

Understanding the Processes in Assessing Risk of Deliberate Self Harm in Systemic Family
Therapy

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The candidate confirms that the work submitted is his own and that appropriate credit has been given where reference has been made to the work of others.

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ABSTRACT

Introduction:

The subject of self-harm in the adolescent population is a source for public concern likely grounded in the suicide rates for this age group and the perception that the risk of suicide is increased for individuals who regularly harm themselves. This leaves clinicians working with those who self-harm with the task of assessing the risk of those who access services. The literature base for risk assessment of suicide/self-harm is populated with studies which focus on the 'whats' of risk assessment, for example: what a clinician needs to cover to ensure safety or what service users think of their assessment. I argue the need to build on this knowledge base, and understand the 'hows' of risk assessment, e.g. how does a therapist complete an assessment and how does a therapist ensure engagement. The current study takes place within the context of a Systemic Family Therapy study and explores how a therapist completes their assessment with a family.

Method:

Grounded Theory was employed in order to analyse videotapes of Systemic Family Therapy sessions. A single case of a female adolescent was selected based on characteristics of her therapy. The key research questions address the processes the therapist employs to move between therapeutic and assessment tasks; how the therapist's approach changes in the face of changing risk; and how the therapist maintains engagement throughout the therapy.

Results:

Themes emerging from the data revealed that the therapist employs a number of subtle processes in order to switch interchangeably between assessment and therapy tasks and that these foci are not mutually exclusive. These processes occur within the context of a balanced, conversational relationship in which therapist and family has an equal footing. When the perceived level of risk changes, the therapist's approach still fits within this framework, with a key difference being a more direct establishment of therapist goals. Engagement is maintained by the therapist's negotiation of balance, collaboration and mutuality within the therapeutic relationship. Furthermore, the therapist moderates emotion in the room in a way that avoids re-traumatisation, and in a way that encourages the family and young person to continue to contribute to the discussions in safety.

Discussion:

The findings of the current study provides a preliminary model of risk assessment for this particular therapy which facilitates thinking about risk assessment in a wider sphere. The

findings of the current study are then considered as part of a growing body of literature, with further recommendations made for future research.

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ABBREVIATIONS

- A&E: Accident and Emergency.
- APA: American Psychological Association.
- BPD: Borderline Personality Disorder.
- BPS: British psychological Society.
- CA: Conversational Analysis.
- CAMHS: Child and Adolescent Mental Health Service(s)
- CAT: Cognitive Analytic Therapy.
- CBT: Cognitive Behavioural Therapy.
- DBT: Dialectical Behavioural Therapy.
- DClinPsy: Doctorate of Clinical Psychology.
- DoH: Department of Health.
- GCSE: General Certificate of Secondary Education.
- GP: General Practitioner.
- GT: Grounded Theory.
- IPA: Interpretive Phenomenological Analysis.
- LFTRC: Leeds Family Therapy Research Centre.
- NHS: National Health Service.
- NICE: National Institute for Clinical Excellence.
- NRES: National Research Ethics Service.

NSSI: Non-suicidal self-injury.
OED: Oxford English Dictionary.
PST: Problem Solving Therapy.
REC: Research Ethics Committee.
RTC: Randomised Controlled Trial.
SHIFT: Self Harm in Family Therapy.
SFT: Systemic Family Therapy.
SLT: Social Learning Theory.
TA: Transactional Analysis.
TAU: Treatment as Usual.
UKCP: The United Kingdom Council for Psychotherapy.
UoL: University of Leeds.
WHO: World Health Organisation.

CHAPTER 1: INTRODUCTION

The subject of self-harm in the adolescent population is a source for public concern (Wood, Trainor, Rothwell, Moore & Harrington, 2001). This concern is likely grounded in the distressing nature of self-harm; the suicide rates for this age group; and the perception that the risk of suicide is increased for individuals who regularly harm themselves (Hawton, Houston & Sheppard, 1999). Furthermore, unique developmental, cultural and social features exist within the adolescent population which can increase the level of clinical complexity for professionals working with adolescents and families of adolescents who engage in self-harm. These layers of complexity can influence the therapeutic work particularly in engagement which can have knock-on effects on the assessment of risk and ensuring that those in therapy reduce or abandon their self-harming behaviours. In the opening chapter of my work I intend to review the relevant literature pertaining to self-harm, risk assessment, and process research in family-based psychotherapies.

Literature Review

Self-harm

I will begin by reviewing the literature pertaining to self-harm paying particular attention to how it is defined in the research literature, examining its prevalence as well as providing an overview of the available psychological models used to understand the function of self-harm.

Definition. A review of the self-harm literature reveals a significantly varied set of defining terminology. Terms including ‘self-injury’, ‘self-harm’, and historically: ‘self-mutilation’ have been used to describe these behaviours. Recently authors have utilised the term ‘Non Suicidal Self Injury’ (NSSI) as an all-encompassing moniker with the view to having a more universal definition. NSSI is defined as “*the deliberate and direct destruction of one’s body tissue without suicidal intent*” (Claes & Vandereycken, 2007; Muehlenkamp, 2005). This definition also considers NSSI to be a socially unacceptable behaviour as there is some debate where ‘acceptable’ forms of bodily modification such as tattooing and piercing falls within the umbrella of self-harm (Klonsky, 2007). As my research takes place within the context of an ongoing family therapy study, I have decided to maintain consistency with this study’s own definition. Ergo, Boston, Eisler and Cottrell (2010), the authors of the manual used by therapists in the study define self-harm as: “*...non-fatal self-poisoning or self-injury...regardless of motivation or the degree of intention to die. (p. 7)*”.

Features of self-harm. Generally, behaviours commonly considered to be self-harm include: cutting, self-mutilation, head banging/hitting, burning, hair pulling; prevention of wound healing, inserting objects into the body and ingestion of poisonous/toxic material (Klonsky, 2007; Nijman, et al., 1999; Skegg, 2005; Mind, 2013). However, the self-harm literature contains an array of terminologies and behaviours considered to fall under the umbrella of self-harm which can make it difficult to define for researchers and epidemiologists (Laye-Gindhu & Schonert-Reichl, 2005).

Throughout the literature there is a consistent finding that skin cutting is the most prevalent form of self-harm (Klonsky, 2007; Nock & Prinstein, 2005). It is estimated that the onset of self-harming behaviours is between the ages of 11 and 25 (Herpertz, 1995; Klonsky & Muehlenkamp, 2007) though the factors which predict continuation of self-harm into adulthood has been sparsely explored (Whitlock & Selekman, in Nock, 2014). It is important to be cautious when considering data pertaining to self-harm reported across the literature as many authors have reported data for individuals whose self-harm may utilise more than one method (Klonsky, 2007; Gratz, 2001) which likely causes some confusion as to the prevalence of specific self-harm behaviours.

Underpinnings and Pathology of self-harm. Although it is not my personal preference to ascertain a ‘pathology’ or ‘pathologies’ of a particular behaviour, with a preference toward a more socially constructed explanation, the literature pertaining to self-harm often makes reference to factors such as early experiences, mental disorders, gender, and physical ailments as being predicative of the development of future self-harm. The act of self-harm has been associated with many psychiatric disorders such as depression (Nock et al. 2006); alcohol and substance abuse (Nock & Kessler, 2006); anxiety disorders and anorexia, with an incidence rate across all diagnoses estimated in some cases to be as high as 20% (e.g. Darche, 1990). Self-harm has also been shown to be highly correlated with the presence of a diagnosed personality disorder, particularly Borderline Personality Disorder (BPD) (Graz, Tull & Levy, 2014). Concurrently, self-harm has also been shown to be correlated highly with physical illnesses such as epilepsy, eczema and diabetes (Singhal et al. 2012). There is some debate as to whether gender differences can be observed, with some authors reporting significant differences between genders (e.g. Fox & Hawton, 2004) whereas others argue that data collection biases may explain these differences, and that there is no significant difference between the genders (Kerr, Muehlenkamp & Turner, 2010; Bowen & John, 2001). Self-harm in adolescents has been correlated with adverse early childhood experiences such as:

emotional and physical neglect (van der Kolk, Christopher & Perry, 1991; Hawton et al., 1995) sexual abuse, (Hawton *et al.*, 1995; Romans, Martin & Anderson, 1995), psychosocial influences such as bullying and victimisation (Evans et al, 2003; Hay & Meldrum, 2010; Barker *et al.* 2008), drug and alcohol abuse (Schwartz, Cohen, Hoffmann, & Meeks, 1989), poor self-esteem (Hawton, Rodham, Evans & Weatherall, 2005; Hawton, et al. 1999), negative body image, (Brausch & Muehlenkamp, 2007), and diagnosis of one or more psychiatric disorder (Haw et al. 2001).

Prevalence. Current estimates suggest that there are around 200,000 incidences of self-harm reported in England each year (Hawton et al. 2007), and that 6.6% of individuals who present to health services may have a history of self-harm (Meltzer et al., 2002). Overall, England appears to have an estimated prevalence of self-harm in the adult population of around 0.4%, which is currently one of the highest rates in Europe (Horrocks & House, 2002). The prevalence rates specifically described for adolescents in England have been reported to be as high as 13.2% (Rodham & Hawton, 2006) which is significantly higher than rates in the adult population. In a recent review of worldwide adolescent self-harm by Muehlenkamp, Claes, Havertape and Plener (2012) show that prevalence rates can vary from country to country with rates of 5.5% in Hungary (Csorba et al. 2012) and rates as high as 30.7% in Belgium (Claes et al. 2010). It is worthy of note that in such large-scale studies such as these cited here, that the data collection strategies may vary dramatically, thus making it difficult to establish truly accurate means of comparison between countries. This is particularly true of how the data is collected and how these rates are subsequently calculated. Furthermore these findings may also reflect the cultural differences in approaches to self-harm rather than a true reflection of prevalence.

In the adolescent population, Hawton, Fagg, Simkin, Bale and Bond (2000) estimate that approximately 25,000 young people *per annum* are hospitalised as a direct consequence of self-harm. As with the adult data, it is difficult to identify reliable data for gender differences as gender differences have been observed in adolescents who self-harm (Carr, 2009). Typically, there is a bias toward girls as being more likely to self-harm than their male counterparts, however boys are more likely to injure themselves by engaging in behaviours that are not traditionally considered to be “self-harm” (for example punching a wall), which can confuse how overall prevalence rates are calculated (SelfharmUK, 2015). Prevalence rates may also be skewed as it has been identified that girls are more likely to seek medical

support for self-harm related injuries whereas boys' injuries are more likely to be attributed to accidents (Laye-Gindhu & Schonert-Reichl, 2004).

Despite these worrying statistics, estimating precise prevalence rates for self-harm has been a difficult task for researchers. This may, in part be due to the wide ranging definitions of self-harm (Suyemoto, 1998), the analysis of data specifically from specialist self-harm services (Gunnell, Peters, House & Hawton, 2004), or because data is often used from individuals who engage in a specific form of self-harm at the expense of those who engage in others (Walsh & Rosen, 1988). For example, self-harm in adolescents has been termed a 'silent' behaviour which is carried out in secret without ever coming to the attention of parents, physical or mental health services (Meltzer, Harrington, Goodman & Jenkins, 2001; Bowen & John, 2001; Boston et al. 2010).

Link with Suicide. The link between self-harm and suicide becomes clear when we consider the potential lethality of self-harming behaviours such as cutting, strangulation and self-poisoning. Further, research estimates that 28-41% of self-harmers experience suicidal ideation (Yates, 2004; Favazza, 1996) and a significant proportion report one or more suicide attempts (Stanley et al. 1992). However, despite this physical link 85% of the responders in the Yates study who reported suicidal ideation attributed their self-harm to a form of release, rather than an attempt to end their lives (Yates, 2004). As such, there is a growing consensus that self-harm and suicidality should be considered not as single entities, but appearing along a spectrum of lethality (Linehan, 2000). In addition to the presence of suicidal ideation in those that engage in self-harm, there is also the concern surrounding a potential discrepancy between an individual's intention (i.e. to not end their life) and their intention of the lethality of the methods they employ (e.g. cutting too deeply; overdosing when not understanding the strength of a particular medication). Therefore, there remains a significant risk of suicide for those who self-harm which has direct implications for the ways that clinicians assess risk in adolescents who self-harm.

Function. Clinicians have access to a number of theoretical models which describe the function of self-harm. By forming and understanding of this function it may be able to identify suitable approaches for its treatment (Johnstone & Dallos, 2006; Bennun, 1984).

Emotional Regulation. There is a way of thinking within the literature, that posits that engaging in self-harm can act as a form of emotional regulation (Mikolajczak, Petrides &

Hurry, 2009; Klonsky, 2007; Gratz, 2003; Nixon et al. 2002). This particular function is one of the most frequently reported by people who self-harm (Suyemoto, 1998; Klonsky, 2007). In the context of self-harm, emotional regulation refers to the act of utilising self-harm as a way to mediate the intensity of, to gain control of, or to relieve the experience of negative emotions (Suyemoto, 1998). Specifically, Klonsky (2007) describes a process whereby preceding intense emotions such as anger, fear and guilt can dissipate following an act of self-harm.

Self-Punishment. Self-harm has also been demonstrated to have the function of self-punishment in some adolescents that self-harm (Nock & Prinstein, 2004; Klonsky, 2009). This is thought to be related to the internalisation of abusive and critical experiences enacted by others (Nock, 2009). Researchers propose that this function is supported by the high prevalence rates of childhood abuse reported by those who self-harm in adolescence (Nock, 2009; Glassman et al., 2007).

Externalisation and Social Signalling. In addition to the above, self-harm may also be understood as a form of externalisation of emotional pain (Leibenluft et al. 1987). Suyemoto (1998) argues that self-harm provides people who self-harm a tangible, external injury which validates their unexpressed internal difficult emotion. Furthermore, self-harm may also be used as a means to externalise intolerable emotions in a way which communicates internal turmoil with others (Suyemoto, 1998; Woods, 1988). In some cases the self-harm is a used as a way of communicating a ‘call for help’ (Lloyd-Richardson et al. 2007). Further, self-harm has also been shown to be a means of increasing social standing amongst peers (Simpson, 1980). It is argued that self-harm may elicit many responses from others such as care-giving (Lloyd-Richardson et al. 2007; Chowanec et al., 1991), status (Offer & Barglow, 1960; Simpson, 1980) and that these responses are positively reinforced by the attention of others (Suyemoto, 1998).

Social Learning Theory (SLT). Self-harm within the SLT model (Bandura, 1973) highlights the role of vicarious learning, self-reinforcement; modelling, and family relationships in maintaining self-harming behaviours (Suyemoto, 1998). Simpson and Porter outline a view that adolescents observe and internalise their parents’ model that harm and care responses are linked, through which self-harm is a direct route to receiving care (Simpson & Porter, 1981). Suyemoto (1998) proposes that this behaviour is further reinforced through other processes such as the feelings of release described by Kinsky (2007). Vicarious learning

may also occur when an individual observes others receiving care following self-harm episodes (Suyemoto, 1998; Ghaziuddin et al., 1992).

Antisucide. Drive models of self-harm are associated with psychoanalytic ways of thinking about behaviour and conceptualise self-harm in terms of life, death and sexual drives (Suyemoto, 1998). The anti-suicide theory of self-harm acknowledges the distinction between episodes of self-harm and actual suicide attempts (Suyemoto, 1998). Analytic theorists posit that self-harm occurs as part of a resolution between life and death drives in that self-harm acts as a moderator for self-destructive death impulses (Firestone & Seiden, 1990).

Summary. Within the literature, there appears to be a diverse array of approaches to understanding self-harm which ranges from contributing factors to factors which explain its emergence. This diversity may also reflect the ranges of psychological models that have been applied to attempt to understand and treat self-harm. In some instances, theories of self-harm are driven by opinion and abstraction of unconscious drives, neither of which are fully explored in a more robust way. What is clear from the above is the idea that self-harm may have different meanings and different functions for a variety of groups of people that self-harm. Ergo, the sense is that there may not be one ‘best-fit’ explanation for why people engage in self-harm and instead should consider the experiences of the person in their current context. It is therefore important, particularly in the setting of the current study (which draws upon data from Systemic Family Therapy sessions), to consider the function that self-harm has for particular individuals, and how this function is perceived and given meaning by others such as family members, health professionals and the wider public. By combining these factors, we can then begin to think about an appropriate intervention.

Interventions for self-harm. The National Institute for Clinical Excellence (NICE, 2014) recommends a number of psychological therapies for individuals who self-harm. These include: Cognitive Behavioural Therapy (CBT) (Hawton et al., 1998), Dialectical Behavioural Therapy (DBT) (Linehan 1987), Problem Solving Therapy (PST) (Townsend et al. 2001) and Cognitive Analytic Therapy (CAT) (Ryle & Kerr 2003; Ougrin, 2009). As this is a study involving data drawn from a comparison of the effectiveness of Systemic Family Therapy (SFT) against usual care, I shall not examine these approaches in more detail as I wish to focus on the role of family therapy in the treatment of self-harm. They are mentioned here in order to place SFT within the context of a number of other recognised therapies/approaches to treatment.

Systemic Family Therapy. The data for the current study is derived from sessions of SFT which were recorded during the SHIFT trial. As an intervention, SFT explores the patient's wider systems in relation to their self-harm and differs from other approaches to treating self-harm as it seeks to transfer the emphasis away from causal explanations of self-harm (Boston, et al. 2010) as this is felt to be blaming, and oversimplifying (White, 2007). Instead, the SFT approach examines self-harm in the context of relationships; in the family and in the wider social spheres (Dallos, 2004).

Risk Assessment

Although the self-harm literature described above suggests that not all individuals who deliberately self-harm have suicidal intent, there is the potential for these behaviours to cause life-changing harm, or even death, irrespective of the person's intent, inasmuch that some authors (such as Lineham, 2000), conceptualise self-harm behaviours along the lines of a spectrum of lethality. I will now endeavour to discuss the concept of risk and broaden this to describe the ways and means of assessing risk with those adolescents who engage in self-harm.

Defining Risk. The Oxford English Dictionary (OED) (2015) defines 'risk' as: "*(Exposure to) the possibility of loss, injury, or other adverse or unwelcome circumstance; a chance or situation involving such a possibility*". In order to operationalize this definition to fit the needs of the context of clinical practice we can further consider how risk relates to clinical practice. Webster (1995) defines the concept of *clinical risk* as: "...*the potential for the occurrence of harm with respect to self-harm or attempted suicide; violence; serious neglect of self or dependants; abuse and exploitation of or by others...*". Both the OED and Webster definitions focus on loss, harm and the more negative aspects of risk in the clinical context. Furthermore, the definition of risk may also be expanded to reflect the potential for positive outcomes from taking therapeutic risk. For example, Morgan (2000) suggests a more balanced view of risk, and posits that: "*Risk is the likelihood of an event happening with potential harmful or beneficial outcomes for self and/or others.*". Therefore the definition of risk may also be expanded to include positive risk-taking within therapy, as well as the potential for the more harmful aspects.

Clinical Risk in Child and Adolescent Mental Health Services. The definitions above provide a useful reminder of what clinicians deal with in terms of risk within their

clinical work. The Department of Health (DoH) (2007), highlight the tension between ensuring that an individual has autonomy (that their human rights, dignity and capacity to make decisions are respected), and public safety (accountability of professionals; agendas of the media; and safeguarding). Reflecting the positive risk-taking definition as described by Morgan (2000) above, Duffy (2008) suggests that where possible, clinical risk should be approached in a manner that does not compromise an individual's ability to live and act in an independent manner, meaning that those working with risk should try to negotiate the least restrictive form of practice to keeping a person safe.

Common Elements of a Clinical Risk Assessment. Now that we have a definition of risk, and can see that in some cases risks within therapy can also have positive outcomes, we can consider how therapists can begin to assess and understand the risks faced (or to be faced) by their service-users¹ which allows the person to recover with minimal interruption to their everyday lives. In the first instance I shall describe the common elements of a risk assessment with people who self-harm then go on to discuss some of the more actuarial tools used by clinicians in their assessments. From here I will then focus on the adolescent population, and consider some of the aspects of working with this service-user group which may also potentially impact on the completion of a risk assessment.

Clinical guidelines for clinicians working in Child and Adolescent Mental Health Services (CAMHS) with those who engage in self-harm cite a number of elements. The National Institute for Health and Care Excellence (NICE) suggest that those working in community teams, and other specialist mental health services should seek to capture an integrated understanding of the following:

- The person's skills, strengths and assets.
- What the person employs as coping strategies.
- The presence of comorbid mental health problems or disorders.
- The presence of any physical health problems.
- The person's social circumstances/problems.

¹A word on Terminology: Throughout the literature on Deliberate Self Harm (self-harm) authors make reference to people who engage in the act of self-harm as "service users" or "clients". It is my own personal preference to use the term service user as I feel that it better suits my background in clinical practice. Therefore, unless otherwise stated I will be using the term 'service user' throughout this review to refer to the people the authors describe.

- The person's psychosocial functioning; occupational functioning and their vulnerabilities.
- Any recent and ongoing life difficulties.
- Whether there is a need for psychological intervention; social care; and/or drug based treatment.

Based on NICE (2014)

Furthermore, clinicians are also recommended to try and understand the meaning behind the self-harm taking into consideration the individual nature of self-harm and that each episode of self-harm should be "*treated in its own right*" (NICE, 2014). There is a consensus in the clinical literature that the intention of a full risk assessment should be completed within a biopsychosocial model and that it should seek to establish:

- The frequency and methods of the self-harm.
- Current and historical suicidal ideation and/or intent.
- The presence of depressive symptoms and how these relate to the self-harm.
- Other mental health problems and their relationship to self-harm.
- Any antecedents to the self-harm (for example life events; unpleasant affective states).
- Immediate and longer term risks.
- The presence of other risk-taking behaviours (e.g. unprotected sex; drug misuse; excessive alcohol consumption).
- Whether the person has access to the medications of others.

(Based on: NICE, 2014; Gelder, Mayou & Geddes, 2005)

Across the literature for risk assessments within therapeutic interventions with young people, couples and families, it is recommended that a risk assessment should also seek to identify protective factors (Johnstone & Dallos, 2009; Gelder, Mayou & Geddes, 2005). Ougrin (2009) describes three areas which may be considered to reduce the likelihood of further self-harm and should be explored by the assessor. These include: the individual's resilience (e.g. their problem solving style, social skills, and academic achievement), their family's resilience (e.g. relationship with caregivers, open communication styles and sense of family coherence)

and environmental resilience (e.g. relationships with educators, good friendships and community involvement).

Methods of Gathering Risk-Related Information. In order to gather this information, Morgan, Nathan and Brown describe and recommend three approaches to risk assessment which are commonly utilised by professionals when working with individuals who self-harm. These include the unstructured clinical approach, the actuarial approach and the structured clinical (or professional) judgement approach (Morgan, Nathan & Brown, 2007). There are also a number of commonly used risk assessment/screening tools for professionals working with people who self-harm, of which some are cited by the Department of Health (DoH, 2014) and have been included in table 1.

Table 1.

Details of common self-harm and suicide assessments described in NICE (2014) guidelines.

<u>Assessment</u>	<u>Author</u>	<u>Description</u>
Beck Hopelessness Scale	Beck et al. (1988)	20 item self-report measure. Service-users are required to answer True/False to statements
SADPERSONS	Patterson et al. (1983)	Records whether the patient has any of the 10 risk factors for suicide/self-harm.
Suicide Intent Scale Scale for Suicidal Ideation	Beck et al. (1974)	Interview/self-report scale. 21 item interview/self-report scale.

Assessing Risk Adolescents and families in SFT. In addition to the above general guidance for suicide risk-assessment, there are a number of considerations for the adolescent population which the assessing clinician should be aware of (Hawton & Fortune, 2008).

Demographics. In terms of gender related risk-factors, it is commonly acknowledged that males are more likely to complete suicide than females (Carr, 2009). Social class has also been shown to be a risk factor, with adolescents coming from lower socioeconomic groups (specifically group five) being more likely to attempt suicide (Carr, 2009).

Familial Factors. A familial history of suicide, social isolation and drug and alcohol abuse have been considered to be risk factors in adolescent suicide risk assessment (American Academy of Child and Adolescent Psychiatry, 2001). A loss of a parent in early life may also increase the risk of suicide in adolescence (Berman & Jobes, 1996).

Development of Emotional Language. It has been suggested that younger service-users may have a limited emotional vocabulary. This limitation may hinder the young person from being able to verbally articulate their experiences and as a result have subsequent difficulty in discussing them with others, including therapists (Boston et al., 2010).

Intentionality and Lethality. Further, there may be discrepancies between the intent and method that the young person utilises in that they may have limited knowledge as to the effects of particular methods meaning that a relatively small overdose may not reflect a low risk of suicide (Boston et al., 2010). Further, males are more likely to employ more ‘lethal’ methods than females, thus being more likely to succeed in taking their own life (Carr, 2009).

Impulsivity. From a neurodevelopmental perspective, a link between brain development and impulsivity in adolescence due to the on-going maturation of the frontal and parietal regions of the brain has been identified (Romer, 2010). This may suggest that adolescents may act in a more impulsive way, and that they are more likely to inadvertently engage in more lethal means due to an inability to inhibit impulsive behaviours.

Engagement with professionals. The importance of forming collaborative, open and trusting therapeutic relationships has been widely highlighted across the empirical literature (Sexton & Whiston, 1994; Friedlander, Escudero, Heatherington & Diamond, 2011) for all therapies. The need for the formation of such robust relationships is reflected in the outcome data in that it is widely accepted that serviceusers reported to have felt more hopeful and engaged if they were involved in and had the assessment process explained to them (Orbach, 2001; Jobes & Drozd, 2004). Research has demonstrated that this ‘involvement’ can also

extend beyond face-to-face contact and has included therapists contacting service-users via telephone, letters and other forms of indirect contact (Cooper et al., 2011; Kapur et al., 2010). Furthermore, SFT poses a unique set of challenges to the therapist in that they are required to form multiple relationships and alliances (Pinsof, 1994). From the start of therapy, therapists are required to acknowledge the necessity for encouraging discussion around self-harm with and within the family as a whole, whilst simultaneously allowing the adolescent to have their own voice within the therapy room (Boston et al. 2010). The complexity is further increased by the likelihood of conflict, vulnerability and emotionality across these alliances (Rait, 2000) and that those involved in the therapy will be influenced by the actions, beliefs and feelings of other family members (Friedlander, Escudero & Heatherington, 2006). Within the outcome literature, a number of key themes have emerged particularly that positive outcomes were reported for service users who felt valued, listened to and supported (Arnold, 1995; Cooper et al., 2011), and relationships in which empathy, collaboration and teamwork are valued by the professional (Orbach, 2001; Jobes & Drozd, 2004). These findings reflect the ‘common factors’ of the therapeutic relationship described by Lambert and Barley (2001) which include empathy, warmth and congruence.

The social constructionist approach to understanding self-harm also comes to the fore when considering the context in which meaning is developed by individual family members. Although not unique to SFT, the self-harm literature suggests a number of societal factors which might influence the engagement of adolescents in discussing their own self-harm with professionals in terms of stigma. These include the experience of negative perceptions of self-harm in schools (e.g. Toste & Beettham, 2006; Heath et al., 2011; Moses, 2010), health professionals (Law, Rostill-Brooks & Goodman, 2009; Mackay & Barrowclough, 2005; Wheatley & Austin-Payne, 2009; Saunders, Hawton, Fortune & Farrell, 2012) and from closer social networks such as friends (e.g. Whitlock, Powers & Eckenrode, 2006; Harris & Roberts, 2013; Lewis et al., 2012; Baker & Fortune, 2008) and family (e.g. Moses 2010; Oldershaw et al., 2008).

Summary. We can identify what the risks are to individuals, the consequences of not assessing the extent of these risks thoroughly enough and what information we might need to gather in order to complete a ‘thorough’ risk assessment. We can also identify a number of levels of complexity within the adolescent population which may influence a clinician’s thinking or their approach to assessment. The literature posits distinct modules of information important in keeping someone safe and in ensuring their autonomy should a response to this

risk be needed. As such, the content of a risk assessment has been widely discussed with a seemingly concurrent agreement as to what a more ‘complete’ assessment should include in order to assess, formulate and manage the risk to an individual.

However, what is striking about the literature is the times at which the data which informs these models is gathered, particularly that the majority of studies adopt *post hoc* questionnaire/interview, review of clinical notes approaches which ask service users and clinicians to recall their experiences after the event (the assessment etc.). What results is a fairly static ‘one-for-all’ approach to risk. The reality of SFT is far from this approach in that the therapist has many competing demands within the session in that there may be multiple assessments occurring simultaneously (e.g. how safe is the young person; how are the parents keeping them safe); and that there may be differing levels of commitment and engagement within the room (e.g. parents’ own mental health difficulties; ruptures in alliance; lack of understanding of approach). In other words, these studies examine *what* has happened during these events rather than *how* these events have transpired. To my knowledge there are no studies which utilise *en vivo* data to examine how all of these aspects may come together, and how the changing dynamics of a therapy session can influence the approach a clinician takes. It therefore may be pertinent to begin to use this type of data to consider the processes involved in assessing, formulating and managing risk in order to understand how assessment is undertaken in SFT, and how these demands are simultaneously managed.

Researching Processes in Assessing, Formulating and Managing Risk

Thus far, with reference to adolescent populations, I have defined self-harm; described functions of self-harm; highlighted the link between self-harm and suicide and briefly discussed some of the treatments available to clinicians. This has been widened to include some of the additional risk assessment processes which may occur in SFT and what some of the challenges may be in this type of therapy, particularly when working with adolescents who self-harm. Concurrently, in the context of suicide risk assessment, I have defined ‘risk’, described the content of and approaches to assessing risk with people who self-harm, and discussed some of the complexities of completing risk assessments with adolescents in the family therapy setting. With these contextual aspects in mind I will now move into the literature concerned with describing how professionals go about assessing and managing risk in their day-to-day work.

Models of Risk for Clinicians. In order to understand the current literature pertaining to models of risk assessment a search of the literature was undertaken with particular focus on risk assessment process. This revealed one guidance paper “*Best Practice in Managing Risk*” which cites a model for clinicians proposed by Sayers (in Morgan, Nathan & Brown, 2007). At this point it is worth noting that this particular model relates to risk management, rather than risk assessment, however I feel it is useful to consider this model in the context of the risk assessment literature. The model consists of two cyclically represented risk-related processes and are supported by an amalgamation of research evidence informed by data gathered from clinicians, service-users and services. These processes describes “*collaborative*” (figure 1.) and “*defensive*” (figure 2.) approaches to working with risk. The models seek to clearly define how particular approaches to risk can lead to positive and/or negative outcomes for service users and provides a starting point for beginning to understand how theory derived from the research literature can put into clinical practice.

Collaborative and Defensive Approaches to Risk Management. Within the collaborative cycle, Sayers suggests that risk is more effectively managed through the provision of positive experiences for the patient. From this, it is proposed that service users will engage further with the assessment/management process which in turn results in greater collaboration with services. Further, this increase in collaboration is thought to reduce risk through a more open approach from both the clinician and the patient.

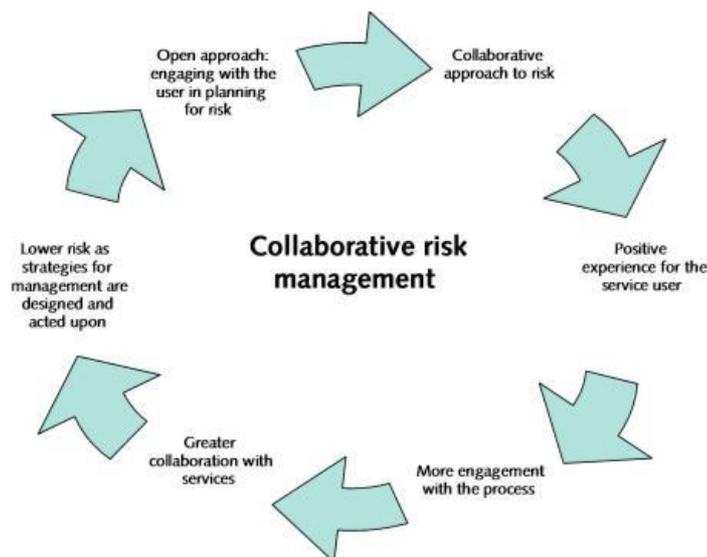


Figure 1. “Collaborative” Risk Management (Sayers, 2007).

The second cycle described by the model: “*Defensive risk management*”, highlights how adopting this particular approach to risk management can lead to negative outcomes for service users (figure 2.). Conversely to the “*Collaborative*” cycle, negative experiences are described to result in disengagement from services, thus escalating risk which causes the clinician to become more defensive in their approach.



Figure 2. “Defensive” Risk Management (Sayers, 2007).

Summary. The Sayers model may provide clinicians and researchers with a model gleaned from data gathered from both clinician and service-user perspectives, which allows theory-practice links to be made in order to improve the way that risk is managed by professionals. The two approaches to risk management described in the model have very clear outcomes for service users should one or the other approach be employed by professionals.

A particular limitation of this model is the methodologies employed in the studies used to support it. Authors such as Arnold, (1995); Whitehead, (2002); Henriques, Beck, and Brown, (2003); and Cooper et al., (2011) utilised questionnaires and focus groups with both service users and clinicians in order to gather data after therapy had ended. This particular approach carries potential biases in terms of the data they gathered particularly if a significant amount of time has elapsed between the end of therapy and the administration of the questionnaire/group. This method has the propensity to tap into a service-user’s understanding/experience of broad concepts such as ‘clinician empathy’, yet says very little about any more subtle influences and processes within the therapy room. The research

literature that informs the models allow us to loosely outline what “*collaborative*” and “*defensive*” approaches look like as well as what ramifications of adopting these approaches in therapy have to the service user, yet these definitions remain largely undefined and vague. However; these processes appear broad and there is no real understanding as to the processes involved which led the clinician to adopting these approaches in the first place. Further, these processes may not be consciously acknowledged by service users or therapists, and therefore missed by questionnaires and focus group discussions. Furthermore, and in relation to Systemic Family Therapy, is the sense that these approaches do not capture the sense of how dynamics in risk assessment may change over time, or in response to changing levels of risk. This implies that risk assessment is more than the interactions between individuals in the therapy paradigm (therapist, young person and family members) and these processes may be better described using a naturalistic observation of or qualitative analysis of therapy sessions themselves. Grounded Theory, for example, is an ideal starting point as it allows data to be viewed beyond the interactional level, and can be employed to describe the processes within the data.

Sampling bias has also been identified in the current literature with studies focusing on the experiences of service users’ risk assessments completed by ‘non-therapists’ for example Accident and Emergency workers, nurses, and medical doctors. These studies rely on data regarding assessments completed usually during an acute stage of distress following an episode of self-harm rather than within therapy per se and would suggest that these forms of risk assessment form part of an immediate response to the self-harm. Therefore it is important to question the purpose of Sayers’ model, in that the data it draws on comes from this ‘immediate response’ population and may occur as a one off. If we are to consider this model as one that can be used to describe the risk assessment process in SFT, we must look beyond these one-off, immediate response type assessments, and think about the longer-term, dynamic assessment which occurs with multiple people, over multiple sessions.

Again, these studies appear to utilise methodologies in which quantitative data is gathered. Further, a significant amount of the current literature which has examined relationships with professionals have focused on professional groups such as GPs (Herron et al., 2001), Psychiatrists (Gask et al., 2006) and Accident and Emergency Department staff (Hemmings, 2003; Hopkins, 2002) as it is these professional groups who are usually encountered first in a time of crisis. Although, the findings of these qualitative studies are largely consistent in that they have revealed common themes for what service users consider crucial to forming positive

therapeutic relationships with healthcare professionals they do not describe these experiences in an SFT setting. In order to explore this, it may be useful to analyse *en vivo* data gathered from therapy sessions to begin to develop theories and models which describe the experiences of therapists and service users in a purely therapeutic setting. By broadening the samples to therapists these models may enable therapists working with adolescents who self-harm to work in a more collaborative manner.

The focus of the current study is toward developing a model which describes the approaches to risk assessment in a family therapy setting in which Systemic Family Therapy is used. In this sense the applicability and generalizability of the Sayers model for these means is fairly limited as the literature has primarily focused on self-harm treatment, suicide risk assessment and therapeutic relationships in the context of short-term assessments outside of the therapy context. However, there are elements of the model which can be used to sensitise us to the importance of particular approaches and their link with particular outcomes for service users. Further, this review also highlights the dearth of research exploring suicide risk assessment in family therapy and how suicide risk assessment is approached by family therapists. Therefore, it would be pertinent to expand the applicability of the Sayers model in order to try to describe the interactional processes within family therapy that contribute to collaborative or defensive risk management.

The manner in which the model is presented is also limiting. If we are to begin to apply the model to family therapy, the model becomes restrictive due to its linear approach to risk management. Further, it also describes two distinctly dichotomous approaches which do not appear to interact at any point. This significantly underappreciates the dynamic nature of risk assessment and the complexities of family therapy. Such a linear model cannot reflect the numerous alliances, points of view and personalities encountered during the course of family therapy. It is likely that therapists, service users and their families enact defensive and collaborative approaches to assessment within and between sessions rather than a simple 'one or the other' process. The reasons for these switches may be dependent on numerous individual factors which are missing from the model. A future model is required to be more interactionist, and less linear. Only then will it begin to accurately describe the complexity and dynamism of the family therapy setting.

Alternative Methods for Understanding Risk Assessment Processes. As I have outlined above, the research literature pertaining to assessing and managing risk is scant and

what is available is limited by its linearity and modular nature. Although the intention of the model described by Sayers (2007) is to outline how risk management should look, it says very little about how a clinician may actually assess risk and how they may manage the many dynamics at play. This reflects the key criticism of the literature in that it is permeated with studies looking at the ‘whats’ of assessment (what to do, what is helpful in the service users’ eyes, what to include in order to understand risk); but as of yet there are no published studies which explore the ‘hows’ of assessment (how is the therapist collaborative, how do they ask difficult questions, how can they maintain engagement). One particular way of exploring processes in the family therapy realm is to apply qualitative methodologies to analysing data obtained from actual therapy sessions. This has been particularly useful in understanding the change process in family therapy, or in describing how meaning is shared between family members (e.g. Green, 2015). The processes between creating meaning, and understanding change within therapy can be compared to aspects of assessing risk in that assessing risk involves giving meaning to behaviours and understanding their significance in day-to-day life with the view to increasing sharing understanding and keeping the person safe. Therefore I think it would be pertinent to review the literature, particularly paying attention to the methodologies of these studies. I shall now consider studies which have examined process within family therapy. At the time of writing there have been no reported studies which have investigated risk assessment processes in SFT, therefore I shall consider studies related to this particularly those that consider change in therapy, and one that explores how meaning of self-harm is negotiated in SFT.

Rationale for the current study

As we have seen, the subject of self-harm is a hot topic for health professionals, mental health professionals and policy makers. The clinical presentation of self-harm is complex and the ways of defining it. Furthermore, self-harm in adolescents also presents a number of complexities for professionals, particularly in terms of understanding and communicating the associated risks of engaging in episodes of self-harm. The literature generally gives excellent guidance on what information professionals should gather and what a good risk assessment looks like in order to keep their service users safe. These studies which examine the experiences of adolescents and therapists who have been a recipient/assessor usually utilise post-hoc methodology whereby participants were asked about their experiences retrospectively. This has led to models such as the one presented by Sayers (2007) which undoubtedly has useful applications for practice as they can allow a therapist to be aware of where they are in a process, be mindful of their approach and modify their approach if

necessary. However, by their nature, these findings present half a story, and fail to reflect the dynamic nature of therapy. Therefore, I have identified that what is lacking are studies which explore *how* these assessments are completed.

Research using qualitative methods such as Grounded Theory, Conversational Analysis and Interpretive Phenomenological Analysis has effectively demonstrated intricate therapeutic processes beyond the concrete descriptions of *what* is occurring. Therefore I am proposing that the same can be applied to the exploration of the risk assessment process, in order to explore and model the ‘hows’ of assessing risk.

Research Questions

The following research questions have been identified:

1. How does the therapist move from a primary focus on therapeutic work to a primary focus on evaluation of risk?
2. How does the therapist’s approach to assessing risk change in response to changes in perceived risk?
3. How does the therapist maintain the engagement of the young person and their family in the face of emotionally challenging material?

CHAPTER 2: METHOD

Design

The current study's aim was to investigate and describe the process of risk assessment with adolescents who self-harm and their families within the context of Systemic Family Therapy (SFT). A qualitative methodology was identified as most appropriate due to the exploratory nature of the study. The data used in the analyses was the video and audio taken from *en vivo* family therapy sessions which was transcribed and a Grounded Theory (GT) approach (Corbin & Strauss, 1998; Charmaz, 2006) for the analysis was utilised.

Ethics

Ethical approval was applied for and approved in June 2015 by the NHS Health Research Authority NRES Committee South West – Central Bristol (Appendix II).

Confidentiality and data protection. Confidentiality of participants was maintained throughout the study via the anonymisation of transcripts, and pseudonyms being allocated to the adolescent, her family, the therapist, and the reflecting team. Video recordings were stored on the University of Leeds secure drive with the researcher and transcriber only being afforded access to those participants' video recordings identified as being appropriate for use in the study. Furthermore, transcription files were made in Microsoft Word, given passwords and stored on an encrypted memory stick provided by the University of Leeds. Video recordings were made available to transcribers who had signed a confidentiality agreement (Appendix III) and viewed using University of Leeds computer facilities in a private room.

Informed consent. Participants had given informed consent for their video data to be used in future research as part of their participation in the original SHIFT trial (Appendix I). As the SHIFT trial had ended at the commencement of the project, ethical approval was not needed from the trusts in which the data was initially gathered.

Managing risk. Although data for the study had already been collected and risk issues related directly to the participants resolved, there was a small risk of vicarious distress being experienced by the researcher and/or transcriber when viewing participants' description of their own traumatic experiences. As a researcher, I was supported by the University of Leeds Doctorate in Clinical Psychology Programme staff in the form of Clinical and Academic Tutors. The transcriber was also offered this support, as well as being signposted toward other external sources of support should this be indicated. I can report here that none of these issues arose throughout the project.

Participants

Self-harm in Family Therapy (SHIFT) trial. Data was collected from the video recordings of a pre-existing self-harm trial; the SHIFT Trial. The SHIFT Trial was a randomised controlled trial (RTC) funded by the Medical Research Council. The study compared SFT and treatment as usual (TAU) for adolescents aged 11 to 17 years who had engaged in at least one incidence of self-harm. The project had centres in Yorkshire, London and Greater Manchester. The therapy was delivered by qualified therapists utilising the *Leeds Family Therapy & Research Centre Systemic Family Therapy Manual* (LFTRC Manual; Pote et al. 2000). The primary outcome measure for the study was the rate of recurrence of self-harm leading to attendance at hospital 18 months after randomisation. Secondary outcome measures included recurrence of self-harm leading to attendance at hospital after 12 months, quality of life, and cost-effectiveness.

SHIFT Inclusion/Exclusion criteria. The SHIFT study recruited 832 participants aged 11 to 17 years who had been referred to CAMHS from Accident and Emergency, General Practitioner (GP) or school settings following more than one episode of self-harm. This group were then randomly placed in either the treatment as usual (TAU) or family therapy intervention (n=416). Inclusion criteria for the SHIFT study were:

- *Aged 11 to 17 years.*
- *Self-harmed prior to assessment by the CAMHS team (self-harm being the key feature of presentation).*
- *Engaged in at least one previous episode of self-harm (recorded by CAMHS or via self-report) prior to the index presentation.*
- *Where the presenting episode was due to alcohol or recreational drugs, the young person had explicitly stated that he / she was intending self-harm by use of these substances.*
- *The clinical intention was to offer CAMHS follow-up for self-harm.*
- *Lived with primary care-giver.*
- *Both young person and primary care-giver gave written informed consent, as appropriate.*

Exclusion criteria were:

- *At serious risk of suicide (clinical judgement).*
- *An ongoing child protection investigation within the family, which would have made treatment difficult to deliver.*
- *Would not have ordinarily been treated in generic CAMHS but rather by a specific service (for example, psychiatric inpatient care for severe major depressive disorder).*
- *Pregnant at time of trial entry.*
- *Actively being treated in CAMHS (as the possibility of randomisation might disrupt ongoing therapy).*
- *In a children's home or short-term foster placement.*
- *Moderate to severe learning disability or lacked capacity to comply with trial requirements;*
- *Involved in another research project - at the time of trial entry or within the last six months.*
- *Sibling had been randomised to the SHIFT trial, or was receiving family therapy within CAMHS.*
- *The young person and one main care-giver had insufficient proficiency in English to contribute to the data collection.*

From Wright-Hughes et al. (2015)

In terms of randomisation, service-users were afforded two CAMHS meetings prior to their allocation to the TAU or therapy groups. Following this, the benchmark for treatment was set at monthly sessions which lasted for a duration of approximately six months.

Inclusion Criteria for the Current Study. A discussion pertaining to the inclusion criteria for the current study was conducted and a number of potential participants were identified. In order to capture data that would include examples of risk assessment participants who were deemed to be “*high risk*” at their initial assessment were identified by a senior SHIFT researcher. Ultimately, one therapy was selected to be analysed from session one to completion. There were seven sessions in total which yielded approximately 10.5 hours of video footage. Using previous DClinPsy qualitative studies as a precedent, it was decided that this volume of footage would be sufficient to produce an in-depth analysis. The reasoning behind selecting a single family's therapy was to ensure that the change process within and between therapy sessions was captured which would not be captured between therapies of

multiple families. It was important to capture how a therapist's approach to assessing risk emerges and changes over time, rather than comparing their approaches at specific times in therapy (for example in the first and last session). This could only be done using a single family. Furthermore, the research question asks how a therapist works in response to *changing* levels of risk, therefore a case was selected which indicated changes in potential risk over the course of therapy. The inclusion criteria for the analysis were defined as follows:

- A young person identified to be at 'high risk' of self-harm.
- A full course of therapy.
- Digitised video and or audio data for all therapy sessions.
- A change in circumstances which increase the perceived level of risk over the course of therapy.

Three therapy cases that met these criteria were identified by a member of the SHIFT team and recordings of their therapy sessions were made available to me. Two cases were rejected on the basis that familial attendance was thought to be too inconsistent with many sessions only including the young person and one parent. In addition to this, the other cases involved a number of sessions in which the young person was taken out of the room to talk with the therapist away from their parents due to the high levels of distress experienced in the room. I felt that using these cases would also take the focus of my analysis away from how the therapist engages the family together as a cohesive group in the room. Following this review, one particular case was selected and given the pseudonym 'Hannah'. Hannah's family were selected as I felt that the consistency of attendance of all the three family members across the therapy following Hannah's hospital admission was greater than in the other two. My rationale for this was that this consistency of attendance would allow an understanding of how the therapist engaged family members who were not present, how they were subsequently brought into the group and how this engagement was maintained. A description of Hannah, her family and her therapist can be found below on page 33.

Selected Therapy: A Pen Portrait

Hannah, her Family and their Therapy. Hannah is a white female in her late teens with a history of two self-harm episodes prior to therapy. Hannah's family is made up of: Mum; Dad; older brother; and Nana and Granddad. Hannah and her family live in the north of England, where she attends sixth-form studying for her GCSEs. In terms of prior index events,

through therapy it is learnt that before being referred into the service, Hannah was raped by a friend of a friend and later experienced a miscarriage.

In terms of the therapy, there were seven sessions. Hannah and her Dad attended all of these with her Mum attending sessions three to seven. An eighth session was also recorded, however this was not used in the analysis as it was a short discussion between Hannah, Wendy and Hannah's boyfriend. As indicated above, Hannah took an overdose between sessions two and three which led to a hospital admission which acted as the circumstance which changed the level of perceived risk for the therapist. Hannah had video and audio data for all of her therapy sessions.

Wendy. Wendy (also a pseudonym) was Hannah's family therapist for the duration of the therapy. Unfortunately, demographic details for the therapists were not collected as part of the SHIFT trial nor were specific background data. Further, specific permission was not given by therapists for their information to be shared at the time of data collection. In addition to this, my view is that my own observations of Wendy (e.g. race and age) may be inaccurate and/or could increase the risk of her being identified. Although this information may have been useful here, I have chosen not to include it for these reasons. However, a more general picture of the therapists who were recruited into the SHIFT trial is that they were all eligible for registration to the UK Council for Psychotherapy (UKCP), qualified SFT therapists (to Master's degree level) with at least two years of supervised practice, a professional mental health background and qualification (e.g. social work or nursing) and had experience in a CAMHS setting (Wright-Hughes, et al. 2015; D. Cottrell, personal communication March 17, 2017). Prior to the commencement of the study, training was also provided by a specialist in adolescent self-harm with facilitated discussions specifically on clinical risk and each therapist was assigned a pilot case (i.e. a family who had not been recruited to the SHIFT trial) prior to moving on to a recruited trial case (D. Cottrell, personal communication March 17, 2017). For the duration of the trial therapists received two hours of supervision per month which was facilitated by senior family therapists which included the discussion of their cases and adherence to the SHIFT manual (D. Cottrell, personal communication March 17, 2017).

Data Analysis

Process Research in Family Therapy. Process research in SFT is characterised by four distinct fields: outcome studies, process studies, studies that explore subjective experience of participants and methodology development (Burck, 2005; Elliot, 2010). Charlotte Burck argues that the increase in demand for evidence-based therapies has seen a surge in the need for outcome-based research which serves the purpose of strengthening the

position of SFT within the psychological therapies (Burck, 2005). However, there is a viewpoint within the psychotherapy research community that there is a degree of superficiality to this approach, in that it can only ever tell a part of the story. Therefore we must be able to consider alternative methods.

During its formative years, Greenburg (1986) posited that process research could be broken down into two approaches: task analysis and sequence analysis of in-session behaviours. More recently however, the idea of process research has been broadened to be defined by: “*the processes by which change occurs in psychotherapy, including both the in-therapy processes that bring about change and the unfolding sequence of client change (which changes occur first and lead to what subsequence client changes)*” (Elliot, 2010; p 123). Process research in therapy has largely utilised quantitative methodologies which in themselves have their numerous strengths (Sprenkle, 2003), however it has been argued that these studies fail to bridge the gap between theory and practice, in addition to being limiting in their ability to understand the nuances of therapeutic processes (Burck, 2005). Heatherington, Friedlander and Greenberg (2005) highlight the importance for ensuring that the processes for exploration are well defined, their reasoning being that without such definition; potential analysts will be unable to employ a robust methodology.

Considering Other Qualitative Approaches. As discussed in Chapter One, process research in family therapy has utilised a number of qualitative approaches to analysing data. A selection of these qualitative approaches was considered prior to settling on Grounded Theory for the analysis of data in the current study. Approaches which were initially considered for data analysis were: Interpretive Phenomenological Analysis (IPA), Thematic Analysis (TA) and Conversational Analysis (CA).

An IPA approach was considered as the approach allows researchers to understand participants’ experiences and can be used to gather data from multiple participants’ experiences simultaneously. One outstanding criticism of the current process literature is that studies have focused on the wider themes (the ‘what’) rather than the process (the ‘how’) and we decided that there was a risk that an IPA approach to the data would seek to perpetuate this trend by producing general ‘themes’ rather than describing processes. Further, an IPA approach would also require the interviewees to retrospectively reflect on their own approach to risk assessment which is accompanied by its own biases. For these reasons, it was identified that IPA would not effectively answer the research questions posed. Similarly, TA

and CA were also considered as a potential approach as they have been used in qualitative research using observational data (e.g. Sutherland & Strong, 2011). Again, it was felt that a TA approach would only suit a more general analysis of themes rather than the more subtle processes and was subsequently abandoned. Furthermore, CA focuses more on the pragmatic elements of interaction, for example: prosodic features; pauses in speech and how speech overlaps (Sutherland & Strong 2011; Sacks, 1995) rather than on the wider content of interactions occurring within therapy such as how a therapist may create the conditions for talking, or negotiate meaning (Green, 2016).

Considering other Data Sources. Although I was aware of the SHIFT data from the outset, I also considered other approaches to data collection which could also yield useful data related to understanding risk assessment in SFT. One idea which was considered was developing an interview schedule and to interview therapists who had worked in the SHIFT study in order to understand their assessment process. This approach was particularly appealing as I would be able to have some control over the questions asked, and would also be able to encourage the interviewees to expand on particular points of interest should they emerge during the interview process. As the researcher I would also be able to conduct the interviews and begin thinking about the data ‘as it happened’. As has been argued throughout my introduction, the limitations of this approach, particularly in process research are many.

With these considerations in mind a Grounded Theory approach was identified as the best way to approaching the research question. The early coding processes are key in teasing out the key themes within therapy in order to understand what is happening and the adoption of a social constructionist approach as described in the GT can further increase understanding of how these things are achieved.

Grounded Theory

Grounded Theory (Glaser & Strauss, 1967) is a form of qualitative data analysis which provides a systematic means of analysing data allowing the researcher to create their own theory which is “*grounded*” in the data (Charmaz, 2006). GT is an inductive process and was developed by Sociologists Glaser and Strauss, originally as a means of exploring death and dying in hospitals in the United States. A key distinguishing feature of GT is that data is collected and analysed concurrently. With regards to the SHIFT data, although the video had already been collected, I was able to carry out analyses as I was watching these tapes for the first time which allows a degree of concurrency in this respect. Evidently, this method does not allow myself as a researcher to fill-out the data

by asking further questions or encourage participants to expand on topics further in the moment, however, this can also be considered to be a relative strength as I was able to view the data as-is and remove this potential opportunity for experimenter bias. In other words, the sessions occurred in real-time, without the influence of the researcher. GT also makes use of constant comparison; ongoing development of theory throughout collection and analysis; and using memos to strengthen and define categories and their relationships to one another (Glazer & Strauss, 1967; Glaser, 1978; Strauss, 1987 in Charmaz, 2006).

Rationale. Following the considerations for other qualitative approaches described above, GT was identified as being the most appropriate method of analysis for the data. The aim of the current study is to understand the processes involved in assessing risk in SFT, particularly how the therapist works and how they respond to changes in their understanding of the risk in therapy. As of writing, there have been no published studies which have explored and described the process of risk assessment in SFT which suggests that there would be limitations in attempting to approach such a study from a quantitative perspective. Furthermore, across the literature authors have highlighted the similarities between the skills and approaches used in GT and those employed by therapists in SFT (e.g. Rafuls & Moon, 1996; Burck, 2005).

My background in psychological therapy has led me to a perspective of social constructionism. I hold the view that meaning is constructed between individuals and that 'reality' is a construction which is created by circumstance, and may be influenced by individual differences such as an individual's life experience and linguistic flexibility. Within my description of my methodology I have recognised that as a researcher I am also influenced by these aspects. Therefore I have outlined how my own experiences (be they professional; social and/or personal) in order to understand my own relationship to the data.

Methodology

In the following section, I will outline the process of my analysis using examples where it is deemed appropriate. It is important to note that the following description of my coding process is presented in a seemingly stepwise progression as I feel this best encapsulates the process in an easy to follow manner for the reader. However, it should be acknowledged that in practice, this process was fluid, and that I would jump between each level of coding in response to emerging themes within data.

It is generally recommended that data analysis and data gathering occurs simultaneously in traditional GT, however, as it transpired, the therapy videos had already been recorded prior to this study which meant that this particular aspect of GT was not possible. As such, prior to the transcription of the sessions I familiarised myself with the therapy videos by watching each session several times over. This was to both ensure viability of both the visual and audio tracks and to allow me to familiarise myself with the participants and the set-up of the therapy. At this point I began to note down any initial thoughts I had about each session, what the therapist was doing and/or any processes I noticed. I was able to return to my supervisors with these notes and seek clarification for any technical (i.e. SFT related queries) and/or analysis related questions that I had. I felt that this process was an adequate compromise for the concurrent analysis described above and that it allowed me to become familiar with the data as I would if I had collected it myself.

Transcription. Soon after, I transcribed the first three therapy sessions personally. Again, this allowed me to further engross myself in the data and to become familiar with it. I also continued making notes on what I was noticing which were taken to supervision. For timing purposes, the remaining four sessions were then transcribed by a University of Leeds (UoL) approved transcriber (see Appendix III for the UoL transcribers' confidentiality agreement). As detailed above I also viewed these sessions and made notes on them prior to them being transcribed.

Memos. Throughout the process of analysis, starting at the transcription stage, I kept a journal of memos (Glaser, 1998) which enabled me to track my thinking behind the coding decisions I was making. These were done in an A3 booklet with several pages dedicated to individual sessions, as well as pages dedicated to the process of the therapy. Due to the abstract nature of the data I was trying to code, I also found it helpful to draw out processes in visual form as this allowed me to better understand how codes may be related to one another. From these initial thoughts, I then began looking more closely at the data and began coding the transcripts in a line-by-line manner.

Constant Comparison. Charmaz (2006) describes the process of constant comparison as being core to GT research as it allows the researcher to compare their analysis to the rest of the data (Urquhart, 2013). In the early stages of the analysis I began working on a single therapy session with the processes involved in the risk-assessment at the forefront of my thinking. I thought about what the therapist was doing beyond the questions she asked and identified the responses the young person gave in response to this. When working through the subsequent therapy sessions I was able to compare and contrast elements of the therapist's approaches between and within each session and how this impacted on the process. By doing

so I was able to look at the intricacies of individual exchanges within sessions whilst simultaneously developing a wider narrative that appeared across sessions.

Coding. I will now describe the process I went through in order to code my data. Table 2. below has examples from each of these stages as well as where in the original transcript data they relate to.

Open coding. My first task in coding the data was to begin the process of open coding which was done on a line-by-line basis as described by Charmaz (2006). This was done directly onto a Microsoft Word version of the transcripts utilising the Insert Comment function. By recording these codes electronically I was able to highlight specific elements of the data such as full sentences, or individual words as well and ensure the centralised storage of my notes and ideas behind each of my coding decisions. Further, keeping electronic notes in this way allowed me to easily share my codes with my supervisors who could also add their own notes to the codes/data, again ensuring that our collective thought processes were kept in one place and could be referred to more easily as the analysis progressed. A difficulty I encountered at this stage was that I had perceived these codes as an end-point of my analysis, rather than a part of the process of understanding the data. Furthermore, my supervisors and I noticed that the language I was using in my codes perhaps reflected my own experience as a therapist. During early iterations of my open coding we noticed I was using words such as ‘assessment’, ‘boundaries’, and ‘symptoms’ which did not reflect an emergent quality to the data. Supervision in these early stages was key in helping me understand when this was occurring, and well as being important in moving away from my role as a therapist, to the role of researcher. This was reflected in subsequent rounds of coding which involved the increased use of verbs. Table 2 below details an example of these codes.

Focused coding. My next task was to try and make sense of my open codes in a way that facilitated the synthesis of broader themes emerging from the data (Charmaz, 2006). I found that my focused codes reflected both *what* Wendy was doing and *how* she was doing it and that in some cases codes spanned both of these categories for example ‘clustering questions’ (see 5.6 below). I found it useful to synthesise the ‘what’ elements first as these provided the substance of the therapy sessions, with the hows following more naturally as I filled in the gaps between by reflecting on the conditions Wendy created in order to do what she was doing.

Table 2.*Examples of Coding*

<u>Transcript Extract</u>	<u>Open Code(s)</u>	<u>Focused Code(s)</u>	<u>Theoretical Code</u>
<i>W: Yeah that's working fine Kevin, that's lovely thank you [Wendy takes the paperwork from Dad and places it on the floor] so you have been here before in this building but not in this room when you came to, was that when you came for the follow up? After you had been in hospital?</i>	Communicating unfamiliar customs	Adopting a conversational tone ^h	Finding Out
	Setting the scene	Finding meaning together ^w	
<i>H: Twice when I was in hospital I can't remember how far away it was, the follow up was on the following week...</i>	Talking about hospital admission		
<i>D: The follow up was on the Thursday after and we were down stairs</i>			
<i>H: Yeah because I didn't know upstairs existed.</i>			
<i>W: Mm, so I haven't spoken to the doctor that you saw, but I have got some notes that he has sent through from the time that he saw you, you when you were in hospital...but I haven't actually got any notes from the time you after that they must still be in the pipeline on the way to us so I feel that I know some things that you have talked to him about but there are things that I don't know.</i>	Communicating not knowing	Encouraging family to be experts of their own experiences ^h	Negotiating balance
<i>H: I didn't really tell him what happened.</i>	Opening up about communication		
<i>W: Mm, so maybe...</i>	Continuing discussion		

H: Did you? [looking at Dad]

Involving Dad

*D: It depends what you mean by what happened?
At what point are we at?*

Communicating confusion

H: Where I had to go to a doctor.

Clarifying confusion

*D: We have a, in mine and my wife's eyes we have
a trigger point of what we think the issue of
everything*

Establishing a trigger

Talking about risk^w

Risk Assessment

Notes: ^w = 'what' code, ^h = 'how' code.

Theoretical Coding. Once I had my focused codes, I then began the task of theoretical coding. Charmaz (2006) describes this stage as the identification of relationships between focused codes and helps to make sense of the data, rebuilding these to create my theory. These broader, theoretical codes were used to build my theory/model presented in Figure 3.

Creating the Model. Initial difficulties I encountered in modelling my data included how best to conceptualise these abstract processes in a visually useful format. The key difficulty being that some processes occur simultaneously, and that in response to changing dynamics in the room Wendy's and the family's approaches may change subtly and quickly. Early versions of my model included a spiral structure as it was felt that this best reflected the back and forth nature of Wendy's approach to assessing risk and showed it as a semi-fluid process. However, I felt that this appeared too linear and did not capture the concurrent nature of some of what was occurring in the session. As described above, it was also important to include the family and their contribution to the sessions, as later in the therapy Wendy encouraged them to take on some of her roles as therapy came to a close. The final model is presented in Figure 3.

Quality Assurance in Qualitative Research

Throughout the analysis I employed a number of strategies which would enable me to ensure the credibility of my approach. I will now describe these processes and my rationale for doing so.

Researcher Reflexivity. As I have alluded to above, I have had to be mindful of my own position, and to consider elements of myself which may likely influence my process as a researcher. These aspects are described below in order to contextualise my own leanings and how these may influence my approach to the analysis.

Researcher Demographic. I am a 33 year old, white male and I identify as coming from a working-class background. Throughout the duration of the study I was undertaking a Doctorate in Clinical Psychology at the University of Leeds of which this project makes up the doctoral thesis requirement.

Clinical background and interest. I am currently in my third year of clinical training and have experience in working with adults, children and adolescents, and families in a number of clinical populations. My decision to undertake research in this particular area is based on my clinical interest in managing, and assessing risk, particularly in identifying ways in which this can be done in a collaborative and useful way which enables service users to feel included and unashamed. I have worked in areas where risk is at the forefront of many care-related decisions and I have come to appreciate how some decisions may be made reflexively

rather than reflectively. I feel that risk assessment is an important aspect of the health-professional's role particularly when working with high-risk patient groups. I have worked in outpatient settings whereby my contact with service users is fleeting, and in some cases the need to ensure a persons' safety between sessions has been paramount.

Model Credibility. The finished model was also shown to three Clinical Psychologists with experience working with families within a family therapy context with the view to getting feedback on the processes within the model and on how understandable the model is. This was done as a stand-alone model and with a descriptive narrative of each aspect of the model. This feedback allowed me to change some of the processes to make them more accessible, with each Psychologist being able to recognise aspects of and interpret the model both with and without the narrative.

Potential areas for bias. I remember my early experiences of risk-assessment as both a Trainee and Assistant Psychologist to be quite challenging with very little in the way of literature pertaining to the process of how risk assessments are completed. It is possible that I may have focused on the more actuarial aspects of risk assessment, for example closed questioning, as these feel 'safe' for me at the expense of the processes of such sessions. Therefore it was essential that I spoke about these concerns in supervision with my thesis supervisors. Furthermore, throughout the study I was mindful of being a 'researcher' rather than a 'therapist'. In this sense, in early attempts at coding, I found myself attaching therapeutic terms to my codes such as "assessment", "actuarial" and "boundaries" which were largely unhelpful in describing the process which were emerging during each session. Although this is an inevitable side effect of the analysis process I utilised supervision in order to identify when this was occurring and draw my attention further into the process in lieu of my concrete descriptions.

Supervision and Further Support. My experience of qualitative research, up until beginning the project was fairly limited and was identified as an area I would benefit from further guidance. Similarly, my experience working in Systemic Family Therapy was equally scant and an area I identified as needing support in.

Supervision. Throughout the project I attended supervision sessions with an SFT therapist and GT researcher who were also my project supervisors. This allowed me to ensure that my approach to the research, and my interpretation of what I was seeing within the sessions could be thought through and tweaked when needed. Supervision sessions also

allowed me to ‘think aloud’ and talk about my reasoning behind my coding strategies and the development of hypotheses. Face-to-face supervision occurred on a monthly basis for an hour, with annotated transcripts being sent more frequently for review by my supervisors in between these times. The Clinical Psychology training programme at the University of Leeds has also provided qualitative research methods workshops, of which GT was demonstrated, that I have attended. Furthermore, the training programme also provided specific teaching days on family therapy.

Peer support. I also received support from other Doctoral Trainees who were also utilising a GT approach in their theses. By doing so I was able to check my techniques with others and garner support outside of my more formal supervision sessions. Importantly my peers were completing projects with topics unrelated to mine which ensured my analyses of the data were not influenced by others.

CHAPTER 3: RESULTS

Before I continue and begin discussing my results in a more narrative-led way, I shall discuss the model of Wendy's risk assessment that emerged from the data across the therapy. Following this, I shall then describe my coding strategies with examples from the data to highlight these processes within the context of the data.

The Seesaw of Systemic Family Therapy: an analogy

The data revealed what appeared to be a 'balancing act' through which Wendy attempted to complete her therapy and risk assessment. The analogy assumes that throughout the therapy, Wendy, Hannah, Mum and Dad's relationships with one another are in differing states of balance. By this I mean each individual within the therapeutic relationship has their own goals, languages and expectations of the therapy. Within Figure 3. I have highlighted that there are three balancing acts at work throughout the therapy:

- 1) Hannah and her family's shared goals with Wendy.
- 2) Hannah's goals with her parents.
- 3) Mum and Dad's goals with one another.

When these goals are not shared, it causes an imbalance which prevents therapeutic intervention and/or risk assessment. Processes emerged from the data in which Wendy attempts to promote balance within each of these relationships in order that within the therapeutic relationship there are a set of shared goals in order for the assessment/therapeutic work to continue.

A Model of Wendy's Risk Assessment processes. Traditionally authors present their qualitative results prior to their completed theory/model. I have decided against this for the following reason(s). As I have stated in Chapter Two, I began thinking about my theory/model concurrent to the later stages of my analysis and at times this felt like I was developing a 'map' of my data as I brought together my theoretical codes. As I had found this useful in understanding how the data fits within the context of my theory, I thought I would invite the reader to do the same. By presenting my model prior to my analyses I hope that it may be used as a referential 'map' in order to understand how the analysis below fits within the theory/model. My focused and theoretical coding suggested that there were (often multiple) processes occurring simultaneously and I felt that this could best be conceptualised by semi-concentric circles. The final model can be likened to Bronfenbrenner's (1979) Ecological Systems Theory model in that particular aspects of the risk assessment occur within and between different levels and at different and/or the same time(s). The solid box which

surrounds the inner processes represents the work Wendy and the family do in order to first approach the seesaw.

These processes allow Wendy and the family a starting point with which to begin. From here Wendy and the family negotiate balance within the relationship. The dashed lines of this particular process represents the idea that the movement between this negotiation and approaching the seesaw is non-linear, and that both of these processes can be occurring simultaneously. The negotiation of this balance then allows Wendy to elicit further information from the family. Again, this box is represented with a dashed boundary as negotiation and eliciting of information can occur at the same time with changes between each process being discreet at times. An intervention, again represented with a permeable box occurs both within negotiation and eliciting further information. This could represent the idea that the act of Hannah talking about her experiences of being bullied could in fact serve as an intervention as it has allowed her to perhaps see things in a more objective manner. Risk assessment is also represented within this particular area as in eliciting information from the family, Wendy is able to formulate this risk and act accordingly.

Narrative Accounts of the Data/model

With this model in mind, I will now begin to discuss the processes represented within them in more detail, using examples from the data to illustrate my points. I feel that the examples I have used best illustrate the processes I have coded, however unless otherwise stated, these appear across sessions.

Abbreviations and Notes on Transcript Examples. The following is a list of abbreviations which are used throughout the data extracts in the following results section:

H ‘Hannah’ – young person, service user.

D ‘Dad’ – Hannah’s Dad.

M ‘Mum’ –Hannah’s Mum.

S ‘Simon’ – Hannah’s brother.

W ‘Wendy’ – family therapist.

K ‘Kevin’ - reflecting team member.

L ‘Leanne’ - reflecting team member.

[...] – Text omitted from the transcript.

[Laughs] – Non-verbal information cited for context.

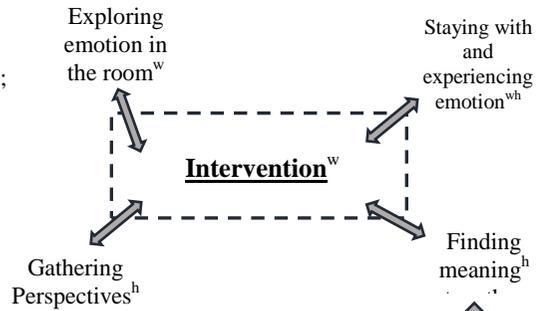
[*] – Speech incomprehensible from the original video.

Onto the Seesaw^h

Negotiating Balance^h

Finding out^{wh}

Facilitating Indirect Communication^h;
Switching Focus: Emotional vs. Factual;
Information^h; Gathering Perspectives^h;
Clustering Questions^{wh}; Exploring
Consequences of Previous Session^{wh}



Exploring Significance of endings^{wh}

Exploring Therapeutic Change^h

**Off the seesaw –
Independence from
therapy^w**

Risk Assessment^w

Developing and identifying goals^h; Encouraging the family to
be experts of their own experiences^h; Developing a shared
language for difficult conversations^h; Preparing for
surprises^w; Developing a mutual pace^h; communicating
rationale for interventions^w; finding meaning together^h

**Moderating
Emotion^h**



**Family
Moderated
Emotion^h**

**Moderating
Emotion^h**

RISK-RELATED GOALS
LANGUAGE
GOALS FOR THERAPY

RISK-RELATED GOALS
LANGUAGE
GOALS FOR THERAPY

RISK-RELATED GOALS
LANGUAGE
GOALS FOR THERAPY

Hannah

Mum & Dad

Family

Wendy

Adopting a conversational tone^h; talking about talking^w; keeping Mum in mind^h

Key
^w = What process
^h = How process

Figure 3. Model describing Wendy's processes in risk assessment through therapy 46

1. Approaching the seesaw – creating the conditions for talking

A theme which emerges from the data is Wendy's approach to creating suitable conditions which might allow for open discussions to occur within the family, and amongst Wendy and the family. These processes appear to serve the purpose of creating safety in the room in a way that the group can begin negotiating aspects of the therapy such as goals, language and expectations. As the therapist, Wendy sits within a socially constructed position of power within the therapy in that she is the 'expert healthcare professional' and the family are 'service- users'. The data suggests that Wendy creates conditions which appear to balance this power dynamic which gives the impression that each group member has equal footing within each session prior to any conversations occurring. Ways in which Wendy seeks to establish balance are by creating a conversational tone, talking and exploring previous experiences of therapy and also seeking to involve Mum's perspective despite her absence.

1.1. Adopting a conversational tone. From the beginning of each session, Wendy engages with the family in a way that appears conversational in tone. This facilitates creating a seemingly informal atmosphere in which the group are potentially about to discuss quite difficult topics. In the examples given below, Wendy's conversational approach allows the group to open up about different topics ranging from triggers to planning for the future. Wendy uses her own position in the relationship to steer the family towards these topics, however ultimately they appear to be initiated by the family. This is particularly true of session one, as this is the first time that Wendy, Hannah and Dad have met in person and the first tentative steps are taken towards discussing Hannah's self-harm.

[Session One]

W: Yeah that's working fine Kevin, that's lovely thank you [W takes the paperwork from D and places it on the floor] so you have been here before in this building but not in this room when you came to, was that when you came for the follow up? After you had been in hospital?

H: Twice when I was in hospital I can't remember how far away it was, the follow up was on the following week...

D: The follow up was on the Thursday after and we were down stairs

H: Yeah because I didn't know upstairs existed.

W: Mm, so I haven't spoken to the doctor that you saw, but I have got some notes that he has sent through from the time that he saw you, you when you were in hospital...but I haven't actually got any notes from the time you after that they must still be in the pipeline on the way to us so I feel that I know some things that you have talked to him about but there are things that I don't know.

H: I didn't really tell him what happened.

W: Mm, so maybe...

H: Did you? [looking at D]

D: It depends what you mean by what happened? At what point are we at?

H: Where I had to go to a doctor.

D: We have a, in mine and my wife's eyes we have a trigger point of what we think the issue of everything

In the preceding excerpt, Wendy initiates an informal discussion about the building the group are in by asking Hannah and her Dad whether they have been to the building before. Within this opening question Wendy specifically mentions “*hospital*” and Hannah’s follow-up appointment which primes Hannah and her Dad to begin thinking about these topics. As mentioned above, this is an example of Wendy steering the topic of discussion. Hannah and her Dad subsequently confirm that they have been to the building for a follow up after Hannah’s admission, but that they were unfamiliar with the upstairs rooms. Following on from the discussion about familiarity and linking to her mention of hospital, Wendy then communicates to Hannah and her Dad that she has not spoken to Hannah’s doctor, that she has seen some notes from the time of admission, but that she has not seen any notes for the period following discharge. At this point Wendy has communicated that her understanding of Hannah’s problems may be ‘second hand’ as what little she knows about her has come from her doctor. Hannah responds to this by saying that she “*...didn't really tell him what happened*” which suggests that Wendy’s perspective may be incomplete and may need to be elaborated on and at this point Hannah and Dad are placed in a position in which they are experts of their own experiences (see 1.2. below). Wendy appears not to be an ‘all-knowing’ healthcare professional. Hannah and her Dad discuss whether Dad had told the doctor “what happened”. Wendy provides little input at this time and continues to follow the family’s lead as to what point they are at. Dad then mentions a “*trigger*”: “We have in mine and my wife’s eyes; we have a trigger point of what we think the issue of everything is”. From this seemingly innocuous conversation about whether the family have been to the building before, Wendy has already identified an important risk-related piece of information; that Hannah’s Mum and Dad feel that there is a particular trigger to Hannah’s overdose.

In the opening exchanges of the first session it is also worth noting that Wendy discusses very little of what therapy is and how it will look to the family as it proceeds. Wendy talks about the earpiece through which Kevin (who is a member of the reflecting team) will be communicating to her, however she gives little detail as to what he may be conversing with her about: “*he may ask me about such and such*” nor does she talk about the nuances of therapy. There is a paucity of content from Wendy, particularly of an instructional or explanatory nature and her input early in the session appears to be made in a casual or offhand manner and appears informal.

This style of communicating is also demonstrated in session three which is the first time Hannah's Mum appears in the session:

[Session Three]

W: She's taking her shoes off as well...It's that kind of day isn't it.

[M is filling in forms]

W: it's the 20th today.

W (to M): It's good to see you here as well as the two of you (D and H).

[...]

W: so you've been working?

M: yeah, unfortunately I drive, I drive a van that's full of fresh food and pies

[H puts her head in her hands and laughs]

M: what's up don't you like my van anymore?

H: It's a nervous laugh! It's not that it's just the whole [gesticulates with her hands towards her Mum and Dad]

M: So the daughter's on holiday and there's so many people on holiday because of the family wedding, I can't get the time off. Like D, he works a lot and it's a big company.

W: yeah, yeah. I'm really glad you have made it today, that's really good, and particularly what's happened in the past week, um. It felt really important to me to...

M: Yeah

W:...meet up with you and for you to become part of this [pause] um...so..I would, the last...

H: (laughs)

M: am I making everybody feel silly because you're used to your (gesticulates towards H and D).

In session three, in which Mum attends for the first time, Wendy appears to return to the conversational style seen in session one. Wendy begins the session with an offhand remark “*she's taking off her shoes[...]*”. Wendy then focuses on Mum by asking about work to which Mum begins talking about how busy she had been recently. Wendy follows this up by welcoming Mum and communicating that she is glad Mum could make it to the session today particularly considering that Hannah has recently been hospitalised following another overdose, although she does not mention this directly. This is done in a similar way to the “*hospital*” remark Wendy made in session one as it appears to prime the family into thinking about the past few weeks, and that this may be a potential discussion for the day. As Wendy talks Hannah begins to laugh to which Mum communicates feeling uncomfortable. The family then go on to talk about Hannah's laughing (this is described later in ‘preparing for surprise’

2.4. below). Again, this seemingly informal start has allowed Mum to contribute early on in the session in that she has been able to communicate to the group that she feels uncomfortable. Wendy intervenes at this point by talking about why Hannah may be laughing.

In session six Wendy returns to a more informal approach to starting the session and discusses Hannah's upcoming driving test. As this session appears towards the end of therapy in session six, talk about the future and jobs emerges from Wendy's informal discussion:

[Session Six]

M: [to H] I think you need to tell her this date and remind her of your test date.

H: [after accidentally kicking D] Oh, sorry.

W: You've got a driving test?

H: Yeah, I passed my theory first time around.

W: Oh, you good girl! That's great-

H: Yeah.

W: Because that's quite tough, isn't it? Doing-

[Interrupted by someone entering room; M, H and D greet them]

H: Yeah, I passed that first time around and I was crying when I went in and crying when I came out. When I got my results I was I cried and screamed even more. [W, M and D laugh].

W: You're not a very emotional person, are you? [Laughs again]

H: I am.

W: And when's the [makes a motion of driving a car]

H: 12th of December.

W: Right. So what have you got to drive then, when you pass?

H: It's- oh, nothing. [Looks at M and D who both laugh] I haven't got anything to drive when I pass.

M: It's such a hard life isn't it?

H: Well, everyone else is getting one.

M: Would you like a little scooter, a push along?

W: It's so expensive isn't it? The insurance is the killer.

D: [nodding] the insurance.

H: I'd buy my own car.

M: You need to be working full-time to pay for it, it's-

W: But once you've got the licence, it can be useful for jobs can't it?

D: It's like I said to her, once you've got your licence they can only take it away if you're stupid.

M: Uh- huh.

D: If you do what you're supposed to do, you've got it for life, you know, until they find you not fit to drive or whatever, and that's it.

In Session seven, Wendy makes a direct reference to her lack of this type of talking:

[Session Seven]

W: [...]I've just launched in at the beginning and not asked you all how you're doing. [M and D laugh slightly] Do you want to get straight in with thing you want- are there thing you want to think about today?

M: No, I thought things were going okay until Hannah said last week she had to go back on to antibiotic- [to Hannah] was it viral, for your throat were it? No, your shoulder that was it?

D: Shoulder.

M: Uh-

H: My shoulder dislocated in my sleep last week so they had to trust me to get tablets out because nobody was around in the day and I needed the tablets to keep the pain under control. Um, [pause] it's...

M: Wasn't it just you said you were glad that we just left the required dose rather than extra because you still feel like you can't trust yourself?

W: Right. So you thought Hannah was okay so that was a bit of a surprise for you to hear?

As a session which appears later into the relationship, Wendy notices that she is moving things forward which may be out of the family's comfort zone. Wendy goes back after her short talk about beginning to end the therapy together and asks the family if there is anything they would like to talk about (see 2.1. below). This allows Mum to begin talking about her concerns surrounding Hannah's dislocated shoulder and that she has started a new set of medication. Similarly to the examples above, the family quickly begin talking about their concerns which gives Wendy an idea of the current risk posed to Hannah's safety. Furthermore, this discussion also reveals a number of other life events that the family feel have been emotionally quite difficult for Hannah. In the context of the session, Wendy's slowing down and adopting a more conversational approach to the session enables the family to begin talking about difficult subjects relatively quickly.

Summary. The conversational tone and creation of an informal atmosphere permeates the seven sessions; however the degree to which it is employed changes. For example, in session two, this 'small talk' appears to diminish somewhat in that Hannah and her Dad are more familiar with therapy and Wendy appears to begin talking about more focused topics from the start of the session. However, as other members of the family begin to join the group, Wendy returns to the more conversational approach which appears in session one in order to facilitate their integration into the group. Although the therapy is aimed at understanding Hannah's self-harm, Wendy does not mention this at the start of the therapy. Instead, these

discussions are held later in the sessions when the family are seemingly more relaxed and secure. The conversational approach also appears to promote a sense of collaboration, as Wendy follows the family's lead, i.e. she picks up on and explores the topics that emerge rather than impose her own agenda.

1.2. Talking about Talking. During the early stages of sessions one and two Wendy involves Hannah and her Dad in a direct discussion about Hannah's previous experiences of therapy and what has worked for her in terms of how she communicated with her therapist. Wendy also explores the 'talking' that Hannah does with the rest of her family. Before Wendy proceeds to talk about difficult topics, she attempts to identify preferences for Hannah, particularly what the "right" kind of talking may look like. Through this, Wendy begins to understand Hannah's willingness to talk about her difficulties in the current therapy. It also gives Wendy information about how Hannah is communicating her experiences of therapy.

1.3. Keeping Mum in mind. Although Mum attends most of the sessions, I feel that it is important to mention how Wendy keeps her in the group's mind in the first two sessions during which she is not present. In the first two sessions Wendy finds out that Hannah's Mum is unable to attend due to her work commitments. It is established early on that Hannah's Mum intends to attend future sessions and Wendy attempts to facilitate her attendance by arranging for her to attend a subsequent session. Hannah's Mum is kept in mind, and despite her absence, is still part of the session:

[Session two]

D: I think it would be interesting if Mum comes 'cause it is alright us trying to explain but it's totally different when you are in the room with you so I think about whatever else.

W: Yeah well we will take our time with her to get her started when she comes, I really glad she is coming, so we have got that time booked so do you want to put another one in so you know the one after that is?

The talk about Mum and her absence in session one and two enables the group to keep her present and part of the group in lieu of her physical absence in the session. When Hannah's Mum finally attends in session three, it is as if she is already part of the group.

W: ...It's different for different people, how did, did your Mum hear about what we were talking about, about sessions?

D: Yeah

W: What did she say? If she was here about you know that first session what would she have noticed afterwards or what would she have

D: Erm, she would have probably noticed how close we were 'cause we have tried to explain to her as much as possible kind of talked about what we talked about what had gone on and everything.

W: So that was different from when you are there though trying to explain.

D: I think she probably had some regrets she can't get here when we found out that she can't get here because of work so hopefully when she is able to come on the next one then you know she'll get a different feel for it.

W: Do you think she will come to the next one?

D: Yeah we booked her one in we did it from that time for that reason.

Summary. From the data, there emerges a number of interconnecting processes represented in the above codes which describe Wendy's approach to getting the family talking. These appear primarily focused on engaging the family and removing a potential imbalance of power by allowing the therapy to feel like a conversation rather than a list of 'things to do'. Furthermore, this approach also allows Wendy to move her focus between the therapeutic and assessment elements of their relationship. The examples cited above show, for example, how a seemingly innocuous conversation about having been to the building before can lead to a more in-depth discussion about a potential trigger to Hannah's self-harm. Once these conditions have been established, Wendy's approach appears to change toward a more focused one, specifically into a negotiation of balance within the therapy.

2. Negotiating balance within therapy

With this preparation done, Wendy, Hannah and her family can now begin to think about the more focus aspects of their therapy. Within the data a number of processes emerged which were coded as being 'negotiating balance'. In the following processes Wendy and the family engage in a collaboratory process in which shared understanding of each's goals, language and expectation is attempted. Wendy also opens the floor to the family, and encourages them to be experts of their own experiences. Other potential for imbalance is also explored in that Wendy thinks about Hannah's parents' ability to hear potentially difficult information about their daughter, and prepares them for 'surprises' that may occur. This negotiation appears within the context of the processes described above, in that it occurs conversationally; it is done using the "right" kind of talking; and balance is also negotiated in the absence of Mum as her views (goals, language, expectations) are also discussed between Hannah and her Dad.

2.1. Developing shared goals. One way that Wendy attempts to maintain balance within the therapy is the development of shared goals. These goals appear to either be session-based, in that the group develop goals to be addressed within a particular session or more global goals which persist across the course of therapy. Within the data there are instances

throughout the course of therapy in which Wendy allows goals to emerge from the conversations that the group have and these emerge in an organic fashion. Contrary to this, there are times where Wendy is more direct with what her goals are particularly when they are in response to the changing levels of risk. This example from session three details the latter:

[Session Three]

W: erm, I wonder where we should start, what do you want us to, what you want to get out of today?

H: I want my Mum to see the timeline, because it's very important that she sees it, recently it's just like ... because that is pretty much a summary of the majority of difficult things that happened starting with, like when I was 13 and I []*

M: yeah, is that that letter that I read

D: yeah it will have been by then

H: Yeah read a letter

W: you've got the letter?

[EXTRACT CONDENSED FOR BREVIETY]

M: yeah, I've read it

W: so, okay, so you're thinking that you want your Mum to know and want to see the timeline what about you two, what would you like to get out of today, because this is our session three and we've got six months of work with, with you.

M: yeah

W: if that's what you want, so, it's like, what's the most important thing for you today, as it won't be the last time we see you, and we can't do everything all at once so what can we do today considering what has happened in the past week...what would be really important, what would you want us to, what would like to get out of today?

D: I'd like to look at the timeline, that erm, H went out of the room the last time, []*

W: uh huh

D: it needs discussing because it ties into last week. Whether or not H will be ready to talk about it is a different matter. Because at the time and everything [] and we can't skirt around it.*

W: that's, that's, that's a clear bit for Dad then

D: you can't skirt around it, you know what I'm saying (to Hannah)

W: and do you know what caused thinking about...

M and D: (together) yeah

W: (to Mum) and to you M what would you like to get out of today

M: erm, before last week it would have been just about...getting us all on the right track and... getting H's way of thinking to how she looks at a lot of things so that she's not thinking the worst about how she sees a lot of things, erm, but since last week and being in hospital I'd say that [LONG PAUSE, BECOMES TEARFUL] I'd say it's more trying to see why she felt the way she did to take tablets again, erm...to really sort of try and, help her get on the right road so that she isn't feeling like that.

The example above demonstrates a more direct negotiation of goals in that the exchange begins with a direct question to Hannah as to what she would like to discuss in that particular

session. Hannah says that she would like Mum to see the timeline that she and Wendy completed together in session two. Wendy then turns her question to Mum and Dad, asking them directly what they would like to achieve in that particular session. Within this, Wendy also ensures that the family are aware of the amount of time that they have together in therapy suggesting that there is no rush to discuss everything (a form of mutual pacing 2.5. below). Wendy shares her own goal of wanting to discuss what “happened in the past week” (Hannah’s overdose) and highlights this as being important. Dad agrees with Hannah that he would also like to look at the timeline as well as discuss what happened when Hannah left the therapy room in the previous session (this is discussed in 5.7. below). Wendy asks the family whether they know what had caused this (talking about Hannah’s miscarriage) to which they both reply that they do. In this sense Wendy is preparing the group for surprises (see 2.4. below). Finally, Wendy turns towards Mum and asks what her thoughts are for this session. Mum’s goal appears to be more direct in this instance in that she feels that her goals may have changed from what they may have been at the last session. Talking about these topics appear to cause some emotion to surface in the room and the course of the conversation changes into an intervention in which Wendy encourages the family to moderate their own emotion (see 4.3. below). The group continue to talk about Mum’s concerns about how things were “on the right track” before the overdose last week and how Mum is struggling to understand how Hannah got to the place that she is in. Together, with a direct question to the family, and by highlighting the importance of discussing Hannah’s most recent overdose, the group appear to have established a shared goal for this session and that they agree to talk about the circumstances which occurred over the preceding few weeks since the last session.

Summary. In early sessions, in keeping with the conversational tone of the session, Wendy adopts a more implicit approach to developing goals in that she allows the family to lead the topic of discussion and that goals emerge from these conversations in a natural manner. When the level of risk changes, Wendy becomes more explicit in her setting of goals and directly talks to the family about what her goals are. However, this is still discussed with Hannah, a rationale for this change is clearly given and a familiar means of gathering information (a timeline) is used.

2.2. Encouraging the family to be the experts of their own experiences. The data also reveals a process whereby Wendy encourages the family to become experts of their own experiences. This example demonstrates this process in a more subtle way:

W: Mm, so I haven't spoken to the doctor that you saw but I have got some notes that he has sent through from the time that he saw you, you when you were in hospital but I haven't actually got any notes from the time you after that they must still be in the pipeline on the way to us so I feel that I know some things that you have talked to him about but there are things that I don't know.

H: I didn't really tell him what happened.

W: Mm, so maybe

H: Did you? [Looking at D]

D: It depends what you mean by what happened? At what point are we at?

H: Where I had to go to a doctor.

D: [To W] We have a... in mine and my wife's eyes we have a trigger point of what we think the issue of everything

W: Sorry, just for you to know what I know to make it easier. I know that about 18 months ago you had the experience of being raped by a friend's brother and that you took that to the police, and then that wasn't pursued because the young man denied and your young friend kind of went along with his story and so you were left with it. So that's what I have picked up. I thought it might be helpful that you know I know that I don't know if that's right but that's what I've, so I don't know if that's what you've...

D: For us that is where it all started.

In the above extract, Wendy begins talking about what she 'does' know as she talks about how she has seen notes from Hannah's doctor from the time she was in hospital, however she also tells the family that she does not have any notes from after this time and encourages the pair to discuss this further from their own perspectives. This exchange starts with a statement rather than a question to which Hannah adds that she did not tell her doctor what happened.

Following this Wendy communicates her understanding of the situation, making reference to the rape that Hannah experienced and the circumstances following it. Again, this takes the form of a statement rather than a question which invites Hannah and her Dad to fill in the gaps. Wendy shows understanding and encourages them to be experts of their own experiences. Wendy communicates that she knows about the rape and some of the circumstances for Hannah after this experience which brings this to the discussion. Dad then adds "*For us that is where it all started*", leading Hannah and Wendy to the shared understanding, that from Dad's perspective at least, this is where Hannah's difficulties all started.

Within the therapy, Wendy encourages talking between family members in establishing their expertise for relational aspects and characteristics of the immediate family. The following excerpt is used to highlight this process:

[Session three]

W: but you're alright?

M: yeah, I've always been a blubberer

W: have you?

H: [laughs] a blubberer. We're like a family of fish. [...] King prawn over here...

D: King prawn?

H: a goldfish over there

W: mm

H: an Angelfish here

W: (laughs)

(H holds M's hand)

D: angel?

H: yeah. An angelfish M (laughs) a black and white []*

W: which one's the angel?

H: ...me Mum. The angelfish is a black and white fish, erm...

D: oh you're on about a tropical one?

H: yeah, I'm on about actual fish

M: like a tropical fish?

W: so your Mum's a black and white...

H: angelfish

W: [...] angelfish, what are they like?

H: they're just like...calm and peaceful and soft.

(M, H & D laugh)

W: and which one are you?

H: I'm the gold fish.

W: what are goldfish like?

H: memory span of a goldfish

D: attention span of 30 seconds

(H laughs)

H: and me Dad's king prawn.

W: and what's a king prawn like?

H: really strong shell...

W: ...strong shell...

H: mushy inside, then mushy inside. [] and I just look at them and want to be sick... but that's not like I am with you, that's just the opinion of the fish...*

(H laughs)

W: so that's your family as fish?

H: no we've got our Simon...

W: yeah

M: I never thought you pictured us as fish

H: I don't, it's just you came out with "blubbering".

[...]

H: Simon is a, I don't know the name of them, they're about this big (shows size with her fingers), but he is only little, that, this long and this thin and they've got a red blood straight through them, a red streak, it's just a red and a blue line through them and they're like see-through.

W: oh yeah, yeah

H: and it's, Simon is like, he like doesn't like talking about stuff but he is quite easy to read. So...

W: you can see through?

H: I can see straight through him, me personally, I can...

W: but he doesn't like to be open about stuff?

H: (shakes head) no, no he's very to himself isn't he?

D: Yeah

W: Yeah

D: That's a family thing

H: Yeah that's a family thing...We should buy some fish

D and M: (together) No!

In the preceding transcript, Hannah begins an exchange in which she describes her family as a "family of fish". Prior to this conversation, Hannah's Mum becomes upset and Wendy checks in with Mum: "are you alright" which leads her to use the word "blubberer". Hannah picks up on this and attributes this word to them being a "family of fish". Hannah then proceeds to give her present family members fish names. Wendy encourages this discussion, and asks clarifying questions about why Hannah has chosen these particular names for her family members. From this Wendy is able to garner an understanding of how Hannah sees her family: her Mum is "soft and calm"; Dad is "strong on the outside but mushy in the middle" and her brother is "see through". Wendy's facilitation of this discussion allows Hannah to talk about her family in a non-threatening way, using language that is meaningful to her. This could be contrasted with asking a direct question like 'what is you Mum/Dad/brother like' which appears to be more confrontational than the natural conversational emergence of this information from a simple phrase made by Hannah. This conversation also appears to be a form of moderating emotion in the room, as this discussion comes after a particular difficult conversation in which Mum begins to cry (see moderating emotion 4. below).

Through the moderation of this emotion (see 4. below) Wendy is then able to return to a comment made by Mum prior to this conversation about strength:

[Session Three]

W: thinking about strengths, (to Mum) you say you're not as strong as D, what, how would you, what do you mean by strength...

M: I just mean erm, in the way of... I cry, I'd say I cry a lot more and a lot easier if I think about things.

W: yeah, yeah, err, what do you think about crying, is that, what does that, does that mean you're less strong or...

M: no, no, I just mean that I know I'm always the first to cry anywhere whether it's at a concert or

[Hannah laughs]

H: I don't know I think I've, I think I'd be the first one when I saw [omitted] On stage last year.

W: yeah...and what about, what do you [to Hannah] think about strength, what kind of strengths there are between the three of you?

H: when it comes to me personally

W: mm

H: I always used to kind of have the perception of, if you asked for help, it means you're weaker than other people and if you cried then you was also weaker than, but if you cried to yourself it wouldn't make a difference because no one else would know about it. Erm. Like my Mum said she can cry really easily if she's upset, erm, there is a strong bond between me and my Mum, there is a strength there, erm, there is between me and my Dad. My Dad does cry easily, he's not, he is mushy... erm, he just doesn't let on as much when he does. Erm, there's been a few times where he phoned me at work and he'd been upset, and that's made me been really upset, crying on the phone. Erm,

W: you used to think that it was best to be, to not to cry and not to sort of talk about stuff, and now? What are you thinking?

H: now, it's...it's different because...as my Dad always reminds me, obviously keeping things to myself isn't the best strategy because it's come to the point where I've been in hospital twice and I keep that to myself, but that doesn't change how I feel about other people and the way ... even if it is one way

Through the discussion of how Hannah sees the rest of the family, using the fish analogy, Wendy is then able to begin thinking about some of the relational aspects of the family, and opens a more focused discussion about “strength”. The conversation began with a therapeutic feel to it, with Mum’s distress being moderated. This allowed Wendy’s therapeutic focus to move towards a more evaluatory focus. For the purposes of assessing risk, Wendy has identified relational elements of the family and how these dynamics play out in everyday life. Wendy has also been able to elicit information about Dad’s attitudes towards talking, and that he encourages Hannah to talk about her difficulties.

Summary. An emerging theme throughout the therapy was the idea that Wendy places the family in the position of experts of their own experiences. This appears to create a more balanced relationship in which the family can contribute to the discussions more freely. Again, this appears to maintain engagement with the family as it places them and their narratives at the fore, with Wendy joining this as an outsider.

2.3. Developing a shared language. In some examples within the data, Hannah appears not to be able to verbalise some of her emotional experiences which may allow her to communicate what she is feeling both inside the therapy room with Wendy and with her family outside of it. Wendy negotiates balance through the process of developing a shared emotional language which allows Hannah to begin putting words to potentially emotional experiences.

In some instances Wendy's negotiation of the use of particular language is clearer:

[Session Three]

W: (to H) what do you have to say if she's not sure about using, about what words we're using, are you okay with straight words, or do you have code words...

H: I don't know

W: what would you prefer, would it be easier if we could actually talk or put into words, what sort of words.

M: whatever H finds comfortable. I mean there's only two words that I'm aware of that H doesn't like, but I don't know if not saying them is a good thing as to saying them in this room.

W: yeah, yeah. Sometimes when you've got words that you don't like, the more you don't say them the more awful they get...

M: yeah

W: ...sometimes actually bringing them out and saying what they are is quite helpful...Shall we go for it H? Just use the words that fit?

H: Whatever you think's best

W: I think that's best actually

Wendy begins by exploring whether the family have a specific set of words they use when talking about Hannah's overdose/rape/miscarriage. By enquiring about the type of language the family use Wendy builds her own understanding of the family's approaches to talking about these topics and can potentially modify her own responses to reflect this. However, Wendy picks up on the family's uncertainty about using certain 'real' words and Mum communicates that there are "two words that Hannah doesn't like". Mum then says that she is not sure if saying them is a good thing or not, to which Wendy says that she thinks it would be best if the group started using these words. This process highlights a subtle move

through each of the processes in my model. Wendy establishes a shared language; then elicits further information about this; then negotiates an intervention in that she begins to encourage the family to use commonly used words that may be uncomfortable in the therapy room. By the end of the exchange Wendy and the family, guided by one another, agree on a shared language for them all to talk about these experiences which continues throughout therapy. This approach, again allows a shared understanding to be developed in a way that meets the goals; language and expectations of Wendy, Hannah and her family.

There are also examples of Wendy ‘normalising’ Hannah’s experiences throughout the data which further allows the group to develop their shared emotional language. In some instances Wendy uses her own experience of working with other families to communicate how others may have experienced being in a situation similar to Hannah’s:

[Session two]

H: Yeah, but it’s nice to know that I do actually have like someone there which is really good but then sometimes if we are both sat on sofa and I’m quiet and he will ask me what’s wrong and there could be nothing wrong but he will ask me again and ill still tell you there is nothing wrong and you will ask me again and that’s when sometimes it’s a bit not too much but I’ve told you there nowt wrong the first time and there might not be anything wrong.

D: Yeah I get that, it’s like if you had the concept of what we’ve been through over the last few months I feel like I have got to because you have not always told us everything that is going on and us not knowing what’s going on is what got us to the point, so I feel I have to ask,

W: Yeah some of the other families that we have met through this work we kind of come to realise that when self-harm happens in the family then it can, you know, everybody acts to it in the best way that they can and quite often when we meet people that are in a process of doing just what you’re doing they’re readjusting they’re working out how to live after the self-harm, after the really scary thing and about how close to be and how much to be worried and how much to let go of the worry so. Maybe this is something we will talk a bit about as we move forward in the therapy. And are those times when you feel distant those times when you’re sitting on the sofa and your Dads saying are you alright,

H: Yeah they’re like the distant I’m like, yeah.

W: What were your thoughts about that first session? [ASKING D]

Hannah talks about appreciating that her Dad is available when she feels distressed, however she also feels that he can ask her if she is ok too much which in itself can cause some distress. Dad responds to this in a way that communicates his worry for Hannah and that his experience is that in the past she has not been as open with him and that prompts him to ask. However, neither Dad nor Hannah use the word “worry” directly nor do they use any emotional language in these instances. Wendy begins this process by summarising what she has just heard. As stated above, Wendy uses the examples of other families in therapy which normalises the situation of family members being concerned for their children. Wendy highlights Dad’s concern and introduces emotionally oriented words such as “scary” and “worry” which gives the group a shared lexicon for their experiences. With these words

introduced, Wendy then turns the focus of the discussion away from this and asks Dad about his experiences of the first session. In this sense, Wendy has ‘parked’ the topic of talking about “worry” and the “scary” nature of Hannah’s self-harm and continues talking about their experiences of the first session.

Summary. Again, the need to develop a shared language which the group can use together is an approach Wendy uses to keep the family engaged. By working with the family to understand their own nuances and idiosyncratic language, Wendy becomes ‘part’ of the family. Wendy’s switch between assessment and therapy is also clear in the examples above, particularly in her negotiation of using ‘real’ language (i.e. that they should use potentially emotive terms such as “*overdose*” and “*rape*”) as Wendy hears the family’s capacity to hear these words said aloud, and provides an intervention.

2.4. Preparing for Surprises. Wendy considers the impact on others that hearing emotional material from Hannah may have. Hannah has talked about not communicating her difficulties with others therefore there is a possibility that the family could be hearing about these difficulties for the first time. This example from session two demonstrates this process in response to the group starting writing out their timeline together:

[Session two]

W: 16 and what I would like us to begin to do today is to put in this is time before I don’t know how far back we will be going that’s up to you and for instance you talked about a time there was a really little thing that maybe it was the thing that tripped you into doing that, where you erm but there are other things in your mind that come before. So if we start to sort of put some of those things down ok, if we do that do you think your Dad knows all about it or is there some things that he knows a bit but not everything, some new things?

D: I certainly wouldn’t be surprised if something appeared on there that I didn’t know about.

W: Ok, that’s a possibility.

D: Yeah I do, if that makes it easier for Hannah to put it down then so be it because it’s... I’m not here to judge.

Wendy stops her exploration of the overdose and begins to talk about whether Dad may know about everything, or if there is anything that he may not be aware of. Dad responds by saying that he would not be surprised if something came up that he did not know about. This approach allows Dad and Hannah to be aware that there may be aspects of the conversation that are unknowns, however this has been discussed and may be negotiated if this situation

arises. Hannah has heard from her Dad that he would not be surprised if “*something came up...*” and she hears that Dad is not there to “*judge*”.

Summary. The data reveals examples of Wendy preparing others for surprises which forms the basis for negotiating balance within the therapeutic relationship. Wendy is also mindful that there is a balance to be had between family members, and Hannah’s willingness to discuss certain topics with her family present may also create an imbalance between Hannah’s relationship with her parents and vice-versa. Through understanding Hannah in terms of how ready she is to talk about her difficulties, Wendy shifts focus from this to a therapeutic standpoint by allowing Hannah to hear from her Dad that he has the resilience and capacity to hear the distressing content and that he will be okay if he hears it. By doing this, Wendy maintains the engagement of Dad, but also of Hannah as she continues to negotiate the balanced conditions for talking.

2.5. Developing a Mutual Pace. Throughout therapy, Wendy attempts to work with the family in order to develop a pace that is mutually helpful and allows the exploration of risk in relative safety. Across the therapy there are examples where the perceived risk may be raised and Wendy changes her approach. Wendy utilises a number of strategies which allow the group to explore these risks further. Prior to the following exchange, Wendy had previously talked about finding a pace that suits Hannah in order to talk about this in a constructive way.

[Session Two]

H: Yeah it’s just like I said in the last session I don’t like talking about stuff before I’m ready to talk about it, but then I see where my Dad is coming from where the fact is what if I never feel ready to talk about it? Then it’s got to be brought forward.

W: Can I ask a bit about how you have been in the last few weeks, just ordinary stuff like are you in exam time now?

H: I’ve got an exam on Monday and one on the 4th June that’s about it I did have activity but when it came they had dropped the subject but they have still put me in for the exam but because I had not been in the lessons because I had not been on the course anymore I had not done any of the work that had been given for my exams so pointless me sitting because I wouldn’t even get like 3 marks which would just make me feel bad about myself even though it wouldn’t have been my own fault, I have my last on Monday and 4th of June and then I am done.

W: How are you doing with the exams?

H: Well erm, what do you mean?

W: Like I don’t know if, I suppose I see a lot of people going through the exams at the moment and I know that for some young people it can be a really really stressful time, for some young people it’s not too bad and I was just wondering what’s it like for you is it a very stressful thing?

H: I’m petrified of an exam room, when I was in high school if I start an exam and I don’t do well in it and my re-sit will be in a separate room to everybody else.

W: Do you find that really hard?

H: Yeah, so many people around and...

W: How do you think you are managing with this lot and your exams?

In this example from session two Hannah communicates her reluctance to talk about her difficulties, however she uses the term “*bringing things forward*” referring to how she notices how important it will be for her to talk about her overdose and other difficulties in therapy. Wendy does not attend to this, and instead begins talking about Hannah’s current college/school situation. (This is an example of parking a topic (see 4.1.). As Wendy moves forward into talking about Hannah’s current college circumstances she begins exploring how Hannah feels she is currently coping with these potential stressors. The important part of this particular exchange is that Hannah has given her ‘permission’ to “*bring forward*” difficult conversations, however Wendy has not directly gone into discussing these things and instead focuses on coping and current levels of stress.

This has characteristics of the conversational approach described in section 1., however this also has characteristics of exploring risk in that this approach allows Wendy to begin identifying potential current stressors in Hannah’s life and also for Dad to hear how Hannah feels she is coping. This indirect approach keeps the pace comfortable for Hannah with Wendy able to gather risk-related information in order to explore it further. This conversation continues for a few more minutes, which leads Wendy on to talking about things that she enjoys doing alone and with her family. Hannah also talks about her sleep pattern and concentration.

[Session two]

W: Ok well thank you for telling me all that. I have had an idea for today about just, just what you were saying at the beginning of the session where you were saying about us being here trying to understand how you got to the point of taking the overdose and that, I wondered if we could begin to do some work on that together.

[Hannah nods]

W: If we do that is there anything else that you, is there anything else that you think we should be doing at this time? Anything that you really wanted to talk to me about this time?

H: I’ve got a question I don’t know if you would be able to answer it or not?

The prior ‘permission’ to “*bring things forward*” and the subsequent conversation about some of Hannah’s current difficulties allows Wendy to return to the subject of the overdose. Further, Wendy also gives Hannah the opportunity to have further input into the conversation (see developing shared goals 2.1.) and discuss anything else that may be

concerning her. Hannah feels that there is something that is concerning her and the group go into this discussion. These questions maintain a pace comfortable to Hannah, in the context of Wendy wanting to talk further about the overdose. After talking about the other issues Hannah raises, Wendy again then moves back to discussing the overdose using the timeline.

[Session two]

W: Ok well I'm glad that you mentioned it and we will have a think about it, I wonder if K has some ideas about it that they can talk about. Ok so are you ok with about putting things down on paper?

H: Mm

W: You have talked about there's [date], have you done time lines to do with other things in school or?

H: I've done time lines in history on like working stuff out in maths

W: Yeah in maths, we find time lines are sometimes quite useful just to try to get a bit of an understanding of what happened when and what's linked to what. So if we put [date] and that was when you took the, do you want the date?

Wendy develops a mutual pacing in this task by ensuring that Hannah is familiar with timelines and that she is okay with putting “things down on paper”. From the beginning of this exchange, Hannah has stated that she understands that talking about the overdose needs to be “brought forward”. In a sense, during this exchange Wendy is bringing forward the discussion of the overdose but allowing Hannah to do so at a comfortable pace as this occurs relatively early on in therapy, with the two arriving at a mutual, comfortable pace of discussion.

Summary. The negotiation of balance within the therapeutic relationship allows Wendy to move between both therapeutic and assessment-based foci as well as serving the purpose of keeping the family engaged. The process leads to the group sharing risk-related and wider goals for therapy; as well as establishing a pace that is comfortable for Hannah to begin discussing her difficulties. It is from this position that Wendy can begin exploring risk further and engaging the ‘finding out’ processes which serves as both a therapeutic and assessment simultaneously.

3. Responding to Emerging Risks.

In the following section I will now describe how Wendy responds to risks as they emerge within the therapy. In essence, some of the processes remain the same, e.g. the way that

balance is achieved, however with the sense of risk being raised, Wendy takes a more direct approach to communicating her own worries and goals.

3.1. Communicating and negotiating Therapist-driven goals. A similar pattern of negotiating balance (see 2. above) occurs at the beginning of session three, however in terms of this ‘balance’ within the relationship, Wendy’s agenda of assessing Hannah’s risk may be in conflict with Hannah’s previous reluctance to discuss her distress and events leading up to previous overdoses. This is the extract from session three:

[Session three]

W: I know we wanted to show your Mum the timeline today, and we might get to it through this, but I’ve got a bit of an admission to make

H: You’ve lost it

W: no, I haven’t lost it, but it’s not in this building. I took it away when I was writing you this letter I took it away to this other place to write the letter and left it there. So, I can remember what was on it, but I don’t actually have it on me this time.

H: so it’s all your fault?

W: so we could re-write it, or Kevin has a shorthand version. I think having had a look at it, that might take a long time, and I think what your Mum’s saying, she’s right, It’s just thinking about you’ve had an overdose last week and we need to talk a bit about what happens at the times when you take overdoses, we need to look at that...because I think if we could build up a bit of a picture or understanding about what happens to you at those times erm that will help us to keep you safe, safer and go on to do more work with you, so we can look through the timeline and all the stuff you want to do, but if you’re not around because you’ve taken another overdose, we can’t do anything so we’ve got to think about the overdoses first...okay?

H: Yeah

W: and maybe what we can do, is we can do a timeline again, we do different timelines, which has the overdoses on so we’ve got one last week, [date], which is [month] does it matter...

D: [Month]

W: yeah, and then February...and one before that you said.

[Pause]

H: [month]

Wendy begins with her “admission” that she has forgotten the timeline that was completed in the previous session. Wendy gives Hannah a few options on how to proceed (e.g. to re-write it) however she also gives her reasoning as to why this might not be helpful today (it would take too long). Wendy also makes explicit Mum’s goal of discussing the last week and how it might be important to talk about the overdose in order to understand “*what happens to [Hannah] at those times...*” and how Hannah may be supported to keep safe in times of distress. By doing so, Wendy reiterates her own goals in that she feels that it would be useful

to talk about what happens in the times leading up to when Hannah takes an overdose. Wendy, Hannah and her family negotiate a way of doing this that incorporates everyone's goals in that Wendy suggests using a timeline (which was Hannah's goal for the session) which can be used to further explore Hannah's risk.

Summary. Above is an example of how Wendy raises and negotiates balance when the goals and expectations regarding discussions which occur in the context of escalated risk. Although this imbalance appears to be in the direction of Wendy, by engaging Hannah in similar processes to the ones described earlier, Wendy and the family are able to begin to discuss potentially difficult experiences in a safe way. The process also differs in how explicit Wendy is about her goals for the session as prior to this Wendy's approach to setting shared goals had been in a less direct manner. By using a familiar tool (the timeline) Wendy is able to gather factual information in a less direct manner which also keeps Hannah engaged in the process. As this conversation continues, Wendy and the family further develop their understanding of events leading up to the most recent overdose, and even begin to formulate a plan together which is aimed at keeping Hannah safe. This is described in further detail in section 6. below.

As described above, Wendy introduces her goals more directly than she may have done previously, however the other approaches she employs to ensure that these goals are shared are similar to the others described across this chapter. In terms of answering the question 'how does the therapist's approach to assessing risk change in response to changes in perceived risk' Wendy's approach to broaching the assessing risk becomes more direct in terms of her communication of her goals.

4. Moderating Emotion

Within the data there are a number of examples whereby Hannah, and/or a member of her family become visibly upset, distressed or uncomfortable with what is being discussed in the session. The data also reveals Wendy's responses to this emotional distress and how it is moderated in order to ensure that these distressing experiences are talked about in a way that promotes the shared understanding of the distress in the group. Moderation of emotion is represented within the model (Figure 3.) at various stages and it appears throughout the course of the therapy. By paying particular attention to the impact the discussion is having on Hannah and/or her family Wendy guides the family in and out of these discussions in order to keep the family engaged in the assessment/therapy process. The processes Wendy employs to moderate

the emotion experienced in the therapy room are both explicit (e.g. Wendy talks openly about what she is doing) and implicit (e.g. Wendy may do things that are not as obvious to the family); and these approaches appear to change over time.

4.1. Parking Topics. An emerging theme within the data was Wendy's approach to broaching difficult topics but not necessarily discussing them straight away dependent on Hannah or her family's distress. Initially Wendy tests out Hannah's willingness to discuss these topics, however if they become too difficult to discuss, Wendy 'parks' them for discussion at a more appropriate time. In some instances the topics parked by Wendy are broad and named in an overt way for example:

[Session Two]

W: Yeah it is also therapy for you so let be clear about that and I am very interested in how you got to the point of doing what you did my main thing is that I'm therapist for you, there's the researchers that will have a look at what we have done and they will be thinking how can we use that for other people, but in the therapist for you so I am interested in how come you got to that point but then thinking about how can what needs to happen for you to make sure you that you don't get to point again. That's one thing from therapy that I want us to work at. You may have other things that you want to get out of therapy which I will ask you about, yeah it was strange coming last time very emotionally draining and I remember you went away and it had been an emotional process, what was it like afterwards you know when you left here and you know the next couple of weeks? What effect did coming here and talking with your Dad have on how things carried on after that? Have you noticed anything?

H: We were a lot closer straight after er we were closer after and like some days we were really close and then others it feels like we are really distant.

In this example Wendy begins by asking about Hannah and her Dad's experience of the first session. This leads to Hannah talking about the SHIFT research project to which Wendy clarifies her role as therapist, then talks about her interest in the events leading up to the overdose and understanding them in a way that means that Hannah does not reach that same point again. Wendy has the opportunity here to pursue this line of discussion in order to move the therapy forward into thinking about how Hannah got to the point that she did, however Wendy moves the topic of conversation away from this and returns to Hannah's experience of the first session by asking a cluster of questions (see 5.6 below) about their experiences following session one. These incidences of parking topics appear most frequently in earlier sessions with Wendy returning to these later.

Within these examples there are also elements of parking topics for the future and these processes serve a dual purpose in terms of assessing risk now and in the future. The following extracts from session one highlight this process:

[Session One]

W: Ok, do you know how come the two of you ended up not talking about what had happened was that kind of what you wanted, what you thought she wanted, what was it?

H: We never really got round to it and at the time I didn't really feel comfortable talking about it.

W: Yeah, do you think in this therapy it is something that you would like some space to talk about, or?

H: At some point yeah.

W: At some point, would that be important for you?

H: Other than the police I haven't really told anyone in detail what happened cause I don't want to upset anyone I don't want to see them upset and I defiantly don't want them to turn round and say something ridiculous like if they could have had it happen to them instead of me then they would have done because it don't make me feel any better it don't make it easier it just reminds me of the fact that it did happen to me and it's me that has got to deal with it and not them and I don't feel comfortable talking to somebody about it when I don't, when they don't know how I feel and they say oh I know how you feel and they don't they don't have the slightest clue and as awful it makes me sound extreme I just and it don't make it easier saying that and it don't reassure them and they don't know, it's upsetting because it makes you feel more alone cause of the fact that they are saying they know but you know they don't you really don't so you are on your own again.

[Hannah becomes tearful]

W: Sounds like you have thought about what would, would wouldn't make it work for you to not talk about it, have you got an idea that it may it could at some point be important that at some point talk about it so long as it was the right kind of talking. So we can come back to that we can think about it once you have got to know us a little bit better as well. And your Mum's not here?

Wendy begins by asking about Hannah's previous experience of therapy and wonders with her why the overdose was not discussed with a cluster of questions (see 5.6. below). Hannah reveals that she did not get round to this as she did not feel comfortable in discussing it with her therapist. Wendy then asks about how important it would be for Hannah to talk about these experiences and whether she would consider talking about these in her current therapy (an example of negotiating balance; shared goals). From this Hannah discloses that she had not discussed these difficulties with anyone other than the police and one of the key reasons is that she does not want to "upset anyone" and that perhaps others' responses might not be helpful. Hannah then appeared tearful. Wendy, instead of pursuing this summarises what Hannah has said (that she has thought about what might/might not be helpful for her in terms of talking) and explicitly 'parks' the topic by saying: "...we can come back to that, we can think about it once you have got to know us a little better...". With regards to moderating the emotion in the room, Wendy has noticed Hannah's distress, and with this coming early in the therapy has 'parked' the topic for later discussion and changed the subject to gathering Hannah's thoughts about Mum not being present.

In the opening to session one, a seemingly innocuous comment about whether Hannah and her Dad were familiar with the building, a conversation about triggers to the overdose is opened up and a shared understanding of these triggers is established. The opening exchange

has an emergent quality about it in that Wendy appears to do very little in the way of explaining how family therapy works, or giving the family topics for discussion, yet the group find themselves talking about a topic relevant to Hannah's overdose which builds in richness over a short space of time. Wendy does not communicate an agenda other than that they are there to complete a piece of work around Hannah's overdose and the family chose the topic of discussion. Wendy was mindful to address potential concerns (e.g. the length of previous therapy) and posed questions and made statements in a way that allowed further details to emerge. Through this process the group have developed a joint understanding that there were a number of aspects which triggered the overdose and that these aspects are now floated for further discussion.

Summary. Parking topics appear to play a dual role in Wendy's approach to focusing on therapy and assessment as well as to maintaining the family's engagement. In the first instance, discussing the topics allows Wendy to gauge Hannah's and her family's capacity to discuss them in the room and gives an idea as to where the family are at in terms of discussing these topics. When this capacity is reached Wendy acknowledges the distress, but also acknowledges that these topics need to be discussed, thus parking them for future discussion. By parking them in this way, Wendy is able to agree with the family that they will return to them in the future when the conditions are right again. By doing so she also ensures the family are not overwhelmed and that they remain engaged in the work.

4.2. Changing focus in the room. In response to emotional distress in the room, Wendy also moderates emotion by changing the focus of who is speaking. An example of this happens early on in the therapy and occurs between Hannah and her Dad:

[Session One]

W: What is it is that like cutting off not taking it in

H: Yeah but it's not something I do on purpose it's just happens

W: No, no it's ok it's really important that we talk about this and is that partly because in the past when people when you have talked to them and they have talked back that's been its not gone terribly well

H: I'm doing it again,

[Hannah becomes tearful]

W: it's ok

H: It's not because it makes me feel really rude and I'm not, I am listening I just can't take it in

W: That's kind of important for us to know, can I take the spotlight off you for a minute

H: Yeah

W: Dad, what was it like for you, us talking with you here?

In this example, Wendy begins by eliciting further information from Hannah about what it is like when she “*cuts off*” from her surroundings. Hannah appears to defend herself at this point “*I don’t do it on purpose*” and Wendy is sensitive to this and attempts to re-balance the situation by reassuring Hannah. Hannah notices that she is “*doing it again*” (i.e. that she feels that she is “cutting off” in the room) and in communicating this becomes tearful. Again, Wendy picks up on this and asks Hannah if she can “*...take the spotlight off [her] ...*”. Wendy then explicitly turns her attention to Dad, taking the focus away from Hannah. On this occasion Wendy asks a question unrelated to Hannah’s “cutting off”, and asks Dad what his experience is of Wendy and Hannah talking with him present. In contrast to this, in other sessions the change in focus can also bring about further discussion and Wendy asks questions that shift focus but with the topic of conversation remaining the same. In other examples the focus is taken off Hannah and Wendy talks with her parents with Hannah still listening. Later in the discussion Hannah then comes back into the discussion unprompted and allows Wendy and the family to increase their shared understanding of the issue being discussed from all perspectives.

Summary. This process is not a unique one between Wendy and Hannah, as in some instances other family members become distressed in the session and Wendy recognises the need to both give that person space, but to also keep the topic of conversation on track. This moderation re-establishes the balance in the relationship as it takes the focus from the individual person thus maintaining their engagement, however it allows Wendy to continue gathering information related to her risk assessment.

4.3. Encouraging the family to moderate their own emotion. Wendy also makes use of the family’s own resources as an intervention for moderating emotion that arises within the room. In this example, Wendy encourages the family to support Hannah when she becomes distressed:

[Session Three]

M: so, I find it a bit... sort of hard and confusing really why she did it again

W: yeah, yeah

M: you know just

W: Yeah

M: *there's so many [*] there's more going off in H's mind that...*

W: yeah

M: *That I know of...or realise*

W: yeah

M: *you know, to actually make her take tablets again*

W: *yeah, H...are you upset now?*

[H is crying] [nods]

W: *yeah. What do you want to do...what do you want...what do you usually do when you're upset? When H is upset?*

[M and D make physical contact with H]

W: *move the chairs to where you want them to be, there's a bit of a gap between them*

[D moves coat/bag from next to H]

M: *what have I said that's upset you?*

[D moves chair to face H]

H: *it's not something you've said...or done*

[PAUSE 10secs]

W: *it's when you were talking about, you know before, before last week you thought that, you were thinking maybe you were on a good road, and then, and that your confidence was maybe...*

M: *yeah when we were at work and that we were quite comfortable with her being in the house and we weren't thinking well, is she feeling that bad again, so...I thought things were going well...I think she hasn't, she's never really discussed much about, what I'm not sure is the main issue about what she doesn't speak about much. I'm not sure if I'm using the words or not, erm, she hasn't spoken to me much about it as to as she has her Dad who has been coming to the sessions so I didn't know that had affected her as much...*

W: no

M: *as it has done*

W: yeah

At the beginning of this exchange Mum talks about how she finds it “*hard*” and “*confusing*” as to why Hannah took the most recent overdose. Wendy listens to Mum talk encouraging her to continue talking. When Mum mentions Hannah taking the overdose directly and Wendy asks her if she is upset, Hannah begins crying. Instead of moderating this emotional response using some of the strategies highlighted in my previous examples, Wendy instead asks Mum and Dad “*what do you usually do when H is upset?*”. The family move physically closer to Hannah and Mum asks what she has said that has upset Hannah. Hannah communicates to Mum that it is not something she has said or done. With the family sitting physically closer to each other and Hannah seemingly feeling more emotionally contained by this, Wendy continues the topic of discussion by summarising the conversation that has preceded the

emotion. This encourages Mum to continue talking about how she and Dad had felt comfortable leaving Hannah alone at home as they did not think she was feeling bad. By allowing the family to moderate their own emotion (in this example by being physically closer to their daughter when she is distressed) Wendy and the family have been able to continue their discussion.

Summary. Perhaps in itself, the act of encouraging the family to moderate their own emotion can be considered as an intervention. In early sessions Wendy asks the family what they “do” when Hannah becomes distressed. By doing so Wendy is able to observe the family’s response to Hannah’s distress, and what this looks like, and gives her the opportunity to give support should they require it. As the sessions progress Wendy’s input in this type of emotional moderation becomes less pronounced, leaving the family with the knowledge and understanding that they can rely on one another should any one member of the family require it.

4.4. Giving space. Wendy also allows a mutual pacing to develop within the sessions by allowing Hannah and her family the space to talk freely. These incidences were coded at times where Wendy’s input into the conversation is minimal and consisted of non-verbal utterances. In contrast to this, there were times in which Wendy appears to hold off from asking questions at the time, which allows the family to talk at their own pace unabated. In this particular extract, Wendy allows Hannah to talk freely about her experience of being bullied:

W: And you talked about girls pinning you up against the wall?

H: Yeah in the girls toilets.

W: Were you physically being, were you being hurt physically? Were you scared?

H: No I was just being pushed against the wall erm nobody kind of laid a finger on me I was squared up to by a couple if the girls at different times all in the kind of same space of time but at different points of being against the wall.

W: It must have been really frightening.

H: For a 12 year old yeah

W: Were they the same age as you?

H: Yeah but they were the oldest in my year.

W: Which makes it different at that age doesn't it

H: Yeah, and I wasn't tall then I hadn't really grown at all, I hit my growth then.

Wendy gives Hannah some space by allowing her to talk at her own pace, then return to these topics later on: “*You said something about girls pinning you up against the wall*”. When Hannah replies sparsely, Wendy asks clusters of questions to keep the flow of the discussion going “*were you physically being, were you hurt physically? Were you scared?*” This gives Hannah an opportunity to answer a ‘concrete’ question or an abstract ‘emotional’ one. Hannah answers with a ‘factual’ answer which Wendy then follows up with “*that must have been frightening*”, in an attempt to understand the underlying emotional experience. Wendy then moves away from the emotional experience and goes back to exploring the factual details (age of perpetrators etc.).

Summary. Wendy’s approach in the sense of giving Hannah space to talk in this way allows her to gather information about Hannah’s experiences and in a therapeutic sense, perhaps allows Hannah to view them from a more objective perspective. The moderation of distress in this sense is achieved through Wendy taking Hannah’s lead and allowing her to speak at her own pace. This ensures that Hannah (who says she is reluctant to talk) to continue to tell her story, thus increasing Wendy’s and Dad’s understanding of the context of her self-harm.

Summary

Moderating emotion within sessions allows Wendy and the family to negotiate difficult conversations and experiences. The items coded above also appear to allow Wendy to maintain engagement with the family in that she does not allow them to experience emotions which are likely to re-traumatise or distress Hannah and her family, thus preventing them from continuing their conversations. By moderating the emotion in the room Wendy is also able to change her focus from primarily therapeutic endeavours to more risk-assessment-related tasks.

5. Finding out

An emerging theme within the data was Wendy’s exploration of particular topics the family had brought to therapy. Wendy explores these topics in a way that allows her and the family to ‘fill out’ the details surrounding them, and perhaps expand their shared understanding of them. Finding out information is a process which emerged from the data at every point of the therapy and can be used as a means to negotiate balance the relationship, negotiate an intervention and to gather relevant risk-related information. Other than the conversational tone that Wendy fosters, eliciting further information appears to be the backbone of Wendy’s therapeutic and risk-assessment activities.

5.1. Communicating Indirectly. Early in the therapy Wendy and Hannah have various discussions about the best way of enabling Hannah to talk about her difficulties and Wendy establishes that talking directly about her experiences has been difficult in previous therapies as well as in the present therapy. In some instances, Wendy uses indirect means of allowing Wendy and her family to talk about their difficulties. Within my description of this coding decision my aim is not to describe these interventions *per se*, instead I shall describe how Wendy facilitates this indirect way of talking.

In the following example, Wendy has identified with Hannah, that Hannah has something she would like to communicate with her Dad. However, this is a particularly distressing piece of information:

[Session one]

W: Ok, sounds like it is something that you just have to say you have done quite a lot of preparation with your Dad

H: what do you mean?

W: You have explained that you don't want to see his immediate upset that you know that he will probably be upset

H: I feel, I feel like I don't respect him because of the fact that I can't even tell him to his face

W: But I think you are being quite mature and thinking about how to do it, something that I pick up from you on this first meeting is that you're really thoughtful about how other people will be affected by things you think about that an awful lot and you really try to plan and prepare the ground so it is not too awful but life happens things happens and on balance you try to tell your Dad even you take a risk you know what it's going to do to your trust, I think that you are probably thinking that even though it might be a bit difficult for a bit it's better for him to know. I would guess that since the overdose you have reassessed the idea of keeping everything to yourself and now you're wanting everything to be more open, I might be wrong but you think is that right?

H: I don't know just things that have happened before the overdose that kind of all lead up to it and like when I came out of hospital some of it didn't work I didn't think that it would be mentioned I just thought I could do what I did like about what had happened before in august and just kind of not talk about it the fact that like literally two people knew about it and just completely forget about what happened and feel like it didn't happen.

W: The rape?

H: No something else

W: Something else ok that your Dad knows about.

H: Yeah that I didn't want him to know about because I didn't want him to kind of be ashamed of me or owt.

W: Yeah so he does know about that

H: Yeah

W: And was he ashamed of you

H: He said he wasn't but I don't believe that

W: Yeah and this is something else now

H: yeah

W: Yeah ok, have a go at saying

H: Saying what? I don't want to say that I don't want him to get upset about

W: Mm mm, if you want to

H: Its weird, it's just difficult.

W: Do you think here is the place to do it or somewhere neutral, it's a really [*] situation Hannah because we have limited time, I don't want to put any pressure on you we want it to be done the right way for you so I guess you can say now

H: It's on the tip of my tongue I just can't bring myself to say it bit I need to

W: Do you want to write it down

H: Yeah, I'll just lean onto this

W: You do that

[Hannah starts writing]

W: Have you written it

Hannah nods

W: Ok can you read it, can you read it now you have put the words on paper? Do you want to hand it to your Dad?

H: I want to go to the toilet

W: OK that's fine I'll show you where it is, and would you like me to give it to your Dad or do you want to give it to your Dad and you can go to the toilet

H: yeah

W: Yeah ok, and then we'll come back?

H: Yeah

W: Ok, and do you want Kevin and myself to read it as well, or just your Dad?

H: I don't mind you can read it

W: Ok, you're being very brave.

H: Ok shall I leave my stuff in here? It's annoying me that he can see me but I can't see him

Wendy and Hannah enter the room

W: Your Dads ok would you like him to come through we will have a brief talk and finish off?

H: Yeah

W: Good

Wendy summarises with Hannah that she has been “*preparing*” to tell her Dad difficult things and clarifies her meaning that she feels that Hannah does not want to see that her Dad's upset when she tells him (Wendy is preparing Dad and Hannah for potential surprises here, section 2.4. above). Hannah then talks about worrying about her Dad not respecting her if she is not

able to tell him in person and that she feels that he is ashamed of her miscarriage. Wendy continues to summarise Hannah's dilemma (that she wants to talk but she fears upsetting her Dad), and re-frames telling Dad as being potentially a more positive thing to do ("*...it might be a bit difficult for a bit it's better for him to know...*") and explores Hannah's thinking about wanting to be more open since the overdose (*...I would guess that since the overdose you have reassessed the idea of keeping everything to yourself and now you're wanting everything to be more open, I might be wrong but you think is that right?*). By asking these questions Wendy is assessing Hannah's ability to speak aloud her distress, but also finding a way of allowing her to do this in a safe manner. Hannah talks about why she feels that it would be beneficial for her not to talk about her miscarriage, that if she did not talk about it then it means it "*didn't happen*". Wendy states that their time is limited in the session and that she wonders if this situation is the best place for Hannah to discuss this with her Dad. Wendy then asks Hannah if she would like to talk to her Dad about the miscarriage, however Hannah says that she is unable to; "*it's on the tip of my tongue*". Instead of following this up Wendy then gives Hannah the opportunity to write down what she would like to say and Hannah agrees. Wendy gives Hannah the opportunity to hand the paper to her Dad; however Hannah declines and wants to leave the room which Wendy facilitates. Wendy identifies that this intervention is a particularly useful one and gives Hannah a rationale for going through with this (more about interventions can be found in section 7.). Through this she facilitates a form of communication that Hannah is happy to proceed with and gives Hannah the opportunity to do this in a way that is meaningful to her. Although Hannah has talked about how difficult it is for her to discuss things face-to-face with others, Wendy has found a way for her to do this safely and in an early session.

Wendy also seeks to facilitate communication between family members using other indirect means. In session six, Wendy introduces the task of using Play Dough to further facilitate discussion in the group by making models of how Hannah sees her family before and after her overdose.

[Session Six]

W: I've got an idea of something to do, can I just suggest it and just-?

M: Yep [moves chair closer to centre table]

W: Because sometimes we just when we talk with families we do [moves tissues of the table and put several pots of Play Dough on the table]- when was the last time you used Play Dough?

M: I don't know, but I don't like the smell of it [turns to B and D who are laughing]. You know the smell, I hate the smell of it.

W: Oh, I love the smell of Play Dough .

H: I can't imagine my Mum playing with Play Dough.

D: That's her Christmas present sorted! [H and D laugh]

W: What I was thinking was that we're talking about looking back at how things were and looking forward to your life in the future and thinking about all of you, this is suppose about you as a family and [to H] you've got the [other counselling service] as your own. I was wondering if you could pretend you were a sculptor, okay? You don't need to work hard here, but if you could just show us how you think you would have arranged your family before, before you came here you know-

H: What do you mean arrange?

W: Well, if you take some [holds up Play Dough] –that's about being a sculptor- if you use the Play Dough and take some to represent yourself, some to represent your Mum and Dad –

I don't know if you want to include Nana or other important people- and sort of maybe place, or show us by where you put the little bits- show us how things were in your family. So you might be thinking-

H: Before?

W: Yeah, we'll do one before and then, yeah, and then maybe how you want it to be. So, where you are, where your Mum and Dad are, where your relationship is with your Mum and Dad.

H: [meaning Nan] Does she live near you [M]?

M: About five miles away, so she's not far, about fifteen to twenty minutes.

H: Is she on her own?

M: No, no.

D: She has a better social life that we do.

M: So is this Nana and all the family?

H: It's not the whole family; Nana is just there because of the smoking thing that we spoke about.

Wendy begins the exchange by asking the family their permission to bring another idea to the group. Mum agrees and Wendy asks when the last time the family had used Play Dough. Mum says that she does not know but says that she does not like the smell of it. Wendy's tone becomes conversational at this time and the group have a brief discussion about Play Dough itself which ends up with Hannah and her Dad laughing. After this short exchange Wendy then gives a rationale for using the Play Dough. She does not mention that it is a means of allowing the family to talk, more giving a narrative of what she would like Hannah to do. Wendy uses the word "arrange" which Hannah asks for clarification about and Wendy continues to give her rationale for completing the task. Following this there is a discussion between the group around Play Dough and Hannah begins sculpting her Nan. As above, the session follows a conversational, informal pattern until the following exchange takes place:

H: Oh my Mum got bitten by a dog, so that was a bit upsetting because I wasn't told.

M: Because I didn't know how to tell you on the night. [to W] I didn't tell her until the next day because, knowing how emotion [H] is-

H: *Oh I was in tears.*

M: *-I've gone to stay at my old time best friend, [H] couldn't come over because she was working, she couldn't get the weekend off. So I didn't tell her 'till the next day when I got home.*

W: *Hmm.*

H: *I didn't get told, I just saw it.*

W: *Was it a bad bite [M]?*

M: *Uh., Yeah, quite bad [gesturing to her arm] there are a few marks but it was four weeks ago now so it heals up, I has sutures strips on them, but I didn't tell her because she was staying at her friends having a 'girly night', so I didn't want her in tears and upset when I 'm fine and I'd spoke to her on phone. I were fine so-*

H: *I was really quite upset [carries on modelling some other pieces]*

In this exchange Hannah mentions that her Mum was bitten by a dog and that it was upsetting. Mum then talks about not wanting to tell Hannah because she was “*emotional*” at the time. Hannah says that as a result of this she was “*in tears*” and Wendy asks if the bite was bad. Mum talks about why she had not told Hannah. Wendy’s input into this particular exchange is minimal, and through the use of the Play Dough, Hannah begins talking about a time where her Mum had withheld upsetting information from her. In terms of understanding interrelational aspects of the family, Wendy has been able to gather information about how Hannah’s Mum may not communicate emotional information due to a fear of Hannah becoming more upset.

Summary. In terms of the ongoing assessment of risk that Wendy is completing, the facilitation of communication within the family in ways that allows the family to speak freely about their difficulties is important. In a therapeutic sense Wendy has facilitated a limited discussion between Hannah and her Dad by encouraging Hannah to write down that she had a miscarriage. This is an important step for Hannah as she has consistently described her reluctance to talk about her distress out of fear that she will upset her Dad. By going through this process Wendy has enabled Hannah to experience talking in a supportive way. In other examples, Wendy’s indirect communication comes through the use of other means. Again, she gives a rationale for using these particular methods, but does not explicitly mention or introduce a specific topic of conversation. This allows the family to say aloud difficult things and to have the dialogue, but also allows Wendy to observe others’ capacity for care and support/guide them should they require it.

5.3. Switching focus emotional vs factual information. Within the data there are examples of Wendy switching between gathering concrete ‘factual’ information about Hannah’s experiences and exploring the emotional responses. In some aspects this also

reflects a moderation of emotion (see 4. above); however this switching of focus appears to have a different quality to it:

[Session two]

H: It was the [date]

W: The [date] so and that was when you took an overdose of?

H: erm, Paracetamol

W: How many?

H: 16

Above, Wendy uses 'real' language ("overdose") and gathers information about how many tablets Hannah took and the date of the overdose. At this point Wendy focuses on gathering 'concrete' information as opposed to Hannah's emotional state at the time or currently. Wendy then pre-empts emotional responses from Dad in that she prepares for surprises (see below) and continues with the timeline.

W: where shall we start, do you want to start near or further back?

H: There. [POINTING TO TIME LINE]

W: Yeah ok, would you like me to write it?

H: yeah. My problem was first at []*

D: Mm yeah.

H: With all the threatening erm when I was in

D: Year 7

H: Year 7 no it wasn't year 7 it was 8, 8 or 9, end of year 8 I think it was

D: Is that when it was?

H: Yeah I was going to say it was 2009

D: Yeah that's when I think it was

H: Yeah [year] and it was in [month], it was [omitted].

D: Summat like that

H: Well somebody called [Omitted] was constantly threatening me to basically kill me, she'd push me up against walls at school and have loads and loads of girls surrounding me and I was by myself, she really did bully me the police got involved, my Dad went into school several times and nothing got done about it and then eventually she got excluded for having a knife on her in school and her intensions, apparently that was for me whether that was true or not I don't know but that's the first thing that kind of.

W: Yeah how long did that go on for would you say? How long were you living with being threatened?

H: erm I don't know... (to Dad) how long would you say how long was I living with being threatened?

D: I don't know it was quite intense for a long long period

H: It wasn't long but it was...

W: Intense

H and D: Yeah

H: I think it was a couple of week, it was two weeks before I told you it was when I got the text when I had come home from kickboxing and I got the text saying she was going to kill me and that's when I kind of broke down.

D: And that was the first time I knew about it.

H: And that was when the police got involved, that was like on a Tuesday.

W: You kept it to yourself for a couple of weeks and then you told and then the action happened.

H: Yeah.

W: The police got involved and...

H: For about two week I didn't say anything I just thought it would go away and then when I got the text saying she was going to kill me, I mean I was what 13 14?

D: No I would say you was about 12.

W: So 12 and being threatened to be killed was a pretty scary thing,

H: I Yeah it is so scary. Yeah so I kept it to myself for about two week and then when I got the threatening text that's when it took its toll and I was like right obviously I need to tell my parents here. I think you was at work (to D) it was in the [Omitted] so Mum was sitting on the sofa in [Omitted] I think you was at work, but yeah that's the first thing.

W: And you talked about girls pinning you up against the wall?

H: Yeah in the girls' toilets.

W: Were you physically being, were you being hurt physically? Were you scared?

H: No I was just being pushed against the wall erm nobody kind of laid a finger on me I was squared up to by a couple of the girls at different times all in the kind of same space of time but at different points of being against the wall.

W: It must have been really frightening.

H: For a 12 year old yeah

W: Were they the same age as you?

H: Yeah but they were the oldest in my year.

W: Which makes it different at that age doesn't it

H: Yeah, and I wasn't tall then I hadn't really grown at all, I hit my growth then.

As this continues Wendy's questions follow a more concrete, information-gathering line of enquiry as opposed to the emotional responses to being bullied. Hannah does talk about being "scared", however Wendy does not pursue this outside of demonstrating empathy "Yeah it is so scary". In terms of the developing relationship, Wendy is exploring aspects of risk i.e. the circumstances leading up to the overdose whilst keeping Hannah in a relatively emotionally safe space.

Following on from this discussion, Wendy asks about the “*impact*” that these experiences had on Hannah:

W: Yeah, and what impact did that have on you? If you think of you before then and you after then.

H: That's []*

W: What did you notice? (Asking D)

D: I would say she went a bit quiet for a bit.

W: For a bit? At home at school?

H: Everywhere,

D: I'd say everywhere to be honest a little bit withdrawn so.

W: Ok, a bit withdrawn yeah. So that's what your Dad notices. How would you say it affected you, you know to how you were before to...

H: I tried making myself invisible, tried not getting involved in any kind of bitch arguments that would happen anything, I wasn't in lessons I was in it was like a room where you can they have like tutors and things that can teach you.

W: Because of this? After this you were out of the main class.

H: The only thing I do remember is it was definitely year 8 because you know it could have been year 7 actually because I went into [name] lesson no it was year eight because it wasn't [name] it was [name] and you came in with me and they were like is that your Dad and I was like yeah and she was like he's well good looking and I thought no, but she was like are you alright and I was like yeah and she was like come sit next to me and she was like the first girl that had the guts to be actually like do you know what I'm not gonna follow everyone else I'm not going to be awful to her because I had not actually done anything she had just targeted at the time somebody weaker than her but if I see her nowadays she tries smiling at me but I just want to rip her head off her shoulders she don't deserve the time of day.

W: So was that like out of the blue for you that that started happening?

H: Yeah.

W: You had never had anything like that happen before it sounds really really horrible, ok. So you are putting that at the beginning what next?

Wendy asks a more emotion-related question: “*what impact did that have on you*”. Hannah does not respond directly to this so Wendy asks Dad about what he had noticed at this time. As above, Dad responds with information about Hannah’s behaviour at the time in that he noticed that Hannah had become more “*withdrawn*”. Instead of pursuing the emotional content, Wendy continues with gathering this concrete information. This exploration, as indicated above encourages Hannah to begin talking more freely about her experiences. This way of interacting from Wendy’s point of view ensures that the timeline is completed and the group’s understanding as to how the overdose(s) came about begins to grow. Furthermore, from a risk perspective, Hannah has talked about some of the concrete information about her self-harming, particularly the means and quantity of tablets she took and that in times of distress she may become “*withdrawn*”. Wendy also involves Dad in this process, asking what

he notices and allows Hannah to hear another perspective. This change in focus (see 4.2. above) also allows Wendy to assess Dad's capacity to respond to risk. This allows Wendy to gather behavioural information related to these triggers, whilst simultaneously allowing Hannah to elaborate on her experiences. Wendy begins by getting concrete information about this (date, type of overdose, number of tablets). This results in Wendy handing over where to go next to Hannah "*where shall we start...?*". By doing this, Hannah has free reign (within the context of the timeline) to set the pace, however Wendy has also set her own pace by "*bringing forward*" discussions of the overdose. From this, Hannah begins talking about where her "*problem*" began. During this exchange the group discuss the topic of a traumatic event which has also been identified as a potential trigger (Hannah's rape), with Wendy putting it on the table for future discussion. In contrast to the indirect, casual approach to instigating this discussion in the first exchange, the relaxed opening talk about triggers has allowed Wendy to become more direct in her line of questioning. Wendy's questions appear in clusters which start off broadly and narrow in focus as the conversation progresses, which leads Hannah to talk about feeling "*alone*". Wendy is sensitive to Hannah's emotional response to this discussion and summarises the discussion which further crystallises the idea that the rape will be discussed later on in therapy. Wendy's sensitivity to Hannah's emotion ensures that she remains engaged with the process, and that the experience of emotion within the session is not

Summary. As I outlined above, the switching between factual and emotional information appears to moderate emotion in the room. However, this process differs in that the emotional moderation allows Wendy to understand some of the family's experiences in real-time without the need to stop the conversation or park the topic. In essence Wendy engages the family, assesses their capacity to hold particular conversations, whilst simultaneously gathering important factual information about Hannah's self-harm and the family's responses to it.

5.4. Gathering perspectives to encourage further talking. Wendy encourages other members of the family to comment on what another member has said in order gather further perspectives:

[Session Five]

W: [to Hannah] do you think that you do bring it up a bit more with your Mum and Dad than what you would have?

H: What?

W: Things that are on your mind.

H: No, because there hasn't been owt on my mind.

M: It's just the last two weeks, everything's come at once again, but a lot of it is just daily life things that you can't avoid, like [Omitted] going to college and [Omitted] moving-

W: [to Hannah] What does it feel like when your Mum says that? How does that reflect how you're feeling?

H: It make me, like- I just don't understand what I'm feeling. 'Cos it's not daily thing for me [Long pause]-

W: What do you think, Mum?

M: Um, I don't know because we do see things different. You know, if you see things different to me Hannah, I don't think there's a lot of point in trying to sit down and explain stuff, because Hannah sees it how she sees it and no matter how I'll try and explain it, it won't-

W: She won't change her mind?

M: No. She'll see it as she sees it.

W: But what- if Hannah is upset and you see it differently, what would you want to do about her upset?

M: Well, I wouldn't want her being upset, but some things like [name] moving to college and [name] moving away but there's- there's nothing we can really do to change what they've chose as their paths at the moment.

W: So, do you think- do you think Hannah will just be upset and you can't change-?

M: Yeah. I think with time she'll get used to not seeing [Name] as much as she used to does now, um-

Wendy asks Hannah “*what's it like to hear your Mum say that?*” which allows Mum to hear Hannah's perspective and thoughts on her Mum's perspective. In this instance everyone hears each other's perspective. In this sense Wendy has implemented a therapeutic intervention as Hannah and Mum share their perspectives in a way that allows the family to strengthen their understanding of Hannah's upset. However, simultaneously, Wendy has also been able to understand Mum's perspective on Hannah's distress, and perhaps some of her attitudes towards it. There is an element of change within the discussion as Wendy encourages Mum to reflect on her perspective of not being able to change Hannah's upset to which she offers her thoughts on Hannah maybe “getting used to not seeing” her friend eventually.

5.5. Returning to Parked Topics. Throughout the data, there are examples which highlight Wendy's returning to topics that have previously been ‘parked’ (see 4.1. above). The benefit of returning to these topics in such a manner is that within this data, the topics were usually agreed by Wendy and Hannah/her family thus making it a shared decision. With the balance of power in mind, the group start off discussing a pre-determined topic which was parked earlier on in either a preceding or same session. Although Wendy asks this question in such a direct manner, she highlights that Hannah has made this decision to discuss the topic

earlier in the session, and in addition to this, asks Hannah permission to proceed with the discussion.

5.6. Clustering Questions. One approach that Wendy employs which facilitates further exploration of a given topic is her use of clustered questions. Clusters of questions appear throughout the therapy and take the form of a number of related questions asked one after another. Particularly in the early sessions, Wendy utilises this style of questioning which appears to have a balancing function within the session in that it enables the family to almost ‘choose’ the question they would like to answer. This style of questioning is characterised as a group of questions asked together and are aimed at particular aspects of Hannah’s experiences.

[Session Five]

W: Do you talk to your Dad about them? Do you talk to your Mum? Do you talk to your friends? Or do you keep them inside at the back of your mind?

M: I say she must talk to her friends more than she talks to us.

H: I don’t talk to my friends.

W: What stops you talking to people about the bad things that are happening?

H: Because they just start crying themselves, I don’t want that because it’s complicated-

W: Is that because they’ve got a lot of problems going on, so they can’t take stuff on?

M: I think some of it is just general chit-chat, you know. Different people go to college and we know- well, I personally don’t think of it as a big deal because her auntie’s gone to college and it’s just sort of growing-up, moving on with next sort of chapter and, you know, we’re still going to see her and that.

This particular cluster of questions are primarily aimed at understanding who Hannah talks to about her difficulties. This prompts Mum to intervene stating that Hannah “*must talk to her friends*” and Hannah disagrees as she says that she does not talk to her friends. Common to this process throughout the data, Wendy then proceeds to focus on one particular aspect of Hannah/Hannah’s family’s response. In this case Wendy asks about what stops Hannah talking to her friends to which Hannah says that her friends start crying themselves. Wendy continues to focus in on this and wonders about Hannah’s perception of why her friends may become upset when she talks to them about her difficulties. This exchange, following the clustered questions, allows Wendy to also assess isolation and parental awareness. As is deduced from the above exchange, Hannah’s family appear unaware of her levels of isolation, which now that it has been discussed is out in the open for Wendy and the family to explore.

Clustered questions appear in a number of situations and are used to explore a wealth of topics. In the extract below, Wendy asks a cluster of questions related to the previous counselling that Hannah attended through school:

[Session one]

W: when you went to [previous counselling] what was the talking? How did you talk, how did it work going to [previous counselling].

H: She came to my school, she would ask how I was feeling, what I had been up to, we would go in this room in the English block and we kind of talked about, we never spoke about what had happened we spoke about what I was going through at the time if there was any problems that I had so it was never a conversation about what had happened, it was what was going on now. We spoke about the police case err and how it has cautioned if they take me to court and she would be like the person who's representation or summat err like if my parents can't get time off work and stuff and obviously my parents wouldn't represent me anyway, she informed me how they had been to his house, how he like denied it yeah pretty much that was it

W: Ok, do you know how come the two of you ended up not talking about what had happened was that kind of what you wanted, what you thought she wanted, what was it?

H: We never really got round to it and at the time I didn't really feel comfortable talking about it.

W: Yeah, do you think in this therapy it is something that you would like some space to talk about, or? At some point, would that be important for you?

H: At some point yeah.

In the extract Wendy asks three distinct questions which explore Hannah's experience of counselling and covers; 'what they talked about'; 'how they talked' and 'how did it work'. In response to Wendy's clustered questions, Hannah gives a cluster of answers of her own in that she talks about her experiences of the content of the sessions (how she "...never spoke about what happened..."), the physical setup of the sessions, some aspects of the court case, and how her therapist offered to act as a representative for her should she have to appear in court. From this cluster of questions, Hannah gives a lot of information about her experience, particularly that she did not talk about "what happened" and focused on how things were going at that moment in time. Wendy follows this up with another cluster of questions directly related to the aspect of 'talking': "do you know why you did not talk"; "was that what you wanted"; and "was that what you thought the therapist wanted". Hannah reveals that there were two reasons why the rape was not discussed in her previous therapy: because they "never got round to it"; and because she "didn't feel comfortable talking about it". On hearing this, Wendy then focuses her line of questioning further and asks a singular direct question "do you think in this therapy it is something that you would like some space to talk about, or?" to which Hannah says it would be. Discussing "what happened" then becomes a tabled topic (see below) which has been initiated by Hannah, which the group can return to later.

Summary. From the perspective of risk, asking clusters of questions allow Wendy and Hannah to identify what is most important to talk about and allows Wendy the chance to gather important information. Clustered questions also appear to ‘scaffold’ responses by offering Hannah and her family something to hang their responses on, particularly in situations where words may be difficult. The examples above give Wendy clear instruction on who Hannah discusses her difficulties with outside of the therapy room, and also her previous experiences of therapy.

5.7. Exploring Consequences of Previous Session. One of the potential consequences of engaging in any form of psychotherapy is the potential for the therapy itself to be a trigger for distress and that potential re-traumatisation may occur if service users are pressured into talking, thus potentially increasing the risk of self-harm. Wendy ensures that she devotes time to talking to Hannah and her family about their thoughts and feelings toward their previous sessions and exploring the consequences of coming to therapy.

[Session two]

W: [...] what was it like afterwards you know when you left here and you know the next couple of weeks? What effect did coming here and talking with your Dad have on how things carried on after that? Have you noticed anything?

This continues into:

[Session two]

W: And is the kind of closeness you have had afterwards is that something that is good for you or is it mixed or?

H: I think it's good, I don't know what's up with me today, it is good cause it's nice it know somebody's there but sometimes [laughing] why am I laughing so much.

W: Why do you think?

H: I don't know it's not normally this bad it's like a nervous laugh but its

W: You're putting important things into words your saying knowing somebody is there which is like really, really important it's not just a casual thing is it, so is it quite nervous putting something personal and important into words?

H: Yeah, but it's nice to know that I do actually have like someone there which is really good but then sometimes if we are both sat on sofa and I'm quiet and he will ask me what's wrong and there could be nothing wrong but he will ask me again and ill still tell you there is nothing wrong and you will ask me again and that's when sometimes it's a bit not too much but I've told you there nowt wrong the first time and there might not be anything wrong.

In session two, Hannah talks about “closeness” with her Dad in the time between session one and two and Wendy seeks to explore this together with a clustered question (see 5.6. above). Hannah replies that she feels that the closeness she experienced was “good”. Wendy then

involves Dad in the discussion and attempts to garner his thoughts on how he felt the previous session had gone. Dad talks vaguely about getting a lot from the session, that they had covered “a lot” and feeling emotionally drained afterwards. Wendy picks up on Dad’s cluster of answers and asks a more specific question which focuses on what Dad “got out of it”. Wendy gives a rationale for asking this question “...to help me understand”. Dad notices that Hannah has been more open making particular reference to writing down the thing that Hannah was unable to say out loud in the previous session. Wendy also says aloud that she appreciated Hannah’s openness in the previous session which involves Hannah in the conversation indirectly, and keeps her involve. Wendy notices Hannah becoming upset in the room.

A consistent process across each session is the returning to the previous one:

[Session Two]

W: I just wanted to ask you about the last session, what did you did think of the last session the last time you were here Hannah?

H: It was an emotional drain, really emotional draining strange cause I don’t really talk about my business I don’t really talk about personal stuff, but...

W: So that was kind of different coming and talking about personal stuff?

H: Yeah, even though it wasn’t actually personal stuff like actual thing that’s like, obviously you’re here trying to kind of figure out why I ended up like I did.

W: Yes I am interested in that yeah you’re right.

H: So you can kind of help other people like not necessary get to that point but to help them through the emotion, shouldn’t do it basically.

W: You’re thinking about this has been a research project?

H: Yeah

W: Yeah it is also therapy for you so let’s be clear about [] yeah it was strange coming last time very emotionally draining and I remember you went away and it had been an emotional process, what was it like afterwards you know when you left here and you know the next couple of weeks? What effect did coming here and talking with your Dad have on how things carried on after that? Have you noticed anything?*

H: We were a lot closer straight after, er, we were closer after and like some days we were really close and then others it feels like we are really distant.

W: You’re doing a good job of putting things into words.

In the example above, Wendy starts the session by exploring Hannah and her Dad’s feelings about the previous session in a direct way. This contrasts with the more conversational approach that Wendy adopted at the start of session one. Hannah talks about how she and her Dad became closer at times after the session, but at other times she felt more “distant”. Wendy picks up on this and gives positively reinforcing statement “you’re doing a good job of putting things into words”. Hannah replies “No I’m not” however Wendy does not follow this up with

further reinforcement and instead continues to explore the emotional consequences of this distance and closeness, particularly if it was a “good”, “bad” or “mixed” thing for her. Hannah states that it is a good thing, but finds herself laughing. Wendy wonders why Hannah thinks she is laughing, to which she replies that it is a “nervous” laugh. Wendy is demonstrating that she is accepting of Hannah’s laughing, and by asking a reflective question, together Hannah and Wendy have made sense of what it might mean: that it is a “nervous” laugh and it may come from the discussion they are having not being “casual” and possibly something that can make someone “nervous”. This interpretation is shelved for the time being by Hannah, and she notices that it is “nice” knowing that someone is there to support her but that this has also been difficult for her as there have been times where her Dad has asked whether there is anything “wrong” when there was not.

Summary

‘Finding out’, as mentioned above, is a particularly crucial aspect of the risk assessment process, as it allows Wendy to elicit information in a number of ways. The engagement of Hannah and her family is maintained through a combination of Wendy maintaining the balance within the relationship, and moderating emotion.

6. Negotiating an Intervention – bringing it all together

Throughout the therapy Wendy and the family negotiate a number of smaller interventions which can be as simple as allowing Hannah to discuss a difficult topic with her Dad. The sound base that Wendy creates with the family, allows them to begin thinking about interventions with a broader scope. In the middle of therapy, there is an example of an exchange where the group think about how to help plan for an upcoming anniversary (the anniversary of Hannah’s miscarriage). Although the negotiation of the intervention begins, the process can also appear to yield risk-related information for Wendy and appear to give her perspectives of the family’s coping with distress. The intervention, in this sense, is implemented with the view to perhaps lower the risk of future self-harm if the family are on board with it and utilise this in times of distress outside of the therapy room. The example from the data I have chosen to use has not been edited for brevity as it was a substantial part of the session, however it highlights how Wendy negotiates an intervention with the family. I will also refer to other previously mentioned thematic elements (detailed above) with the view to detailing the process from start to finish.

6.1. Communicating a rationale for the intervention (Negotiating balance). Prior to the exchange highlighted in the transcript below, Wendy and the family have negotiated

balance by setting shared goals for the session. Through the process of eliciting further information, Wendy and the family have identified that there is an important date for Hannah coming up that is likely to cause her distress. They now have a shared goal and Wendy introduces the discussion:

W: yeah [pause] so now, this, the date is coming up, you know it's coming into your mind, about what could have been, what would have been, and I wonder what, what, there's an idea about spending the day with your gran, but I was thinking in a slightly different way about how are you going to think about it on the day. Are you like, doing something to mark the loss of something even if you hadn't [pause]

H: I wouldn't know what to do

W: you wouldn't know what to do. You'd be making it up, you'd be making it up wouldn't you because there's not a book that says "this is what you do in this situation"

H: what do you mean "making it up"?

W: Well, sorry, you're saying that you wouldn't know what to do, and I suppose what I'm saying is, I'm not surprised because there aren't any rules for what to do in this situation, you'd have to, you'd have to make a, create something from scratch, you'd have to sort of make something that fitted for you and I guess maybe if possible fitted for all of you that maybe showed some feelings or some respect or something for what's happened because it's been such an important thing...

Wendy introduces the idea of the date coming up and gives Hannah a few reasons as to why this may be an emotional day. In a previous exchange Hannah talked about spending the day with her Nan giving the fact that Nan does not know about the miscarriage as a reason for spending the day with her. Wendy summarises this briefly and introduces the idea to the family that there may be another way of marking the day. Hannah then says that she "...wouldn't know what to do". Wendy normalises this by talking about how there is not a set of instructions that help people through these experiences. Hannah asks for clarification as to what Wendy means by "making it up", to which Wendy then talks more explicitly about how the family would have to "create something from scratch" and that whatever the family decide to do would be unique to them. At this point, within the theme of communicating a rationale for the intervention, Wendy is also balancing the relationship by arriving at a shared understanding with Hannah as to why it would be important to think about how she is going to spend the day. Wendy makes specific reference to "showing feelings" which moves Hannah away from the idea that she could spend the day not thinking about the anniversary whilst staying with her Nan. At this point Wendy has given her rationale for the intervention, stated that the family will be attempting to find something that "fits" them, and highlighted the importance of doing something that shows feelings.

6.2. Gathering perspectives (eliciting information). Now that there is a shared understanding as to why it may be important to think about staying safe on this day, Wendy

then widens involvement from Hannah to the immediate family in negotiating the intervention (“...maybe if possible, fitted for all of you...”) which prompts Mum to give the first idea to how the family could mark the day:

M: like writing down [] somewhere*

W: ...to almost like, mark, even if you have a birthday...

M: you know, sit and have a drink somewhere, something to try and I don't know, I don't suppose you can put a lid on your feelings because it's all in time but something to...

H: like a tree?

M: ...stop the feelings going all the time

D: something to mark the occasion.

W: mark it, to mark it, yeah, that's, something to mark it.

D: yeah? It's not something [pause] no one's asking you to forget about her

H: what about a tree?

D: a tree might, be quite a bit...

H: why not?

W: People do trees for people who have died don't they?

D: we can always do something to mark the occasion. It's not. It's not something that we're asking you to ever forget about, because I don't think you ever will, it's more about learning how to cope and to deal with different situations. Because every year that day is going to be there.

M: oh it will do, yeah

D: so if every year if you want to mark the occasion we'll do something. Yeah? No matter what it is, light a candle, whatever. What you can do is mark the occasion, what you can't do is let it hold you back in life.

[...]

W: it sounds like your Mum and Dad are on board with this idea quite quickly, does it, does it feel right to you to do something that will mark the...

M: if it's something that H feels that will help her because I just, I just like H to try and get past that first step of thinking of what life is going to be like for her, she's got so much to look forward to now rather than sitting on what's happened and it'd be just nice to see, you know, like before last weeks' incident she'd just been told that she'd got a part time, well little job of four hours a week in [omitted] and things were, well I thought things were starting to look up and she'd been riding [omitted] a bit cos I'd been on a friend's horse so we've been able to go out riding together which has been lovely. Then of course, out of the blue, we, you get that dreaded phone call that something's happened again and you feel you're two steps further back from where you were and I think that's what H said to D about how she felt.

D: H thinks she's gone back to square one, and I [] that she hasn't, since the two sessions that we've had, we've spoke about it and for us have been absolutely massive because we've covered, and I don't know what you talked about in other sessions, but I felt that we've probably covered six months' worth of stuff in two hours, so yeah we've covered such a massive range, of different subjects, her feelings and everything so [*] we might have taken a couple of steps backwards, but by no means are we back at square one. Nowhere near close to it.*

W: did you know, D, that the dates were in H's mind before...

D: no, not until it was on the day and we would have discussed it while were at the hospital yeah. It was all on the day.

H: [*]

D: yeah, it was all on the day once I knew she had taken something. I knew.

Again, Wendy and the family are negotiating balance at this stage, still within the realm of negotiating an intervention. Wendy supports the family in thinking about something at this stage, and guides the conversation by giving a “*birthday*” analogy and reiterating what Dad says about “*marking*” the occasion. This prompts Mum to give her perspective to which Hannah mentions a “*tree*”. Dad initially communicates reluctance at this idea giving his perspective of what a tree may signify, however Wendy asks the question “*people do trees for people who have died, don’t they?*”.

At this point Mum and Dad appear to be doing much of the talking around Hannah, Wendy as the mediator, encourages Hannah to re-join the conversation and get her perspectives on the idea of having a memorial tree. The discussion then focuses on Mum and Dad’s ideas as to where Hannah is emotionally at that moment. Wendy then re-focuses the discussion on the marking of the occasion:

W: what, what do you feel about this idea of marking

H: it depends in what way

[pause]

W: yeah. What’s your gut feeling, what’s your instinct about whether there should be some sort of marking.

H: I’m just confused [pause] at least I think [*]

[pause]

6.3. Finding meaning together (eliciting information/negotiating balance). In

formulating the intervention together, Wendy facilitates further discussion which allows the group to find meaning together. Wendy, keeping Hannah at the centre of discussions, returns to her idea of planting a tree:

W: a tree came into your mind didn’t it?

H: (laughs) yeah

W: yeah. What were you thinking about, what made, what do you, what does that mean to you, planting a tree?

H: I don’t know, just trees like, new life, they grow, they get bigger, stronger, and when it’s fully grown it’s difficult to knock it down.

D: [*]

M: *but do you think though if we plant this tree in the back garden when H's feeling down it's just going to trigger...*

H: *not necessarily*

M: *...the thoughts off if it's there in view, you know how we've spoken about [name] memorial and I said "oh I don't know if I'd like to look out the back door and see his little stone engraved and stuff" because it might just be too much to see all the time*

H: *even in black, I say on the bench next to it [*] constantly looking at it.*

M: *unless it's somewhere quite not in eye view of the back door you know because when you're sat on the settee you can see straight out the back door...*

H: *where that old tree used to be, that you cut down, on the left hand side of the garden*

D: *tree [*]*

M: *What, palm tree? No that broke down with wind.*

D: *no broke down, I didn't cut it down. It broke down [*]*

M: *I'm sure we can make an area that side*

H: *even right at the back [pause] I don't know.*

W: *...Do you think, what do you think, if you did something to mark this, I'm wondering what that might do to how much at risk you are of trying to kill yourself. That might seem like a funny question.*

H: *I don't really understand it.*

W: *Well last week you showed us that you were at a really high risk of killing yourself again, didn't you, because of the feelings and thoughts that you were having. If you do something to mark what's happened with your Mum and with your Dad, something special what, how will that affect your thoughts about...*

H: *I don't know*

W: *you don't know. So you might not know until after you have done it? and you might be able to see what affect it has.*

[TRANSCRIPT EDITED FOR BREVIETY]

D: *While they're talking she mentioned some where I didn't hear it [*]*

W: *Ok*

M: *It can't be some huge sycamore tree that's going to take over cemetery*

D: *Yeah you will have to find*

M: *You just want a little evergreen and just leave it to mature and then when you go talk to [name] but it's not on your back door step where your gunna see it out of the window every day when you are feeling down which is then gunna make you feel worse because I don't want anything to trigger things off again to start*

W: *I think one of the reasons people have it away from their house is that they are not going to live in that house forever and if you're not going to live in that house forever you know it gets really difficult you know when you think about moving away where as if you put it somewhere wherever you are you know you can you know it's not going to be in someone else's back garden but you have really got your thinking going on this now and you are talking about it quite openly*

M: *What they were saying near the end of the conversation though about how you will be feeling by next week, we've got a good idea how we think you will be feeling and that's why we were discussing maybe going up to Nana's but like they said have you actually thought to yourself right what am I going to do on that Wednesday, rather than sitting at home having it ticking over on my mind sitting stewing on it while we're at work you know where as you know right actually I'm not I'm going to get myself up and dressed I'm going to go [*] for two hours and then I'm gunna go find a nice spot at [name] or something, something*

that means you're not going to sit at home start letting everything take over your mind and think right I'm gunna walk to nearest chemist

D: []*

H: To be honest I'd rather have one of my friends they are aware about it

D: Right

H: And even []*

M: To stables and what sorry

H: Just to take [Horse's name] out

W: So do something who's aware what happened, have you got someone in mind?

M: Well say 'cause if your wanting them to stay over we are going to know they know anyway love

H: I know it's just, just let me think cause [] not necessarily to stay over just to be there on the day but I know I can't*

M: I was going to say where is he is he in Manchester now

H: No London

M: London oh rite, well we know that that's not viable so we've plenty of time to think about it so

Wendy asks Hannah about the tree she mentioned earlier. Wendy directly asks Hannah about what a tree would mean to her, and allows her to talk about this meaning. Hannah says that it would represent growth and life, however Mum then talks about her worries about how seeing the tree may trigger Hannah's self-harm. The family and Hannah discuss amongst themselves with Hannah's Mum appearing reluctant towards this particular memorial. Wendy then asks Hannah perspective as to whether having a tree in the garden would increase her risk, to which Hannah says she does not know. Wendy then suggests that Hannah may not know what will happen until afterwards, and in trying she may be able to "see what affect it has". This is a particularly good example of how Wendy goes about gathering perspectives and restores balance not only between herself and Hannah, but also between Hannah and her Mum. By the end of this exchange, Hannah and her Mum share together their concerns and through Wendy's questioning both perspectives are heard. Following the end of this particular conversation, the reflecting team enter the room and continue to discuss the idea of the tree, along with other ideas with which the family can mark the anniversary in a way that encompasses all of their perspectives. This discussion also reveals information about Mum's resilience and capacity to care for Hannah, and suggests that she is still worried about Hannah's self-harm and is reluctant to take what may be a positive risk.

W: Is this something that you will be able to go on talking about away from here? Is it going to be ok for them to keep on talking to you about it so you can get something sorted?

M: Well it's something else you can think about isn't it instead of being down on that day do something to turn it round

([] between H and D)*

W: What do you think you want from your Dad and your Mum on that day?

H: Just some support.

W: Yeah what kind of support would be good, what's it look like?

H: Pardon

W: What would they be doing?

H: Erm I don't know just being there

W: What kind of things do your Mum and Dad do that make you feel like you are been supported

H: They just []*

M: grounding

H: No

M: Oh right

[](between H, M and D)*

W: Is there a way of adapting that to now?

H: What do you mean to now?

W: Is there a way I don't know can it be recreated to

M: Throws everything on floor cousins on floor plotted around and just a blob on the floor

H: []*

W: So is that another bit of the plan that you will go on talking away from here

H: No I probably won't I'll probably wait till I come here

W: Just to make a plan of what you are going to do

H: It's not even a plan, it's just I don't want to just come out with it

M: Well just come out with it love

H: It's not that easy Mum

M: Was it the baby, right what name was it M and W pull the table towards H

W: That's really important that you talk about it

H: I can't just talk I can't just come out with stuff like that

M: Are you going to write it down like you did before if that's easier I'm not forcing you it's just a suggestion

H: I've got nothing to lean on the pens just gunna go straight through M passes H a box

M: Have you got any other excuse

H is writing something down

H: making a paper aeroplane

M: Make sure it doesn't fly, it's got no chance

H: I bet it doesn't fly, it looks more like a truck

6.4 Exploring emotion in the room. Wendy's approach to emotional responses within the room appears to change across sessions. Above I have described instances where in early exchanges, Wendy seeks to moderate emotion when it arises through a variety of means. However, in later sessions, Wendy seeks to explore emotional responses, and allow Hannah and her family to experience them. Again, if these emotions become too distressing for Hannah and her family, Wendy moderates, or encourages the family to moderate their emotion. This often results in a separate process (described in 6.5. below) in which Wendy encourages the family to stay with the emotion as it emerges.

6.5. Staying with and experiencing emotion. In session five, there is an emotive discussion in which Hannah becomes visibly upset with her Dad. Dad also becomes upset with Wendy in that he feels that as a therapist, she does not understand the perspective of the parents.

[Session Three]

W: Yeah, I appreciated Hannah's openness, what is it that brings that tear?

H: It's because I've had counselling sessions before for different stuff and it wasn't really talking about, like, the reason I ended up being there and it wasn't even talking about any problems it was just about what I had been up to and what I had been kind of doing so to have one session where I'm like kind of opening up a little bit about stuff, I just don't like opening up about stuff and it's difficult so to be having another kind of session like I'm glad I'm here and I know I need the help, I know that we all do, it just don't change the fact that I don't like it.

Wendy asking "what brings the tear" serves a dual process as it allows Wendy and the family to hear Hannah talk about her distress (in a therapeutic sense), and also allows Wendy to understand the source of Hannah's distress in the room. In the example above, Wendy does not change the subject or moderate the emotion per se, instead Hannah is encouraged to experience the emotion, and perhaps appreciate that her Mum and Dad are able to experience it without being overwhelmed.

7. Getting off the seesaw – exploring independence from therapy

Towards the end of therapy there comes a time where the family and therapist part ways and what has been achieved within the therapeutic relationship is required to stand independently outside of sessions. In this respect the family are leaving the therapy seesaw and going off into

the world. This may happen at the end of a particularly hard session, or even at the end of therapy itself. It is possible that the ending of therapy can cause distress in itself as the end of the relationship with the therapist can be considered a significant loss for the family/young person. As such Wendy seeks to explore the impact that leaving the therapy room may have. Wendy pays particular attention to endings of individual sessions as well as the ending of therapy itself.

7.1. Exploring the significance of endings. In session two where the talk moves onto the discussion of Hannah's miscarriage, there is a risk that Hannah may be leaving the session feeling uncontained. Wendy begins to explore what Hannah's plans are for the immediate period following the session:

[Session One]

D: are you alright [Hannah starts crying] I'm alright honestly ok so whatever it is you won't upset me now you need to talk about it I don't want to push you for it but you defiantly definably need to get it off your chest

W: What will you do when you go from here? Will you be able to go find a quiet café or something to sit in and have a bit of time the two of you?

D: Yeah we will probably have a chat

H: Why do we have to do that?

D: What have a chat?

W: What instead of rushing off into the rest of life

D: Yeah I think we better do a bit of retail therapy

W: Yeah

D: Who that got your attention didn't it

H: What's that?

D: retail therapy

W: Shopping [Hannah Laughs] Just go for a quiet coffee to start with?

H: You know like when I said to you that I don't like being introduced to new people until I like em because you often judge straight away and stuff

Wendy begins talking about ending the therapy as early as session five. She uses a timeline as reference for the family to begin talking about how things have changed during the therapy, and what they feel they have achieved over the course of their sessions together. The exchange presented within the following transcript extract has been edited for brevity, however I have highlighted the key processes that emerge through the talk of endings with Hannah and her family. This particular example follows a brief conversational start to the session.

[Session Five]

W: So I was thinking I want to catch-up with you, with what we were talking about. One of the things is [Wendy begins drawing a timeline] if, um, we just think about the [pointing to X-axis of timeline] that's like the end [draws a point on the paper] and the at the beginning of therapy [draws another point] there was a really big worry about you killing yourself, self-harm and that possibility, so there was a really big worry then and it's really important that we find out from you today where you think you're up to now. What's changed and what still needs to be thought about? [Pause for a bit] I've just launched in at the beginning and not asked you all how you're doing. [M and D a laugh slightly] Do you want to get straight in with thing you want- are there thing you want to think about today?

M: No, I thought things were going okay until Hannah said last week she had to go back on to antibiotic-[to H] were it viral, for your throat were it? No, your shoulder, that was it?

D: Shoulder.

M: Uh-

H: My shoulder dislocated in my sleep last week so they had to trust me to get tablets out because nobody was around in the day and I needed the tablets to keep the pain under control. Um, [pause] it's-

Wendy begins the exchange discussing the ending of therapy and sets clear goals as to what she would like to achieve paying particular attention to talking about the overdoses in the context of keeping Hannah safe after therapy ends. Wendy then identifies, and says aloud, that she has “*launched in*” without consulting the family. The talk of endings appears to prompt the family into this more focused way of talking. This also gives Wendy rich information about Hannah’s current intentions of taking another overdose without having to ask directly about these intentions.

In the final session, Wendy broaches the topic of endings directly with the family from the start of the session and asks Hannah what the ending feels like:

[Session Seven]

W: So I think this is the last time we meet with you, it that right? [H, M and D nod]

D: Yeah.

H: Yeah

W: What does that feel like?

H: Strange [slight laugh]

M: Hopefully a good thing, though.

W: Do you feel ready or do you think you'll struggle or-

H: Um-

W: -not at all really?

Wendy directly asks what this might feel like and Hannah says that she will find the ending of their therapy “strange”. Wendy then asks about her perceived readiness for ending using a cluster of questions. This leads Hannah into talking about whether she feels ready:

H: I don't know, half-and-half. Because there are still the days where I can get down and upset and stuff, um, and even like the smallest thing can still get to me whereas if I were in hospital first time, I could keep it in easily, now I just get into tears.

W: Yeah.

H: Um-

W: You could keep it in before?

H: Yeah.

D: But that were a problem.

H: But now I'm just an emotional wreck! If something makes me cry, there'll be so many tears.

D: Well, love, that's-

H: Yeah, but I don't like it. It's not normal.

D: It is normal.

H: You say that-

D: It is, because bottling it up is what got you in hospital-

H: Yeah.

D: Here you've been able to release it out.

W: Yeah.

D: That's the difference Hannah.

W: And what do you think will happen to the tears over time? Do you think that'll work out by itself or-?

D: She'll learn to cope with it, because it is- [to Hannah] it is what we do, you're emotions get you and you just let it go and crying is- it's like you're good and if you're doing that that's the biggest step and you realise.

H: Sometimes you ask me what's wrong and I'm not ready to talk about it, or I know it's going to blow over.

D: [pause] Hmm.

W: Is that maybe you're in middle- it's not like you're at the end of the path but you're a long way along the path. So, at the start of the path you bottled things up and then they kind of exploded into an overdose-

H: I couldn't cry very much at all.

W: No, not crying, not crying.

H: Very rare and when I did it was rare that people knew I did.

W: Yeah, people didn't know, nobody really knew what was going on for you and your Mum and Dad didn't know, and you were the rock for friends, but they weren't being the rock for you, so it kind of exploded. Yeah. [to Hannah] Hmm- shall we draw it?

7.2. Exploring therapeutic change. A consistent finding throughout the data is Wendy's on-going exploration of how Hannah and her family feel that they have, or have not changed over the course of therapy. This appears to be crucial information in understanding how efficacious the therapy is and whether the family can identify a change process occurring.

D: It's after the busy Christmas period, which she's really pleased about so she wasn't worried about it, I think it's just Hannah getting a bit worked up about what she was going to say and how she might take it.

W: Yeah. But it sounds like you've 'ridden that wave', you've come through that [D nods] and- yeah. [to M and H] And have you two tried that kind of listening without feeling like you have to be thinking about thing too much?

M: Yeah. When we left here, for quite a few weeks afterwards we started – yeah, we do still have some disputes and disagreements now and I don't think that will ever change- but definitely I stopped myself a few times from –not arguing- but putting across my opinion and I just let her choose, you know, what she chose when we were discussing stuff-

[Session Seven]

W: Were you creeped at bit?

H: Yeah, I found on the last bit I wanted to say a little word but I wouldn't say what I was thinking.

W: Are you okay about being creeped out?

H: It doesn't get any less weird.

W: What would you say- what could we say to other families about it? Because I don't know- how have you found this bit of the therapy, hearing-?

H: I wouldn't suggest not to do it because I think it is good, just it's like, in a way you're only talking to one person but two other people can hear you and if they didn't come in at the start of the session, I'd forget they were there, other than you tell me about it. Um, but no- it's like sometimes someone else's opinion of stuff you can't always say owt to them, if you know what I mean. So, I wouldn't- I would keep it.

W: Yeah. [M,] for you, what was it like listening to them? Is there anything in particular that was tricky?

M: Um, no. I think when it first started it felt really weird but it was good to hear what you were saying from how other people saw it.

W: Hmm.

M: Um, and that made you realise that at some points throughout the counselling that: "Well, actually I didn't see it like that," you know, it does make you think differently sometimes on the surface bit- I can't remember what surface bits- but in the past, um, I've found it different but I've found it good as well. I couldn't say there was a bad thing about it.

W: [nodding] Okay. Was there anything that they were saying today that, um- do you want to say anything else about what-?

M: No, no.

W: Okay.

M: No, I think each time we've come it'd got better and better with the sessions I would have said.

W: Hmm.

H: [to D] Your turn.

D: [smiling] My turn?

W: What about you [D], you know how to do it now [All laugh].

D: I always think it's interesting listening, because sometimes you can get caught up in what's happening and the madness but when they come in it helps. If you are able to listen to them it sort of reinforces that, you know, other people think you're doing well. Sometimes you hope you're doing the right thing-

H: Reassuring.

D: Yeah, it is I suppose the same as what we've done today, you know by talking about you and saying this and that about you, it's nice to hear someone reaffirm that for you.

W: Yeah, reaffirm.

D: Yeah, it's sort of been interesting with them coming in anyway, it's a bit surreal kind of listening to them-

H: It's like it's happening to your face but not bad stuff.

W: It's a different way of doing things.

D: Yeah, it's like a having your own little cheerleading squad on the side, sort of saying [gestures pom-poms] "Yay, you're doing alright!" [W and H laugh]

W: And they wouldn't be doing that if they didn't think that.

In this extract from session seven, Wendy begins talking with the family about their experience of the reflecting team and asks direct questions about how they have found it in their final session together. Initially the direct questions yield quite limited responses from Hannah, and instead Wendy asks Hannah to imagine talking to other families about what to expect from the reflecting team. Wendy also gathers the perspectives of Mum and Dad and allows them to share their experiences of the reflecting team.

Wendy explores the family's perception of change in session seven:

[Session seven]

W: So, the last few weeks have been quite hard whereas before that, since the last time you'd been in hospital, things were not too bad- is that what you're saying?

M: Yeah, [to Hannah] it's just the last two weeks isn't it where everything seems to be hitting back with a hammer.

W: But [M] what you said was that Hannah had told you that she felt a little bit at risk of taking more pills and [to Hannah] you haven't taken them yet. [Hannah nods]

M: She's just been taking her daily dose, haven't you love? [Hannah nods]

W: Hannah, is that quite different from before when you didn't tell anybody- this is what your Dad- you didn't -?

H: It wasn't that I thought I was going to do it [pause] I just didn't want the chance or opportunity to do it.

W: Yeah.

H: Because there was nothing wrong with me to do it, really, there was nothing that- yeah, my shoulder's dislocated but that's nothing new, that's-

M: Yeah, there's not a lot you can do about that, the surgeons say the Physio will start working.

W: That wasn't the reason. What else were you thinking about back then?

H: I were really upset, I was in flood of tears but, um, I rang my Dad. But then I got a text message saying that my baby cousin had been born-

W: You what?

H: My cousin was born.

W: So, you got bad news and good news?

H: It kind of cancelled out the failure of my results. Um, I haven't really thought much about that since, 'cos I set myself up thinking I was going to do really well because even though I'd had a bad year I put all my effort into the second exam and I did appalling in it, really appalling. [Hannah looks upset]

W: That's alright. What's your plan then for the future, then?

H: I don't have one.

W: Okay, are you just working that out?

H: Just work.

D: Well, you applied for-

H: Yeah, I applied for college but my course is full. They said [] so their course is full, so they offered me the best out of two.*

Wendy begins by asking a direct question which encourages Hannah's Mum to think about change in terms of how things differ at that current time, to how they were after her overdose. Wendy then highlights another shift in Hannah's coping in that she says that Hannah has communicated to her that she feels at risk of taking more tablets yet she has not done this. Hannah then says that she did not feel at risk of taking more tablets, more that she felt that she did not want to get to the point where she did. Wendy summarises this in terms of how this is a change compared to how Hannah has coped in the past. The group find that Hannah's shoulder injury was "nothing new" and not something that would contribute to this thought process. Wendy explores this further by asking about what Hannah was thinking at the time. Hannah goes on to communicate that the surprise of her GCSE results was behind her thinking at the time. This prompts Wendy to ask a question about Hannah's plans for the future.

Executive Summary

In thinking about how Wendy moves between focusing on therapy or assessment, the data reveals that these foci are not mutually exclusive. There are rare occasions throughout the data in which Wendy takes a purely 'therapeutic' or 'assessment' role, however on the whole, these tasks occur extremely subtly and simultaneously. This process is based within the context of a balanced, conversational relationship in which each participant in the therapy has an equal footing. Even when the perceived risk changes, i.e. when Hannah takes an overdose between

sessions, Wendy's approach still fits within this framework, with a key difference being Wendy's more direct establishment of her own goals. Despite this, because of the balance Wendy negotiates within the relationship, the change in perceived risk has a limited impact on the relationship, and despite communicating goals more directly, Hannah and her family continue to contribute to the sessions. Engagement also appears to be maintained by the theme of balance, collaboration and mutuality. In addition to this Wendy moderates emotion in the room in a way that avoids re-traumatisation, and in a way that encourages Hannah (someone who reports to be reluctant to talk) to continue to return to the therapy and contribute to the discussions. In some instances Wendy encourages the family to moderate on their own.

CHAPTER 4: DISCUSSION

In the final chapter of my work, I shall now summarise the findings of my analysis and how these relate to the current literature. Furthermore, I shall then argue the implications of these findings for clinical practice. Finally, I shall then consider the strengths and limitations of the current study with the view to identifying directions for future research.

Project Summary

The aim of the current study was to explore and describe how a family therapist moves focus between therapeutic and risk-assessment endeavours, how she maintains engagement, and how her approach to assessing risk changes in response to changes in perceived risk. Grounded Theory was employed and a process model of the approach to risk assessment employed by Wendy during the seven therapy sessions was presented (figure 3; Chapter Three). The model focuses around Wendy's negotiation and balancing of power within the therapeutic relationship, creating a more equal footing between the 'expert' therapist and the 'service users' in the family. By creating a sense of discussion and informality, the family are encouraged to contribute to their own agenda and to become experts of their own experiences. Wendy also seeks to moderate the experiences of emotion within the therapy room and does this in a number of ways which then facilitate the discussion of risk-related information. Furthermore, the combination of creating a safe space, negotiating an equal relationship and moderation of emotion Wendy is able to explore risk and instigate the planning of interventions with the family and Hannah.

This level of informality, negotiation and moderation of emotion allows an atmosphere of joint discussion where power is shared which leads either directly or indirectly to a discussion of risk in the first instance, and subsequently a joint understanding of the risk(s) posed in the second instance. From this Wendy facilitates potential interventions which the family can implement themselves thus reducing the risks of self-harm outside of the session. It is important to notice that these processes are interchangeable and non-linear, and that the formulation presented in figure 3 (Chapter Three) is a simplified version of these processes.

Where do these findings sit within the current literature?

The current results are unique, in that as of writing there have been no process-driven studies which examine risk assessment in family therapy. As such, the current study provides the groundwork for further research which will be discussed below. The study does fit within the literature of qualitative studies which investigate post-hoc implications of risk assessment. The

effort to create an equal and balanced relationship within the therapy is reminiscent of the “*Collaborative*” risk management style cited in the Sayers (2007) model. The current study, however takes this model a step further in that it sought to explain how a therapist/practitioner creates this atmosphere of collaboration.

Although the study was designed to investigate the processes of risk assessment in family therapy, in my analysis there were a number of practical elements of risk assessment identified which reflect the recommendations of the current literature, particularly the NICE (2015) guidelines on assessing risk in CAMHS settings. There are a number of examples of the therapist gathering the information suggested by the guideline, however in the current study (as with the Sayers, 2007 study) the process is taken a step further, and it has been demonstrated *how* a therapist may gather this information in a mutually supportive manner.

Implications for clinical practice

The implications for clinical practice are potentially far-reaching. Previous research into risk assessment has focused on the ‘what’ of risk assessment, meaning that practitioners have a good idea of the sorts of questions to ask at the time in order to gather information about the level of risk posed to a particular person. These studies have largely recommended actuarial approaches to assessing risk.

The literature describes an emotive topic in which engagement is key in understanding someone’s difficulties. Engagement, of course, can be difficult at this time particularly if the person being assessed is experiencing shame, guilt and remorse which may be related to the popular perception of SH or even by the assessing practitioner’s approach. The current study moves away from the ‘what’ and begins to describe the ‘how’ in a particular case of therapy. Not only is this important to consider for those in family therapy, but these findings could also begin to describe processes of assessment which can be extrapolated beyond family therapists to encompass other professionals such as A&E workers, General Practitioners and Psychotherapists.

Wendy also engages in the key features of a risk assessment described within the literature (e.g. NICE, 2015). How this is done however, is more of a protracted endeavour in which the severity of the self-harm is kept in the minds of the family.

Critique of the current study

One of the strengths of the current study is the dataset used to examine the risk assessment process. Previous models (such as that described by Sayers, 2007) have utilised post-hoc approaches and asked therapists about their decisions and process whilst simultaneously watching videotapes of their own sessions. From this approach there are a number of biases. These include the amount of time between the session and the interview afterwards; the fallibility of the therapists' memory; and the limitations of the questions asked by the interviewers. The *en vivo* nature of the current study allows for a real-time analysis of the data as well as the opportunity to complete a number of iterations of analysis.

The application of Grounded Theory also adds credence to the current study in terms of what has been achieved analytically. Although there are some limitations to this approach (see below) the use of Grounded Theory is well documented throughout the process literature. As indicated in my methodology, other approaches were considered such as IPA and CA and after completing the project the Grounded Theory approach remains justified. The use of this approach to describe the processes at hand within the therapy sessions is greatly appreciated in the moving forward of research in this area. GT has been shown to be an excellent form of methodology in other areas of family therapy and this tradition is continued in the current study.

Furthermore, there are a number of limitations to the study which I shall also describe here. Firstly, I feel that my knowledge of Grounded Theory grew in parallel to the growth of my analysis. By this I mean my knowledge of GT was limited to the workshops facilitated by the Leeds training course, my own reading and understanding; and that of those who attended the peer support sessions. By the end of my analysis I felt that I had a clearer understanding of the methodology, however equally I feel that I still have a lot to learn about using this approach in qualitative research. This is not to say that my analysis is incomplete or flawed, more that I feel that starting off in a more accomplished position would have yielded a more accomplished set of results.

As described above, the use of a single case of therapy could be considered both a strength and limitation. This choice of data is limiting in the sense that the model shown in figure 3 can only be considered for this particular incidence of therapy and describes the experience of one therapist, young person and her family. There is a concern that the data may not be as generalizable to other incidences of therapy and that the model described in figure 3 can only be applied to this instance. Contrarily, I feel that the quality over quantity approach to this

project is justified in that a single case of therapy has allowed me to identify how some of these processes provide context for the therapy; how they are interlinked over time; and how particular processes can lead into others. I feel that these opportunities would be missed if I had analysed multiple therapies. The process of risk assessment and maintaining engagement in Hannah's case was on going, and continued throughout the therapy. If we were to take an example, say 'the first and third session from four therapies' we may not appreciate how subtleties such as 'maintaining a conversational tone' permeates across the sessions.

We may also consider the selection of the case for the analysis. In the search for a suitable candidate for the analysis who met the inclusion criteria described in the methodology, I was presented with three cases of therapy by a member of the SHIFT team. Due to time constraints associated with workload demands, I was not able to view each and every therapy from start to finish and Hannah's case was chosen due to the perceived severity of the risk involved and the attendance of the rest of her family at the majority of the sessions. One reflection that could be made was that the trigger for the self-harm appeared to come from a source which was external to the family (Hannah's rape). It may be interesting to consider whether we may have observed different approaches to assessing risk, engaging the family and devising interventions if the young person had experienced a trigger for their self-harm which emerged from within the family. Furthermore, in considering future projects it may also be worth reflecting on how a therapist's approach to assessing risk may change in terms of the perceived suicidality of the young person, for example utilising a sample of young people whose methods of self-harm differ in perceived lethality to the case used in the current study.

My knowledge of SFT was also limited at the start of the project and, as with the GT methodology was required to learn a lot of the terminology and techniques as I was completing my analysis. At this stage it was particularly useful for me to seek support from my clinical supervisor, who is a family therapist herself in order to check-in on my thoughts, feelings and interpretations of particular behaviours within the therapy room. However, despite this extra support, there is the possibility that my interpretation of particular interventions of the therapist were misconstrued or misunderstood thus affecting the final analysis.

Finally, the model I present may appear to be linear, a criticism I made of the current literature pertaining to risk assessment. Perhaps in my analysis I focused too exclusively on the family's influence on the therapist which in turn led to a less robust analysis of the influences of Wendy on the family. Furthermore, the analysis focused on Wendy's approach to assessing

Hannah, yet there may have been more subtle processes at play, including how Wendy assessed the family's capacity to keep Hannah safe when she engages in self-harm. In my analyses I have demonstrated how these processes overlap and intertwine which lends credence to the idea that complex processes such as those described here cannot easily be boiled down into operationalized diagrams or charts.

Further research

The current study uses a single case of therapy followed through from start to finish. Further research could focus specifically on some of the themes identified within the model I have proposed paying particular attention to a wider number of cases. Further research projects may, for example investigate the ways that family therapists manage the balance of power. Wendy's approach was largely conversational with little attention paid to the intricacies of the therapy such as the reflecting team's role or what sessions look like in general. Perhaps other therapists take a more direct role in talking about what to expect and it would be important to investigate common themes and processes across therapists rather than within one course of therapy.

The current study does not use any quantitative means to gather information such as mood measures and satisfaction ratings. A future study may also investigate the impact of these processes on how the therapist is perceived in therapy using a mixed-measures design which looks at process using a qualitative approach, whilst simultaneously gathering the perspectives of the family. By doing this, researchers may have the opportunity to measure the efficacy of such approaches as during my work on the project I was left wondering how the family perceived and experienced Wendy's approaches and whether they found them helpful.

Personal Reflections

The current study has been a learning process for myself and on the whole, has been an enjoyable process. I feel that my capacity for reflecting on the data increased over the course of the project largely due to my academic supervisor who has challenged me at each stage to look at the data in a more critical way. At times I felt myself describing what I was seeing rather than thinking more reflectively about the processes unfolding within the therapy room. Asking questions such as 'what is happening here'; and 'how did we get to this point' enabled me to produce an analysis that has added to the current literature on risk assessment from another, qualitative angle. Although the number of iterations of analysis that I completed

throughout my analysis was a cause for frustration (in total there were more than five), I felt that by going back to the data and looking at it through different lenses meant that the final analysis was much more thorough.

An aspect of the project I have particularly relished is the challenge of pictorially representing the processes identified within the analysis. The dataset consisted of almost 11 hours of therapy data with processes which interlinked, appeared and disappeared across and within sessions. Although I feel that the resulting diagram perhaps oversimplifies the processes, I also feel that it equally amalgamates them into a readable and useful formulation which can be used to inform future research.

Throughout my analysis of the data I felt myself taking on a number of different 'roles' when looking at what was unfolding within the transcripts. As a Trainee Clinical Psychologist I have been encouraged to think about therapeutic technique and to observe what occurs during therapy. I found this particularly difficult to 'switch off' during my analyses as I felt a particular draw towards understanding SFT from a professional standpoint which meant that I was again focusing on the 'what', rather than 'how' of therapy.

In the early stages of trying to understand how to 'do' grounded theory, I found myself looking at other DClinPsy projects which investigated a wide range of topics. Initially I felt that GT could be implemented in a stepwise, almost mechanical manner. I feel that my previous experience in completing quantitative research contributed to this as my previous studies have encompassed statistical analyses in their methodologies. Furthermore, I found it difficult to move away from this as it felt 'safe' to be able to follow a prescribed set of instructions in order to produce an effective analysis. As the project has progressed I found myself being better able to deal with these uncertainties which freed me up to think about my analysis in a more idiosyncratic way. I am particularly proud of this achievement as it has enabled me to produce an analysis that is unique, yet can be replicated in future studies.

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APPENDICES

APPENDIX I: SHIFT Consent Form

Recording Family Therapy Sessions for Research

INFORMATION AND CONSENT FORM

Participant ID:	Initials:
Date of Birth:	CAMHS:

- Your family are involved in the SHIFT study.
- The members of your family who have already provided full consent to take part in the study have agreed to family therapy sessions (like this one) being recorded.
- However, sessions don't have to be recorded if anyone would rather this didn't happen. This is why we are asking you all to sign this form to be sure that you are happy for the recording of each session you attend to go ahead.
- Sessions that are recorded will be kept securely by the family therapists so that they can review what happened in the session.
- Tapes may also be reviewed by their Supervisors and by members of the SHIFT Research Team.
- When you have completed therapy, the tapes will be held securely by the Research Team at the University of Leeds until at least 5 years after the end of the study, and then confidentially destroyed.
- You can withdraw your consent for the tapes to be kept at any time prior to the study being analysed.
- We are also asking if you would be willing for tapes to be used for future research by other Researchers. If this happened we would be sure that an ethics committee had approved any new research projects before they started, and that secure storage and confidentiality were maintained at all times.
- Results of any research studies (including SHIFT) would not identify anyone involved.

Please circle yes or no for each question below.

You will all need to sign and date this form too.

We have read and understood the points detailed above Yes / No

We agree to all sessions we attend being recorded Yes / No

If either of the above answers are 'no', sessions will not be recorded.

We agree to all tapes being stored & reviewed for the SHIFT study Yes / No

We agree to the tapes potentially being used for future research projects Yes / No

We understand that this form & the tapes will be stored at the SHIFT Research Office at the University of Leeds Yes / No

Signatures

Name	_____
Signature	_____
Today's date	_____
Name	_____
Signature	_____
Today's date	_____
Name	_____
Signature	_____
Today's date	_____
Name	_____
Signature	_____
Today's date	_____
Lead Therapist	_____
Signature	_____
Today's date	_____

APPENDIX II: Ethical approval Letter



Health Research Authority **NRES Committee South West - Central Bristol**

Whitefriars
Level 3, Block B
Lewin's Mead
Bristol BS1 2NT
Email: nrescommittee.southwest-bristol@nhs.net

Telephone: 0117 342 1335
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09 June 2015

Mr David Marshall
Institute of Health Sciences (Clinical Psychology Programme)
Charles Thackrah Building, 101 Clarendon Road
Leeds
LS2 9LJ

Dear Mr Marshall

Study title: Suicide Risk Assessment in Systemic Family Therapy
REC reference: 15/SW/0161
IRAS project ID: 168763

The Proportionate Review Sub-committee of the NRES Committee South West - Central Bristol reviewed the above application on 03 June 2015.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager Mrs Naazneen Nathoo, nrescommittee.southwest-bristol@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

On behalf of the Committee, the sub-committee gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Condition specified by the REC:

1. A copy of the consent form used for the SHIFT study should be submitted.

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which can be made available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see “Conditions of the favourable opinion”).

Summary of discussion at the meeting (if applicable)

The PR Sub-Committee agreed that this was a well presented study with no material ethical issues. However, they wanted sight of the consent form used for the SHIFT study.

Approved documents

The documents reviewed and approved were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Letter]	V1	01 May 2015
IRAS Checklist XML [Checklist_18052015]		18 May 2015
Other [email response to queries]		20 May 2015
Other [Email re: consent]		26 May 2015
REC Application Form [REC_Form_18052015]		18 May 2015
Referee's report or other scientific critique report [Transfer Report]	V1	02 March 2015
Research protocol or project proposal [Proposal]	V1	23 March 2015
Summary CV for Chief Investigator (CI) [D Marshall CV]	1	23 March 2015
Summary CV for supervisor (student research) [Mary Godfrey CV]	1	01 May 2015

Membership of the Proportionate Review Sub-Committee

The members of the Sub-Committee who took part in the review are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol

A Research Ethics Committee established by the Health Research Authority

- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:

<http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

15/SW/0161

Please quote this number on all correspondence

Yours sincerely



pp. Dr Pamela Cairns
Chair

Email: nrescommittee.southwest-bristol@nhs.net

Enclosures: *List of names and professions of members who took part in the review*
"After ethical review – guidance for researchers" [SL-AR2]

Copy to: *Clare E Skinner, Faculty of Medicine and Health Research Office*

NRES Committee South West - Central Bristol

Attendance at PRS Sub-Committee of the REC meeting on 03 June 2015

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Robert Beetham	Retired Consultant Clinical Biochemist	Yes	
Dr Pamela Cairns (Chair)	Consultant Neonatologist	Yes	
Dr Julie Woodley	Senior Lecturer/ Chair of Faculty Ethics Committee	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Naazneen Nathoo	REC Manager

APPENDIX III: University of Leeds Transcriber Confidentiality Form

Transcription of SHIFT sub-study family therapy sessions: Confidentiality Agreement

This is an agreement between:

David Marshall, Psychologist in Clinical Training, University of Leeds

And

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I,, confirm that all information I am exposed to whilst transcribing the family therapy sessions will remain confidential. I understand that the data has been provided by NHS service users and therapists as part of the SHIFT trial on the condition that any information about them will not be shared with anyone outside of the research team. I hereby agree not to disclose information regarding the participants to anybody.

Transcriber signature:

Signed

Print name

Date

Researcher signature:

Signed

Print name

Date

Transcriber confidentiality agreement. V1: 19/6/2014