<td>3.9</td>
<td>5</td>
<td>5.5</td>
<td>0</td>
</tr>
<tr>
<td>Trainee factors</td>
<td>5</td>
<td>3.9</td>
<td>4</td>
<td>4.4</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
<td>4</td>
<td>3.1</td>
<td>2</td>
<td>2.2</td>
<td>2</td>
</tr>
<tr>
<td>Nothing</td>
<td>1</td>
<td>0.8</td>
<td>1</td>
<td>1.1</td>
<td>0</td>
</tr>
</tbody>
</table>

(1) Pearson’s Chi Square, degrees of freedom = 1

* p<0.01

**p<0.001
8. DISCUSSION

8.1 Facilitating provision of placements

The dominant reasons identified to facilitate psychologists in offering placements were principally ways in which they benefited, more specifically enjoying contact with learners, promoting a reflective style of working and awareness of other models and secondly, benefits the trainee contributes to the service in terms of client work. This finding was applicable to both providers and non-providers of placements.

These results suggest Clinical Psychologists were attracted to offering placements if they personally benefited from it i.e. in terms of continued professional development, enjoyment etc. The qualitative analysis from this study suggests that they did. The most frequently given reason why current supervisors offered placements was because of the benefits to them in terms of the personal and professional development/gain they experience. Although some supervisors did emphasise the contribution trainees made to the service (the second most important domain to help in the provision of placements), the majority of supervisors emphasised offering placements as an integral part of their professional role and a pre-requisite for developing the profession (refer to MacKenzie and Roth, 1999 for research detailing the positive contribution trainees make to services).

In subtle contrast to this, some psychologists, who did not offer placements, appeared to view offering placements as an additional aspect of their work, requiring a change in job characteristics or time demands to be able to offer placements. Further qualitative analyses indicated that the pressures of workload and time in hindering placement provision for the majority of Clinical Psychologists should not be minimized; considering over 50% of all respondents later identified this as the main hindrance to placement provision.

Course input was not dominant in facilitating placement provision in general. However this domain appeared more pertinent to those who did not currently offer placements. Specifically non-providers appeared to want training from the course on
supervision. This may merely reflect the fact that placement providers feel adequately trained to offer supervision, which may explain the resulting discrepancy between the two groups. Alternatively, however, questions are raised whether non-providers are aware of the workshops run by courses on supervision and/or whether the workshops are an effective way of training all Clinical Psychologists? A longitudinal survey of those who have undertaken the workshop might help address such questions.

8.2 Hindering provision of placements

The provision of placements was hindered principally by time limitations due to other commitments and secondly practical difficulties. Once again this finding was applicable to both providers and non-providers of placements. Of some concern, is the finding that those who currently offer placements reported feeling burnt out by their previous supervision load.

There was a clear match between the results from the quantitative analyses in terms of domains that hinder placement provision, and main hindrances, identified by responses to open ended questions. Thus qualitative analyses also highlighted workload and time and additionally insufficient practical resources as dominant hindrances to placement provision. The latter was more applicable to providers of placements, whilst the need for personal and professional development was more applicable to non-providers. The latter result highlights further the apparent need felt by some non-providers for further training or further professional development to facilitate supervising trainees.

About half of the sample not providing placements emphasised personal circumstances hindering placement provision. This may reflect a proportion of this sample who are recently qualified, relatively new in post, returning from maternity leave etc.

Current supervisors reported other commitments, which limited their time to offer placements, included increased managerial responsibilities and the supervision of others (same profession). For those not offering placement such commitments were
significantly less applicable. Supervision of other staff from different professions appeared more pertinent to many non-providers in limiting their time to offer placements. One might hypothesise from this that some psychologists, not currently offering placements, may place greater emphasis/priority on providing supervision to professionals within their own multi-disciplinary team/service, rather than providing placements to trainee Clinical Psychologists.

8.3 Comparisons with previous literature

The importance of work pressures and time in hindering placement provision is congruent with statements previously highlighted by MacKenzie and Roth (1999) i.e. increased pressure and demands placed upon Clinical Psychologists within the NHS are leading to less time to offer placements. Specific pressures identified in this study are increased managerial responsibilities and the supervision of others.

A number of the suggestions made in the TAG (1998) document are not evident in the findings of this study. For example, the sample did not appear to prioritise statements of equivalence candidates over clinical psychology trainees. Also the study demonstrated that lack of team/trust management support for trainees was not a dominant hindrance to placement provision for the majority of the sample. Although these factors may have some importance, they were not reported as dominant hindrances in this study.

8.4 Limitations of the study

The relatively lower response rate from those not providing placements may provoke questions over the generalisation of results from this group. Further research might target non-providers specifically to gain further insight.

In addition, some specific statements that hindered or facilitated placement provision may have been missed by this questionnaire. For example, although the majority recorded ‘time limitations due to other commitments’ as applicable, only about half recorded more specific statements within this domain as applicable to them. This suggests that other factors might not have been considered. Although open questions
were incorporated to address this, this may merely reflect a limitation of the questionnaire design.

Further research might follow up this questionnaire with interviews to gain further clarity. Replications of this study would contribute to the validity of the findings, and help in identifying whether these findings are applicable across regions.

### 8.5 Conclusions

This study found clear facilitators and hindrances to placement provision. Increasing work pressures and demands on Clinical Psychologists are the dominant hindrance to offering placements. Earlier in this study consideration was given to the potential impact of placement shortages on the expansion of the profession i.e. the profession is constrained and work pressures will continue to mount. This study has highlighted the benefits of offering supervision (pre-dominantly professional development but also service contribution) and possible ways to cut into this cycle. For example, the profession needs to advocate offering placements to trainees as part of the professional role of the Clinical Psychologist, as we have seen reported by current placement providers. In addition, non-providers appeared to want further training from courses and/or professional development. The profession may also need to prioritise the provision of supervised placements to Trainee Clinical Psychologist over the supervision of other professionals. Further research is suggested to validate and generalise these findings.
REFERENCES


### APPENDIX 1

Table 16 Percentage agreement between 2 raters on identified themes – qualitative measures

(1) Themes that hinder – all responders

<table>
<thead>
<tr>
<th>Identified theme</th>
<th>Agreed</th>
<th>Disagreed</th>
<th>% agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient practical resources</td>
<td>9</td>
<td>1</td>
<td>90.0</td>
</tr>
<tr>
<td>Workload and time</td>
<td>13</td>
<td>4</td>
<td>76.5</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Problems with the university</td>
<td>1</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Organisational issues</td>
<td>5</td>
<td>1</td>
<td>83.3</td>
</tr>
<tr>
<td>Appropriateness of work/ setting of supervisor</td>
<td>3</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Trainee factors</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Others</td>
<td>5</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Nothing</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>38/45</td>
<td>6/45</td>
<td>84.4%</td>
</tr>
</tbody>
</table>
(2) Themes that facilitate - responders who did not offer placements

<table>
<thead>
<tr>
<th>Identified theme</th>
<th>Agreed</th>
<th>Disagreed</th>
<th>% agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved practical resources</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Change in job characteristics/ time</td>
<td>2</td>
<td>1</td>
<td>66.7</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Links with university</td>
<td>2</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Type of placement/ supervision offered</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Nothing</td>
<td>1</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>1</td>
<td>92.3%</td>
</tr>
</tbody>
</table>

(3) Themes why supervisors offer placements - responders who did offer placements

<table>
<thead>
<tr>
<th>Identified theme</th>
<th>Agreed</th>
<th>Disagreed</th>
<th>% agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contribution to the service</td>
<td>6</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Support in the training model</td>
<td>8</td>
<td>2</td>
<td>80</td>
</tr>
<tr>
<td>Links with the university</td>
<td>1</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Promoting interest in specialty</td>
<td>4</td>
<td>1</td>
<td>75</td>
</tr>
<tr>
<td>Personal and professional development</td>
<td>11</td>
<td>2</td>
<td>84.6</td>
</tr>
<tr>
<td>Development of profession</td>
<td>4</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Part of role of a clinical psychologist</td>
<td>5</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>Total</td>
<td>39</td>
<td>5</td>
<td>88.6%</td>
</tr>
</tbody>
</table>
APPENDIX 2

The resulting domains from the card sort task

Facilitates placements

1. Ways in which the course can help you as a supervisor
2. Benefits that the trainee may contribute to the service in terms of client work
3. Other general benefits to the team/ organisation
4. Other ways in which you as the supervisor may benefit e.g. professional development, job satisfaction

Hinders placements

1. Supervisors personal situation/ difficulties
2. Problems with the course
3. Not enough time due to other commitments
4. Practical difficulties
5. Lack of organisational/ team support to take on trainees
6. Difficulties with clients/ nature of work
APPENDIX 3

The following statements were identified from interview with 5 current supervisors, 3 clinical psychologists who did not currently offer placements and 2 university placement tutors. 8 psychologists were then asked to sort the statements into groups, results of which are tabulated overleaf.

Facilitating statements
1. Having open and/or close communication with the course
2. Clear and concise contracts between trainee and supervisor
3. Being provided with training from the course on supervising
4. Opportunity to meet other clinical psychologists in the region also providing supervision
5. Being in a position to feedback to the course on that way it is run
6. Provision of accurate information on the trainees previous experience
7. Receiving information on the course content and trainees stage of learning
8. Clear and concise evaluation procedures
9. Enjoying contact with learners (stimulating, read recent books, new ideas)
10. Helping supervisor become more aware of their own style of working and/or consider other models e.g. promote a reflective style of working
11. Encourage supervisors to keep up to date with theories/ research
12. Adds to your status in the team – as someone who trains others
13. Provides opportunity for more varied work, i.e. clients seen by trainee
14. Trainee is able to provide therapy that the supervisor is unable to due to time constraints
15. Trainee feedback about service to potential employees – recruitment possibilities
16. Good for organisation to be seen to have trainees
17. Get a lot of good work done for free
18. Helps reduce waiting lists – more clients are given a service
19. Many help provide additional resources for service as a result of trainee being there e.g. extra desks, secretarial support, access to libraries
20. For trainee to have had experience of clinical supervision before
21. For the trainee to have had a pre-placement visit.
Hindering statements
A. Not getting enough information from the course
B. Feeling the course is not supportive of you as a supervisor
C. Disorganisation of the course i.e. asking you too late
D. The course failing to attracting good enough trainees
E. Too little time as I am supervising statements of equivalence candidates
F. Too little item as I am supervising others (same professions)
G. Too little time as I am supervising others (different professions)
H. Too little time as I am currently taking my conversion doctorate
I. Too little time due to increased managerial responsibilities
J. Too little time due to research commitments
K. Newly qualified
L. Personal circumstances (sickness, maternity leave, new in post)
M. Not feeling confident enough to take on trainee
N. Feeling burnt out by previous supervision workload
O. Wanting to do other things not compatible with offering supervision
P. Disagree with orientation of course in terms of models taught
Q. Feel that 6 months is too short for trainee to make real contribution
R. Feeling unable to provide a supportive role to trainee
S. Too specialised clinical work
T. Insufficient quantity of clinical work due to increased managerial work
U. Lack of support from team/ trust management for you to supervise as it is seen as reducing your direct client contact
V. Lack of support from team/ trust management for you to supervise as it is seen as reducing your indirect clinical work i.e. consultation, supervision of other team members, other professionals
W. Inappropriate setting i.e. working with dangerous clients
X. Referrers are not happy for their patients to be seen by trainees
Y. Patients are not happy about being seen by trainees
Z. Lack of space i.e. rooms to see clients, office space
aa. Too little equipment i.e. desks, tests
bb. Too little secretarial support
cc. No/ limited access to computers/ word processing facilities
dd. Travel difficulties i.e. isolated location

ee. Trainees contribution to the service not recognized as beneficial by the trust/ team management
APPENDIX 4

Specialty

Table 19 The number and percentage distribution of respondents in each specialties compared to clinical psychologists within the region in each specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of respondents in each specialty (percentage)</th>
<th>Number of clinical psychologist within the Old South West Thames region in each specialty (percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult mental health</td>
<td>42 (32.8)</td>
<td>86 (33.7)</td>
</tr>
<tr>
<td>People with learning disability</td>
<td>23 (18.0)</td>
<td>35 (13.7)</td>
</tr>
<tr>
<td>Child and Adolescents</td>
<td>23 (18.0)</td>
<td>41 (16.1)</td>
</tr>
<tr>
<td>Older Adults</td>
<td>9 (7.0)</td>
<td>16 (6.3)</td>
</tr>
<tr>
<td>Specialist/ others</td>
<td>30 (23.5)</td>
<td>77 (30.2)</td>
</tr>
</tbody>
</table>

Years practicing, in specialty and in current post

Table 20 The range, mean and standard deviation of years practicing as clinical psychologist, working in current specialty and current post

<table>
<thead>
<tr>
<th>Number of years:</th>
<th>Range</th>
<th>Mean number of years</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Practicing as a clinical psychologist</td>
<td>0.5 - 30.0 years</td>
<td>11.6 years</td>
<td>8.0</td>
</tr>
<tr>
<td>2. In current specialty</td>
<td>0.5 - 29 years</td>
<td>8.8 years</td>
<td>6.6</td>
</tr>
<tr>
<td>3. In current post</td>
<td>&lt; 0.5 - 20.0 years</td>
<td>4.6 years</td>
<td>4.0</td>
</tr>
</tbody>
</table>
Figure 1: A pie chart showing the number of years worked in current post

Preferred therapeutic model

Figure 2 Pie charts to show the percentage of respondents' preference in therapeutic models for (1) all respondents, (2) those that did offer placements and (3) those that did not currently offer placements

(1) All respondents
(2) Respondents who did offer placements

(3) Respondents who did not offer placements
## APPENDIX 5

Table 21  Group comparison between domains recorded as applicable

<table>
<thead>
<tr>
<th>Domain</th>
<th>Offered placements:</th>
<th>Pearson’s Chi Square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n=91)</td>
<td>No (n=37)</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>% applicable</td>
</tr>
<tr>
<td>Facilitators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Ways the supervisor may benefit e.g. professional development, job satisfaction</td>
<td>83 91.2 34 91.9</td>
<td>1 0.90</td>
</tr>
<tr>
<td>2) Benefits trainee contributes to service in terms of client work</td>
<td>86 94.5 33 89.2</td>
<td>1 0.29</td>
</tr>
<tr>
<td>3) Other general benefits to team/ organisation</td>
<td>86 94.5 33 89.2</td>
<td>1 0.29</td>
</tr>
<tr>
<td>4) Way the course can help the supervisor</td>
<td>80 87.9 33 89.2</td>
<td>1 0.84</td>
</tr>
<tr>
<td>Hindrances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Not enough time due to other constraints</td>
<td>82 90.1 29 78.4</td>
<td>1 0.76</td>
</tr>
<tr>
<td>2) Practical difficulties</td>
<td>75 82.4 29 78.4</td>
<td>1 0.60</td>
</tr>
<tr>
<td>3) Supervisors personal situation/ difficulties</td>
<td>55 60.4 20 54.1</td>
<td>1 0.51</td>
</tr>
<tr>
<td>4) Lack of organisation/ team support</td>
<td>45 49.5 19 51.4</td>
<td>1 0.85</td>
</tr>
<tr>
<td>5) Difficulties with clients/ nature of work</td>
<td>44 48.5 15 40.5</td>
<td>1 0.42</td>
</tr>
<tr>
<td>6) Problems with the course</td>
<td>49 53.9 14 37.8</td>
<td>1 0.10</td>
</tr>
</tbody>
</table>
APPENDIX 6

The Questionnaire (4 pages)
PLEASE COMPLETE IN RELATION TO YOURSELF AND YOUR CURRENT SITUATION:

1. What is your specialty? (Please specify if this is a split post) ..........................................................

2. How many years have you worked in this specialty? ............................................................................

3. How long have you worked in your current post? .............................................................................

4. How many years have you been practising as a clinical psychologist? ..............................................

5. What is your preferred therapeutic model? .........................................................................................

The provision of placements to trainees

6. Do you currently offer placements to trainees? □ Yes □ No
   
   If Yes go to question 7
   
   If No and you have never offered placements to trainees go to question 8a
   
   If No and you have previously offered placements to trainees go to question 8b

7. If YES
   
   For how many years have you offered placements to trainees? ........................................................
   
   What is the main reason why you offer a placement to trainees?
   
   What is the main hindrance to you offering placements to trainees?

   Go to question 9

8. If NO
   
   (a) Never offered placements
   
   What is the main reason why you do not currently offer placements to trainees?

   What would attract you to offering placements to trainees?

   Go to question 9

   (b) Have previously offered placements
   
   When was the last time you offered a placement to a trainee? ..........................................................
   
   What was the main reason why you decided to stop offering placements to trainees?

   What would attract or help you to re-initiate offering placements to trainees?
9. What type of placement do you, or would you, offer if circumstances were favourable? Please circle

(a) Core  
(b) Specialist  
(c) Both

FACTORS THAT MAY FACILITATE PLACEMENT PROVISION

10. The following areas may help you offer a placement to a trainee. Please rank them in order of importance to you and your current situation, (1 being the most important). If any area is not applicable to you please write N/A.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Ways in which the Course can help you as a supervisor</td>
</tr>
<tr>
<td></td>
<td>B. Benefits trainees may contribute to your service in terms of client work</td>
</tr>
<tr>
<td></td>
<td>C. Other general benefits to the team/organisation</td>
</tr>
<tr>
<td></td>
<td>D. Ways in which you as the supervisor may benefit e.g. professional development, job satisfaction</td>
</tr>
</tbody>
</table>

11. Within each of these areas, there are a number of more specific factors that may help you to offer a placement to a trainee. Please rank them in order of importance to you and your current situation, (1 being the most important). If a factor is not applicable to you, please write N/A.

A. Ways in which the Course could help you as a supervisor

- Having open and/or close communication with the Course
- Clear and concise contracts between trainee and supervisor
- Being in a position to feedback to the Course on the way it is run
- Provision of accurate information on a trainee’s previous experience
- Receiving information on Course content and a trainee’s stage of learning
- Clear and concise evaluation procedures
- Being provided with training from the Course on supervising

B. Benefits derived from trainees undertaking client work

- Helps reduce waiting lists - more clients are given a service
- Trainee is able to provide therapy that the supervisor is unable to due to time constraints
- Get a lot of good work done for free

C. Other general benefits to the team/organisation/service

- May help provide additional resources for service as a result of trainee being there e.g. extra desk, secretarial support, access to libraries
- Good for organisation to be seen to have trainees
- Trainees feedback about the service to potential employees - recruitment possibilities
A survey of factors that may facilitate or hinder the provision of placements for trainees - the supervisors’ perspective

D. Benefits for you, e.g. professional development, job satisfaction
- Opportunities to meet other regional clinical psychology supervisors
- Enjoying contact with learners (stimulating, read recent books, new ideas)
- Helping supervisor become more aware of their own style or working
  and/or considering other models e.g. promote a reflective style of working
- Encourage supervisor to keep up to date with theories/ research
- Adds to your status in the team - as someone who trains others

12. Please add any other benefits to you or any other factors which would facilitate you offering placements that have not been identified above ...........................................

FACTORS THAT MAY HINDER PLACEMENT PROVISION

13. The following areas may hinder/prevent you offering a placement to a trainee. Please rank them in order of importance to you and to your current situation, (1 being the most important). If any area is not applicable to you please write N/A.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. Supervisors personal situation/ difficulties</td>
</tr>
<tr>
<td></td>
<td>B. Problems with the Course</td>
</tr>
<tr>
<td></td>
<td>C. Not enough time due to other commitments</td>
</tr>
<tr>
<td></td>
<td>D. Practical difficulties (physical and environmental restrictions)</td>
</tr>
<tr>
<td></td>
<td>E. Lack of organisation/ team support to take on trainees</td>
</tr>
<tr>
<td></td>
<td>F. Difficulties with clients/ nature of work</td>
</tr>
</tbody>
</table>

14. Within each of these areas, there are a number of more specific factors that may hinder/prevent you offering a placement to a trainee. Please rank them in order of importance to you and your current situation, (1 being the most important). If a factor is not applicable to you please write N/A.

A. Supervisors personal situation/ difficulties
- Newly qualified
- Personal circumstances e.g. sickness/ maternity leave/ new in post
- Not feeling confident enough to take on trainee
- Feeling burnt out by previous supervision load
- Wanting to do other things not compatible with offering supervision
- Feeling unable to provide a supportive role to trainee

B. Problems with the Course
- Not getting enough information from the Course
- Feeling the Course is not supportive to you as a supervisor
- Disorganisation of the Course i.e. asking you too late
- The Course failing to attract good enough trainees
- Disagreeing with the orientation of the Course in terms of models taught
- Feeling that 6 months is too short for trainee to make a real contribution
A survey of factors that may facilitate or hinder the provision of placements for trainees - the supervisors' perspective

C. Not enough time due to other commitments

- Too little time as I am supervising statement of equivalent candidates
- Too little time as I am supervising other staff (same profession)
- Too little time as I am supervising other staff (different profession)
- Too little time as I am currently taking my conversion doctorate
- Too little time due to increased managerial responsibilities
- Too little time due to research commitments

D. Practical difficulties (physical and environmental restrictions)

- Lack of space i.e. rooms to see clients, office space
- Too little equipment i.e. desks, tests
- Too little secretarial support
- No/limited access to computers/word processing facilities
- Travel difficulties i.e. isolated placement location

E. Lack of organisation/team support to take on trainees

- Lack of support/encouragement from your team/Trust management for you to supervise as it is seen as reducing your direct client contact
- Lack of support/encouragement from your team/Trust management as it is seen as reducing your indirect clinical work, i.e. consultation, supervision of other team members/other professionals
- The trainee contribution is not recognised as beneficial by team/Trust management

F. Difficulties with clients/nature of work

- Referrers are not happy for their patients to be seen by trainees
- Patients are not happy to be seen by trainees
- Inappropriate setting i.e. working with dangerous clients
- Too specialised clinical work

15. Please add any other factors which would hinder you in offering placements to trainees that have not been identified above

...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................
...........................................................................................................................................................................

Thank you for your time. Please return in the S.A.E. provided
APPENDIX 7

Covering letters for questionnaires
28th March 2000

Dear Clinical Psychologist

PsychD First Year Research
“A survey of domains that may facilitate or hinder the provision of placements for trainees - an analysis of clinical psychologists views”

Let me introduce myself. My name is Sarah Adams and I am a first year on the University of Surrey PsychD course. I am currently undertaking this research project on behalf of the course placement committee. We would very much appreciate your help.

Rationale for the study
As you are no doubt aware, the demand for qualified clinical psychologists is constantly growing and this has led to a gradual increase in the number of training places being made available by universities throughout the country. However the rise in training places has placed considerable strain upon the current availability of supervisors at both a national and regional level. Unless this shortfall is addressed the expansion of the profession and meeting the demand for the profession may be placed at risk.

The Training Advisory Group, a sub-committee of the Regional Heads of Department Group produced a report containing suggestions on how to tackle the shortage of placements. However they relied largely upon the experiences of regional training courses who have the task of securing placements, rather than on the views of qualified clinical psychologists working in the field. This research sets out to find the views of qualified clinical psychologists about offering placements to trainees.

My plans
Please find enclosed a copy of my research questionnaire. I will be disseminating this questionnaire to all qualified clinical psychologists within the Old South West Thames region. All questionnaires are anonymous and confidential. The questionnaire should take about 10 minutes to complete. Please return the questionnaire in the stamped addressed envelope enclosed.

If you would like to discuss this research further please feel free to contact me at the University of Surrey. Thank your time. Your help is really appreciated.

Yours sincerely

Trainee Clinical Psychologist
28th April 2000

Dear Clinical Psychologist

PsychD First Year Research
“A survey of domains that may facilitate or hinder the provision of placements for trainees - an analysis of clinical psychologists views”

As you may recall I sent out a questionnaire on this research in March. If you have already completed the questionnaire, let me take this opportunity to thank you for your help and ask you to please ignore this reminder. If you have not yet had the chance, please complete the enclosed questionnaire and return to me as soon as possible. It should only take about 10 minutes to complete the questionnaire.

If you wish to discuss this research further please contact me at the University of Surrey.

Thank you very much for your time.

Yours sincerely

Trainee Clinical Psychologist
APPENDIX 8

Feedback findings to placement committee

Miss Sarah Adams
Trainee Clinical Psychologist
Psychology Department
University of Surrey
Guildford
Surrey

*****
Clinical Psychologist

11th July 2002

Dear *****

Re: Service related research project -
Factors that facilitate and hinder provision of placements to trainee clinical psychologists

On behalf of the University of Surrey placement committee, I completed a research project that attempted to survey the views of qualified clinical psychologist in terms of what hindered and facilitated the provision of placements to trainee clinical psychologists. This study aimed to identify the views of both those who currently offer placements and those who do not. Unfortunately, I understand that the placement committee has now disbanded. Therefore please find enclosed a copy of the abstract for this project, which details the main findings. Linda Dowdney supervised this project and we are in the process of trying to publish this research.

Please feel free to contact Linda or myself if you would like to learn more about this project.

Yours sincerely

Sarah Adams
Trainee Clinical Psychologist
A CROSS SECTIONAL SURVEY OF FACTORS THAT FACILITATE OR HINDER THE PROVISION OF PLACEMENTS TO TRAINEE CLINICAL PSYCHOLOGISTS - AN ANALYSIS OF CLINICAL PSYCHOLOGISTS' VIEWS.

Abstract

The increase in training commissions has placed considerable strain upon the current availability of supervisors leading to placement shortages. The shortage of placements for trainee clinical psychologists has serious implications for the expansion of the profession. On behalf of the University of Surrey placement committee, this study aimed to survey qualified clinical psychologists views on what currently hindered and facilitated their provision of placements to trainees.

Design: A cross sectional survey of qualified clinical psychologists views via a postal questionnaire.

Sample: 255 clinical psychologists currently working in the old South Thames region were sent the questionnaire over two mail shots. 128 responded, providing a 50.2% response rate. 91 (71.1%) of respondents currently provided placements, the remainder did not.

Main findings:

• Both providers and non-providers of placements reported that 'benefits to the supervisor' (enjoying contact with learners, developing their own clinical style and keeping up to date with research/theories) and 'benefits the trainee brings to the service in terms of client work' were important in facilitating the provision of placements.

• Significantly more non-providers than providers felt further training would facilitate placement provision; which raised the question of whether non-providers are aware of the Universities training workshops in supervising trainees and also whether such workshops are the best way of training all clinical psychologists.

• Not enough time and practical difficulties were dominant hindrances for both providers and non-providers. Specifically, however, current providers were more likely than non-providers to report that 'increased managerial responsibilities' and the 'supervision of others (same profession)' was applicable to them in hindering placement provision. Of further concern is that many providers felt burnt out by their previous supervision load.

• Problems with the course did not appear to hinder placement provision, as these were ranked as least important hindrance to placements.

• The need to advocate offering placements to trainees as part of the professional role of the clinical psychologist is discussed along with a consideration of whether the profession needs to prioritise the provision of supervised placements to trainee clinical psychologists over the supervision of other professionals.
Feedback received from one member of the placement committee

Dear Sarah,

Thank you for the research project.

Feedback: Unfortunately, the recent S16 was cancelled so I wasn't able to check on jobs running up around the region. I'll keep an eye on those out. Meanwhile, we may be putting together a London post if that is of any interest. I'm not clear about sessions on

194b
LITERATURE REVIEW

THE TREATMENT OF ADOLESCENTS WHO DELIBERATELY SELF-HARM - A REVIEW AND CRITIQUE OF THE LITERATURE

Year 2

September 2001
INTRODUCTION

The current literature on deliberate self-harm focuses predominantly around a number of inter-related areas including: - (1) The prevalence and incidence of deliberate self-harm (2) Guidelines for the acute management of deliberate self-harm incidents (3) Identifying risk factors in predicting the likelihood of repeat incidents to inform risk assessment procedures and (4) Investigating the effectiveness of treatment initiatives for patients who have engaged in deliberate self-harm. This review aims to: - (1) briefly review the current literature on the definition and prevalence of deliberate self-harm in adolescents in order to demonstrate that it is a clinically important area and (2) review treatment initiatives for adolescents who deliberately self-harm (DSH) and critique evidence for the efficacy of such approaches in reducing repetition rates. Consideration of risk factors will be undertaken only when it informs treatment initiatives; however a comprehensive review of all documented risk factors and risk assessment procedures for adolescents who DSH will not be possible (for a review on risk factors and risk assessment refer to Spirito, Brown, Overholser and Fritz, 1989 or Miller and Glinski, 2000).

Due to the paucity of research into the treatment of adolescents who DSH, many of the interventions used with this population are based on the treatment effects found with adults who DSH. Although such information is useful, Spirito et al. (1989) and Hazell (2000) argue that studies on adults who DSH might not be generalisable to an adolescent population. They propose a number of reasons for this including: - (1) adolescents who DSH have been found to have a lower risk of suicide completion in the short and medium term when compared to adults who DSH; (2) adolescents differ from adults in terms of their financial status, responsibilities and difficulties faced and possibly their ability to engage in treatment (practically and emotionally); (3) it fails to take into consideration the developmental stage and transitional difficulties faced by the adolescent and his/ her family; and (4) adolescents do not necessarily respond as well to treatments that have been shown to be effective with adults, such as pharmacological treatments (Hazell, O’Connell, Heathcote, Robertson and Henry,
In light of this, this review will focus on research specifically aimed at the target population, that is adolescents who DSH.

Due to the limited number of treatment studies, the underlying assumptions/theory upon which the most frequently cited interventions are based will also be reviewed and the empirical evidence for these assumptions critiqued.

1.1 Clarifying the Problem of DSH

"The evaluation and treatment of adolescent suicide attempters is one of the most common, and most demanding emergencies in child and adolescent mental health practice," (Brent, 1997).

DSH accounts for approximately 100,000 referrals to general hospitals each year in England and Wales (Hawton and Fagg, 1992 cited in Hawton, 1997) and a significant proportion of these referrals are adolescents (one fifth). In some health districts within the UK, deliberate overdoses account for one fifth of all referrals to child psychiatry (Kerfoot and McHugh, 1992 cited in Harrington, Kerfoot, Dyer, McNiven and Gill, 1998). Clinical follow up studies suggest that many adolescents who DSH will repeat self-harm (Brent, Kolko, Wartella, Boylan and Moritz, 1993) or even complete suicide (Goldacre and Hawton, 1985). At least 1% of patients, who present to hospitals in the UK after DSH, complete suicide within a year, this figure rises to 3-5% within 5-10 years (Hawton and Fagg, 1988). Suicide is among the leading causes of death in this age group and efforts to reduce suicide rates have been recognized by government initiatives in the past.

DSH presents a major health problem due to the increased likelihood of co-morbid physical and psychological problems, the associated increased risk of suicide (Goldacre and Hawton, 1985) and the economic cost on the health care system (Spirito, Brown, Overholser and Fritz, 1989). Treatments are required for those at high risk of suicide or further self-harm. Yet, despite the high prevalence of DSH in adolescents, there remains little consensus about what constitutes the most effective treatment initiatives for this population. In a systemic review of randomized...
controlled trials of psychosocial treatments (Hawton, Arensman, Townsend, and Bremner, 1998), only a single study was included that investigated treatment effects, specifically on adolescent self-harmers (Cotgrove, Zirinski, Black and Weston, 1995). This raises concerns given the current pressures within the National Health Service (NHS) to provide treatments that are supported by empirical evidence (evidence-based practice). This review aims to pull together the limited, but important literature on the treatment of adolescents who DSH in order to develop a coherent understanding of the literature to date, to inform future models of treatment and highlight areas for future research.

1.2 Definition of DSH and prevalence studies
Jones (1987) defines DSH as “any non-accidental behaviour, initiated by the individual, which directly results in the physical harm to that individual” (Jones, 1987:287). Yet the definition of deliberate self-harm is not universally accepted, which has implications for prevalence rates and research in this field. Indeed Burrows (1992) referred to the state of literature on such behaviour as a ‘semantic paella’, including terms such as self destructive behaviour, parasuicide and attempted suicide. Contention surrounds the intentionality of the act e.g. whether the adolescent intended to kill themselves. Miller and Gliński (2000) conclude that it is not possible to differentiate clearly between suicide intentional behaviours and non-suicidal self-harming behaviours.

Most prevalence studies focus upon the incidence of adolescents presenting to health services after engaging in DSH. Such prevalence figures are likely to reflect an under-estimate of the extent of the problem, as many incidents of DSH may go un-reported as no medical attention is sought (Smith and Crawford, 1986; Hawton and Goldacre, 1982). There is evidence to suggest that the prevalence of DSH in the Britain is increasing (Bialas, Reid, Beck, Lazarus, Smith and Scorer, 1996 cited in Hawton et al., 1998). However it is possible that this may merely reflect more accurate prevalence figures (i.e. professionals are getting better at detecting the problem) rather than an actual increase in the problem.
2 A REVIEW AND CRITIQUE OF PREVIOUS INVESTIGATIONS

2.1 Cognitive Behavioural Approaches for Adolescents who DSH
Two interventions are considered from a cognitive perspective in treating adolescents who DSH including: - (1) Cognitive Behaviour Therapy and (2) Problem Solving Therapy.

2.1.1 Theoretical rationale

Cognitive behaviour therapy
Cognitive behaviour therapy (CBT) was originally developed for use with depressed adults (Beck, 1976) and assumes DSH is a consequence of cognitive distortions and a negative attributional style. Cognitive distortions that may lead to acts of DSH include arbitrary inferences (making assumptions based on little or no evidence), over or underestimating the significance of events, all or nothing thinking and catastrophising (Hazell, 2000). CBT aims to help the individual challenge their negative cognitions about themselves, their situation and their future and consider other ways of viewing and reacting to events in order to reduce the repetition of DSH.

Problem solving therapy
A specific form of cognitive therapy is problem-solving therapy. This assumes that DSH is the result of deficits in problem solving skills, which limits the adolescent’s ability to cope with interpersonal problems and regulate their emotions. The application of problem solving therapy is linked to the diathesis-stress-hopelessness model. This hypothesizes that cognitive rigidity, or the inability to identify problems and generate solutions, leads to hopelessness when facing difficult situations, placing the individual at heightened risk of self-harming (Schotte and Clum, 1987). Deficits in problem solving skills are particularly significant given the transitional phase of adolescence and the likely high incidence of life events and difficulties encountered during adolescence (Hawton, 1997). Problem solving therapy aims to help the adolescents (and sometimes their families) learn steps to solve problems, including defining problems and brainstorming alternative solutions (Spirito, 1997 cited in Hazell, 2000).
2.1.2 Evidence to support a cognitive behavioural model of DSH in adolescents

Do adolescents who engage in DSH have a negative attributional style/ cognitive distortions and/or poor problem solving skills?

Rotherum-Borus, Trautman, Dopkins, and Shrou (1990) compared the attributional style and problem solving ability of 77 female adolescents who DSH with 2 control groups without a history of self-harm: 39 adolescents with psychiatric illness and 23 adolescents with no psychiatric illness. Both IQ and depression were controlled due to the impact each might have upon cognitive style (only those with IQ over 70 were included in the study). Given the risk of type 1 error, due to the number of comparisons being made within the study, the Bonferroni equation was used to appropriately modify the significance levels. A further strength of this study was that problem-solving skills were measured using tests standardised on an adolescent population, including the Means-Ends Problem Solving Test (Platt and Spivack, 1975 cited in Rotherum-Borus et al., 1990).

The study found that adolescents who had engaged in DSH “had poor interpersonal problem-solving skills relative to both psychiatrically disturbed non-attempters and non-disturbed non-attempters” (Rotherum-Borus et al., 1990:559). Therefore, adolescents who engaged in DSH were more focused on problems than either control groups and generated significantly fewer alternatives to solve stressful situations. Some might argue that difference in problem solving abilities might have reflected greater levels of depression. However these differences remained after depression was controlled.

Evidence, regarding the relative importance of cognitive distortions and attributional style in adolescents who DSH, was less clear within Rotherum-Borus et al’s (1990) study. They report that self-harming adolescents reported fewer dysfunctional attributions in positive situation than psychiatric controls; thus self-harming adolescents appeared able to attribute positive events internally, more so than psychiatrically ill adolescents who did not self-harm. This finding conflicts with a cognitive behavioural approach to treatment, which assumes that self-harming adolescents would lack these skills. Yet this finding should be interpreted with
caution, as differences were not statistically significant according to the Bonferroni equation.

Whilst poor problem solving appeared to be present in all adolescents who DSH, a negative attributional style was only relevant to adolescents who DSH who also presented with depression. Such findings advocate the potential of using interpersonal problem solving therapy for adolescents who DSH. However the findings also identify a sub-group of adolescents who DSH, who also suffer depression, for whom intervention focused upon ‘modifying attributional style’ in the form of CBT might be useful. Rotherum-Borus et al’s (1990) findings are specific to females and the authors advocate the need for further research with larger sample sizes and including both sexes.

Evidence to support Rotherum-Borus et al’s findings comes from Asamow, Carlson and Guthrie (1987), who found that depressed children, rather than specifically self-harming children, had negative cognitions of themselves and their future. Additionally children who had self-harmed generated fewer active coping strategies than non self-harming children. Asamow et al’s (1987) study is limited as it focused on a pre-adolescent sample and failed to have a non-psychiatric control group, thus were unable to see how the resulting performance of their sample compared to the general population.

2.1.3 Evidence for the use of CBT/ Problem solving therapy with adolescents who deliberately self-harm

It is often difficult to separate CBT and problem solving therapy within the current literature, as the terms are used interchangeably and studies often lack detail about the exact nature and content of the intervention. Some degree of caution is thus required in identifying which aspect(s) of treatment was most effective.

Lerner and Clum’s (1990) randomised controlled study compared a social-problem solving group therapy to a supportive group therapy for a non-clinical sample of 18 college students who reported significant levels of depression and suicidal ideation.
Each treatment group ran for 10 sessions over a 5-7 week period. Interestingly, although participants in the problem solving group had significant reductions in measures of depression, hopelessness and loneliness, both treatment groups reduced suicidal ideation post treatment and at follow up. Consequently, the social problem solving group therapy appeared no more effective than the supportive group therapy in reducing suicidal ideation. One might question the extent that the two therapies differed. For example, the ‘facilitated group discussion’ of the supportive group therapy (the control group) might entail some extent of social problem solving. In addition, Miller and Glinski (2000) argue that the results need to be treated with caution due to the limited number of subjects. One might also question the usefulness of comparing the treatment of a non-clinical sample (college students who had not engaged in self-harm) with a clinical one.

Donaldson, Spirito, Arigan and Aspel's (1997) study does tentatively suggest the efficacy of a problem solving intervention with a clinical sample. They found that telephone administered, problem-solving therapy with adolescents led to fewer repeat DSH incidents than standard aftercare. However this study is limited as the finding was not statistically significant, subjects were not randomly assigned leading to possible confounding variables and there was a considerable difference between the size of the treatment group (23 subjects) and the control group (78 subjects).

Rudd, Rajab, Orman, Stulman and Joiner (1996) completed a randomised controlled study comparing the effectiveness of an intensive, time limited, group therapy aimed at improving problem solving and coping strategies and learning ways to cope with anger, stress and emotions. Intervention entailed patients spending 9 hours a day at the treatment facility for 2 weeks. This study claimed to be advantaged, as the sample was relatively diverse in terms of ethnic distribution. However, the sample focused upon young adults (mean age was 22 years), rather than focusing specifically on a purely adolescent population. Similar to Lemer and Clum’s study, Rudd et al. (1996) acknowledged the difficulty in making clear-cut discrepancies between the experimental and the control groups, stating that the control group which was ‘treatment as usual’ might have similarly focused on problem-solving strategies. The
theoretical rationale and treatment techniques of the control group, was not specified. Rudd et al. (1996) also state that it is difficult to clarify what aspects of the treatment lead to observed effects on outcome measures, given the quite complex combinations of treatment (problem solving, experiential groups and psycho-educational groups).

Post intervention and follow-up results illustrated no significant difference between the two treatment effects. In fact both treatments lead to improvements in social problem solving and reductions in suicidal ideation and DSH. Despite the lack of differences in treatment effects, Rudd et al. (1996) argued that this study illustrated that adolescents and young adults who engage in DSH can be treated using time limited, intensive outpatients methods, as opposed to traditional, highly costly inpatient approaches. However Miller and Glinski (2000) argue that this study is limited by the high attrition rates, which were significantly higher in the control group. Rudd et al. (1996) argue that the differential attrition rates suggest that the treatment group might have been more able to engage in treatment and retain those who were most at risk of repeat self-harm i.e. those with the poorest problem solving strategies at initial interview.

2.2 Family Therapy
2.2.1 Theoretical rationale
The theoretical rationale behind the application of family therapy for adolescents who engage in DSH, is that self-harm arises out of family dysfunction and relationship difficulties that are in crisis and that DSH is an attempted solution to this crisis, which is out of control (Reder, Lucey and Fredman, 1991). Aldridge (1984) argues that DSH “occurs as part of a process of escalating family disturbance when previous attempted solutions to maintain stability in the face of developmental change have failed,” (1984:318). An advantage of this rationale is that it takes into consideration the developmental changes for the adolescent and his/ her family and the impact these changes have upon the family system. Family therapy aims to improve family functioning, enhance family communication and problem solving within the family to reduce stress within the family, increase the families ability to understand the current difficulties being experienced and ultimately reduce repetition of DSH (Harrington,

Harrington et al. (1998) states that the National Health Service Health Advisory Service report (1995), which is influential in the United Kingdom, gives priority to enabling children and their families' greater access to child and adolescent mental health services. Harrington and his colleagues (1998) suggest that family based interventions for problems, such as DSH, might be one way in which to achieve such accessibility to services.

2.2.2 Evidence for role of family dysfunction in adolescent DSH
Do families with a self-harming member have poor family functioning/poor relationships and difficulties coping with crises?
In general, there is considerable evidence pointing to the role of poor parent-adolescent relationships in contributing to an adolescent’s psychological health (Fleming and Offord, 1990; Forehand, Wierson, Thomas, Armstead, Kempton and Neighbors, 1991). Indeed positive parental relationships have been shown to be important to adolescents as they act as a ‘stress-buffer’ in coping with stressful/emergency situations (Frey and Rothlisberger, 1996 cited in Hurd, Woeding and Noller, 1996). Poor parental relationships therefore have considerable implications, especially if they coincide with an adolescent’s poor interpersonal problem solving and cognitive distortions.

Indeed the family context holds specific relevance to adolescents who DSH as, unlike adults, the adolescent has been frequently found to engage in DSH within the family setting and in response to family stress (Kerfoot, 1980). Kerfoot, Dyer, Harrington, Woodham and Harrington (1996) found that the majority of incidents of DSH were precipitated by arguments with parents. Recent research has tried to identify factors associated with families with an adolescent who has engaged in DSH and considers whether such factors are evident in general psychopathology, or specific to DSH.
Hurd, Wooding and Noller's (1999) qualitative study found that adolescents who had engaged in DSH reported less satisfactory and more conflicting relationships with their parents than adolescents with a psychiatric problem without a history of DSH and a non-clinical control. Interestingly, this research identified that control participants acknowledged the presence of family conflict but rationalized it. Therefore the discriminating factor was not the presence of family conflict but adolescent’s perception of that conflict as detrimental/ unhelpful. The qualitative methodology was advantageous in this study as it enabled the investigators to gain a direct understanding of the adolescent’s perception of their relationships.

Family dysfunction has been found to distinguish not only psychiatric patients who self-harm from non-psychiatric patients who self-harm, but also students who had suicidal ideation from students who did not report suicidal ideation (Adams, Overholser and Lehnart, 1994). Specifically, suicidal adolescents’ perceive their families as having a number of difficulties: “trouble adapting to change, poor at problem solving and prone to crisis...as having insufficient, ineffective or confusing communication...ineffective methods of control” (Adams et al., 1994:504). They found that suicidal adolescents also perceived family relationships as either emotionally enmeshed or disengaged.

In a study critiqued in the cognitive behavioural section, Asarnow, Carlson and Guthrie (1987) found the child’s perception of their family environment was the strongest predictor to differentiate self-harming children from non self-harming children. Important factors included perceiving “their family environment as unsupportive and stressful with poor control, high conflict and a lack of cohesiveness” (Asarnow et al., 1987:365). These findings are specific to the adolescent’s perception of family functioning; it is unclear whether this perception reflects actual functioning (Adams et al., 1994) or cognitive distortions. Asarnow et al's (1987) study was undertaken with pre-adolescent children and one might intuitively consider the role of the family as more pertinent to pre-adolescent children. However, similar findings are evident in research on adolescent’s aged 13-18 (Adams et al., 1994).
Research fails to consider the role of external pressures of family functioning and the extent of external social support for the family. Adams et al. (1994) argue that an understanding of the variables that contribute to family dysfunction will aid our understanding of adolescents who DSH and might help pinpoint intervention and even preventative strategies. They suggest that emotional disengagement might be caused by the lack of time the family has together due to financial pressures and job demands. Considering these variables helps us to understand the difficulties and avoids the over-simplified tendency to blame the parents.

2.2.3 Evidence for the efficacy of family therapy for the treatment of DSH in adolescents

Family based intervention strategies have been devised for adolescents who DSH (Kerfoot, Harrington and Dyer, 1995; Reder, Lucey and Fredman, 1991). They focus upon learning about the episode of DSH within the family context, developing family communication and problem solving and considering some of the pertinent developmental issues for the adolescent and the impact of these issues on the family (Harrington, Kerfoot, Dyer et al., 1998). There are only 2 randomised controlled trials that investigate the efficacy of such interventions to date.

Harrington et al. (1998) completed a randomised controlled study which compared treatment as usual (77 subjects) with a time limited, home based family intervention (85 subjects) for children who DSH (age ranging from 10 - 16 years). This study specifically looked at young adolescents and children, aged between 10 and 16 years and focused upon the treatment specifically of self-poisoning only. Results identified that home family-based interventions had a positive impact upon compliance rates. This finding contradicts previous research, which found that compliance reduces with family-based treatment compared to individual psychotherapy (King, Hovey, Brand, Wilson and Ghaziuddin, 1997). It is unclear whether the improvements Harrington and his colleagues found in compliance rates were due to the family being involved or because the intervention was provided at home, rather than in hospital.
Overall, however, brief family therapy was no more effective than ‘treatment as usual’ in reducing suicidal thinking or repeat episodes of DSH in children who also had major depression. Yet this intervention did not have an impact upon family functioning, as no changes were observed in the studies main measure of family functioning, the Family Assessment Device. Harrington and his colleagues (1998) suggest that the intervention in this study might not have achieved its aims. Thus changes in family functioning might still be relevant in reducing adolescent DSH, but clinicians are yet to establish adequately how family interventions can achieve such changes. One might also question the extent that the Family Assessment Device is sensitive enough to detect changes in family functioning. Harrington and his colleagues consider whether ‘brief’ family therapy is suitable in treating quite complex and possibly ingrained systemic difficulties that might have lead to the DSH. Indeed they suggest that longer-term family therapy might be more appropriate. This requires further investigation.

The only significant treatment effect on suicidal ideation/ DSH was in a specific sub-group of children, specifically those who were not depressed. Harrington et al. (1998) argue that this has limited clinical significance, as previous evidence suggests those children who DSH, who are not depressed, are less likely to engage in repeated incidents (Pfeffer et al., 1993 cited in Harrington et al., 1998) which might well account for the observed treatment effects. However Hurry (2000) argues that such interventions are useful as there is currently no standard treatment initiative for this sub-group, who actually constitute a significant proportion of adolescents who DSH and present to services. Whether such interventions are appropriate given the scarcity of resources warrants further consideration.

Cognitive therapy has been found to be more effective than family therapy and supportive therapy in treating depression in adolescence (Brent, Holder, Kolko, Birmaher and Baugher, 1997). In light of this finding and the fact that family dysfunction plays a role in DSH, adolescents who engage in DSH and suffer depression might benefit from a combined treatment initiative. Such an initiative is discussed by Rotheram-Borus, Piacentini, Miller, Graae and Castro-Blanco (1994)
who developed a brief (6 sessions) standardised, cognitive behavioural treatment for adolescent self-harmers and their families, which they termed Successful Negotiation Acting Positively (SNAP). Although the approach is based predominantly upon cognitive behavioural principles (Beck, 1976), the inclusion of family members in treatment indicates an acknowledgment of systemic influences. Treatment assumes that adolescents who engage in DSH do so because of poor problem solving skills, cognitive distortions and a negative attributional style, plus a negative family atmosphere and poor problem solving within the family. Despite reference to a forthcoming outcome study, which investigates the effectiveness of this approach, there has been no published study detailing this. Miller and Glinski (2000) argue that this approach is worth attention as it is one of the few treatments specifically designed for adolescents who DSH. It would be difficult to clarify from such research which components caused any treatment effect, yet one might argue that it is too simplistic to assume one variable accounts for treatment effects on such a complex issue as DSH.

2.3 Other treatment initiatives for adolescents who DSH

2.3.1 Dialectical Behaviour Therapy

Dialectical Behaviour therapy (DBT) combines treatment strategies from behavioural, cognitive and supportive psychotherapies (Linehan, Armstrong, Suarez, Allmon and Heard, 1991). Although it has been modified for use with adolescents (Miller, Rathus, Linehan, Wetzler and Leigh, 1997), there is scant research into its efficacy with adolescents who DSH. This reflects a gap in the current literature. The single pilot study to examine the efficacy of this approach with adolescents, to date, focused upon suicidal adolescents with a diagnosis of Borderline Personality Disorder. Rathus and Miller (1999 cited in Miller and Glinski, 2000) found that DBT for adolescent (DBT-A) was more effective at reducing DSH than ‘treatment as usual’. It also led to reductions in psychiatric hospitalisations and improved treatment compliance. The sample studied was relatively homogeneous and it remains unclear whether the results would generalise to self-harming adolescents without a diagnosis of Borderline Personality Disorder.
2.3.2 Psychodynamic Therapy
Psychodynamic perspectives consider the impact of early childhood experience, including loss and abuse; issues frequently found in the histories of adolescents who DSH (Spirito, Brown, Overholser and Fritz, 1989). Although psychodynamic principles may inform our understanding of DSH, there is limited research on the efficacy of such approaches in the treatment of adolescents who DSH. Psychodynamic interventions are long term, and it is therefore difficult to clarify whether improvements are due to intervention or a result of the passage of time (Bateman, 2001). Current research looking at the efficacy of psychodynamic approaches is limited to high-risk groups such as adults with Borderline Personality Disorder (Bateman and Fonagy, 1999).

2.3.3 Pharmacological Treatments
There is somewhat contradictory evidence regarding the effectiveness of pharmacological treatments for people who DSH (Hawton et al., 1998) especially with children and adolescents (Sprague, 1997; Hazell, 1995). There are important risk implications when prescribing medication to potentially suicidal/ self-harming patients (Salkovskis, Atha and Storer, 1990), especially given the association between availability of medication and increased risk of overdoses and the fact that overdoses are the most frequently used form of self-harm by adolescents (Hawton, 1982; Hawton, 1986 cited in Hurry, 2000). DSH can occur among those without a formal psychiatric diagnosis (Hawton and Catalan, 1987); this is especially the case for many adolescents. In the absence of psychiatric diagnosis, Salkovskis et al. (1990) argues that pharmacological treatments may not be appropriate.

Pharmacological treatments might be useful in helping alleviate associated conditions that interfere with a patients ability to engage in treatment, but there needs to be caution when prescribing medication to adolescents. The risks associated with prescribing medication makes a good argument for psychological therapies/ case management as an adjunct to pharmacological treatments with adolescents who DSH, who present to mental health services.
2.3.4 Other Initiatives
A number of other initiatives have been studied, which focus on access to services and psycho-educational support, predominantly for the acute management of DSH incidents. These include a specialist emergency room program (Rotherum-Borus, Piacentini, van Rossem, Graae and Cantwell, 1996), no-suicide contracts (Brent, 1997), the use of emergency cards (Cotgrove, Zirinskil, Black and Weston, 1995) and psycho-educational support for adolescents and health professionals (Deykin, Hsieh, Joshi and McNamara (1986).

3 SUMMARY OF THE METHODOLOGICAL DIFFICULTIES INVESTIGATING TREATMENTS OF ADOLESCENTS WHO DSH
This review has illustrated that there are many methodological difficulties researching this field, which may have impeded the development and evaluation of treatment initiatives for adolescents who DSH, in the past. Difficulties include the lack of adequate sample sizes, poor non-compliance and the use of low frequency outcome measures, specifically the repetition of DSH, which gives researchers little power to detect statistically significant treatment effects. In addition some studies failed to focus purely on an adolescent sample which impacts on the generalisation of findings.

Hawton (1997) argued the need for multi-centre studies to increase the sample size or alternatively to concentrate the sample selection on those at highest risk of repetition of DSH, such as in Linehan et al.'s (1991; 1993) or Salkovskis, Atha and Atorer's (1990) studies with adults. In addition Hawton (1997) suggests that other outcome measures require consideration in thinking about the efficacy of treatments.

4 SUMMARY OF FINDINGS AND FUTURE AREAS OF RESEARCH
4.1 What are the most effective treatments for adolescents who DSH and what future research is needed?
Consistent evidence is available to suggest that deficits in problem solving and family dysfunction are evident in adolescents who DSH, that these difficulties are specific to
DSH rather than general psychopathology and that DSH is often precipitated by arguments with parents. Therapy aimed at improving an adolescents' problem solving skills and their family functioning, thus appears to be appropriate.

Problem solving therapy does appear to be beneficial in reducing DSH and other factors, including depression and hopelessness, which are often considered risk factors for repeat incidents. However, studies to date, have not been able to demonstrate that such interventions are any more effective that treatment as usual in reducing repeat incidents of DSH. The lack of information regarding what constitutes the control treatment within studies may account for this e.g. 'treatment as usual' might entail some problem solving therapy as well. Given the nature of the problem under investigation, a no treatment control would be unethical and impractical (Linehan, Armstrong, Suarez, Allmon and Heard, 1991). Further consideration of what within the 'treatment as usual' is warranted which might help account for the observed treatment effects. Somewhat contentiously, Sudak, Ford and Rushforth (1984) suggest that the theoretical underpinnings of the therapy is irrelevant and that the only relevant factor to therapies being effective in reducing DSH is the one held common to all therapies, which is the relationship between the clinician and the patient. This relationship is viewed as the crucial factor in that it involves “trust...implicit or explicit support and a relatively neutral, non-judgmental attitude” from the clinician (1984:424). They acknowledge their claims lack empirical evidence. Further research which is service-user orientated might be useful in identifying what aspects of treatment, whether within treatment as usual or experimental interventions, adolescents found most helpful/ least helpful in preventing repetition of DSH. This might entail more qualitative research, which is advantageous in being able to gain a more direct understanding of the adolescents' views. There is a lack of qualitative research on DSH within the current literature.

Family based interventions need to demonstrate efficacy in affecting family functioning before conclusions can be made regarding the usefulness of influencing such variables in the reduction of deliberate self-harm. The use of brief family therapies has been found to be effective in reducing DSH with non-depressed
adolescents who DSH. However its implementation with a relatively low risk group needs further consideration given the scarcity of resources within the NHS. In addition, seeing as family functioning was not changed by the therapy, it is unclear what accounts for the treatment effects on this sub-group. There is contradictory evidence whether family involvement in treatment helps or hinders treatment compliance. Hawton (1997) suggests that studies into the efficacy of family interventions need to consider the attitude of families to psychological intervention, as negative parental attitudes have been found to be associated to poor treatment compliance (Taylor and Stansfield, 1984 cited in Hawton, 1997).

The heterogeneity of adolescents who DSH and the consequential lack of a unified theory of DSH makes studying this area difficult. Isacsson and Rich (2001) argue that using single management strategies for a heterogeneous sample, such as adolescents who DSH, might not demonstrate treatment effects for the whole sample, although some sub-groups may benefit. Indeed within the current literature, specific sub-groups of adolescents who DSH have emerged to benefit from specific treatments. For example CBT, in terms of addressing cognitive distortions, appears relevant when the adolescent also presents with depression. As mentioned earlier, future studies might investigate the use of treatments for specific sub-groups of adolescent self-harmers, such as Linehan et al. (1991) study with females with Borderline Personality Disorder. Alternatively single case studies might be useful in building up a knowledge base of what works with certain types of adolescent self-harmers.

Treatments specifically designed for adolescents, such as Rotherum-Borus et al’s (1994) SNAP and Miller et al’s (1997) DBT-A, require evaluation. There is considerable interest in the application of Dialectical Behaviour Therapy, given the demonstrated efficacy of this approach in reducing DSH in adults (Linehan, et al., 1991). The pilot study using DBT with adolescents with Borderline Personality Disorder (Rathus and Miller, 1999 cited in Miller and Glinski, 2000) is promising, albeit preliminary. Further research is warranted into its application with adolescents who DSH without a diagnosis of Borderline Personality Disorder, the relevance in terms of how the approach has been modified for use with this population (currently
modifications are based on clinical experience rather than empirical evidence) and investigation into the relevance of the theory, which underpins this approach, to an adolescent population.
REFERENCES


MAJOR RESEARCH PROJECT

YOUNG PEOPLES’ VIEWS ABOUT THEIR DELIBERATE SELF-HARMING BEHAVIOURS – AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

29th July 2002

Word count: 19,952
ABSTRACT

Objective/design: Interpretative Phenomenological Analysis was used to gain the perspective of young people who had repeatedly engaged in deliberate self-harm (DSH) and their views of what helps, in order to inform theory and clinical interventions with this population.

Methods: Ten young people (psychiatric inpatients, 14 to 17 years, 9 females, 1 male) were interviewed about their experience of DSH and their views about what helped them. Considerable emphasis was placed on ensuring the validity and reliability of this study, in keeping with the epistemological routes of qualitative research.

Results: An over-riding theme emerging from transcripts was the conflicts and paradoxes experienced by young people who engage in DSH alongside the cyclical trap of DSH. DSH itself, was interpreted as a powerful and addictive solution to avoiding emotional distress. Difficulties tolerating emotions were understood within the context of their poor experience of relationships. Participants appeared to often view relationships as either lacking trust or reciprocity. Participants' narratives were considered within the context of attachment theory.

Conclusions: This study highlights the utility of gaining “insiders’ perspectives” (Smith, 1996; Smith, Jarman and Osborn, 1999) in informing our understanding of the behaviour and the difficulties faced by people who engage in DSH, but also in informing treatment initiatives. The need to address both individual deficits in emotion regulation and problem solving in interventions with this population, and the need to provide a containing, emotionally validating experience, are highlighted. Clinical and research implications of this study are discussed.
ACKNOWLEDGEMENTS

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STATEMENT OF CONFIDENTIALITY

In order to maintain the anonymity and confidentiality of participants, all names are fictitious and identifying details have been changed.
INTRODUCTION

Deliberate self-harm (DSH) appears to be an unavoidable issue for clinicians working with young people in mental health services. Not only does it account for approximately one fifth of all referrals to mental health services within the UK (Kerfoot and McHugh, 1992) but the prevalence of DSH by young people appears to be rising (Hawton, Fagg, Simkin, Bale and Bond, 2000). Repeated engagement in DSH is a serious issue, often associated with co-morbid psychological problems and increased risk of suicide (Hawton and Fagg, 1988). Indeed government legislation has emphasised the need to reduce suicide rates in young people, emphasising the need to develop more effective interventions with young people who repeatedly self-harm given that they are at risk of suicide. However there are currently no empirically supported treatments specifically for young people who repeatedly self-harm (Miller, 1999). Much of the current research in this field focuses on identifying risk factors associated with repeat incidents of DSH (Hawton, 1982; Hurry, 2000). Although such research is vital in informing clinical risk assessments, it provides little insight in helping clinicians understand the meaning of DSH for their patients (Harris, 2000; Crockwell and Burford, 1995). Indeed little has been documented about the 'lived experience' of people who deliberately self harm (Crockwell and Burford, 1995), especially young people.

The main aim of this research is to learn about the young person's view of their DSH and what it means to be helped. This insider's perspective will contribute to a theoretical understanding of the behaviour in young people, vital in informing treatment initiatives.

The following review sets the scene for this study, providing a definition of DSH, explaining the problem of DSH, the limits of current research and the importance of gaining an 'insider's perspective'. Consideration is given to how psychological theories currently attempt to explain DSH and reviews some of the recent studies which try to investigate the views of adults and young people who self-harm. The rationale for the current study and the Interpretative Phenomenological approach is discussed.
1. DEFINING DSH AND THE PROBLEM

1.1 The distinction between suicidal behaviour and DSH

"The clinical paradox of DSH is that persons with apparent consciousness and wilful intent perform painful, destructive and injurious acts upon their own bodies without the apparent intent to kill themselves" (Pattison and Kahan, 1983: 867).

There is considerable confusion over defining deliberate self-harm within the literature, reflected in the variety of labels the behaviour has been given. These include parasuicide, self-injurious behaviour, self-mutilation and attempted suicide. This confusion may stem from the difficulties distinguishing suicidal behaviour and DSH.

Hurry (2000) argues that suicidal behaviours and DSH are clinically different, reflected in their epidemiology. For example research suggests there is a gender bias for each behaviour: more males engage in suicidal behaviours (Anderson, 1981) and more females engage in DSH (Hawton, O'Grady, Osborn and Cole, 1982; Lumsden Walker, 1980). For some, DSH may be antithetical to suicide. Lowenstein (1990) found self-cutting was a means of gaining a return to reality rather than an escape from it.

However, distinguishing between the two behaviours can be difficult, given the subjective and possibly the contextual nature of intent. As a result, Miller and Glinski (2000) conclude that it is not possible to differentiate clearly between suicidal behaviours with intent and self-harming behaviours without intent. The important point, however, is that not all acts of DSH are suicidal (Pattison and Kahan, 1983; Spandler, 1996). Indeed in a study examining young people's views about their deliberate self-poisoning, very few reported wanting to die (Lumsden Walker, 1980).

For the purposes of this study, DSH may be defined as: -

"any non-accidental behaviour, initiated by the individual, which directly results in the physical harm to that individual" (Jones 1987:287).
This study focuses on young people who engage in repeated acts of DSH, of which suicidal intent may or may not feature.

1.2 The problem with DSH

1.2.1 Association of DSH with increased suicide and co-morbid psychological problems

Young people who engage in DSH are at much greater risk of suicide than the general population (Goldacre and Hawton, 1985). It has been estimated that as many as one in ten children who take overdoses or deliberately self-harm will complete suicide in the next few years (DoH, 1994; Dikstra, 1989 both cited in Hurry, 2000). Also repeated acts of DSH are associated with increased likelihood of co-morbid psychological problems, most notably depression, personality disorders and conduct problems. Repeated engagement in DSH into adulthood is often characteristic of Borderline Personality Disorder, which is very difficult to treat (Vito, Ladame and Orlandin, 1999) illustrating the importance of addressing such behaviours in adolescence.

1.2.2 The negative view of those who self-harm

Aldridge and Dallos (1986) suggest that clinical staff and society at large generally view DSH and attempted suicide as ‘illegitimate’ responses and view those who engage in such behaviours as weak and deviant. Lowenstein’s quote illustrates the frustration and lack of empathy clinical staff and significant others may feel when faced with a young person engaging in DSH.

“One cannot help but be struck by the anomaly of those who seek to destroy themselves, one way of another, even though they subsequently have much more reason for living than those who persist in continuing to live and even enjoy life despite severe physical or emotional difficulties” (Lowenstein, 1990:155).

This view of self-harm as ‘illegitimate’ and the fact that DSH is often construed as attention seeking is likely to impact on the sympathy and helping behaviour of others (Ramon, 1975 cited in Michel, Valach and Waeber, 1994). Indeed research has found
that DSH can have a negative impact on the helping behaviour of staff working with adults with personality disorder (Norton and Dolan, 1996).

1.2.3 **Physical and social consequences of engaging in DSH**

Physically, DSH, such as cutting, head banging and self-ligature can lead to permanent scarring, infections and in extreme cases death. Socially, DSH has been considered to pose a serious barrier to normal social development (Carr, 1977); a pertinent issue for young people faced with the developmental stage of adolescence.

1.3 **Current research focus, its limitations and the need for this study**

1.3.1 **Research investigating risk factors associated with repetition of DSH**

Isolated incidents of DSH can occur in relatively normal young people, often in response to acute crisis and for whom no formal psychiatric intervention is necessary (Hawton et al., 1982). Much of the current research in this field has tried to identify risk factors pertinent to those who go on to repeat DSH. Identified factors include: having a previous history of DSH, co-morbid mental health problems, substance abuse and a history of childhood abuse (Anderson, 1981; Hawton, 1982).

Although such research is important in informing clinical risk assessment and in targeting intervention strategies, it provides little insight into the meaning of the behaviour for the individual (Crockford and Burwell, 1995) nor does it help clinicians trying to develop a therapeutic relationship with this often 'hard to engage' population (Miller, 1999). Harris (2000) argues that focusing on risk factors alone identifies those patients “at most risk” in order to target scarce resources, rather than developing insight into the behaviour, which might give rise to comprehensive treatments. The current researcher considered that although attention to risk factors is vital, there needs to be a balance between such research and research aimed at increasing our insight into the behaviour and ascertaining patients’ views about what it means to be helped.

1.3.2 **The importance of learning more about the therapeutic relationship**

In a critical review of studies investigating the effectiveness of interventions for young people who self harm, Adams (2001, this portfolio: 8) concluded that current research has not been able to demonstrate the efficacy of specific treatment initiatives.
over ‘treatment as usual’ in reducing repeat incidents of DSH (Lerner and Clum, 1990; Rudd, Rajab, Orman, Stulman and Joiner, 1996). This outcome lends supports to Sudak, Ford and Rushford’s (1984) argument that the most important factor in therapy to contribute to a positive treatment outcome may be the one factor common to all interventions: the therapeutic relationship. Intuitively, a positive, supportive therapeutic relationship seems important for young people who have engaged in DSH given the relational context in which the behaviour often occurs. For example, DSH by young people is often precipitated by an interpersonal crisis such as falling out with parents, or boy/girlfriends (Hawton et al., 1982; Kerfoot, Dyer, Harrington, Woodham and Harrington, 1996) and is often associated with poor family relationships (Kerfoot, 1980) and communication difficulties (Hawton et al., 1982). Yet building a therapeutic relationship with young people who deliberately self-harm can be very difficult and young people frequently drop out of therapy (Trautman, Steward and Morshima, 1993) and are often reluctant to seek help (Choquet and Menke, 1989).

There appear to be many factors that make this issue particularly difficult with young people who engage in DSH. For the young person, engaging in a therapeutic relationship may be difficult given potential difficulties expressing himself or herself or building trusting relationships. The process of therapy may feel at odds with their developmental desire to be independent and autonomous. Furthermore young people may be reluctant to seek help due to fears that they will be viewed derogatorily. Difficulties engaging may not only to be an issue for the young person. As discussed earlier, DSH is often viewed as attention seeking which may impact on clinical staff’s helping behaviour. Negative attitudes may therefore impact on clinical staff’s ability to develop therapeutic relationships with their patients who self-harm.

Given the potential importance of the therapeutic relationship and the number of difficulties there may be in developing such relationships with this patient group, it seems pertinent that this area be investigated. Indeed Adams (2001, this portfolio: 211) concluded that there is a need for more service-user orientated research, to help identify their views on building therapeutic relationships and more generally their views about what it means to be helped.
1.3.3 The importance of hearing the young person's voice

The literature suggests there has been a tendency to avoid directly interviewing people who self-harm, researchers often using other ways to access their participants' views, such as asking participants to tick off a list of motives for their behaviour (Hawton et al., 1982). Even recent forms of qualitative research with adults who engaged in DSH have used letter writing rather than meet face-to-face (Harris, 2000) or relied on retrospective accounts (Crockwell and Burford, 1995). In her research on women's understanding of their DSH, Harris (2000) talks about her concerns about subjecting 'all parties' to the interview process. This implied her concerns are not only focused on the individual who had engaged in DSH, but also possibly her concerns over subjecting others to this process, such as clinical staff, family members and even herself as the researcher. It appears that DSH is quite a taboo subject. The current researcher felt that such attitudes had left a population of people, who experience such significant distress as to lead them to physically harm themselves, without a voice. Other research with this population suggests that the process of asking for their views can be empowering for young people (Spandler, 1996).

This study aims to empower participants (young people who have engaged in DSH) in a supported way, to ensure that they have their views heard, which may in turn empower helpers to work more effectively with this population. This is in line with governmental legislation. For instance, the Children's Act (1989) placed greater emphasis on the rights of the child, meaning that their voice and their views on issues that impact on their lives need to be heard. Furthermore, research is increasingly seeking to assess service user's views in informing service provision (Stansfield, 1998).

2. HOW DO PSYCHOLOGICAL THEORIES CONCEPTUALISE DSH?

Many theories attempt to explain DSH (Favazza, 1989), each varying in its emphasis either on aetiological or maintaining factors. For a flavour of how DSH has been conceptualised, prominent psychological theories are now considered.

Behavioural theories focus on how DSH may be maintained, either by negative reinforcement, such as the avoidance of something aversive, or positive
reinforcement, such as attention or concern (Carr, 1977). From this perspective, the
notion of contagion of DSH within institutional care is understood. Hawton (1982)
states that rivalry between patients and desire for staff attention can lead to
"outbreaks" of the behaviour and represents one of the main arguments against
inpatient admission in treating this behaviour.

Cognitive behavioural theories view DSH as resulting from cognitive rigidity/ biases
and deficits in problem solving skills, which limit the young person's ability to cope
with interpersonal problems and regulate their emotions. Schotte and Clum (1987)
suggest that this places the young person at increased risk of feeling hopeless in
difficult situations and increased risk of DSH. These difficulties may be exacerbated
given the transitional phase of adolescence and the potentially high incidence of life
events and difficulties encountered during this developmental stage (Hawton, 1997).

Systemic theories advocate that DSH in young people arises out of family dysfunction
and relationship difficulties that are in crisis. DSH is an attempted solution to this
crisis, which is out of control (Reder, Lucey and Fredman, 1991). Aldridge and
Dallos (1986) argue that it is important to consider a systemic view of DSH given that
such behaviours are often precipitated by interpersonal conflict (Hawton et al., 1982).

Attachment theory, similar to psychodynamic theories, focuses on the aetiological
basis of DSH, viewing DSH in terms of internal, often unconscious, processes or
conflicts resulting from abusive or poor early experiences. Bowlby (1980) viewed
suicidal behaviours as an attempt to punish the un-protecting caregiver with whom the
child is insecurely attached, and as a means of conveying their emotional distress to
signal the need for comfort. Both psychodynamic and attachment theories tend to
emphasise the conflictual nature of DSH.

Psychological theories may help conceptualise young people's experience of DSH, as
they are concerned with the possible function and meaning of the behaviour. Turp
(1999) argues, however, that current theories are inadequately balanced with
testimonies of the people who engage in DSH, illustrating the importance of the
present study.
3. CURRENT RESEARCH THAT INVESTIGATES THE VIEWS OF PEOPLE WHO ENGAGE IN DSH

3.1 Adults' narratives of their deliberate self-harming behaviour

Michel, Valach and Waeber (1994) interviewed 66 inpatients (aged 17 to 80 years) admitted for attempted suicide about their experience. They concluded that suicidal behaviour was not primarily aimed at manipulating others or communicating how they felt to others, but was a means of finding "relief from an unbearable mental state" and this was particularly evident in younger participants. Approximately half of the sample felt that friends, relatives, doctors or other health professionals could have taken action to help. It would have been of interest to clarify further what type of action would have been helpful.

This study has a number of limitations. The interpretation of qualitative information is questionable given that it was analysed into categories on an "ad hoc" basis. The authors acknowledge that the list of motives may have led participants to give more socially acceptable responses, which ultimately limits the study's capacity to provide an accurate account of participants' views. Although entitled "understanding deliberate self-harm: the patient's view" the study focused on patients who had been admitted to hospital after an isolated suicide attempt, rather than those who had engaged in repeated incidents of DSH. This point is important, given that isolated incidents of DSH can occur in relatively normal people, for whom no psychiatric intervention is necessary (Hawton et al., 1982). 82% of participants in this study reported positive outcomes after the suicide attempt. It is unclear what happened to the remaining 18%; one might hypothesise that they represented those who went on the self-harm again.

Harris (2000) analysed the correspondence of four women (aged 20 to 45 years) who wrote to her about their experience of DSH. Her analysis stressed the association of DSH with early and recent abusive experiences and that DSH had an internal logic in preserving participants' life by relieving overwhelming emotional pain and regaining control, thus antithetical of suicide. Harris felt that this way of conceptualising DSH contrasted with the way DSH is generally viewed by health professionals and that such divergence in views increased participants' distress, aggravating their difficulties further. For instance, participants felt angered, ashamed and more depressed by their
treatment from accident and emergency (A&E) staff, which led to increased incidents of DSH. It will be of interest to clarify whether young people similarly experience negative reactions from others and whether this contributed to their distress and desire to self-harm further. Unfortunately Harris’ (2000) study is limited, as the analytic process is not made clear.

3.2 Young people’s narratives about their deliberate self-harming behaviour

In a North American study, Crockwell and Burford (1995) interviewed three young women (aged between 16 and 23 years) in order to gain a retrospective account of their experience of engaging in multiple suicide attempts during adolescence. Their findings highlight the dilemmas experienced by these three young women, which (like Harris’ study) were understood within the context of their early abusive experiences. An awareness of the dilemmas faced by these young women may help clinicians understand the often-inconsistent attitudes and highly changeable behaviour of people who engage repeatedly in DSH. The study highlights how a phenomenological, qualitative study can provide useful insights to inform clinical practice. It is advantaged as the authors provide some information about the analytic process employed, namely constant comparative method (Glaser and Strauss, 1967). This meant that the authors inspected and compared all the data fragments arising from their interviews, in an effort to ensure comprehensive data treatment (Silverman, 2000:179). However this study focuses on the retrospective accounts of young women who had attempted suicide, rather than DSH. It would be of interest to clarify whether these dilemmas were also evident in a British sample of young people who currently engage in DSH.

4. RATIONALE FOR THIS STUDY AND THE CHOSEN METHODOLOGY

4.1 Rationale for the research project

Through this review, the need for this project has been developed, in that: (1) DSH is an unavoidable and serious issue; (2) Current research on risk factors for repeat incidents of DSH fail to provide adequate insight to help clinicians understand DSH in young people and contributes little to bridging the gap between clinical staff and the young person’s views about DSH; (3) Given the difficulties, yet potential importance,
of a positive therapeutic relationship, the views of young people around what it means to be helped seems important; and (4) despite the potential difficulties talking to young people about DSH, it is important that their voices are heard to inform our theoretical understanding and clinical interventions.

4.2 Research Aims

1. To gain an insider’s perspective of young people’s views of their deliberately self-harming behaviour.
2. To find out what young people view as helpful in reducing distress and the likelihood of repetition of DSH, to inform treatment initiatives and specifically the therapeutic relationship.
3. To assess the impact of talking about DSH on the young person.
4. To empower young people who engage in DSH and give them an opportunity to express their views and have their voice heard in a supported manner.

4.3 Research questions

1. How do young people describe the process of engaging in DSH and coping with their emotions?
2. What do young people, who engage in DSH, view as helpful?
3. What do young people value in helping relationships?
4. What is the impact of talking about DSH on the young person?

4.4 Rational for methodology employed

4.4.1 Why choose a qualitative method?

There has been a considerable increase in the use of qualitative methods in psychological research (Elliot, Fischer and Rennie, 1999) and, concurrent, increasing recognition of its role for clinical psychology (Turpin, Barley, Beail, Scaife, Slade et al., 1997). Qualitative methods tend to be concerned with meanings, how people make sense of their world and how they experience events (Willig, 2001). Such an approach fits well with the aims of this research project, in ascertaining young people’s views of their DSH and what it means to be helped. Turpin et al. (1997) suggest that the strength of qualitative methods is the emphasis placed on “revealing meanings” in human behaviour and may help to “reveal patterns of meanings, interpretations and understanding inherent within individual’s experience” (Turpin et
al., 1997:4). Crockwell and Burford (1995) stress the importance of this type of research as “practitioners know that discovering the young person’s .... perception of events is the key to understanding and successful resolution” (1995:2). They argue that qualitative methods are highly relevant to clinical practice given its aim of gaining the patients’ perspective of their difficulties.

4.4.2 Why choose Interpretative Phenomenological Analysis (IPA)?

Qualitative methods, such as IPA and grounded theory, provide a way of structuring participants’ accounts into a set of theoretical outcomes. A dominant criticism to grounded theory (Glaser and Strauss, 1967), however, is its assumption that the researcher is merely a ‘witness’ to the participants’ accounts (Willig, 2000) and that the researcher’s identity and prior conceptions do not bear on accessing participants’ true accounts of their experience (Charmaz, 1990; Willig, 2000).

Previous literature and the researcher’s own clinical experience suggested that young people, who engage in DSH, are often difficult to engage and may have difficulties expressing themselves. In light of this, it was thought important for the researcher to be relatively flexible during the process of interviewing and to have prompts ready in order to remain responsive to the participants’ needs and create an optimum setting in which participants could express their views. Given that the process of gaining the young person’s view was likely to entail an interaction between the researcher and participant, it was important to acknowledge the possible influence of the researcher over the data collection and interpretation. The strength of IPA is that, although the researcher tries to ascertain the young person’s perspective as closely as possible, the researcher also acknowledges her own role and biases in the process of data collection and interpretation of the other’s perspective. IPA acknowledges the impossibility of directly accessing participants’ personal experiences due to the ‘dynamic process’ of the research investigation (Smith, Flowers and Osborn, 1997). Accessing the individual’s perspective is “dependent on, and complicated by, the researcher’s own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity” (Smith, Flowers and Osborn, 1997:70). The researcher’s own conceptions are not viewed as biases that need to be eliminated but as “necessary preconditions for making sense of another person’s experience” (Willig, 2001:66).
4.4.3 About Interpretative Phenomenological Analysis (IPA)

Originally developed by Smith (1995, 1996), IPA aims to explore the participants’ experiences and views in order to gain an “insider’s perspective” (Smith, 1996; Smith, Jarman and Osborn, 1999). It takes a phenomenological perspective, in that it is concerned with the individual’s perspective of their world (their stories and perceptions) rather than searching for an objective truth about a topic. Indeed one of the strengths of this approach is in its efforts to look at a phenomena from the viewpoint of those who experience it (Willig, 2001), thus “capture an experience and unravel its meaning” (Willig, 2001:62). The aim of IPA in this study was to produce a detailed, analytic account of the experiences and views of young people on their DSH and what it means to be helped, whilst recognising the role of the researcher in the interpretative process.
5. PARTICIPANTS

5.1 Inclusion and exclusion criteria

For inclusion in this study, young people were required to:

1. Be over 13 years of age (ethical committee guidelines);
2. Have engaged in DSH repeatedly and at least once in the last six months;
3. Be considered by their responsible medical officer (RMO) at their current inpatient facility to be appropriate candidates for participation in this study (i.e. that participation did not impact on their current treatment);
4. Give written consent and parental consent, as appropriate.

Due to resource limitations, those whose first language was not English were excluded from the study. DSH was defined in section 1.1 (Jones, 1987).

5.2 Sampling rationale

The aim of the sampling procedure was to employ theoretical sampling (Mason, 1996). Theoretical sampling involves the systematic selection of participants to build in certain characteristics or criteria which are likely to help develop an explanation or description of the phenomenon under investigation (Mason, 1996, Silverman, 2000). The aim of sampling was to ensure that a diversity of young people who engaged in DSH participated in this study, including both male and females, differing psychiatric diagnoses and different experiences of help. The adequacy of the sample is considered in the discussion.

5.3 Recruitment procedure

RMO's from four adolescent units identified 13 current inpatients (one had previously been an inpatient and was currently seen by an Outreach service) that had a history of engaging in deliberate self-harm. These patients were given an information sheet, which detailed the purpose of the research project, the voluntary nature of participation, their right to withdraw without their current treatment being affected, what participation would involve, the possible benefits of participation and possible disadvantages (appendix 1). Patients were given time to consider their participation.
(minimum of 2 days). This provided them with an opportunity to discuss participation with others if they wished, such as with parents, nurses or their RMO. With their consent, the researcher contacted the patient to answer any questions and, if they agreed, to arrange a time to conduct the interview. Of the 13 young people who were approached, two declined participation and one left the unit before an interview could be scheduled.

All participants had to sign a consent form (appendix 2). Signed consent from parents/ guardians was formally required when participants were: (1) under the age of 16 years, (2) were not current inpatients (i.e. Outreach patients) or (3) when the RMO requested it (appendix 3).

5.4 Summary of the participants included in this study
The sample consisted of ten young people (one male, nine female) who had engaged in varying types of DSH, aged 14 to 17 years of age (table 1). It was hoped that the sample was broadly representative of young people who engage in repeated DSH, accessing inpatient adolescent services in the South of England. The representative nature of the sample is considered in the discussion.
Table 1  Demographic information of sample

<table>
<thead>
<tr>
<th>Fictional name</th>
<th>Age</th>
<th>Gender</th>
<th>Ethnic background</th>
<th>Currently on section</th>
<th>Age first DSH*</th>
<th>Types of DSH used*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louise</td>
<td>17</td>
<td>Female</td>
<td>White European</td>
<td>Yes</td>
<td>15</td>
<td>Cutting, hitting yourself, self-induced vomiting, banging head on wall</td>
</tr>
<tr>
<td>Tamsin</td>
<td>15</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>13-14</td>
<td>Cutting</td>
</tr>
<tr>
<td>Matthew</td>
<td>14</td>
<td>Male</td>
<td>White European</td>
<td>Yes</td>
<td>15</td>
<td>Self-ligature, cutting, inhaling aerosols</td>
</tr>
<tr>
<td>Joanna</td>
<td>15</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>12-13</td>
<td>Cutting, overdoses, burning</td>
</tr>
<tr>
<td>Lucy</td>
<td>15</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>11-12</td>
<td>Overdose, cutting, inhaling aerosols</td>
</tr>
<tr>
<td>Emma</td>
<td>17</td>
<td>Female</td>
<td>White European</td>
<td>Yes</td>
<td>7</td>
<td>Cutting, self-ligature, overdoses, jumping in front of traffic/ off bridges</td>
</tr>
<tr>
<td>Rachel</td>
<td>17</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>17</td>
<td>Overdoses, cutting</td>
</tr>
<tr>
<td>Willow</td>
<td>15</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>15</td>
<td>Overdoses</td>
</tr>
<tr>
<td>Cindy</td>
<td>16</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>11-12</td>
<td>Cutting overdoses.</td>
</tr>
<tr>
<td>Karen</td>
<td>17</td>
<td>Female</td>
<td>White European</td>
<td>No</td>
<td>7-8</td>
<td>Hitting and burning herself, “anything”.</td>
</tr>
</tbody>
</table>

* Self reports

Participants’ names and identifying features were changed to ensure anonymity and maintain confidentiality. Participants were given names as opposed to codes, to enable the researcher and readers to relate to participants as people and to provide clarity to the presentation. To enable the reader to get a sense of the individuals who participated in this study and their situations, table 2 provides brief vignettes of each participant. All vignettes are based on participants’ accounts.
Table 2 Brief vignettes of each participant

- **Louise**, aged 17, was placed on section after constantly trying to run away from the hospital. She had been on an adult ward before coming to the adolescent unit 2 weeks ago. She said that she had withdrawn more and more from any engagement in life, and fell increasingly behind on her schoolwork. She began cutting at home and at school. Louise felt she had wasted her life as she compared herself to her friends who were about to start university.

- **Tamsin**, aged 15, was admitted to the adolescent ward due to repeated cutting. This is her first admission to specialist services. Tamsin had recently disclosed that her grandfather had sexually abused her as a child. Tamsin was not sure her family believed her.

- **Matthew**, aged 14, suffers from Anorexia Nervosa. He has cut his arms on several occasions and has made two suicide attempts involving self-ligature and overdose. This is his second admission to the ward. Staff had initiated drip-feeding Matthew against his will when he took part in this study.

- **Joanna**, aged 15, had been on the unit for 3 months and had previously been seen by CAMHS. She reported that her father frequently physically abused her brother. Joanna was now pregnant and she was trying to stop cutting because of this. Her mother was placing her in care because of the pregnancy.

- **Lucy**, aged 15, had been on the unit for 5 weeks following an attempt to hang herself in response to voices in her head. Lucy had fallen behind on her schoolwork, started hanging around with “Goths” and she said she found it hard to say no to boys. Lucy had seen a counsellor since age 7. Lucy’s father had survived an overdose when she was younger. Whilst being on the ward she had developed a trusting relationship with a nurse and had disclosed that her father had physically and sexually abused her as a child.

- **Emma**, aged 17, was an unwanted child, both her parents wanting a boy. She was placed in care aged 14 years. After her first admission to the adolescent unit, over 12 months ago, she lived with foster carers, until she set fire to the house. This led to her second and current admission. She has now been at the unit for the last 8 months. Emma had recently been told that she has a personality disorder.

- **Rachel**, aged 17, took an overdose on the anniversary of having an abortion, which coincided with the birth of her niece. She was admitted to an adult ward for assessment before being transferred to the current adolescent unit. She had started cutting herself since this time. Her sister had also taken an overdose a few years earlier.

- **Willow**, aged 15, has a history of Bulimia and Chronic Fatigue Syndrome. She has taken a number of overdoses over the last year. In the last month she took a large overdose, which led to her being in a coma for 18 hours and her first admission to the unit.

- **Cindy**, aged 16, was seen as an outreach patient. She had overdosed on contraceptive pills. Cindy felt that she heard voices but psychiatric assessment did not feel she was delusional. Cindy felt others just thought she was a troubled teenager, whilst she and her mother, after looking on the Internet, felt she might have schizophrenia.

- **Karen**, aged 17, lived in supported accommodation until it was shut down after her friend, another patient, killed himself by jumping in front of a train. Karen had an abusive childhood and had also spent time living on the streets.
6. THE INTERVIEW

6.1 Rationale for semi-structured interview
Semi-structured interviews were used as it allowed an in-depth study of the young person’s personal experience (Silverman, 1993). Other approaches from phenomenological research could have been used (Willig, 2001), such as Harris’ (2000) letter writing task. Given that talking about DSH or recounting their experience may be distressful for the young person, a face-to-face interview was favoured as it enabled risk to be assessed and anxieties contained.

6.2 The interview schedule
A semi-structured interview schedule was developed (appendix 4) based on the main research questions. The development of the schedule followed guidance from Smith (1995) and was undertaken in consultation with experts in the field, including the consultant psychiatrist and consultant clinical psychologist from one of the adolescent units, and university research tutors experienced in the use of qualitative research methods. The interview schedule included open-ended questions, asking participants about their experience and views of deliberate self-harm and getting help for their difficulties (summarised in table 3). Given that emotion regulation was a dominant theme in earlier literature conceptualising DSH, young people were also asked about their emotional state and coping with emotions. Given also that previous qualitative research has found other peoples’ responses to the DSH can be influential, the interview schedule also included questions on how other people have reacted to the DSH and their expectations of the young person. Although psychological theories were considered when developing the interview schedule, the interview remained relatively open to allow for other factors, not accounted for by these theories, to emerge from the data.
Table 3 Summary of the interview schedule

<table>
<thead>
<tr>
<th>Introductory questions/ rapport building</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>About DSH</strong></td>
</tr>
<tr>
<td>1. As you know, this research is all about your views on self-harm. What do you think deliberate self harm means?</td>
</tr>
<tr>
<td>2. What thoughts/feelings have you had about taking part in this interview and talking about self-harm?</td>
</tr>
<tr>
<td>3. Could you describe the first time/recent time when you [deliberately self harmed]?</td>
</tr>
<tr>
<td>4. Why do you think you [deliberately self harm]?</td>
</tr>
<tr>
<td><strong>Emotional experience</strong></td>
</tr>
<tr>
<td>1. How would you describe how you feel [your emotional state] from day to day/ in general?</td>
</tr>
<tr>
<td>2. Can you tell me about perhaps the last time you felt [overwhelmed by strong emotions]?</td>
</tr>
<tr>
<td>3. How do you think others expect you to cope with these emotions and difficult experiences?</td>
</tr>
<tr>
<td><strong>Experience of help</strong></td>
</tr>
<tr>
<td>1. What do you think is the best way to help you when you are having difficulties?</td>
</tr>
<tr>
<td>2. And the least helpful?</td>
</tr>
<tr>
<td><strong>Assessing impact of interview on participant</strong></td>
</tr>
<tr>
<td>1. Finally can you tell me what your thoughts/feelings about completing this interview are now i.e. talking about self-harm and your emotions?</td>
</tr>
<tr>
<td>2. Can I ask you how you are left feeling now?</td>
</tr>
</tbody>
</table>

The schedule remained relatively non-directive to ensure the researcher facilitated the disclosure of participants' perspectives, rather than testing out the researcher's own preconceptions (Flowers, Smith, Sheeran and Beail, 1997). However, given the difficulties young people may have expressing their views, some prompts were included. Initially the researcher started with an open question. If the participant appeared to have difficulty in responding, for instance giving a brief or limited response, prompts were used to facilitate further discussion. Smith (1995) states: “more specific questions (prompts) are there to deal with more difficult cases where the respondent is more hesitant” (1995:15). Overall, the interview schedule was not prescriptive and merely acted as a guide for the researcher. This enabled the researcher to follow up interesting issues that arose during the interview, thus enabling the researcher to get closer to the participants' perspective (Smith, 1995; Osborn and Smith, 1998).

In developing the interview questions, particular attention was paid to facilitating the use of language appropriate to participants. Initial questions focused on checking out their terminology and this was incorporated in subsequent questions. Early questions
were kept general in order to help develop rapport, before moving on to more personal matters. Questions were also included to monitor the impact of the research interview on the participant, as part of the debriefing process for participants.

The first interview was used as a mini pilot of the interview schedule, which ensured language usage was appropriate and that prompts were adequate to yield sufficient data. This pilot went well and no modifications were made.

7. ETHICAL ISSUES AND THE INTERVIEW PROCESS
There were a number of important ethical issues that needed to be addressed prior to commencing this study, specifically around (1) keeping participants safe; (2) keeping information confidential and maintaining participants’ anonymity; and (3) debriefing. Ethical approval for this study was granted (appendix 5).

7.1 Keeping participants safe
The RMO had responsibility for identifying potential participants, who they felt would not be unduly distressed by participation and whose current treatment would not be affected. Both positive and negative outcomes of talking about DSH were made clear to potential participants, in the information sheet and before participation, as was the option of opting out of the research at any time.

Confidentiality was agreed prior to participation and exceptions to this confidentiality, such as risk of harm to self or others, or new disclosures raising child protection concerns. Participants were informed of the researchers professional responsibility to inform RMOs should any concerns, such as this, arise during the interview. If any concerns were raised during the interview a number of measures were in place to maintain the participants’ safety to the best of the services ability. Firstly the researcher discussed with the participant their concerns and together considered ways of accessing support. If concerns remained, the researcher discussed her concerns with the RMO and named nurse and plans were made to ensure participant’s safety. If feedback to staff was necessary, the researcher first discussed with the participant what was going to be feedback and why; this ensured the process of feedback was open.
and collaborative in keeping participants informed. All participants were debriefed at
the end of the interviews.

All interviews were conducted at the adolescent units. Established supports could
then be made available should participants become distressed during the interview, for
example from the nursing staff, duty officers or RMOs. Interviews were conducted at
certain times to ensure they finished when clinical staff were available to provide
support. However the researcher was conscious that some patients might feel less
able to speak openly when at the unit. For example, if the patient had had a bad
experience within the unit, this might impact upon their ability to express themselves
openly for fear of being over heard or revisiting unpleasant memories. In an effort to
minimise this, the researcher ensured that the room was private and no interruptions
occurred during the interviews.

7.2 Keeping information confidential
The researcher conducted all interviews and transcribed all the interviews. Interviews
were audiotaped with participants’ consent and lasted approximately one hour. Interview
were transcribed verbatim. All audiotapes were held in a locked filing cabinet, until they were transcribed, after which they were wiped clean.

7.3 Debriefing
All participants were debriefed at the end of the interview. This involved offering
them space to raise any concerns, ask questions, re-visit what happens to the data and
discuss how the interview had left them feeling. Any concerns raised during the
interview or at debriefing were discussed and appropriate action taken.

Given the distressing nature of the phenomenon under discussion, it was important for
the researcher to access her supervisory supports for personal debriefing. Debriefing
for the researcher promoted reflexivity and helped in starting to build an idea of
emerging themes.

7.4 Engaging young people to talk
When describing the study to potential participants, emphasis was placed on the
research being their opportunity to tell others about their experiences and their views.
It was hoped that this approach, together with the confidential nature of the interview, might encourage them to talk more openly. Initially a few minutes were spent talking to the participants about general issues (such as who was in their family, likes/dislikes at school) in an effort to develop rapport and trust. Participants were also invited to take breaks if they wanted.

Coyle (1998) advocates the importance of using counselling skills, such as empathy, attentive listening, reflecting feelings and using open questions, to tackle participants’ distress but also in helping participants elaborate their thoughts and feelings around sensitive issues. As a trainee clinical psychologist, the researcher was able to use her clinical psychology skills to achieve this.

8. ANALYTIC STRATEGY
8.1 Process of IPA
The process of analysis followed that described by Smith, Jarman and Osborn (1999).

8.1.1 Stage 1
For the initial analysis, one transcript was chosen, which appeared interesting and where the respondent gave relatively full responses. This transcript was also discussed during supervision and with a research group, to provide credibility to the emerging preliminary themes. This transcript was read repeatedly to enable the researcher to become “as intimate as possible with the account, as each reading is likely to throw up new insights” (Smith, Jarman and Osborn, 1999:220). In the left margin, the researcher (in addition to the research supervisor and group members) recorded initial notes, which reflected what the participant said. After collating the comments made by herself, the research supervisor and the research group members, the researcher documented a list of preliminary emerging themes (appendix 6) from this first transcript. Smith and his colleagues describe these themes as “key words to capture the essential quality of what you are finding in the text” (1999:221). During this early stage none of the transcript was excluded. The entire transcript was treated as potential data.
8.1.2  Stage 2
The emerging themes were then analysed for connections (appendix 7) and superordinate themes were developed to pull together initial themes in a sensical, explanatory fashion. Through this analytic process, the researcher was able to make sense of the numerous comments and ideas drawn from the participant’s transcript. Throughout this process, it was important to ensure that the emerging themes reflected what the participant actually said and that themes were not overly biased by the researcher’s interpretations. Consequently it was important to keep returning to the transcripts to find verbatim evidence of each theme.

8.1.3  Stage 3
A list of super-ordinate themes and sub-themes was developed (appendix 8). Each theme was supported with verbatim examples from the transcripts. These themes appeared to capture the participants’ views most strongly. Some earlier themes were not included as they failed to be evidenced fully within the transcript or did not fit well with the developing structure of themes.

8.1.4  Stage 4 – Continuing the analysis with other transcripts
Individually each transcript was read and re-read to find further evidence for super-ordinate themes and sub-themes developed from the first transcript (listed appendix 8). Importantly the researcher remained open to: - (1) new themes being identified in subsequent transcripts, to be considered in the light of original themes; or (2) more information which might have further developed original themes. Two clinical psychologists, with experience working with young people who self-harm, were consulted during this process, in looking at transcripts, identifying themes and developing super-ordinate themes.

Through this process, the original list of themes which emerged from the analysis of the initial transcript was developed further: some themes merging (for example themes from the ‘career of DSH’ appeared to be better explained within the ‘conflicts and paradoxes’ super-ordinate theme); some themes were dropped as they were not rich in evidence in other transcripts or new themes emerging (such as feeling minimised by others). After all transcripts were thoroughly analysed, a list of super-ordinate themes and sub-themes were developed for the group of participants, from
which the researcher was able to develop a coherent, organised narrative summary of participants' experiences of DSH presented in the results section. Each theme was grounded by examples from original transcripts.

8.2 Ensuring quality of the study

8.2.1 Validity

The validity of qualitative research findings is as important as in any other form of research. However Osborn and Smith (1998) stress the importance of using appropriate criteria on which to base the validity of qualitative research, which is likely to differ from that used for quantitative research given the different epistemological roots of these research paradigms. Elliott, Fischer and Rennie (1999) have suggested alternative criteria, which were used to evaluate the quality of this study. Although not aimed as a checklist for all qualitative research, some of the guidelines were particularly pertinent to this study.

**Owning one's perspective.** Mays and Pope (1995, 2000) stress the importance of making clear the researcher's prior conceptions and position in relation to the research from the outset, in order to allow readers to judge how this might have shaped the collection process and interpretation of data. Elliot et al. (1999) argue that owning one's perspective a priori is similar to clarifying researcher's hypotheses prior to quantitative investigation.

The researcher, a 28 year old, white female, is a trainee clinical psychologist and therefore has been trained to understand complex human behaviours within the context of psychological theories. The researcher's main theoretical orientation was cognitive behavioural and systemic, whilst the university and field supervisors were predominantly psychodynamic in orientation. This variety of perspectives was considered useful in widening the possible interpretation of the data. The interpretation of this study was very much based within a psychological framework, as all those involved in the analysis were psychologists. It is important to bear in mind that other professional groups may have interpreted the data differently.

**Situating the sample.** It is important to note that qualitative research differs to quantitative research in that it aims to explore a small, but well-defined, sample in
greater detail (Flowers et al., 1997). On this basis, researchers can make strong claims about that small group, but should be cautious about making generalisations to the wider population. In order to enable readers to judge the generalisability of findings, or specifically “judge the range of persons and situations to which the findings may be relevant” (Elliot et al., 1999: 221), demographic information and brief vignettes of each participant were provided (table 1 and 2, page 239, 240).

Grounding interpretation in examples. Silverman (2000) emphasises that qualitative researchers must convince their readers that their interpretations are “genuinely based on the critical investigation of all the data and do not depend on a few well-chosen examples” (Silverman, 2000:176). He argues that the latter would reflect anecdotalism, which may undermine the validity of the research findings. In this study, there was an attempt to ensure comprehensive data treatment, so that all cases of data were included in the analysis and exceptions to emerging themes were acknowledged. Also all themes and interpretations of the data are illustrated by examples from original transcripts. This process allows the reader to assess the ‘persuasiveness’ of the analysis (Coyle and Rafalin, 2000).

Providing credibility checks. Osborn and Smith (1998) state that the process of checking the analysis ensures that the resulting analytic account is understandable and grounded in the data. It is not intended as a means of inter-rater reliability nor does it pretend to act as a means of finding the one true account of the topic (Osborn and Smith, 1998). Two clinical psychologists with experience of working with people who DSH examined the analysis and supporting data to make suggestions and elaborate on the original analysis (stage 4). Indeed both were keen on developing the super-ordinate theme of paradoxes and conflicts, illustrating its importance in explaining much of the data set. The use of the research group in the analytic process, involving other psychologists from different theoretical orientations, both male and female, with different levels of experience with young people, helped the researcher acknowledge her biases and hopefully develop a broader interpretation and consideration of the data.
8.2.2 Reliability
To promote the reliability or 'auditability' of the study, Smith (1996) argues that the process of analysis should be clearly evident. The researcher made visible the process of analysis and outcomes through careful description of this process and examples of the analytic procedure are included. An original transcript (appendix 9) and the analysis of this transcript (appendix 6-9) are available as appendices, providing a chain of evidence from extracted themes and interpretations back to the original transcripts (Turpin et al., 1997). Access to all transcripts are available from the researcher.
RESULTS

An over-riding theme to emerge from participants' transcripts was the paradoxes and conflicts experienced by the young people in this study and the cyclical difficulties of engaging in DSH. This super-ordinate theme illustrates how DSH provides a powerful and addictive solution to their difficulties, yet similarly aggravates the young person's difficulties coping with emotional distress. The importance and desire to have relationships, despite difficult experiences of such, is illustrated in the second theme - the helping process. In helping young people to engage, talk and change their behaviour, participants focused on the way in which help is provided and talked about in 'creating space for talk and change'. An analysis of the impact of the interview on participants is also considered.

Table 4 helps focuses the reader to the over-riding themes and sub-themes that will now be elaborated.

Table 4 Over-riding themes and sub-themes to emerge from the analysis for discussion

<table>
<thead>
<tr>
<th>PARADOXES, CONFLICTS AND VICIOUS CYCLES</th>
<th>HELPING PROCESS AND CLINICAL IMPLICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cycle of avoiding emotions</td>
<td>1. The importance of relationships</td>
</tr>
<tr>
<td>2. DSH makes me better and worse –</td>
<td>2. Creating space to talk and change</td>
</tr>
<tr>
<td>Vicious cycle</td>
<td></td>
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<tr>
<td>3. Contradictory thoughts around intent</td>
<td></td>
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<td>to die</td>
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<tr>
<td>4. Minimising and/or failing to</td>
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<tr>
<td>recognise the young person's</td>
<td></td>
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<tr>
<td>difficulties</td>
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<tr>
<td>5. Expectations by other people to</td>
<td></td>
</tr>
<tr>
<td>'just talk'</td>
<td></td>
</tr>
<tr>
<td>6. Wanting and not wanting others</td>
<td></td>
</tr>
</tbody>
</table>
9. PARADOXES, CONFLICTS AND VICIOUS CYCLES

9.1 Cycle of avoiding emotions

Participants regularly talked about their experience of overwhelming emotions and not knowing how to cope with them. For instance, in the context of Tamsin’s recent disclosure of abuse she reported: “I get so upset and I don’t know what to do,” (9.08). Many young people in this study talked about DSH providing a release or distraction from negative emotions. For example, Tamsin went on to say how DSH helped her release her upset.

“It was just a way of letting it out...It’s just a way of dealing with it really. I don’t know any other way to do it...” (Tamsin, 7.20)

Other participants provided further insight into the utility of DSH in distracting them from emotional distress.

“I think it is really the pain from my arm is helping me focus on the pain rather than my head” (Lucy, 12.30)

The association of DSH with the need for distraction and release of emotions implies that DSH may be a way of avoiding negative emotions, which implies there is no processing of the difficulties in a way that would allow for some resolution. This avoidance of emotions and lack of resolution may contribute in some way to the build up of emotional distress and the confusion over emotions (see figure 1).
9.1.1 The build up of emotional distress
Louise talked about how “everything would build up again” (7.42) and how she experienced “pent up emotions” (4.23). One might hypothesise that this was the result of failing to process earlier emotions through engaging in DSH and that these pent up emotions may lead to a reduced capacity to tolerate any distress, whatever the size. Indeed Louise went on to state that the size and significance of triggers that lead her to self-harm appeared to diminish over time.

“And if anything just gets a little bit bad. Cause before I used to only do it if something was really really bad but now it’s just really little things and I just cut,” (Louise, 6.48).

9.1.2 The confusion and unpredictability of emotions
Constantly trying to avoid negative emotions may also contribute to the confusion some participants felt when trying to understand their emotions. Tamsin and Cindy commented on how their emotions were difficult to understand and seemed
unpredictable. Indeed Cindy found it difficult to identify any triggers to her changing mood.

"Nothing makes me go up and down and I can't predict when it's going to happen," (Cindy, 12.01).

Avoiding emotions may lead to them re-surfacing later, perhaps out of context, making it difficult to understand what triggered the emotion. Consequently using DSH as a means of avoiding negative emotions may perpetuate the young person's difficulties coping with and understanding their emotions.

9.2 DSH makes me better and worse – vicious cycle
We saw in the previous theme that DSH provided some release or distraction from negative emotions, making the young person feel better. This seemingly immediate change in emotional state appeared to be a dominant motivator for engaging in DSH.

"It [DSH] like releases it all. And it kind of feels good for a couple of seconds or minutes or whatever," (Louise, 4.23).

"When the cuts bleed and I just sit there and [participant exhales deeply] and feel really relaxed" (Lucy, 6.07).

"You get quite a good kick out of it sometimes [...] Adrenaline," (Matthew, 9.03)

As illustrated by Louise's above comment, the positive impact of DSH appeared short-lived. Indeed Emma (8.34) and Lucy (6.20) state that they had to cut repeatedly in order to get the same positive impact.

Part of the dilemma of engaging in DSH seems to be that the consequences of engaging in DSH also has a negative impact, often making the young person feel worse. Louise and Rachel talked about feeling worse because of the scars from cutting, which acted as a visible reminder of their difficulties and engagement in DSH for others to see and belittle.
"You do feel really bad about it. Or at least I do, because of all the scars and that," (Louise, 4.26).

“I don’t like the scars on my arms [...] if I’m at a bar or nightclub and people look at my arms and I get funny looks,” (Rachel, 13.23).

The participants themselves, however, could be similarly disparaging of their behaviour. Both Lucy and Louise said that they “cringed” when they looked at their scars, seemingly disconnected from and disbelieving of their engagement in DSH.

“Cause when I think about cutting myself, I actually sort of cringe. I like look at the scars and like, how can I do that,” (Lucy, 14.39).

Others’ reactions to their behaviour contributed to making the young person feel worse. Emma, Willow and Louise felt that their parents viewed them and their behaviour as “stupid” and “weird”, which made them feel “bad” and “upset”.

Importantly, it appeared that the respite from overwhelming feelings, even momentarily, was better than having these feelings all the time, despite the numerous negative consequences of engaging in DSH.

9.2.1 Vicious cycle of DSH and ambivalence to change

The paradox of DSH, in making the young person feel better and worse, may contribute to a vicious cycle of distress and engagement in DSH (figure 2).
It appeared that participants tolerated the distress of scars and negative reactions from others by adopting an “I don’t care anymore” attitude, at which point DSH became an accepted part of what they do and an automatic response.

“It has just become, like, say familiar. Like normal, that I don’t really think about it that much,” (Louise 13.04).

“It’s what I do and I don’t think there’s anything wrong with it,” (Tamsin, 10.04).

Vicious cycles imply being stuck, a feeling illustrated by Lucy: “I’m just stuck inside me, I can’t sort of scream for help,” (Lucy, 12.25).
Given this paradox it did not seem surprising that there was considerable ambivalence expressed by participants around stopping. This ambivalence was illustrated well by Lucy and Tamsin: -

“It’s like there’s two people, it’s like on opposite days when I’m feeling OK, I think right I’m going to stop, but when I’m upset someday I think so what I don’t care. And then sometimes I just give up, I don’t want to stop anymore. It’s, it’s what I do and I don’t think there’s anything wrong with it” (Tamsin, 10.01).

“In a way no, but in a way yes. In a way it did help but in a way it didn’t. So yes and no. Otherwise I would need to find another way of helping myself that wasn’t cutting,” (Lucy, 16.24).

9.3 Contradictory thoughts around suicidal intent
Some reported wanting to die, which may reflect how overwhelming and hopeless (or stuck) things appeared for them. For Louise there appeared to be a fatalistic quality to her suicide.

“I know I am going to die by my own hands so…” (Louise, 14.04).

This statement also suggests that Louise felt very much in control of her death, as it was in her hands. Perhaps, for some participants, suicidal intent may have reflected a means of gaining control over their life, rather than actually wanting to die. For example, although somewhat paradoxically, Willow appeared to feel that she could control her ‘life’ when she was in control of killing herself.

“I think you have pretty much control when you kill yourself, that’s a statement isn’t it. I can control my life.” (Willow, 13.35).

Participants sometimes made contradictions when talking about their intent. We saw earlier how Louise felt that she would die by her own hands. Yet she also reported being afraid of losing control when self-harming and cutting too deep: -
"I was really anxious about it, cause I thought my whole arm would come off. I was really scared that I would cut deep." (5.34).

Similarly contradictions were evident in Emma’s transcript. She reported feeling “suicidal every day” (7.22). Yet after her mother discovered she was cutting and she was admitted to the unit, she reported:

"It was horrid cause it was like she [mother] was taking my life away. Like she was trying to stop what I was doing," (9.28).

For Emma, stopping her self-harming was ironically like “taking my life away”. Other participants talked about DSH in terms of such survival qualities, which appeared to be the anti-thesis of suicide and perhaps the opposite to how others might come to view their behaviour. Louise talked about how DSH made her feel more able to cope with things during the day.

"Sometimes I can be quite high as long as I know I can always cut myself or do something. I don’t know it makes me feel better," (Louise, 9.12).

Matthew’s account illustrated how DSH was for him life saving and life taking. He found that finding ways of continually exercising and cutting in some way saved his life, stating:

"I think if I hadn’t found out that way [secret exercising and cutting] I might have killed myself;" (10.10).

Yet he also felt that his overwhelming compulsion to engage in such behaviours prevented him from having “any quality of life” (17.41).

Participants regularly talked about distancing themselves from people who self-harmed for attention and that engaging in DSH to gain attention was: - “evil” and “nasty” (Joanna, 6.44). For Cindy, others perceiving her behaviour as attention seeking meant to her that they did not believe her difficulties were real: -
“I’m scared people just think I’m doing this for attention which I’m not,” (20.12).

Expressing suicidal intent therefore may reflect the young persons’ (conscious or unconscious) attempt to make others view their problems as genuine.

9.4 Minimising and/or failing to recognise the young persons’ difficulties

There was a tendency for some participants to feel that others minimised their difficulties either in labelling their behaviour as ‘attention seeking’ (mentioned previously), as ‘stupid’ or in the expectation of others to ‘just stop self-harming’ and ‘get better’.

9.4.1 Minimising their difficulties

Although engagement in DSH appeared, at least initially, to be a response to overwhelming emotions, Willow, Cindy, Tamsin and Emma felt others perceived their behaviour as “stupid”. This seemed to minimise their difficulties, implying that not only was their behavioural response wrong but also suggested that their emotional response was wrong (i.e. ‘you are wrong to feel the way you do’). Indeed Lucy commented on her mother’s difficulties understanding how things could be so bad that she would want to harm herself. This was in spite of Lucy’s recent disclosure of intra-familial abuse.

The perceived minimisation of the young persons’ difficulties was not only evident when talking about how others viewed their DSH. Tamsin’s concerns, about returning to school after being on the adolescent unit, appeared to her to be minimised.

“I wanted to go back to school. I was just worried that... cause everyone kept saying ‘it will be alright, no one will even say anything’. And I knew that wouldn’t happen,” (Tamsin, 12.16).

Lucy and Cindy felt others failed to recognise their problems, by assuming they were merely a phase or hormonal. This made them feel worse and hopeless as they felt others could not help them as they did not see the problem.
“Mum used to think it was just a phase or blame it on the time of the month [...] It made me even more low and upset. They’re not even seeing that there is something wrong so they can’t help me,” (Lucy, 19.42).

9.4.2 Failing to acknowledge the significant difficulty in stopping DSH

Participants regularly talked about how difficult it was to stop engaging in DSH. Often participants explained their DSH as habitual or addictive, some likening it to cigarettes and even heroin and cocaine (Lucy, 6.09; Emma, 14.02; Cindy, 9.08).

“Also it gets really addictive as well. Like when you cut yourself. Once you do it once. There was times when ‘oh I won’t do that again’, but then you find yourself doing it again and again,” (Louise, 4.17).

This is reminiscent of Motz’ (2001) suggestion that engaging once in such behaviour breaks down a body barrier, which makes it easier to engage again. Many who tried to stop, failed to recognise the function of DSH and thus attempts to stop reflected going “cold turkey” (Cindy, 5.23). In the absence of other strategies to cope with emotional distress, there appeared to be a build up of emotions to the point where the young person ended up self-harming, sometimes worse then before; “after that 10 days I cut more than I would have done in those 10 days if I hadn’t tried to stop.” (Cindy, 14.27). Indeed Emma (14.25) became so frustrated when trying not to engage in DSH she attempted to hang herself.

Finding other strategies to compensate for DSH was not easy, seemingly reflecting the efficacy and power of DSH.

“At college they say things such as try sport or art, or that sort of thing but it just doesn’t compare,” (Tamsin, 10.17)

DSH became an accepted part of them, part of their identity. For Louise and Cindy this acceptance of DSH as part of them, made them dismissive of others’ concerns and help.
"But that's just standard anyway. That's just me," (Louise, 15.01).

“Its just the way I am there's always going to be that need to cut myself and harm myself. You know doing something stupid but that's me. And no body can help me,” (Cindy, 10.08).

Conversely, Emma and Tamsin felt that others failed to recognise how difficult things were for them and specifically how difficult stopping was. For Emma others' expectations that she should just stop caused her considerable frustration.

“They expect me to cope really well but I can’t. It’s hard,” (Emma, 17.18).

“Saying “don’t do that” [laugh] “scars you for life”. And you know that but you just can’t stop doing it,” (Emma, 14.02).

For Tamsin, expectations to stop created a dilemma. Stopping felt unachievable, yet admitting that she continued to self-harm felt like she was “failing” (15.27) and feared “it’ll be like I’ve let her [mother] down,” (15.41) and others would not think she is “trying hard enough,” (15.45). This dilemma caused her considerable distress, potentially increasing her desire to self-harm.

9.4.3 Just get better
Willow felt that others were annoyed with her for not feeling “better” or ‘trying harder’ after her suicide attempt.

“There's something about, after you've tried to kill yourself, that you can't look, can't always look back and think I shouldn't have done that or that I feel better now but also that you shouldn't feel that you are just locked away. Yeah because maybe if you come out of hospital you should be able to say I don’t feel any better without people saying right you’re weird. That’s how my mum felt, she said if you don't want to help yourself. You’ve got the opportunity. We are trying to help you and you won't help yourself.” (Willow, 23.39).
In fact Willow felt that others were annoyed that they were now part of "my big horrible secret" (18.01) and in a sense also stuck in her vicious cycle.

9.5 Expectations by other people to 'just talk'

As participants talked about others' reaction to their difficulties, some young people felt that others expected them to 'just talk' rather than engage in DSH.

"I think they just expect you to talk about it, forget about it and that's it. That's what my family are like, you talk about it and then that's it. You are supposed to feel better," (Lucy, 21.26).

"I think people expected me, after that [overdose] to be willing to talk about things and want to get myself sorted out," (Willow, 19.42)

For Louise this expectation also included a reliance on her to approach her parents when she had difficulties.

"...They [parents] expect me to talk about it and say what's on my mind. [...] Just go and talk to them," (Louise, 12.04)

However the emphasis placed on the young person to 'just talk' appeared in conflict with much of what participants were saying. Indeed there appeared to be many variables, described in the following sub-themes, that made 'just talking' quite a demanding, over-ambitious expectation.

9.5.1 Difficulties expressing and understanding emotions

Many participants reported considerable difficulties expressing themselves or, as we saw earlier, even understanding their emotions, which may make 'just talking' difficult. Joanna had difficulties expressing her feelings; when she tried to express how she felt: "it always comes out completely backwards," (17.09). Matthew illustrated the difficulty he had clarifying his emotional state, stating that everything seemed: "a bit of a jumble in there," (9.38). Joanna's account provides considerable insight into the confusion she has in relation to understanding her internal world.
When the researcher asked Joanna how she felt from day to day, she replied, "I don't."

"I don't feel sad. I don't feel happy not properly anyway [...] I'll get angry because I think I should be angry. I'll be happy because I think I should be happy. But I only really get worried. I worry about everything," (Joanna, 15.19).

She talks about her experience of emotions as being governed by what is going on around her and what she thinks others expect of her rather than being governed by how she feels inside. Despite her efforts to feel 'how she should' her anxieties are ever present and overwhelming. In fact anxiety appears to be the only emotion she recognises.

The difficulty understanding and expressing emotions seems to make the expectation to "just talk" meaningless.

9.5.2 Relationships - the lack of trust and reciprocity

A pre-requisite to being able to talk to someone is trust. Some participants had very little experience of trusting relationships, evident in Karen and Lucy's accounts:

"I don't like trusting people, and the nurses always say it's really hard for you to speak about things and you won't let us in. They say you've got a wall and I won't let them in," (Karen, 4.40).

"I never really trusted anyone. Cause anyone I did trust it seemed to just get thrown back in my face, so I never told anyone," (Lucy, 15.06).

Both Karen and Louise talk about their fears of being rejected by others, which prevents them building relationships. Without trusting relationships and difficulties building such relationships the opportunity for talking about their difficulties is diminished. In the absence of trusting relationships, perhaps some young people experience a relationship with their self-harm. This is illustrated by Emma who felt
that when she was distressed the one thing she could turn to was not someone, but "the blade".

"When I get stressed or get very upset or something I don't know what to do, and all I can turn to is the blade I cut with and just cut 'cause I know it will make me feel better," (Emma, 13.15).

There were exceptions, as some young people in this study reported having significant relationships with parents, siblings or friends. What appeared common to all participants however was that close relationships were, to varying extents, experienced as quite demanding, non-satisfying, not genuine and non-reciprocal. Both Rachel and Willow felt close relationships required keeping others happy, implying others are in some way vulnerable and need their protection, but both felt they got very little in return.

"It was OK if I was making other people happy but it wasn't particularly making me feel good," (Willow, 17.29).

9.5.3 Tendency to conceal emotions
In protecting others, many participants concealed their emotions due to fear of upsetting others. Rachel, Karen and Lucy appeared to feel that others would not be able to cope with their emotions and that others might feel blamed or even angry with the young person for disclosing. This may reflect the lack of trusting relationships experienced by the young person, as it appeared that the young person felt others could not contain or help them.

"I just think that when I tell them [how she feels] they'll be angry so I don't tell them," (Karen, 4.20).

"That's the thing I don't know what they'll do. I worry my mum will feel useless that she's not good enough. When she is, it's not her fault," (Lucy, 13.28).
The belief that negative emotions should be concealed and the need to protect others is evident in Karen’s account of what she thinks others expect from her.

“To say I’m fine. [...] To act OK and not say how I feel. And look after other people,” (Karen, 13.16).

For Rachel, concealing her emotions when she felt others couldn’t tolerate them was also a way of protecting herself. Upsetting others by talking to them about her difficulties had the reciprocal impact of making her feel worse, not better.

“I used to always pretend I was happy and put on a happy face. [...] Just make others feel better I suppose, not bring them down. [If I told them] they would make me feel worse,” (Rachel, 7.23)

Lucy felt that her difficulties coping with her emotions led her to self-harm, yet telling, or worrying others, made her feel worse. She felt stuck: “I can’t win either way,” (13.17).

9.5.4 No one else is talking

Apart from the lack of trusting, reciprocal relationships limiting the young person’s opportunity to talk, there also appeared to be little opportunity to ‘just talk’ as participants, families and sometimes services avoided conversations about DSH. Louise said that when her family discovered she was self-harming that:

“After that night we really didn’t talk about it again,” (Louise, 7.11).

Rachel and her sister had taken overdoses, neither of which were discussed in her family. In fact DSH seemed to be a taboo subject.

“If they [nurses] find out here [that she has self-harmed], they ring home but mum and dad don’t really say anything really. I know it upsets them so I don’t bring it up,” (Rachel, 12.26).
The lack of communication may reflect the fact that families do not generally use communication as a way of dealing with distress. Interestingly, although not relevant to all families of participants, a few participants did report their parents and siblings used similarly self-harming methods to cope with distress, including alcohol, smoking and physical aggression (Lucy, Joanna, Louise).

"My mum, in the past when things started getting really bad she just stopped eating and started getting really thin which is kind of ironic because when I didn't eat she started having a real go at me yet she was doing exactly the same. My dad just started smoking more, cause it was getting him down as well. I was getting everyone down. I was just the cause of everything,“ (Louise, 12.14).

We saw earlier that there was a reliance on Louise to approach her parents to talk about her difficulties. Yet paradoxically her parents did not seem able to use talking themselves in coping with their own difficulties, which left Louise feeling responsible for everything.

9.5.5 Disconnected from emotional content of interview

It was important to reflect on the fact that the interviewer expected the participant to 'just talk' in the research. However the most pertinent issue did not seem to be a problem with 'just talking' but the disconnection from the emotional content of what was being said. For instance, many participants appeared to find it difficult to connect emotionally with the content of the interview. This was evident in the use of laughter during the interview. Sometimes participants laughed when talking about difficult experiences.

"Cut myself. Tried to hang myself. Motorway bridges [laughs]. Overdoses and tried to jump in front of cars and vans,” (Emma, 7.17)

"My mum [after discovering that Willow had taken an overdose] was just running around screaming saying “Oh my God what have you done” [laughs] and my, shoving clothes on me and shoving me in the car to go to hospital,” (Willow, 11.12).
This was not always the case; two participants became appropriately tearful when talking about their difficulties. Although the laughter may be interpreted in many ways, such as embarrassment, its seemingly inappropriate use may have implications for those listening, possibly minimising their empathy and their subsequent helping behaviour.

9.5.6 DSH is the solution – the barrier of DSH to talking
Interestingly, the few young people who commented on the interpersonal function of DSH felt that although it may have initially been an attempt to let others know how they felt, it appeared to become a way of coping with upset.

"Before sometimes it was like a cry for help because I wanted people to notice, but then sometimes it is something that I did so... when I was upset,"
(Tamsin, 9.25).

In the context of their difficulties talking about their emotional distress and their fear of upsetting others through talking, it seems that participants felt they cannot cry for help. Indeed Joanna talked quite fatalistically about the fact that no one can help her, which explained why she had originally turned to DSH.

"There isn’t anyway to help me that’s why I did it in the first place. It’s the only way that effectively helps me," (Joanna, 18.39).

In this context, DSH appeared to become a solution to their difficulties, rather than a cry for help. Its effectiveness as a solution (possibly in avoiding emotional distress, albeit temporarily) may be reflected by the ambivalence participants expressed about stopping. Consequently DSH itself may become a barrier to the young person seeking help, or talking about their difficulties. Indeed Lucy talks about DSH as a way of dealing with difficulties “instead of talking” (5.31) about them and Louise found talking was not necessary after engaging in DSH.

"Because I kind of felt better after I done it so I didn’t think there was anything to talk about," (Louise, 7.35).

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9.6 Wanting and not wanting others

There appeared to be a considerable dilemma around wanting closeness or help from others, illustrated well by Joanna.

Joanna: “I had to sit in the bathroom for 2 hours before anyone noticed that I was gone.”

Interviewer: “Did you want someone to come and find you?”

Joanna: “No. I wanted them to leave me alone,” (Joanna, 7.47).

Although Joanna talks about wanting others to leave her alone, she similarly talks about wanting closeness. She was upset for only receiving two telephone calls from her family since she had been admitted three months ago. Her confusion around wanting closeness was heightened by the fact that, although she felt she had changed since becoming pregnant and her relationship with her mother had improved, her mother was placing her in care because of Joanna’s pregnancy. It appeared that when she experienced closeness she was rejected. We saw earlier how others similarly talked about their avoidance of relationships due to fears of abandonment and rejection (Karen, Louise).

It appears that some participants wanted ‘others’ to be there for them, but others being there brought conditions, which, we saw earlier, could not be met, such as ‘you should talk’, ‘you should stop self-harming’ and ‘you should feel better’. In actual fact given the negative interpretation of their behaviour as ‘just attention seeking’ and ‘stupid’, many participants found having people ‘there’ made them feel worse. This creates a significant dilemma for the young person.

9.6.1 Being watched

A common response by services and some families was to watch the young person in an effort to stop them engaging in DSH. In light of the conflict for the young person around wanting and not wanting others, this response had a variable impact.

No participant commented on this process being supportive, in the sense that they were able to talk through problems with the ‘watcher’. For some the threat of being caught appeared merely to make engaging in DSH difficult.
“When I come here I can’t find anything to do it with. They always walk round in the evening as well and there are lots of other girls in the dorm so…” (Tamsin, 13.22).

Despite this however many participants, including Tamsin, continued to engage in DSH. Interestingly for Matthew this seemed quite a challenge, possibly illustrating how empowering this process was for him.

“After a couple of days they noticed that I had done it and asked me when I had done it and who was watching me, because someone is supposed to be watching me all the time [laughs]. And there was but they just didn’t notice, so duh!” (Matthew, 11.41).

For Lucy being watched was a significant source of frustration, which increased her desire to self-harm. It seemed that for Lucy being watched was a constant reminder of how distressed she felt she was making others. Whilst for Tamsin, being watched fuelled her sense of being different.

“I couldn’t do anything without being watched. [...] Frustrating, I felt like I was going mad. I started punching, screaming. Throwing stuff, pushing stuff. What I did was sat there, with my nails and I scrapped my hand until it was bleeding. That was when I was really really really really really stressed that that was the last time I did it. [...] I never used to do it in front of people. But I was so desperate, I just couldn’t be bothered to worry about them” (Lucy, 13.42).

“People tend to watch me. Before it was like, I’d get up for a drink from the kitchen and it would be “where are you going?” Which make me feel a bit silly as well as whenever I go out they say “are you safe?” Which I think is a bit weird as it is not normal,” (Tamsin, 17.38).

There appeared to be a more subtle impact to being watched however. In Cindy’s case, this was the impact of others not watching her. Although she said she wanted
others to leave her alone, she appeared quite upset and rejected by the fact her father
did not stay with her after finding out about her self-harm.

“He never stayed with me to make sure I didn’t cut myself, he just told me not
to do it, that it’s a stupid thing to do,” (Cindy, 9.39).

Although being watched drove her “round the bend”, Willow did comment on finding
another way of coping with her emotions whilst on the ward.

“I was hatching plans in my head about ways in which I could hang myself or
kill myself but it always came back to the fact that I’d get caught so I went and
had a bath and just laid there for quite a long time trying to I don’t know, I
don’t know what I was doing just trying to unwind really so,” (Willow, 18.42).

One hypothesis is that having a bath reflected a creation of distance from those
watching her. Although it may have been risky to leave someone alone in such
distress, for Willow, in this instance, it enabled her to calm herself without the added
distress of someone watching her. However the reason why Willow was able to find
alternative strategies for coping with distress, whilst others were not, is unclear. One
possible reason was that Willow appeared one of the most intent and less
contradictory in wanting to kill herself. Perhaps frequent observations are more
effective with suicidal behaviour than DSH.

10. HELPING PROCESS AND CLINICAL IMPLICATIONS

10.1 The importance of relationships

When participants were asked about what had been helpful, they invariably talked
about relationships. Despite their reported lack of experience of trusting or reciprocal
relationships, their reported fear of being rejected, and the over-demanding
expectations perceived in being with others, this theme illustrates the importance and
desire to have relationships.
10.1.1 Trust before empathy

Trust was, as expected, central to a positive experience of help. Karen and Emma reported that trusting relationships could develop with staff at the unit, but that this took time. For Lucy, trust was important in helping her overcome the self-blame she felt for the childhood abuse she experienced.

"I can talk to her and I know that if it is my fault, if I've done something she'll tell me. And that's how I sort of learnt it wasn't my fault, because [nurse] told me it wasn't my fault. I trust her, I trust her a lot," (Lucy, 11.16).

This process of developing a trusting relationship appeared to help Lucy start to tolerate talking about her difficulties and her emotions with her named nurse, Tina. In her relationship with other health professionals where trust was not present, Lucy had not been able to tolerate their empathy or tolerate focusing on her emotions.

10.1.2 Reassurance, containment and acknowledgement

Fear of upsetting others or letting others down appeared to have led some participants to continue to conceal their emotions and their difficulties. Tamsin stated that she felt it was "easier" to talk during the research interview because she did not think the researcher would get angry with her. This illustrated the importance of reassuring young people that their helper can cope with their emotions and can contain them. Such reassurance would be part of developing a trusting, therapeutic relationship. In addition young people also appeared to want others to acknowledge the difficulties they were experiencing.

10.1.3 Experience of reciprocal friendships with other patients

Tamsin found that it was "easier" (14.19) to talk to other patients (her peers) than nurses. Lucy similarly talked positively about friendships at the unit. She said that in the past she had felt looking after others had meant she had not been able to look after herself. Yet when she talked about her friends on the unit, she appeared to feel empowered by helping and supporting them. In this instance, however, it appeared that this help was perceived as reciprocal, as the friends supported her too.
“Me, Charlotte and Tom we’re like friends and we all help each other [...] And when you know you are helping someone else it makes you feel stronger, cause you think I have to help them. So we all make each other, I think we make each other stronger in a way,” (Lucy, 10.39)

Although the friendships made on the unit are a benefit to an admission, the detrimental consequences need to be considered also, especially the stigma. Stigma of being on a locked ward was evident in participant’s accounts. Tamsin was more embarrassed by others finding out about her being on the unit than about her cutting. Similarly Willow wanted others to realise she was the same person, despite being admitted to a “funny farm”.

10.2 Creating space to talk
The way in which help was offered and talked about appeared important, in needing to create space for talking and for change.

10.2.1 Balanced approach
Given the paradoxes and conflicts experienced by the young people in this study, it is not surprising that many saw a balance of time and space as helpful. For example, given the difficulties talking and tolerating others being there, Lucy and Willow felt that others approaching them to talk, but also being given space, were helpful, possibly contributing to the development of a trusting relationship.

“Like talk to me but give me some space too. Don’t leave me, don’t leave me alone alone but give me some space like don’t be in my face,” (Lucy, 21.46).

Willow stressed that having someone to whom she felt able to talk was important to her, stating that: “it’s all very well having someone that they can talk to but if they don’t like that person, or you’re not comfortable it’s not worth it,” (21.08).

The dilemma for the helper was that participants often liked others to ‘guess’ what their difficulties were; thus avoiding the difficulty of talking or the possible upset it was felt to cause. Some participants even referred to the almost ‘magical’ qualities of their helpers.
“[Keyworker] really understands what goes on in your head really. He’s kind of a psychic person,” (Emma, 5.05).

“They say you’ve got a wall and I won’t let them in but somehow she just managed, I didn’t even realise that I had started telling her things. I don’t know. I don’t know how she does it,” (Karen, 4.42).

Although there appeared to be a desire for others to guess what the difficulties were, there was also pressure on others to ‘get it right’. Both Rachel and Willow expressed their concern over others who “psychoanalyse everything you say” (Willow, 21.26) or “try and twist” (Rachel, 10.07) what they say.

10.2.2 Talking about DSH

Talking about DSH within the unit may impact on the young person’s views around concealing their emotions. For Louise the fact that DSH was not discussed led her to feel that it was “just something” she did.

“No one ever really discussed it. We don’t really talk about it here [adolescent unit]. So there’s not really much to talk about it, it’s just something I do,” (Louise, 8.13).

Not talking about the DSH and Louise’s continued engagement in the behaviour may have led DSH to become an integral part of her identity. Importantly Louise felt that she had to conceal her difficulties in order to be discharged, stating that:

“You just tell people what they want to hear,” (14.22).

In contrast Willow perceived her situation differently. When asked about how she felt talking to the researcher about DSH and her difficulties, she replied that she was used to it as people at the unit had asked her “all the questions under the sun,” (Willow, 22.12). Talking to Willow about her DSH appeared to have a positive impact on Willow in terms of her concealing less. Similar to Louise she wanted to be discharged as soon as possible, yet conversely she felt that in order to be discharged from the unit she needed to start talking.
“When I first came here I didn’t talk to anyone about anything but the way I see it here is if I want to get out of here as soon as possible I have to talk to people and I have to get myself sorted out as much as I can. There are particular nurses that I get on well with,” (Willow, 22.35).

Although there are many variables that may impact on the different experiences and outcomes, the fact that Willow was questioned about her behaviour may have created an expectation that she needed to talk, and she did not need to conceal her emotions and difficulties. Conversely, for Louise, not talking about DSH on the unit may have fuelled her belief that her emotions and difficulties should be concealed.

10.2.3 Using other methods of expression

Joanna and Rachel both felt it was beneficial when other people helped them find ways in which they could relate to and express their emotions, such as using mood boards or pictures.

“You had to cut out pictures and colours and stuff and put them on a board of how you felt. It wasn’t writing, [...] It was quite good,” (Joanna, 17.03)

“She would draw pictures, which would make it easier to understand. Pictures all sorts of different things, triangles. [...] Better than talking that’s for sure. It easier to show her things,” (Rachel, 16.45)

11. ANALYSIS OF THE IMPACT OF THE RESEARCH INTERVIEW ON THE PARTICIPANT

“Its not pushed me either way really, its not made me feel depressed or made me feel different really,” (Willow, 23.27)

Generally the interview appeared to have little self-reported impact on participants. For some the interview had a positive impact. Lucy felt ‘happier’ now she had spoken to someone about her self-harm and Tamsin reported feeling more able to approach nurses and admit that she had cut again. The extent that this apparent
positive impact may have reflected a desire to ‘please’ the researcher is unclear. The researcher did feel that with some participants there was quite a solid rapport built during the interview. For example, at the end of the interview, Willow reported that the interviewer reminded her of her sister, someone she felt she could talk to. The researcher wondered whether talking about their experiences in a supported way might have felt quite empowering for the participants.

Only Louise commented on the association between talking about DSH and the increased desire to engage in the behaviour. However she was dismissive of the researcher’s concerns that she may hurt herself.

Interviewer: “Do you feel any different from when you started this interview?”
Louise: “The same.”
Interviewer: “Well I guess I’m left rather concerned.”
Louise: “Why? (laughs)”
Interviewer: “You have expressed yourself really well. However I have been concerned by your thoughts about killing yourself.”
Louise: “But that’s just standard anyway. That’s just me (laughs).” (Louise, 14.39)

Whether this reflected the fact that talking about her suicidal intent and self harm had become so much part of her identity that it felt normal or whether she was concerned that the researcher may act to make it harder for her to self harm was unclear (although it was made clear to Louise that actions would be taken if concerns were raised).
DISCUSSION

The research aims were achieved in that the researcher gained an apparent insider’s perspective of young peoples’ DSH, their views around what is helpful and the qualities they value in helping relationships. This section summarises the main findings in relation to the research questions (stated in section 4.3). Psychological theories are considered in helping conceptualise and make sense of participants’ accounts, alongside clinical and research implications of this study. Firstly a critical review of the method and process of the study is provided, from which the reader may then judge the analysis and findings.

12.1 Methodological Issues Critiqued
12.1.1 To what extent did the outcome of this study reflect an ‘insider’s perspective’ on DSH?

To a certain extent the quality of participants’ responses, illustrated in examples provided in the analysis, provides some evidence of the quality of this study in accessing their views and gaining an “insider’s perspective”. However, it is important to consider what factors may have impacted on this process. Some might question the extent that participants could be truly open with the researcher when they knew the researcher might report back to staff. The researcher’s duty of care made this an unavoidable issue however and efforts were undertaken to promote openness in feedback to staff. For instance, participants were re-assured that the researcher would discuss her concerns with them first before discussing with staff. If it was necessary to feedback to staff, participants were invited to join this session.

Further ways of ensuring an insider’s perspective might have been for the young people to be involved in the development of the research design and to employ respondent validation. Pole, Mizen and Bolton (1999) advocate that when the child or young person’s views are the aim of the study, they should be considered as agents in the process of the research (e.g. in the development of the study). The pilot was really the only opportunity for a young person to contribute to the design of the study. Consultation with young people who engage in DSH in developing the study might have highlighted more conducive ways of accessing their views, rather than rely on an
interview. Respondent validation is also a method of enabling participants to be actively involved in the research, specifically in the data analysis (Silverman, 1993). This entails checking out the analysis and findings with the original participants to allow them to elaborate, challenge or validate the emerging themes (Willig, 2001). Employing this approach needs careful consideration, however, as it assumes that the young person would be able to voice their disagreement with the researcher and that the young person would be able to see their own perspective within the context of that of the whole group of participants (Bryman, 1988; Mays and Pope, 2000). However, involving participants as agents in the development of the research design and respondent validation were not possible due to the time limitations of this study.

12.1.2 Conceptual limitations of IPA
As with all approaches that try to investigate subjective human experience, IPA has some conceptual and practical limitations. Willig (2001) suggests that IPA relies on the representational validity of language and assumes that language is an adequate tool to capture an individual’s experience. Consider, however, the one participant who said that other young people may engage in DSH as a “cry for help” (Tamsin, 5.37). This terminology usage may reflect how society conceptualises the problem rather than how she does. In this case, Willig might argue that: “language constructs rather than describes reality” (2001:63). It is interesting, however, that she used such terminology to explain why others might self-harm, not herself. This implies that she might have been able to use her own language when explaining her personal experience of DSH.

12.1.3 Sampling adequacy
Although it was hoped that the sample would reflect a diversity of young people who engaged in DSH, some might question the adequacy of the sample achieved. The researcher was keen to recruit participants from different ethnic backgrounds and more males (only one of the current sample was male), but this was impossible within the existing time frame. It was not surprising that the sample was predominantly female; in fact the gender ratio in this study reflects that found in prevalence studies (Hawton et al., 1982).
Difficulties recruiting participants for this study warrants consideration. Originally it was hoped that all 10 participants could be recruited from one unit. However after recruiting a very small number after some months, three other units were approached in an effort to get enough participants within the time constraints of this study. The original unit explained the unexpected lack of young people who fitted the criteria due to the fact that they were not getting many suitable referrals at that time. In addition however there were a number of young people who were considered for participation, but staff at the unit were reluctant to approach them until they were fully engaged with the service (i.e. settle in, had a goal setting meeting). Once this was achieved, however, staff were similarly reluctant to approach the young person or arrange initial visits, as they were then disengaging with services and staff felt they were reluctant to be reminded of their difficulties. Obviously this difficulty ‘catching’ patients was influenced by the researcher’s removed position from the unit. However this raised questions for the researcher about the difficulties engaging young people who self-harm within inpatient services and the perceived vulnerability of the young person to talk about their experiences.

12.2 Ethical considerations critiqued

12.2.1 Was it really informed consent?

Although efforts were made to try and ensure informed consent was achieved, some might still question the extent that the young people were really able to fully consent to participation, perhaps in particular young people on section. Staff had begun drip-feeding Matthew, against his wishes, two days before he and the researcher had agreed to conduct the interview. This raised significant dilemmas for the researcher regarding the appropriateness of conducting the interview. Was it likely, given Matthews current dis-empowered status, that he could have declined participation? Also, was Matthew cognitively able to take part in the research? However, the RMO was still happy for the interview to take place. Further the researcher verbalised her concerns to Matthew and offered him the opportunity to decline participation or to reschedule the interview. Matthew said that he wanted to do the interview but wondered whether he was “worth it”. With Matthew’s consent, stressing his right to withdraw at any time, the interview took place in the context of trying to give back some power to Matthew and value his voice. The researcher tried to remain sensitive to the potential power differentials between her and all the participants when thinking
about consent and to stay attuned to any signs that participants might wish to withdraw. For instance, Karen became quite tearful during the interview. The researcher offered to take a break and Karen was able to decide not to continue the interview. The researcher spent time with Karen after the interview, emphasising the importance of her contribution to the study and providing some therapeutic containment.

12.3 Reflexivity - How did the researcher’s own position influence the analysis?
In recognising the dynamic process of interpretation, IPA acknowledges that the knowledge it creates is reflexive (i.e. influenced by the researcher’s own conceptions) (Willig, 2001). In section 8.2.1, the researcher acknowledged her own position in relation to this project in terms of her training as a clinical psychologist. Upon self-reflection the researcher wondered if her desire to focus on the young people engaged in DSH, rather than their families or other professionals, may have reflected her own position as a young professional in training, eager to empower her clients. In the analysis it was important to balance the need to represent participants’ voices but not to be too biased towards the position of the participants. Although this study provides useful insights for the wider system, it does not consider the views of health professionals, family members and friends who experience the young person engaging in DSH. Considering the systemic issues around DSH, evident in this study and within the literature (Aldridge, 1984; Aldridge and Dallos, 1986; Kerfoot, 1980) such views are important and might be a useful direction for future research.

13. SUMMARY OF FINDINGS

13.1 How do young people describe the process of engaging in DSH and coping with emotions?
13.1.1 Paradoxes, conflicts and vicious cycles
Similar to Crockwell and Burfords (1995) study, participants in the current study described the process of engaging in DSH within the context of conflicts and paradoxes. These conflicts and paradoxes might be viewed not only as factors that contributed to their engagement in DSH, but also sustaining the young person’s
difficulties and further engagement in the behaviour, illustrating the vicious cycle of DSH. Harris (2000) found that negative reactions from A&E staff, made her participants more distressed and more likely to re-engage in DSH. The findings of the present study extend this cyclical notion further by identifying other factors that contribute to the vicious cycle of difficulties in young people who self-harm, such as the use of DSH as a means of avoiding emotions exacerbating the young person’s difficulties and the young person’s own negative interpretation of their behaviour (cringing). These central issues are illustrated in figure 3, overleaf, which attempts to diagrammatically draw together the analysis.

13.1.2 Cycle of avoiding emotions exacerbates young person’s difficulties

Participants’ use of DSH as a “release” or “distraction” from emotions was interpreted as a means of avoiding emotional distress. Avoiding emotional distress suggests that the young person was unable to process his/her difficulties in any way to allow for resolution. Indeed Motz (2001) suggests that DSH replaces and prevents thinking about their internal world. Therefore this avoidant strategy was hypothesised to exacerbate the young persons difficulties, contributing to a build up of emotional distress, increasing confusion around their internal world and further diminishing the young person’s capacity to cope with emotional distress (as the size/significance of triggers to self-harm reduced). The use of DSH appeared to become automatic, whereby the emotion might not even be acknowledged; only the need to self-harm is recognised. Indeed for Louise DSH became: “like normal, that I don’t really think about it that much,” (Louise 13.04). Herman (2000) considers how avoidant or rather, dissociative strategies, can aggravate the individual’s difficulties if the process goes too far, leaving the individual feeling disintegrated and disconnected from others. Some participants did appear disconnected from their own experience of DSH (cringing at the thought of self-harm) and others appeared disconnected from the emotional content of the interview, which might impact on their ability to connect with others at an emotional level.
Figure 3  Paradoxes and conflicts contributing to and maintaining engagement in DSH – Vicious cycle

PARADOXES/ CONFLICT
Perceiving others as minimising and/ or failing to recognise the young person’s difficulties
Expectations of others to just talk
Wanting others and not wanting others

EXPERIENCE DISTRESS
“I get so upset and I don’t know what to do.” (Tamsin, 9.08).

ENGAGE IN DSH
Release/ distraction

Identity – It’s part of me
I don’t care anymore

PARADOXES/ CONFLICTS
Feeling others minimise or fail to recognise their difficulties
Expectations of others to just talk
Wanting others and not wanting others

DISTRESS

Avoidance of negative emotions
Immediate feel better (short-lived) → Addiction

Confusion over emotions
Build up of emotions

Confusion — Build up — engaging in DSH
DISTRESS — Build up — over emotions

Ambivalence to change

Negative consequences of engaging in DSH
(other’s derogatory reactions, scarring, cringing at self, self-criticism)
Anderson (1998) and Bateman and Holmes (1999) provide some insight into why this strategy of avoidance and automatic response becomes evident during adolescence. The developmental stage of adolescence is considered to be a time when it is common to experience contradictory feelings between dependence on parents and independence (Anderson, 1998). Similarly it is also a time when such internal conflicts may become externalised (Bateman and Holmes, 1999). Without the internal capacity (“I don’t know what else to do”) or perceived external support (“no one can help me”) to contain and express these conflicts, the young person can experience considerable anxiety and distress. In such cases “the whole process of experiencing feelings, processing them and working them through is frequently replaced by enactment” (Anderson, 1998:164). For the young people in this study this enactment was the automatic engagement in DSH.

13.1.3 DSH makes me better and worse – vicious cycle

The fact that the young people continued to engage in DSH, despite recognising the negative consequences, is important. It is likely to be very difficult for other people (especially family members and friends) to understand why the young person continues to self-harm when there are such negative consequences. Indeed engaging in DSH was similarly paradoxical for many participants. On the one hand participants cringed at the thought of DSH and hated the scars it led to; on the other hand, however, participants felt that they had no other way of managing their emotions and that DSH provided a powerful solution. Recognising that the young person feels poorly equipped to tolerate or cope with emotions, that they feel there are limited alternatives to cope with distress (i.e. in the lack of opportunity to talk and personal belief that emotions should be concealed for fear of upsetting others) and given the power of DSH, may help other people understand why the young person continues to self-harm.

The few participants in this study, who initially engaged in DSH to communicate their distress to others, appeared to then use DSH as a solution to their difficulties. It appeared that what might have initially been used as a strategy to convey emotional distress to others, became a means, in itself, of coping with the emotional distress. Participants’ focus on the use of DSH as a means of managing emotions was similar to qualitative studies with adults who engage in DSH (Harris, 2000; Michel, Valach
and Waeb, 1994). The sensitivity of the current study, however, highlighted how motives for engaging in DSH can change for some young people, as DSH becomes a powerful solution.

Behavioural approaches suggest that DSH may be maintained by the positive reinforcement of other people attending to the behaviour (Carr, 1977). However, the way in which participants talked about the addictive quality of DSH and the immediate relief from overwhelming distress implies that the behaviour in itself may act as the primary reinforcement. For instance: “when the cuts bleed and I just sit there and [participant exhales deeply] and feel really relaxed” (Lucy, 6.07).

13.1.4 Contradictory thoughts around suicidal intent
Similar to the views of adults in Harris’ (2000) study, some participants talked about DSH in terms of its survival qualities, antithetical of suicide. Turp (1999) provides a useful way of understanding this paradox. She considers DSH as an alternative to suicide or mental breakdown, reflecting a desire for a psychic death, rather than physical death. If DSH does have a survival quality for certain individual’s, focusing only on reducing the behaviour may be dangerous as taking away DSH may actually increase the risk of suicide, illustrated by Matthews comments: “I think if I hadn’t found out that way [secret exercising and cutting] I might have killed myself,” (10.10). This presents a significant dilemma for those caring for the young person.

Some participants reported suicidal intent, illustrating the perceived hopelessness of their situation. Some, however, were quite contradictory when talking about their intent. It was hypothesised that the expression of suicidal intent reflected the young persons’ (conscious or unconscious) attempt to make others view their problems as genuine and, in a sense, legitimise their behaviour and difficulties to others. Suicidal intent reflected a “genuine” problem, whilst self-harming for attention was considered “evil” (Joanna, 6.44). This illustrates the importance of taking all acts of DSH seriously, if not for suicidal intent then as a reflection of the serious distress the young person is experiencing.
13.1.5 Minimising and/or failing to recognise the young person’s difficulties

Many participants, however, felt that others did not recognise the seriousness of their distress and minimised their difficulties, which seemed to fuel their distress and perception of hopelessness (contributing to the vicious cycle discussed earlier). For instance: - (1) “If others do not think I have a problem, how can they help me?” and (2) “Others expect me to just stop self-harming, to just talk and to just get better, which I cannot achieve”. Minimising their difficulties/distress also appeared to convey that not only was the young person’s behavioural response (DSH) wrong but also their emotional response was also wrong (i.e. “I am wrong to feel the way I do”). This may contribute further to the young person’s difficulties understanding their emotions, as they feel that they cannot rely on their own emotional responses to events and have to look to others to ascertain accurate reflections of what is going on (Kiehn and Swales, 2000). This was very evident in Joanna’s account as she looked to others to know how she was expected to feel rather than rely on how she felt inside.

13.1.6 Expectations by other people to ‘just talk’

The perceived expectation to ‘just talk’, instead of engaging in DSH, appeared over-demanding for numerous reasons: (1) participants had difficulties expressing themselves; (2) participants felt they lacked opportunity to talk, either due to a lack of trusting, reciprocal relationships and/or that others similarly avoid talking; (3) participants believed that emotions should be concealed and that others needed to be protected from their distress and (4) the fact that DSH offered itself as a solution and appeared to eliminate the need to talk, therefore DSH itself acted as a barrier to participants seeking help and talking. It may be hypothesised that difficulties in ‘just talking’ (either due to individual difficulties or the result of systemic or psychodynamic factors) may have contributed to the young person’s initial engagement in DSH.

On reflection the researcher was aware that she had similarly asked participants to ‘just talk’. Importantly, participants had been able to talk and provide important insights into their difficulties. Their efforts were reinforced to help them recognise that they were able to express themselves when given the opportunity and support to do so. It was not clear whether participants would be able to express themselves as clearly when in a distressed state.
13.1.7 Wanting and not wanting others
Relationships appeared important to participants’ positive experience of help, illustrating their desire for relationships. Yet relationships appeared to bring with them conditions that appeared to be too over-whelming (i.e. just talk, just stop and just get better). Although participants reported wanting others to ‘just be there’, others actually being there could often make them feel worse. When others reacted to the DSH by watching the young person, the other person was perceived as merely distracting, perhaps similar to the DSH, as opposed to being nurturing or helpful in processing distress. There appeared to be both a desire for others to show they cared by watching, but also a frustration at being watched as it reminded them of the distress they were causing others (possibly contributing to self-blame and guilt) and their difference to others. It was hypothesised that their difficulties coping with negative emotions reflected their difficulties in relationships, implying that emotional expression and quality of relationships seem connected. This hypothesis led to the consideration of attachment theory in helping to conceptualise the young person’s difficulties.

13.1.8 The contribution of attachment theory to understanding the emergent themes
According to attachment theory (Bowlby, 1980) the quality of our early childhood attachment relationships can impact on our ability to hold, makes sense of and cope with emotional distress and acts as a model for all subsequent relationships. Participants’ experience of non-trusting or non-reciprocal relationships might reflect anxious, insecure attachment experiences. Bowlby (1980) proposes that in insecure attachments the child may have tried to maintain their attachment with a caregiver who is unpredictable or rejecting, either through avoidance or adherence. As a result their internal working model is based on accommodating the emotional state and needs of the caregiver rather than vice versa (Holmes, 1999). This may reflect some participants’ desire to protect others and, specifically, Joanna’s tendency to look to others to explain her internal state. Holmes (1999) explains that in insecure, avoidant attachment the child:

“tries to minimise his needs for attachment in order to forestall rebuff, while at the same time remaining in distant contact with the care-giver whose
Defensive exclusion limits the child’s opportunity to process emotional distress, which ultimately restricts their emotional growth and development (Holmes, 1999). An attachment model may be useful in explaining why the young person may have difficulties maintaining trusting, reciprocal relationships; their tendency to use avoidance as a coping strategy; and their difficulties processing and managing emotional distress.

Specifically attachment theory may contribute to understanding some of the paradoxes that participants’ experience. Insecure early attachment leads to internal conflicting desires to be close to others but also to punish their attachment figure for rejecting or failing to protect them, which might explain the paradox of wanting and not wanting others. Indeed Motz (2001) suggests that DSH may actually be an indirect attack on those around the young person who have failed to protect them or help them manage overwhelming emotions.

The perceived expectation from other people to ‘just talk’ in contrast to the perceived lack of opportunity to talk, may reflect a double binding message, e.g. “just talk to me, but I won’t talk to you, and if you talk too much I will get distressed”. Marrone (1998) considers double binding messages to be a pathogenic style of parenting, which may contribute to insecure attachments. Double binding provokes irreconcilable conflicting feelings in the young person and leaves them feeling that whichever way they turn it will be unacceptable or impossible. This impact is well illustrated by Lucy’s comments: “I can’t win either way.” (13.17).

13.2 What do young people, who engage in DSH, view as helpful and what do they value in helping relationships?

13.2.1 The importance and desire for relationships
Sudak, Ford and Rushford’s (1984) emphasis on the importance of the therapeutic relationship appeared to be supported by participants’ accounts. Despite difficulties in relationships, young people in this study still appeared to want relationships,
perhaps reflecting the innate human desire to form attachments (Bowlby, 1980). Trust was vital for developing a therapeutic relationship, in enabling the young person to focus on emotions, talk about their difficulties and accept empathy from the helper. The current study highlights the need to acknowledge or validate the difficulties faced by the young person and provide reassurance that the helper can tolerate and contain the young person’s difficulties to reduce enactment. Motz (2001) states that: “therapy can demonstrate that apparently intolerable psychic pain can be borne and thought about, that memories and feelings of despair do not necessarily require urgent action,” (2001:157).

Inpatient admissions for people who self-harm can be contentious, due to fears of contagion (Offer and Barglow, 1960 cited in Hawton, 1982) and, as illustrated in this study, the stigma attached to an admission. Something not documented before, is the positive and important experience of reciprocal friendships with other patients on the ward, reported by some participants.

13.2.2 Creating space to talk and change
Young people in this study appeared to find the way in which help was provided and talked about was important. They felt that there needed to be a balance of talking and space. Perhaps this would enable the young person to start the process of talking about their difficulties and learning that the helper can tolerate them talking about their difficulties and offer some containment. Overall this balance is likely to contribute to the development of a trusting relationship.

Some participants talked about the ‘magical’ qualities of their helpers and the need for their helper to get things right. This may reflect an unconscious ‘splitting’ (Gobbard, 1989) of the bad and good in that the helper is either all knowing and all good or is useless and gets everything wrong. Helpers must be sensitive this and help the young person start to ‘demystify’ relationships, helping them balance the good and the bad.

The openness of the unit in approaching Willow to talk about her DSH appeared to create a positive expectation that she needed to start talking, whilst not talking about DSH on the unit for Louise appeared to fuel her belief that emotions should be concealed. The latter may have been interpreted as evidence that others cannot
tolerate or contain her distress, which may mirror the difficulties experienced within early attachment relationships.

Not talking about DSH may reflect a behavioural approach, in terms of trying to avoid positively reinforcing the behaviour in any way. It is possible however that this approach can contribute to the perceived minimisation of the young person's difficulties, which, according to this study and that by Harris (2000) increases distress and hopelessness.

13.3 What is the impact of talking about DSH on the young person?
Concerns that talking about DSH may cause young people distress (Harris, 2000) were not borne out in this study. Most participants felt talking about their DSH had no impact, whilst some felt better for talking, which may reflect the power of the interview process in empowering certain participants to express their views. Adshead (1998) states that “confiding in someone, telling one’s story and being listened to are potent modulators of anxiety” (1998:68). Current behavioural strategies may create little or no space for talking about the young person’s experience of which DSH is likely to be an important element.

14. IMPLICATIONS FOR CLINICAL PRACTICE

The paradoxes, conflicts and cyclical pattern of difficulties expressed by the young people in this study well illustrate the entrenched, somewhat hopeless nature of their situation, which provides some insight into why this population may be so difficult to treat. The analysis suggests a number of reasons why this might be so: (1) DSH provides immediate relief from overwhelming emotions and is therefore a powerful solution to their difficulties; (2) It appears to lead to a set of circumstances that increase the likelihood of repetition (negative consequences of engaging in DSH increases internal discomfort, and the short lived impact of DSH means emotional distress returns) and; (3) the young person’s poor early experience of trusting or reciprocal relationships may make them wary of building a therapeutic relationship with helping professionals. The following considers how these issues may be addressed in light of the findings of this study.
14.1 Developing other strategies to cope with emotional distress and providing acknowledgment and containment

The young people in this study did report difficulties understanding and coping with emotions, and they appeared to engage in DSH because they experienced overwhelming emotions and did not know what else to do. This suggests that interventions should be targeted at helping the young person find new ways of coping with emotions, such as cognitive behavioural/ problem solving therapies, which attempt to help the young person learn steps to solve problems, including defining problems and brainstorming alternative solutions (Spirito, 1997 cited in Hazell, 2000). Indeed, given the reported difficulties expressing themselves, cognitive behavioural interventions may provide an important structured approach to interventions with this client group. Working socratically with the young person to challenge their views about the effectiveness of DSH may be useful in addressing ambivalence to change (i.e. considering the negative consequences of DSH, providing only short term relief and the cyclical trap of DSH).

According to this study, however, finding alternatives strategies as effective as DSH is likely to be difficult. Also, focusing solely on changing behaviour may increase the risk of suicidal behaviours for those who view DSH as having survival qualities. Motz (2001) stressed that DSH should not be viewed or treated as simply a "pathological example of an inability to cope" (2001:175). This study illustrates the importance of viewing the young person's engagement in DSH within the context of their limited experience of trusting or reciprocal relationships and their perception of others as not able to contain their emotional distress. Intervention should, therefore, not only focus on developing individual skills in problem solving but should also provide the young person with experience of containment (i.e. that someone else can be consistently available and can cope with their emotional distress). This experience may help young people tolerate thinking about their emotional distress, understand it and start using other strategies rather than automatically turning to DSH. This approach would hopefully make the young person feel that their difficulties were not minimised, that others did recognise their difficulties and therefore that others could help.
Dialectical behaviour therapy, developed by Linehan (1993), may provide such a framework for such intervention. Linehan (1993) recognised the need to develop problem-solving skills but also considered the impact of internal conflicts, named dialectical dilemmas, which resulted from the internalisation of an early invalidating environment. An invalidating environment meant that a child’s expressions of private experiences are not validated, often being punished or trivialised and consequently their emotional reactions are not viewed as valid responses to events (Linehan, 1993). This concept may have parallels to Bowlby’s view of the un-responsive caregiver in insecure attachment experiences. Core strategies within DBT, therefore, focus on problem solving \textit{and} the validation of emotional experiences. Linehan advocates telephone consultations, including out of hours, in helping the patient put into practice problem solving skills during times of distress, which may reflect a secure base in supporting the young person.

DBT has been found to be effective in reducing DSH and suicidal behaviours and improving treatment compliance in adults with borderline personality disorder (Linehan, Armstrong, Suarez, Armon and Heard, 1991; Linehan, Heard and Armstrong, 1993). It has recently been modified for use with young people who engage repeatedly in DSH (Miller, Rathus, Linehan, Wetzler and Leigh, 1997; Miller, 1999). It is important however that any adaptations of therapy, originally developed for adults, consider the developmental context of adolescence, the role of the wider system (such as the family) in contributing to the young person’s difficulties and their role in treatment, and should consider issues of consent. Swales, Heard and Williams (2000) argue that modifications need to be based on theoretical reasoning rather than clinical judgement alone. Given that the narratives of young people in this study were similar to adult narratives (Harris, 2000), this tentatively suggests theories explaining adult DSH may be appropriate in helping explain young people’s engagement in DSH.

When working therapeutically with this population it is important to recognise that the ambivalence participants expressed around wanting and not wanting others may become evident in the therapeutic relationship. As Crockwell and Burford (1995) suggest, struggles in past relationships may be carried over to the therapeutic relationship. It is important that clinicians are aware of the possible ambivalence that
the young person may bring to the therapy and to have considered ways to address this.

14.2 Health professionals as attachment figures
This study has illustrated the importance of trusting, therapeutic relationships and that with time some participants were able to develop trusting relationships with health professionals, specifically nurses and psychologists. Adshead (1998) proposes that psychiatric staff can become important attachment figures for young people, in acting as an affective container, providing information and consistent input. The clinical psychologist may play an important role supporting other professionals, such as nurses on adolescent units, in providing such positive helping relationships to young patients. Given the emotional challenge of working with people who self-harm, health professionals should be provided with adequate supervision. Turp (1999) states that “unless we are well supported in our work, we will tend to defend ourselves against the levels of distress involved and such defensiveness will inevitably interfere with our ability to remain thoughtful in the face of the self-harming behaviour,” (1999:310). Supervision for the researcher during this study was just as important.

14.3 Helping young people and others make sense of their situation
The figures developed in this study illustrate the paradoxical and cyclical nature of DSH and, if used sensitively, may be useful tools in helping young people, and significant others, make sense of what is happening and provide insight into why the young person and those around him/her feel so stuck. The use of figures or pictures appears particularly important given that some participants felt using different modes of expression were helpful. Turp (1999) argues that helping the young person, family members and health professionals make sense of DSH involves finding a way in which “one can think about and think through what has happened, rather than feeling that one must act” (1999:311). This insight may help create space for the young person to engage in treatment. Bion (1962, cited in Turp, 1999) suggests that developing an understanding of difficulties can be containing in itself for young people and those around him/her.
14.4 The involvement of families in treatment

Often the involvement of families is advocated when working with young people who self-harm (Kerfoot, 1980; Harrington et al., 1998). It is important to bear in mind that the young person's difficulties containing emotional distress may reflect familial patterns. Expecting parents, who themselves may suffer internal conflicts, to recognise and contain the young person's distress may be over-demanding, in a similar way to how the young people felt others expected too much from them. If the young person's difficulties did reflect insecure attachments with caregiver, it is unlikely that the caregiver would be able to provide any containment. It would be important to assess the family's ability to recognise and contain the young person's distress and consider ways in which the family may be supported in achieving this. It would be equally important to recognise how the family felt similarly 'stuck' in coping with current difficulties. For example, Willow felt that others were annoyed that they were now part of "my big horrible secret" (18.01) and in a sense also stuck in her vicious cycle. Wagner, Aiken, Mullaley, and Tobin (2000) suggest the importance of acknowledging with families the emotional binds that they may feel when the young person self-harms. Acknowledging this emotional bind may help open communication within families and with services and, in itself, may be a useful way of helping family members gain insight into the conflicts and paradoxes experienced by the young person.

15. IMPLICATIONS FOR FUTURE RESEARCH

This study highlights the potential usefulness of DBT with young people who repeatedly engage in DSH, given its emphasis on building problem solving skills and providing the young person with an experience of validation and a secure base. Although Miller and his colleagues are developing DBT for young people (Miller, 1999; Miller et al., 1997) more research is warranted in assessing the efficacy of this approach with this population.

Importantly this study highlights the ability of young people to provide insights into their difficulties and experience of help. Such qualitative research may provide an

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invaluable adjunct to quantitative methodologies in evaluating treatment efficacy, such as DBT.

To develop a systemic understanding of DSH, it would be necessary to extend this study to examine the views of family members, nursing staff and others working with young people who DSH. How do the views of others compare to that expressed in this study? Given the potential importance of the therapeutic relationship, it would be useful to gain an insider's perspective from the other side of this relationship i.e. the clinician's view. How do they conceptualise the young person's difficulties and manage therapeutic relationships with this population?

16. CONCLUSIONS

This phenomenological study provides a powerful insight into the conflict experienced by young people who engage in DSH and the cyclical trap of engaging in DSH. DSH was interpreted predominantly as a means of avoiding overwhelming emotional distress, which the young person felt unable to tolerate or process. This difficulty was understood in terms of insecure, early attachment relationships, as the participants talked about their experience of relationships as lacking trust or reciprocity. Indeed many felt they had to protect others from their emotional distress. This study highlighted the utility of gaining service users' views, as participants were able to provide considerable insight into their difficulties and what they valued as helpful and, despite concerns within the literature, this was achieved without causing undue distress nor seemingly increasing the likelihood of repeated engagement in DSH. Further research is warranted into the efficacy of interventions, such as DBT for adolescents, which provides a structured approach to developing individual problem solving and emotional tolerance skills in addition to providing a containing, emotionally validating experience. This study suggests that qualitative methodologies might provide an invaluable adjunct to quantitative methods attempting to evaluate treatment interventions for young people who engage in DSH, such as DBT.
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APPENDICES

Appendix 1

Information sheet for patients, parents/ guardians and GPs.
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends, relatives and your GP if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

**Project title:** Adolescents' views about their deliberate self-harming behaviour?

**What is the purpose of this study?** This study aims to find out your views and experiences of engaging in deliberate self-harm and your views about what has been helpful and not so helpful. By listening to your experiences and views on this problem, it is hoped that health professionals can learn more about how they can work with and help adolescents who engage in such behaviours.

**Why have I been chosen?** The health professionals at **** have been informed about this research. They have agreed to approach adolescents, who have engaged in any type of self-harm over the last 6 months, to inform them of the opportunity to participate in this research.

**Do I have to take part?** It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form saying that you would like to take part. Your parents will also need to sign a consent form agreeing for you to take part in the research. If you decide to take part, you are still free to change your mind, at any time and without giving a reason. Participating or not, will not affect the treatment or care that you receive at present or in the future.

**What will I have to do if I take part?** You will be interviewed by Sarah Adams, the principle researcher. The interview will last approximately 1 - 1 ½ hours and will be undertaken in an individual room at **** at a time that is convenient for you. During the interview you will be asked about when you engaged in self-harm and your views about it. The interview will also entail asking about how you and your family cope with strong emotions, both now and in the past. The interview will also ask you about what you have found helpful in coping with your difficulties.

**What are the possible disadvantages of taking part?** Talking about how you engaged in self-harm might be upsetting and it is important that you know you can opt out of this research at any time. You have the right to withdraw at any time from the project. Opting out of the research will not influence your current or future treatment in any way. **** team members will be informed that you are participating in this research and a member of staff will be available to provide you with support after the interview if you need it.
**What are the possible benefits of taking part?** This is your research and it is hoped that the research provides you with an opportunity to talk about your views and your experiences of self harm. Some people find talking about their experiences quite helpful. By listening to your views, it is hoped that health workers may be able to better understand and develop ways of working with and helping adolescents who engage in deliberate self-harm.

**Will my taking part in this study be kept confidential?** Interviews will be recorded on an audio-tape with your consent, so that the interview can be transcribed (written up). After the research is completed the audio-tape(s) will be destroyed. Your interview is confidential and all identifiers such as names and places will be removed. Rather than use your name, you will be allocated a code to ensure you are not identifiable when the research is written up. All information, which is collected about you during the course of the research, will be kept strictly confidential. Any information about you, which leaves **** will have your name and address removed so that you cannot be recognised from it.

Your GP needs to be kept informed that you are participating in this research. Your consent will be requested to inform your GP. If you are not happy for your GP to be informed, it is unfortunately not possible for you to participate in this project.

If, during the course of the interview, the interviewer becomes concerned about your safety, in terms of you harming yourself or others, or others harming you, the interviewer is professionally bound to inform clinical staff at **** to review ways to support you and ensure your safety.

**What will happen to the results of the research study?** The project will be written up as a major research thesis for a clinical doctorate over the next year. You will not be identified in any way during this write up. A draft copy of the results will be available and can be sent to you if you wish.

**Who has reviewed the study?** This research project has been considered by our local Research Ethics Committee. The Committee will contact some participants to check that the research is being done in the right way. By agreeing to take part in this research you also agree that the person doing the research can tell the Research Ethics Committee your name and address so that they can contact you but you need not answer their questions if you don’t want to.

**What do I do now?** If you are interested in taking part or want to find out more, please let the Consultant Psychiatrist, **** or your keyworker on the **** team know. With your permission, Sarah Adams, the principle researcher, will contact you in the next few days to ask whether you would like to take part and answer any questions you may have. If you have any questions in the mean time, please ask your consultant or keyworker from the **** team who can contact Sarah Adams to answer any questions you might have. If you agree to take part, the interview will be conducted at ****.

Thank you very much for considering taking part in our research. Please discuss this information with your family, friends or GP if you wish.
Have I been given enough information? If you have any questions please ask the researcher. If you wish to discuss the research further, before or after completing the interview, please do not hesitate to contact the researcher.

Contact: Sarah Adams, Trainee Clinical Psychologist
         Psychology Department
         University of Surrey, Guildford
         Telephone no. 01483 259441
Appendix 2

Consent form – patient
CONSENT FORM
( Participant )

Title of Project: Adolescents' views about their deliberate self-harming behaviour?

Name of Researcher: Sarah Adams, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read and understand the information sheet dated .......................
   (version ............) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time,
   without giving any reason, without my care and treatment being affected in anyway.

3. I understand that sections of my medical notes may be looked at by the researcher
   where it is relevant to my taking part in research. I give permission for the
   researcher to have access to my records.

4. I agree to take part in the above study.

Name of Patient ____________________ Date __________ Signature ______________

Name of Person taking consent
( if different from researcher )

____________________________ Date __________ Signature ______________

Researcher ________________________ Date __________ Signature ______________

1 for patient; 1 for parent/ guardian; 1 for researcher;
1 to be kept with hospital notes
Appendix 3

Consent form – parent/ guardian
CONSENT FORM
(Parent/guardian)

Title of Project: Adolescents' views about their deliberate self-harming behaviour?

Name of Researcher: Sarah Adams, Trainee Clinical Psychologist

1. I confirm that I have read and understand the information sheet dated ................ (version ............) for the above study and have had the opportunity to ask questions.

2. I understand that ...................... participation is voluntary and that he/she is free to withdraw at any time, without giving any reason, without their care and treatment being affected in anyway.

3. I understand that sections of ......................... medical notes may be looked at by the researcher where it is relevant to my taking part in research. I give permission for the researcher to have access to these records.

4. I agree for ......................... to take part in the above study.

Name of parent/guardian Date Signature

Name of Person taking consent Date Signature (if different from researcher)

Researcher Date Signature

1 for patient; 1 for parent/guardian; 1 for researcher; 1 to be kept with hospital notes
Appendix 4

Interview schedule
Interview Schedule

Ensure that the participant has an information sheet. Read through the information with the participant, drawing attention to the confidentiality procedures and any exceptions to confidentiality. Ensure the participant and their parent/guardian has signed the consent form, agreeing to be interviewed and for the interview to be audiotaped. Ensure the researcher has counter-signed the consent form.

Ask the participant if he/she has any questions and address these before continuing.

"Thank you for agreeing to take part in this research. This is your research, in the sense that it is an opportunity for you to express your views and experiences. I will be asking you a number of questions to learn more about your views on self-harm and about your experiences of self-harm in the past. I will ask you about your emotions and a little about how you and your family cope with strong emotions. I will also ask you about your experience of getting help for your difficulties. I would like to start by finding a little bit out about you."

Introductory questions

1. "How old are you?"
   "What do you do at the moment i.e. school/college/hobbies"
   "Who lives with you at home?"
   "Are there any other important people in your life? Friends/extended family/pets/teachers etc."
   "Who are you seeing at the moment for help?"
   "What sort of help have you received in the past?"
   "How old were you when you first deliberately harmed yourself?"

2. "As you know, this research is all about your views on self-harm. What do you think deliberate self-harm means?"

About self harm

Identify their terminology for deliberate self-harm – to be used in subsequent questioning

3. Thoughts and feelings about participating in this research

   (a) "What thoughts have you had about taking part in this interview and talking about self harm?"

   (b) "How do you feel about this interview and talking about self harm?"

4. "Can you tell me about why you think some young people might harm themselves in this way?"

5. "Could you describe the first time you [deliberately self harmed]?"
6. "Could you describe the most recent time when you [deliberately self harmed]?"

Prompts:
- What was happening in your life at that time?
- What were you feeling/thinking and did these feelings/thoughts change over time?
- Who was around when you [deliberately self harmed]?
- How did others react?
- Did anyone do anything that was helpful/not helpful?

7. "Why do you think you [deliberately self harm]?

8. (a) "Do you want to stop self harming?"

(b) "What needs to happen in order to stop?"

(c) "How would things be different if you stopped?"

**Emotional vulnerability**

"Thank you for talking with me about self harm. I would like to talk a little more now about emotions and coping with strong emotions"

8. "How would you describe how you feel [your emotional state] from day to day/in general?"

Prompt:
- Can you describe how you have felt over the last month?

9. "Can you tell me about perhaps the last time you felt [overwhelmed by strong emotions]?

(Please note that this questions will be re-phrased to reflect the participant’s terminology i.e. if they refer to feeling ‘really down/miserable’ this expression will be used)

Prompts:
- Has this feeling ever led you to [deliberately self harm] in the past?
- How often do you feel this way?
- What types of things usually make you feel this way?
- How do you cope with these feelings?
- Who notices when you have these feelings?
- How do other people react to you when you have these feelings?
- Is there anything others have done which helps you when you feel this way?
10. "How do you think others expect you to cope with these emotions and difficult experiences?"
11. "Can you describe how other people in your life cope with strong emotions/difficult situations, such as other family members?"

Treatment

"I want to ask you now about your experience of getting help for your difficulties."

12. "Can I begin by asking what is it like talking to me about your feelings?"
13. "What is it like talking to other people about your feelings?"
14. "What do you think is the best way to help you when you are having difficulties?"
15. "And the least helpful?"

16. "The interview is nearly over now. Finally can you tell me what your thoughts/feelings about completing this interview are now i.e. talking about self harm and your emotions?"

THANK YOU FOR TAKING PART IN THIS RESEARCH. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

DEBRIEFING

"The interview is now finished. Can I ask you how you are left feeling now?"

If the participant expresses any distress at this time, they will be given time to talk through this further with the researcher. If there are any concerns about the participant's safety, the Consultant Psychiatrist, key-worker and duty officer will be informed and the participant offered further support from a member of staff at the unit.

"The information on the tape will be transcribed and then destroyed. I will be writing about the general issues that rose during the interviews and may use quotes from the interviews to illustrate these issues. Quotes will be anonymous and will not be traceable to you. Any references you have made to people or places will be anonymised.

"Do you have any questions about the interview, the transcription process or about confidentiality?"

"Thank you once again for participating in this research."
Appendix 5

Ethic committees' letters of approval
Dear Miss Adams

LREC 16/01: Deliberate self-harm in adolescents - what adolescents think about it?

The Ethics Committee, at its meeting held on Wednesday, 16th May, considered your application, including the subject background information and consent form, and approved it.

Permission is granted on the understanding that:

i) Any ethical problem arising in the course of the project will be reported to the Committee.

ii) Any change in the protocol or subsequent protocol amendments will be forwarded to the LREC. The principal investigator should see and approve any such changes and this needs to be indicated in the forwarding letter to the Committee.

iii) All serious adverse events must be reported within 1 week to the Ethics Committee, at the same time indicating that the principal investigator has seen the report and whether or not they feel it poses any new ethical or safety issues.

iv) A brief report will be submitted one year after commencement, thereafter annually, and after completion of the study.

v) Approval is given for research to start within 12 months of the date of application. If the start is delayed beyond this time, applicants are required to consult the Chairman of the Committee.

vi) You are required to obtain separate approval for your project from your host body (e.g. Trust, PCG).

Good luck.

Yours sincerely,
Dear Miss Adams

LREC 16/01: Adolescents' views about their deliberate self-harming behaviour?

The issue of 13 and 14 year old young people being included in the above study was discussed at the LREC meeting on 21st November. It was agreed that this was acceptable.

Best wishes with the study.

Yours sincerely
Dear Miss Adams

LREC 16/01: Adolescents' views about their deliberate self-harming behaviour?

Thank you for your letter with enclosures dated 17th September.

I consider it in order for you to include clients currently on the caseload of the Outreach Service as well as inpatients provided that the criteria set out in the third paragraph of your letter is adhered to.

With best wishes.

Yours sincerely
Dear Miss Adams

Adolescents’ views of their deliberate self-harming behaviour
(ACE/2001/77/Psych) — FAST TRACK

I am writing to inform you that the University Advisory Committee on Ethics has considered the above protocol under its ‘Fast Track’ procedure, and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed and the following conditions are met:

- That the age group investigated is consistent with the age range agreed by the Mid Sussex Trust.
- That you provide further clarification of what DBT is, and how it might help adolescent self-harmers.

For your information, and future reference, the Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2001/77/Psych) - Fast Track. The Committee should be notified of any changes to the proposal, any adverse reactions and if the study is terminated earlier than expected, with reasons.

I should be grateful if you would confirm in writing your acceptance of the conditions above, enclosing written clarification of the two points for the Committee’s records.

Contd ....
Date of approval by the Advisory Committee on Ethics: 14 November 2001
Date of expiry of approval by the Advisory Committee on Ethics: 13 November 2006

Please inform me when the research has been completed.

Yours sincerely
Appendix 6

Stage 1 of the analysis –
Preliminary emerging themes and concepts first transcript

“At this stage all of the transcript is treated as potential data and no attempt is made to omit or select particular passages for special attention” (Smith, Jarman and Osborn, 1999:222).

- Running away
- Control
- Giving up
- General withdrawal from life
- No motivation
- No sense of relationships
- Lost relationships
- Someone else worried about me
- Rejecting of help
- Accepting of situation – its me
- Not acknowledging problem or need for help
- Numerous types of self harm
- Determination to self harm
- DSH as a release from emotions
- Emotions need to be controlled
- Turning aggression inward
- Trade off violence to others with violence to self
- Expressing anger outwardly not constructive
- Inability to tolerate others
- Addiction to DSH
- Initial pleasure from DSH is release from pent up emotions
- Subsequent low from engaging in DSH
- Shame
- Threshold of caring
- Trade off emotional pain for physical pain
- Little insight/ understanding around reasoning for initially using DSH
- Impulsive
- Sense of increased external pressures
- Reduced will/ motivation to engage in activities
- Dissociating
- Desire to cut
- Difficulty explaining feeling
- Experimentation
- Overwhelmed
- Isolation – no one cared
- Fear consequences of self harm/ losing control - catastrophizing
- Contradictory thoughts around ‘wish to die’
- Fearful of others reactions to DSH
• Secretive – concealing scars
• Process of revealing
• Others suspicious
• Others look down on me
• Others think I’m weird
• Fearful of others negative view of them
• Others unable to understand
• It’s not normal
• Fear others will minimise their behaviour as attention seeking
• Stigma
• Shame
• Mother’s upset at discovery
• No communication within family about DSH
• Conflict – wanting to cut without scars
• Habituate over time – makes it easier to self-harm
• Size of triggers to DSH reduce
• Becomes automatic response
• Conflict – easier to self-harm now they know vs. guilt and shame.
• Inability to connect with emotional content of interview
• No opportunity to talk – avoidance of talking about DSH in the family
• Lying – keeping it a secret
• Passive process of revealing – others just worked it out
• Others focus on reducing opportunity to DSH rather than focus on emotional distress
• DSH as a means of avoiding talking about difficulties
• Going cold turkey – no recognition of the function of DSH and the need to replace it when trying to stop
• Vicious cycle - efforts to stop lead to constant build up of emotions
• Disconnected from own experience - others who self-harm make me cringe
• Automatic response – don’t think about it
• Lack of opportunity to talk – don’t talk about DSH in unit
• Identity - It’s just something I do
• Power/ control of DSH
• Secretiveness – power
• Conflict – response of system to take control vs. DSH as control
• Feeling stuck
• Nothing else helps
• Emotions should be concealed – always cry alone
• Survival – as long as I know I can DSH I feel better
• Stuck
• Comparison with others (jealousy, shame)
• Sense of loss
• Fatalism/ hopelessness
• Significance of triggers for DSH diminishes over time
• Impulsive
- Becomes means of avoiding any emotion – to extent may not recognise or recall trigger or emotional response and it feels that DSH is engaged in merely as ‘something to do’ (don’t recognise emotional response that lead to it i.e. frustration, lost control).
- DSH becomes a way of life
- Frequently low
- Build up of emotions
- Externalisation – sense of ‘it’ building up and letting ‘it’ out at night
- Turn inwards and dissociate as means of avoiding physical aggression to others
- Avoidance of thoughts
- Getting very little pleasure from anything
- Other strategies of coping or expressing self make her feel worse
- Frustration of DSH
- Others around make it more difficult to self-harm
- Conflict – wanting to self-harm without hurting my body
- Survival – knowing can DSH makes me feel better
- Self hate
- Crying/ expressing emotions evidence of self hate (failure)
- Fatalism – no one can help me
- Feeling low is normal so no one notices
- Avoiding communication about emotions
- Belief – keep yourself to yourself
- Conflict between feeling no one cares but avoiding talking to others or seeking help
- Difficulties understanding emotional state
- Difficulties expressing emotional state
- Shutting everyone out
- Guilt and shame
- Vicious cycle (feel bad – cut – feel shame/ stigma – cut) and sensation of feeling stuck.
- People are helpful as they are distracting and make it difficult to think (similar to DSH), not nurturing.
- Other expectation to talk – conflict
- Families reliance on Louise to approach them to talk
- Self harm as familial
- Expect Louise to talk when they (family) don’t
- Blame and guilt – feeling responsible for others low mood and difficulties
- Not knowing interviewer helped
- Confidentiality helps participant express herself
- Mood impacts on her ability to express herself
- Thinking/ talking about DSH increases desire to DSH
- DSH become normal, way of life, automatic response
- No comfort
- Belief – shouldn’t turn to others for help/ rely on self
- Don’t get close to others out of fear of rejection/ abandonment
- Positive experience of help – cry, listen, comfort
• Conflict around what she wants from relationships – wants someone to ‘be there’, be looked after but wants to be left alone.
• Planning suicide
• Fate/ inevitability of suicide
• Sense of control over suicide
• No future
• Death is easier
• Conflict between wanting to tell verse wanting to get out of hospital
• No emotional change reported after interview
• Dismissive of others concerns
• Acceptance – this is me
Appendix 7

Stage 2 of the analysis
Looking for connections –
The development of themes and sub-themes

Attempting to create some order from “array of concepts and ideas you have extracted from the participants responses” (Smith, Jarman and Osborn, 1999:223). Important to check back to original transcripts to ensure connections and developing themes are reflected in data i.e. what the participants actually said.

- **Perceived increase external pressure and decreased capacity to cope** - Feeling unable to cope with external pressures coupled with decreased will to achieve /engage in life/ withdrawal from life/ giving up.

- **Close relationships** –
  - No quality relationships/ no comfort/ isolated/ feeling no one cares or notices.
  - Lack of relationships may be associated with (or reflected by) lack of communication and opportunity to talk (interpreted).
  - Comparisons with others – sense of loss, jealousy.
  - Difficulty tolerating others.
  - People are helpful as they are distracting and make it difficult to think (similar to DSH), not nurturing.

- **Motivation to engage in DSH** –
  - Releasing emotions, makes me feel better, trade off emotional for physical pain
  - Means of avoiding emotions or talking about emotions
  - Becomes an automatic response to anything – don’t think about it/ becomes way of life. Becomes means of avoiding any emotion – to extent may not recognise or recall trigger or emotional response and it feels that DSH is engaged in merely as ‘something to do’ (don’t recognise emotional response that lead to it i.e. frustration, feeling out of control).

- **Addiction to DSH**
  - Going cold turkey – no recognition of the function of DSH and the need to replace it when trying to stop.
  - Other strategies of coping or expressing self make her feel worse

- **Process of revealing**
  - Secretive
  - Passive in process of revealing - others suspicious, they just worked it out.

- **Experience of emotions** –
  - Frequently low
  - Build up of emotions, overwhelming
  - Shame – others look down on me, think I’m weird, it’s not normal.
  - Guilt - feeling responsible for others low mood and difficulties
  - Emotions need to be controlled
  - Externalisation – sense of ‘it’ building up and letting ‘it’ out at night.

- **Barriers to receiving help** - Not acknowledging the problem or need for help.
• **Beliefs on coping with and dealing with emotions** - "I shouldn’t turn to others for help", "I should only rely on myself" and "I should keep myself to myself". Emotions should be concealed – turning anger inward/ do not cry in front of others.

• **Fatalism** – no one can help me, inevitability of suicide, sense of control over suicide, nothing else helps.

• **Power of DSH** - determination to DSH, no one can stop me, secretiveness

• **Identity** – feeling low is normal so no one notices, being suicidal and engaging in DSH has become part of me, it’s just something I do, lead her to be dismissive of others concerns.

• **Career of DSH** – experimentation, impulsive, threshold of caring = habituate over time – makes it easier to DSH, size of trigger that lead to DSH diminishes over time.

• **Stigma** – Others won’t understand. They will minimise the behaviour as attention seeking. Others look down on me; think I’m weird. It’s not normal.

• **Vicious cycle** - feel bad - cut - feel shame, guilty - feel worse - cut = sensation of feeling stuck. Threshold of caring.

• **Feeling stuck**

• **Disconnected from own experience** – others who self-harm make me cringe.

• **Trying to stop** - no recognition of the function of DSH and the need to replace it when trying to stop (going cold turkey). Efforts to stop lead to constant build up of emotions.

• **Dilemma’s/ conflict and paradox**
  o **It makes me feel better.** DSH makes me feel better (release emotions) and makes me feel worse (scars, stigma, others reactions)
  o **Others expectation to just talk.** Others expectation to talk and reliance on her to approach them to talk conflicts with participants capacity to talk (difficulty understanding and expressing emotional state and feeling disconnected from their own experience), also participants have little opportunity to talk as the subject is avoided by the participant (lies about scratches on her arm) and is avoided by her family and the service (family focused on reducing opportunity rather than on emotional distress; service don’t talk about DSH) and significant others don’t use talking as a means to coping either, often using methods similar to DSH in coping with their own difficulties.

  Also participants appeared to find it difficult to connect with the emotional content of the interview – impact on listener empathy/helping behaviour.
  o **Wanting and not wanting others.** Wanting others to be there vs. wanting to be left alone/ shutting other out. This conflict may be related to the participant’s difficulties getting close to people due to her fear of rejection. Conflict between feeling no one cares but avoiding talking to others or seeking help.
  o **Contradictory thoughts around intent to die.** Wanting to die vs. fearing losing control of DSH (cutting too deep) vs. DSH has some survival quality (as long as I know I can harm myself I feel better) – anti-thesis of suicide.
- DSH as control. DSH as means of gaining control vs. systems response to take away participants control
- Wanting to cut without damaging her body
- The dilemma of telling. Wanting to tell vs. wanting to get out of hospital

- Process and impact of interview
  - No emotional change reported after the interview
  - Inability to connect with emotional content of interview
  - Factors that facilitated talking during interview – confidential, not knowing interviewer, not seeing her again, being in an OK mood.
  - Talking/ thinking about DSH increases desire to DSH.

- Numerous types of DSH
- Positive experience of help – cry, listen, comfort.
- Turning aggression inward – trade off violence to others with violence to self, expressing anger outwardly not constructive.
- Little insight/ understanding around reasoning for initially using DSH
- Running away
- Desire to cut
- Mother upset at discovery
- Turn inwards and dissociate as means of avoiding physical aggression to others
- Avoidance of thoughts
- Getting very little pleasure from anything
- Frustration of DSH
- Death is easier
- No future
Appendix 8

Stage 3 of the analysis –  
An attempt to introduce structure into the analysis

To introduce structure to the analysis, further integration of themes was undertaken, either clustering concepts that shared meaning or due to hierarchical relationships (Willig, 2001) in order to develop higher order concepts. During stage 2, certain themes appeared more dominant in capturing the participant's views or experience of DSH. It was important, once again, at this stage to ensure that all themes were reflected in the original transcripts and prevent "the researcher's own bias distort the selective process" (Smith et al., 1999:223). Some themes, which did not fit well into the emerging theme structure or were not richly evident from the data, were dropped at this stage. They were kept in mind however for subsequent analysis i.e. if other transcripts provided further evidence they were considered for inclusion.

A dominant theme to emerge from the analysis of the first transcript was dilemmas, conflicts and paradoxes. This theme was so dominant, evident in many of the issues raised by the participant, that it was quite difficult organising the remaining data and identifying other super-ordinate themes.

A. CAREER OF DELIBERATE SELF-HARM

1. **DSH as an avoidance of emotions (release/distract)** – "it's a way of coping or like sort of releasing those emotions" (4.01) "It's like you get all these pent up emotions and it like releases it all" (4.23).

2. **DSH becoming an automatic response** – "it's just something I do" (8.15).

3. **Identity** – "But that's just standard anyway. That's just me" (15.01).

4. **Addiction and difficulty stopping** – "it gets really addictive as well. Like when you cut yourself. Once you do it once. There was times when 'oh I won't do that again', but then you find yourself doing it again and again" (4.17)

5. **Fatalism** – "I know I am going to die by my own hands so... " (14.04).

6. **Power of DSH** – "I would just do it at any point, no one could stop me" (8.15)

B. CLOSE RELATIONSHIPS

1. **No quality relationships** – "Well my family because we just don't have a relationship" (9.23). "I never got comfort from anyone" (13.16). Others are merely distracting not comforting "being here there are so many people around me, it kind of distracts you. Which I don't particularly like but it's hard to think about anything when you have people running around" (11.41).
2. **Comparison with others** – “I feel cheated cause we (family) don’t get on, you see people and they are all happy families, and then there’s me and there’s nothing. And school because I have totally f**ked it up. Everyone is going to be leaving for university next year and there’s me totally screwed up the years. Life seems such a waste of time…” (9.24).

C. **DILEMMA’S/ CONFLICT, VICIOUS CYCLES AND FEELING STUCK.**

1. DSH makes me feel better and makes me feel worse – *And it kind of feels good for a couple of seconds or minutes or whatever. But you do feel really bad about it. Or at least I do, because of all the scars and that,*” (4.23). “Especially like doctors. If I walked into a hospital and said look can you tape my arm back together, they would just look down at you” (6.02).

2. Others expectation to just talk vs. barriers to talking. “...They expect me to talk about it and say what’s on my mind. [...] Just go and talk to them” (12.04) vs. lack of opportunity and need after DSH: “After that night we (family) really didn’t talk about it again” (7.11). “Because I kind of felt better after I done it so I didn’t think there was anything to talk about” (7.35).


4. Contradictory thoughts around intent to die. Louise felt that she would die by her own hands yet was fearful about engaging in DSH as she was worried she may cut too deep and lose control: - “I was really anxious about it, cause I thought my whole arm would come off. I was really scared that I would cut deep.” (5.34). Survival quality: “Just as long as I can hurt myself in some way I kind of feel better” (10.42).

5. DSH as control. “Cause when I feel really vulnerable, I can’t get away, it is the only thing I can do that I can control. That I am in charge of...” (8.31) vs. “Being here. It has made me feel worse. You just feel so trapped...” (8.25).

6. The dilemma of telling. Louise found talking to Bob, nurse comforting and felt she could tell him about her suicidal thoughts, however she felt that she couldn’t because “it wouldn’t help me get out of here.” (14.27)

D. **POSITIVE EXPERIENCE OF HELP**

1. Comforting relationship – “When I am really low it does kind of help a bit because I just sit and cry to him (nurse) and I get some kind of comfort that I don’t normally get.” (13.14).
E. PROCESS AND IMPACT OF INTERVIEW

1. **Impact of interview on emotional state of participant** – When asked how she was left feeling after the interview she replied "the same" (14.41).

2. **Difficulty connecting with emotional content of interview** – Inappropriate use of laughter "so there would be a massive gaping wound. But I was like too scared to go and tell anyone about it. So I just got loads of surgical tape and (laugh) taped it back together" (5.37).

3. **Association between talking/ thinking about DSH and desire to engage in DSH.** "I guess it makes me want to cut a bit.... [...] I don't know, because when you talk about it you start picturing it. I can't really explain it" (12.38).
Appendix 9

Example transcript
Louise 26-11-01

Thank you for agreeing to take part in this research. The main thing is that this research is your research, in the sense that it is an opportunity for you to give your views and your experiences of self-harm. I will be asking you a number of questions to learn more about your views about self-harm and about your experiences in the past. I will ask you about your emotions and a little about how you and your family cope with these emotions. I will also ask you about getting help for difficulties. First of all I would like to find out a little bit more about you. So you are seventeen. Is that right?

Yes

And how long have you been here (adolescent unit)?

Well, the first time I came in was in July and I kept running away, just didn’t really want to come back. And then when I got sectioned, that was about...I got put on section 2, I got put on an adult ward, in ******. I stayed there for two weeks, but I felt really rough and that, so they sent me, took me back here about two weeks ago. So only two weeks.

So this is your second time that you have been here?

Am, no I don’t know how many times I have been back (laughs)

OK

I just keep coming back.

When you weren’t here or at the other unit in *******, what were you up to? Where you at school, college or working?

I was sort of started doing my A levels, but I just gave up on it, and stayed at home all the time, stayed in bed.

Really

Yeah?

Where you watching lots of TV?

No, just sleeping and lying in bed.

What types of things are you interested in? Give me some idea about you and your interests?
Am, I like art and music

What type of music?

Am, old music. I like the guitar. I was trying to learn.

You play the guitar?

Yeah.

Is someone teaching you?

No I was learning myself, but kind of gave up on it.

I imagine it is hard to learn?

No, I just couldn’t be bothered.

Who did you live with at home, before coming into the unit?

My parents and two brothers.

How old are your brothers?

20 and 24, no 23.

What are they called?

James and Michael

What do they do?

James works for a computers company and Michael is in to electronics and goes to college as well.

Do they come to see you here?

Am, only when to bring up stuff but other then that no.

How do you get on with your brothers?

We don’t. Not that we shout or anything. We just don’t really have a relationship with them.

Who else is important to you at the moment?

No one.
What about friends, or have you lost touch?

Lost touch.

You said that you see Bob (clinical nurse specialist) for support, an hour a day, is there anyone else? What other help have you received in the past?

_In the very beginning, I used to go and see, amm, a psychiatrist in CAMS, but then they had concerns and referred me here. And since then its just been Bob._

So have you just seen Bob?

Yes, he used to come and see me at home as well when I wasn't here. I don't really want any help. I'm kind of set in my ways.

Do you find it quite difficult to accept help?

Yeah, I don't really think I need any.

Do you remember how old you were when you first harmed yourself deliberately?

_I was in year 10 or 11, before my GCSEs._

Would that make you about 13 – 14?

_About 15._

As you know this research is about your views of deliberate self-harm. What do you think deliberate self harm means?

_Amm. Hurting yourself deliberately._

How can you do that?

_Cutting, hitting yourself, making yourself throw up._

What types of things have you done?

_All of it. I cut myself, I used to make myself throw up. I used to whack my head against the walls. And hit myself, anything really._

In general can you tell me why you think you people may hurt themselves in this way?
Ammm, it's a way of coping or like sort of releasing those emotions. I didn't really like, take, cause if I didn't hurt myself I would take it out on other people. So I used to just like internalise it.

How would you take it out on other people?

Like with my mum, I just used to like hit her. She used to go on and on and on and I just couldn't cope with it. Or I used to just pin her up against the wall and hit her or something. I would lash out at people and start destroying stuff. It wasn't very constructive so...

So you felt that harming yourself was a more helpful way of coping?

Also it gets really addictive as well. Like when you cut yourself. Once you do it once. There was times when 'oh I won't do that again', but then you find yourself doing it again and again.

Can you explain how it is addictive?

Well, it's like the feeling you get when you are cutting. It's like you get all these pent up emotions and it like releases it all. And it kind of feels good for a couple of seconds or minutes or whatever. But you do feel really bad about it. Or at least I do, because of all the scars and that. But then you get to the point when you don't really care. And you just want to do it again.

So is it the release of emotions that make it addictive?

Yeah and just to like see you own blood dripping out.

Does it hurt? Physically?

Yeah. Well sort of, but you don't really think about it like that. It does like make you not want to do it, but then you don't really think about it like that. Because it kind of takes the pain that you are feeling away.

I asked you earlier how old you were when you first hurt yourself deliberately. Do you remember that time?

Yeah, it was when I was in my room and...cause that's when I started to think...well that year... things started really going downhill and I kept thinking about it...and one day I just got out a blade and sliced my arm. It wasn't very much, just a cut or two.
Where do you think the thought came from to cut yourself?

*I don’t know. It was just... I don’t know.*

OK. You said things were going a bit downhill. What was going on your life at that time?

*It was all my exams at school. I wasn’t, I just lost the will to do anything. Just feeling really down...*

Can you remember the first instance when you self harmed. Can you tell me about it?

*I did it after school. I had had a really shit day. (Louise laughs at swearing and points to the tape) oh sorry.*

You can swear if you want to.

*I don’t really remember much. I just remember clearing my head, sitting on the floor in my room. I just had a blade in my hand, I was just staring at my arm. And just wanting to cut. I don’t really know how I was feeling. Probably angry and upset.*

Do you remember who you were angry at? Or why you were angry?

*Probably at myself.*

Was there a particular thing that had upset you or was it a combination of things?

*It was just everything. I didn’t think anyone cared and I just felt really horrid... I cut cause I was interested in, just experimenting. I was really anxious about it, cause I thought my whole arm would come off. I was really scared that I would cut deep. The more I got into it though later on then I just cut really deep, so there would be a massive gaping wound. But I was like too scared to go and tell anyone about it. So I just got loads of surgical tape and (laugh) taped it back together.*

How did you think others would react if you told them about it?

*Well, I used. I think they would look down...Well I told me friends after a while cause in PE and that, I kept wearing long jumpers and they sort of got a bit suspicious, and one day we went out and I just told them. But I don’t know. I wouldn’t tell my parents. Well my parents found out in the end, cause they saw the scratches and cuts on my arms and they said ‘what’s*
that? ' And I sought of hid it away and said nothing. But I just
know they wouldn't really think much. Especially like doctors.
If I walked into a hospital and said look can you tape my arm
back together, they would just look down at you.

Can you explain to me why you think others would look down
at you for doing this?

Cause it is just like, they just think...these people don't
understand things like that. It's not normal to go cutting,
slashing your arm up. They just wouldn't understand.

What? Why you did it?

Yeah. They'll just think you are doing it for attention.

Did you feel that your parents would think that as well?

I don't know what they would think. I just knew I didn't want to
tell them. They would probably just think I'm weird (laughs)

How did your mum and dad react when they found out?

My mum was really upset. My dad...I wasn't worried about
him...I don't know.

Did they say anything about the cutting?

No, it is not something we discussed, ever.

It sounds like it has happened quite a few times.

Well the first time I did it, mmm, I only did it once or twice, well
once and then I left it for a while...and then I started hitting
myself and other things. And then I used to start cutting up my
hands all the time. But I didn't want the scars I just wanted to
like, to cut myself without anyone knowing. But it is horrible
cutting your hands because every time you move your hands the
skin sort of sticks into you, right. But then I thought...after a
while that everything got so bad, that I started cutting my arm. I
just didn't care about the scars or anything.

If you look back to how you were thinking and feeling then, has
this changed know?

What why I did it? Yeah, well after you have done it once it sort
of becomes easier to just slash your arms. Before that I felt
really anxious about anyone finding out but know you just do it.
And if anything just gets a little bit bad. Cause before I used to
only do it if something was really really bad but now it's just really little things and I just cut.

Do you worry less now what other people think?

Yeah. I suppose because they know now it kind of makes it easier.

How did your parents react when they found out?

Upset. After that night we really didn't talk about it again. But I remember sometimes I went into school and the day was really bad sometimes I would just go into the toilets and start cutting up my hands. Just sit there crying (laugh).

Were you always by yourself when you did that?

Yeah.

It sounds like you told your parents but after that you never spoke about it.

No. I don't know how they found out. I never talked about it. Its just they saw a cut. Well my mum did. It was like what have you done to your arm? I was like its nothing. It's just a scratch or something. I kept lying about it. So I have never actually told her that I have cut but she probably just worked it out. I remember after that night that any knives or anything in my room they used to take away. I mean they wouldn't even tell me. They just went in my room, so when I looked they were gone.

It sounds like you were quite overwhelmed by feelings and cutting quite a lot and not telling anyone about it.

No. Because I kind of felt better after I done it so I didn't think there was anything to talk about.

Has there ever been a time when you wanted to stop cutting?

Yeah. Because it would go like in periods when I would cut and then I'd say no, that would be the end. But then everything would build up again. And then I would go through phase of cutting like every, every day. And then it would kind of stop again and then build up again and you would do it all again.

What was the reason behind you wanting to stop?

Because of the scars. And when I look back at them, they make me cringe. It is kind of stupid but when I think about cutting it
kind of makes me...it doesn't make me feel good. I think argh that's horrible I couldn't do that. Which is kind of stupid (laugh). Its like if I see someone, if I saw someone cutting themselves it would make me cringe. And I would think how could they do that. Yet I do it myself. When you do it you don't really think about is it going to hurt, you just do it cause you feel like it.

Did anyone do anything that you found was helpful or did anything happen that you found was helpful in helping you stop cutting and help you cope with difficult times?

Well, like I said no one ever really discussed it. We don't really talk about it here. So there's not really much to talk about it, it's just something I do. I would just do it at any point, no one could stop me.

No one could stop you?

No. Cause they wouldn't know either. I was quite secretive, so...

What do you think hasn't been helpful?

Being here. It has made me feel worse. You just feel so trapped...

Overall do you think you can explain why you cut? You have already told me a few thinks, but can you explain?

I don't know, I just do it as a way of coping with things. Cause when I feel really vulnerable, I can't get away, it is the only thing I can do that I can control. That I am in charge of...

Has there ever been times when you felt low but didn't cut?

Sometimes when I really didn't want to do it but felt I wanted to, I would just sit and cry my eyes out and just sleep. And get away from it all and takes drugs and stuff.

What types of drugs?

Anything. E's, pot, alcohol. Although I found when I drunk alcohol, you lose your inhibitions. You are more likely to do it and you cut deeper. And then you wake up in the morning and you are covered in blood and you think 'damn'.

So sometimes you cry and sometimes you take drugs or drink, but you feel that makes you end up cutting deeper. Is that right?
Yeah.

Thank you for talking to me about cutting. I would like to talk a little more now about emotions and coping with really strong emotions, which it sounds like you have been trying to cope with over the last couple of years. How would you describe how you feel from day to day..in general

Well normally I'm quite quiet..subdued. If I cry, then I do it by myself away from people. I don't like crying in front of anyone. Sometimes I can be quite high as long as I know I can always cut myself or do something. I don't know it makes me feel better. But sometimes I feel I can't do anything and I feel totally trapped. And I just feel really low.

What types of things make you feel really low?

Thinking about my family, school...

Can you tell me a bit more about your thoughts?

Well my family because we just don't have a relationship and well, I hate them, well I think I hate them. I feel cheated cause we don't get on, you see people and they are all happy families, and then there's me and there's nothing. And school because I have totally f**ked it up. Everyone is going to be leaving for university next year and there's me totally screwed up the years. Life seems such a waste of time...

These feelings, feeling trapped, your relationship with your family and feeling you messed up school, are these the things that lead you to cut?

Yeah some of them. But now it can be anything. Sometimes I want to cut because it is something to do. Or if I am pissed off about something. Or if someone..if I have do to something here, do a chore or something stupid I get really pissed off and just do it (cut).

How often do you feel overwhelmed by your emotions..feel low?

Lots of times. The start of the day I normally feel really crap and by the evening I usually feel a bit better...

The things that make you feel this way can be quite minor things now? Is that right?
Yeah, well cause it builds up during the day and then I let it out at night. It stopped for a while and then it started again.

You said earlier that sometimes you harm yourself because it stops you hitting out at others. Have you ever hit others before?

What when I'm not hurting myself?

Yes

Am. Yeah probably but I try and get myself into a state where I can just go into my head and not think about anything and then I won't do anything. Sometimes I just draw.

What types of thinks do you draw?

Really twisted stuff.

And do you see that as a release from your emotions?

Yeah, it can be but sometimes you get really pissed off because you can't draw it properly and it makes you feel worse.

Is there anything else that you do to help you cope with feeling low?

Eat. Sometimes I just eat.

And has that ever led to you throwing up?

It did but I tried to stop doing that because it was not nice. And when you try and throw up you can't and so you are left there sort of, sort of about to throw up and you can't, so it makes you feel worse.

How did you manage to stop doing that?

Am..well you can't really do it here because there are so many people around. But like if I stop eating and keep fasting myself then I won't need to throw up but then it really hurts your body. And I tried to get into a semi normal eating pattern. Because you can always cut instead. Just as long as I can hurt myself in some way I kind of feel better.

Why do you feel you need to hurt yourself?

It's just how much I hate myself. Every time I cry it just says how much I really do hate myself.
Do you think this feeling will go?

No maybe when I'm dead.

Who notices when you feel this way, now and in the past?

When I was home I was always low so there wasn't really much to notice. And here they are just like 'how are you' but it just don't like talking to them.

What is it about talking that you don't like?

I don't know, it's just I prefer to keep it to myself. Sometimes I don't even know what I am feeling, I just feel low. And I can't explain it...

How do others react when you have told them how you feel?

What here?

Here and at home.

Well when was at home I just stayed in my room and didn't talk to anyone. I just shut everyone and everything out. But here...they try talking to me but because I don't say anything they kind of leave me. My mum used to write stupid letters and stuff to me that really geared me up and made me mad. Saying stupid things like 'if you ever did anything to yourself I don't know how I'd cope I wouldn't want to be her either'. And that just used to make me feel really bad. But then the more I got into that kind of state the more I couldn't get out of it. And the more guilty and bad I felt.

It sounds like a vicious cycle?

Yeah.

Is there anything others have done which has helped you when you feel low and break this cycle...lift your mood?

Not so much lift my mood but being here there are so many people around me, it kind of distracts you. Which I don't particularly like but it's hard to think about anything when you have people running around.

Is there anything else?

No
How do you think others expect you to cope with these emotions and difficult times?

...They expect me to talk about it and say what's on my mind.

Looking back how did your family and friends expect you to cope?

Just go and talk to them.

Can you describe how other people in your life cope with strong emotions and difficult situations, such as your mum and dad?

Not very well. My mum, in the past when things started getting really bad she just stopped eating and started getting really thin which is kind of ironic because when I didn't eat she started having a real go at me yet she was doing exactly the same. My dad just started smoking more, cause it was getting him down as well. I was getting everyone down. I was just the cause of everything.

So you felt your mum stopping eating and your dad smoking was your fault.

It is my fault I know it is....It was because of me...

It sounds like you were having a very difficult time yourself. I want to ask you now about your experience of getting help for your difficulties. Can I begin by asking what it is like talking to me about your difficulties?

It has been kind of alright because I don't know you and I won't see you again. So... cause it is kind of confidential and .... It depends what mood I'm in, if I'm in an OK mood.

How does it feel now that we have talked about your feelings?

OK kind of. I guess it makes me want to cut a bit....

Can you explain that?

I don't know, because when you talk about it you start picturing it. I can't really explain it. It's like when you read about it or see pictures it just makes you think, yeah...

It sounds like you used to cut in reaction to stress but now you can cut just after thinking about it, is that right?

Yeah.
Is that to so with just having something to do or...?

Yeah, sometimes. I don't know it has just become, like, say familiar. Like normal, that I don't really think about it that much.

What is it like talking to other people about your feelings?

Am...

You said earlier that you speak to Bob.

Well when I am really low it does kind of help a bit because I just sit and cry to him and I get some kind of comfort that I don't normally get. I never got comfort from anyone. I used to just cry to myself. I don't really like turning to people for help. I'm not just the kind of person who opens up to everyone I meet. I don't have any valued relationships. I don't like getting close to people.

How would that make you feel?

They would just go away at some point. And then you're upset again.

What types of things do you value in relationships?

Love...just being there...I don't know.

Do you talk to others in the unit?

I don't really have time for anyone. I got on better in the adult ward because I was like the kid who they all looked out for. Now I'm like the oldest.

What do you think is the best way to help you when you are having difficulties and feeling low?

Just leave me alone. Let me cope myself.

When you feel very low, what thoughts go through your mind?

That I want to be dead.

When you do harm yourself, do you think about killing yourself?
When I started cutting, I used to start at the top and I kept telling myself that each time I cut I would cut deeper and deeper. And then when I got to my wrist I would have enough courage to cut deep enough and that's what I did try and do. I know I am going to die by my own hands so...

Is that something you have planned?

No it is just a matter of when. It is just the way it is meant to be. Everyone is just wasting their time in trying. I don't even feel I'm better. I will always have this idea that I will kill myself.

Have you always felt this way?

No not when I was little. But when things started going down hill in about year 9, it got worse... I just don't have a future. I would prefer to be dead it would be so much easier.

What type of things do you talk to Bob about?

Don't know. Sometimes we talk about my family or how I am feeling. Just chat really.

Do you think you can tell Bob your thoughts about cutting or killing yourself?

Yeah but it wouldn't help me get out of here.

Do you understand why that is the case?

Because if I say I am going to kill myself they won't let me go. You just tell people what they want to hear.

You have spoken to me very clearly about your feeling and expressed yourself very well. Are you quite surprised by that?

Mmmm.

Do you feel any different from when you started this interview?

The same.

Well I guess I'm left rather concerned

Why? (laughs)

You have expressed yourself really well. However I have concerned by your thoughts about killing yourself.
But that's just standard anyway. That's just me (laughs)

Is there anything you think others could do today or later to support you and make you feel safe?

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Just leave me alone.

The interview is now finished. Debriefing.........

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Given the concerns raised during the interview about: - (1) how talking about self harm made her feel like cutting and (2) her thoughts about killing herself, Louise agreed that I could discuss these issues with Bob. She reported not feeling any different after the interview was completed. I reinforced how well she had expressed herself during the interview and acknowledged that she preferred people to leave her alone when she felt low. However I also acknowledged that having others around distracted her from worrying thoughts. She was reminded that Bob would be available later and she reported that she would probably talk to him. She agreed for my concerns to be discussed with Bob.

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