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Title: Contesting constructs and interrogating research methods: Re-analysis of qualitative data from a hospital-based case study of self-harm management and prevention practices

Authors

Dr Rhiannon Evans (Corresponding Author)[1]

Dr Catherine Sampson[1]

Dr Sarah MacDonald[1]

Dr Lucy Biddle[2]

Professor Jonathan Scourfield[3]

[1] DECIPHer, School of Social Sciences, Cardiff University

[2] Bristol Medical School, University of Bristol

[3] CASCADE, School of Social Sciences, Cardiff University

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ABSTRACT

Discourses of self-harm, and also suicide, are often underpinned by a central tenet: prevention is the priority. This belief is seemingly so inscribed in research that it is rarely interrogated. The present paper re-analyses qualitative data from a hospital-based study of self-harm management and prevention practice. It aims to reflect upon, and disrupt, the authors' latent assumptions about the construct of 'prevention', while reflecting on the research method used. Twenty-five individuals participated in semi-structured interviews: healthcare and affiliated professionals (n=14); parents and carers (n=8); and children and young people (aged 9-18 years) who had presented to an emergency department for self-harm, with or without suicidal intent (n=3). We offer two central discursive considerations: 1) Self-harm prevention is largely an unintelligible concept, having to be reflexively constructed in situ. As such, it is questionable whether it makes sense to discuss the prevention of this amorphous and dynamic phenomenon, which cannot always be disentangled from everyday life; 2) Interviews entail significant biographical work for participants, notably the performance of personal and professional competence for the audience. These interactional dynamics offer a glimpse into the priorities, meanings and needs for participants in relation to self-harm. Together these considerations provide useful insights into how the interview method can serve as both a limiting and illuminating site of knowledge creation.

1. Background

Discourses of self-harm, and relatedly around suicide, are often underpinned by a central tenet: management and prevention are the priority. We have observed a wealth of research based on this core assumption, which seeks to understand the mechanisms through which prevention can be realised or optimised. Qualitative research, including our own, has explored the perceptions and behaviours of healthcare and affiliated professionals, while considering system factors that shape the negative attitudes often reported (Saunders et al., 2012, Gibb et al., 2010, Evans, 2018, Jennings and Evans, 2020, MacDonald et al., 2020a). This has been accompanied by an expansive literature offering insight into the experiences of help-seeking, drawing out recommendations to mitigate barriers to service access (Hunter et al., 2013, Owens et al., 2016, Bantjes et al., 2017). In parallel, we continue to see the proliferation of intervention evaluations (James et al., 2017, Robinson et al., 2018, Zalsman et al., 2016), alongside the progress of clinical guidelines intended to offer standardisation and quality in practice (National Institute for Health and Care Excellence, 2013, National Institute for Health and Care Excellence, 2004).

Tracing the history of research in this area, the advance of critical studies in suicide has served as a vital force in contesting, or at the very least troubling, the prevention agenda in relation to both self-harm and suicide. In some respects we may suggest that the very inception of this voice was a direct response to what some critical studies researchers have identified as an 'objective' evidence-base and its mechanistic, individualist approach to risk management (White et al., 2016, Hjelmeland, 2016, Marsh, 2016, Fitzpatrick and River, 2017, White and Morris, 2010). In drawing upon more critical perspectives, we are faced with important and fundamental debates about the values ascribed to our bodies, and the need to deconstruct seemingly entrenched binaries that position certain practices and outcomes as good and others as pathological (Marsh, 2016). Through the destabilisation of our assumptions, we can begin to fully recognise the fractured nature and experience of self-harm for the individual, and how dominant, biomedically informed approaches to research have risked bracketing out the complexity of lived realities, while introducing moral judgements. From here, the idea of a coherent and systematised approach to self-harm prevention becomes inherently challenging, leading to increased critique that existing treatment and support is falling short of fully understanding the nature of the very phenomena it is seeking to address (White, 2016).

The present paper offers a critical re-examination of data from a study on how, self-harm prevention may be better enacted. The research was intended to understand the experiences of children and young people who present to a hospital emergency department for self-harm, alongside their parents and carers. It aimed to explore how the quality of provision may be enhanced, how future help-seeking may be encouraged and how repeat self-harm may be reduced. It further considered the experiences and perspectives of healthcare and affiliated professionals in treating self-harm, in addition to preventing and responding to suicide. For the purposes of the study, we understood self-harm as the internal or external harming of the body. No a priori distinction was made between non-suicidal self-harm or self-harm with suicidal intent, where the latter may be classified as a suicide attempt (Kapur et al., 2013). While focusing on self-harm, and acknowledging it as a distinct construct, we recognise some relationship to suicide. Across the data there was a sense that self-harm may reduce the risk of suicide for some individuals, and hence they may be treated as related phenomena, although this

relationship is highly complex. The research comprised two components: 1) a systematic review of patient experiences of presenting to hospital for self-harm (MacDonald et al., 2020b); 2) a qualitative case-study of a large urban hospital (MacDonald et al., 2020a). While developed and delivered by the research team, the initial idea for the study was generated by professionals working at the hospital, who expressed concern about their limited insight into patients' experiences.

While having a methodological approach that focused on understanding the nuance and multiplicities of participants' perspectives, the study was clearly orientated to the principle of prevention from the outset. In particular we were working with the assumption that negative experiences of seeking treatment for self-harm might serve to increase such behaviours in future, while inhibiting further help-seeking. This assumption has been evidenced in the existing qualitative literature (Owens et al., 2016), and was strengthened by the study's systematic review (MacDonald et al., 2020b). As such, in aiming to explore the experiences of receiving or providing self-harm management and prevention provision, we were seeking understand how these might be enhanced, partly to prevent repeat self-harm and possibly suicide.

While we were aware of the critical studies in suicide literature, and its problematisation of prevention, this perspective was not at the forefront of our thinking from the outset. However, as data analysis unfolded, we often encountered moments where it was difficult to find coherence in narratives that would allow us to address the aims of the research. Although this is to be expected with complex qualitative data, through our continued reflection, we realised that part of the issue was that we may not have fully realised the very nebulous notion of 'prevention'. Returning to the qualitative case study dataset affords this opportunity, having the potential to draw out important convergences, tensions and discontinuities between researchers and participants. This may help to explain the seeming lack of comprehensibility of the data at times, and offer nuanced understanding that can be elided when prevention is seen to be normatively desirable.

Revisiting the data also affords the opportunity to critically engage with the method used, namely interviews. Arguably the predominant qualitative method within self-harm research, it has experienced recent progression to include the integration of creative and multiple media (Edmondson et al., 2018). This reflects the wider trend within qualitative research, which sees the continued employment of the approach, as part of 'the interview society' (Atkinson and Silverman, 1997, Silverman, 2017). Justifications for its use tend to centre on the ability to surface the intricate and sometimes contradictory experiences of the individual. Yet the method is rarely reflected on or problematised in relation to self-harm or even suicide research, although there have been recent calls for 'promising less' with such an approach (Bantjes and Swartz, 2017). There is rarely consideration of how interviews may serve as a vehicle to reinforce our assumptions or privilege certain normative judgements. In this paper we want explore in more detail how the interview method may have structured and constrained our full understanding of the construct of prevention. We wanted to further detail what the method can offer us, particularly how the dynamics and interactions within the interview context can offer a glimpse into participants' relationship to the topic being discussed.

There is a significant literature on the interview method, across its various formats, mediums and theoretical underpinnings. This paper will not seek to describe them or

appraise them. However, we do engage with radical critiques of interviewing which contest the 'Romantic view' of interviews as meaningfully presenting and reflecting experiences from the 'real world' and participants' understanding of them (Hammersley, 2003, Willis, 2019, Whitaker and Atkinson, 2019, Atkinson, 2013, Hughes et al., 2020). As Whitaker and Atkinson maintain, this Romantic perspective simply "celebrates the exploration of 'experience', while implying – sometimes tacitly – that the task of qualitative research is to reproduce the informant's 'point of view'" (Whitaker and Atkinson, 2019). This orientation risks a glaring omission, namely the constitutive and representational work undertaken by the interviewer and interviewee in situ, and the reflexive construction of the very phenomena under examination.

Taking on board this radical critique, we may then recognise the need to attend more fully to the discursive resources deployed within interviews, which can serve as part of the vital process of identity work (Whitaker and Atkinson, 2019, Bamberg, 1997, Blakely and Moles, 2017). This idea of biographical work is a central and valuable lens for understanding the dynamics of interactions, both on behalf of the interviewer and the interviewee (Cassell, 2005). It entails the individual's positioning of themselves according to various narrative types or genres. This construction can serve numerous functions, but often involves the need to justify and explain, with the individual seeking to compel and persuade the audience of their narrative. There are a litany of rhetorical devices deployed throughout interviews to achieve this end, including stories of atrocities, moral warnings and the ascription of responsibility to both self and others (Whitaker and Atkinson, 2019, Bernhard, 2015, Allen, 2001). A particular act of identity work is the expression of '*contours of competence*' (Atkinson, 2004), where participants' signal their capabilities as part of this narrative positioning. Only occasionally explored within the context of self-harm (Evans, 2018, Jennings and Evans, 2020) and with limited understanding of what constitutive work is intended to achieve, examination of interactional performances may offer important insights into how individuals relate to self-harm and prevention, and their perceived role and responsibility across both.

Re-analysing semi-structured interview data with children and young people, parents and carers, and healthcare and affiliated professionals, this paper aims to examine how participants relate to ideas of 'prevention' in situ, potentially deconstructing the assumptions held by the researchers at the outset of the study. It seeks to link this process to the method where relevant, helping to shed light on how the interview can be both a limiting and illuminating site of knowledge creation. Further, we look to draw attention to the importance of the relational dynamics performed during the process of data collection, and how interactions might offer useful insights into the wider set of identities and performances that are played out in relation to prevention.

2. Methods

2.1. Research Design

For the original study, we employed an instrumental case study approach to explore hospital-based practices regarding children and young people's self-harm management and prevention (Crowe et al., 2011, Prato et al., 2019, Stake, 1995).

2.2. Case: Large Urban Hospital

The case was a large hospital within a major UK urban centre. Provision of care within the hospital is intended to be delivered in accordance with NICE guidelines for

evidence-based practice (National Institute for Health and Care Excellence, 2004, National Institute for Health and Care Excellence, 2013). On presentation to the emergency department, individuals are triaged, with paediatric emergency care treating children and young people up to the age of 16, and adult emergency care treating those aged 16 and over. In some instances, children are admitted directly to the paediatric ward if referred by a GP. On presentation, patients receive medical treatment and a psychosocial assessment. For children and young people, assessments are conducted by the local community-based CAMHS Crisis Liaison Team, consisting of mental health nurses and on-call CAMHS psychiatrists. On discharge from the hospital, children and young people may be referred to a suite of community provision, with the CAMHS Crisis Liaison Team conducting follow-up contact with the family within one month of psychosocial assessment.

2.3. Sample and Recruitment

The study sample comprised of children and young people (aged 8-18 years) who presented to hospital for self-harm. The age of eight is when NICE guidance should be implemented with individuals presenting for self-harming behaviours, while the age of eighteen is where young people are classed as eligible for adult care at the hospital. The study also included parents and carers who had accompanied their child to the emergency department, and healthcare and affiliated professionals employed both at the hospital and wider healthcare system

Different strategies were used to identify and recruit each group of participants. Recruitment of children, young people, parents and carers was undertaken by nurses in the CAMHS Crisis Liaison Team. As the study unfolded, it became apparent that the recruitment strategy for children and young people was not effective, largely due to time constraints on the team. We secured an ethical amendment for retrospective consent, with the CAMHS nurses retrospectively contacting children and young people who had made a previous presentation, working from the most recent. Children and young people were able to participate if their parent or carer declined, as long as parental consent was provided for those aged under 16 years. Parents and carers could participate if their child did not want to take part.

For recruitment of professionals, the research team and study collaborators (e.g. CAMHS nurse serving as study gatekeeper) initially mapped the care pathway, both within the hospital and the wider healthcare system. Participants were purposively sampled and recruited through a range of strategies, including presentations at clinical team meetings. Additional snowball sampling was undertaken as the study progressed, with early interviewees identifying other relevant professionals. Recruitment was intended to continue until rich data had been generated (Charmaz, 2006, Saunders et al., 2018). We felt this was achieved for healthcare professionals, carers and parents. However, despite modifying recruitment strategies there was a paucity of children and young people.

In total the study included three children and young people aged between eight and sixteen. One child was male and the other two were female. All three of the participants had experiences of self-harm. Throughout the narratives, the extent to which actions could be considered suicidal or non-suicidal was ambiguous. For example, one young person had previously been treated for an overdose at the hospital, and while it seemed that medical professionals classified it as a suicide attempt, they seemed less sure about their intent. Eight parents and carers participated. One had previously been a foster

carer and one was a grandparent. One was male and seven were female. They all had experience of their child self-harming, though again the degree to which this could be considered suicidal was often unclear. Fourteen healthcare and affiliated professionals also took part. Two were male and twelve were female. Participants represented a diverse range of roles: emergency department clinicians (4); emergency department nurses (3); paediatric ward nurse (2); community paediatric mental health clinicians (2); community paediatric clinician (1); community paediatric mental health nurse (1); and a voluntary group coordinator (1). Professionals spoke of treating and managing both self-harm and suicide attempts. On occasion they discussed them as related or even interchangeable constructs and in the analysis, we considered both constructs as part of self-harm.

Reflecting on the sample in relation to experiences of self-harm, it is important to note that children and young people's experiences, and those of their parents and carers, were exclusively related to non-fatal self-harm. No parents had a child die by suicide, although they expressed concern about the risk of suicide. Meanwhile, healthcare and affiliated professionals had direct experience of managing and responding to both self-harm and suicide, and hence there was also explicit consideration of suicide prevention in addition to self-harm prevention within this group.

2.4. Semi-structured Interviews

Semi-structured interviews were conducted by one member of the research team (CS). A flexible topic guide was used for each group of participant. The interview schedules were developed through consideration of the research literature and consultation with the project steering committee, which included health and affiliated professionals and children and young people who had presented to hospital for self-harm. The research materials, methods and interview schedules were also explored with a young people's research advisory group at the DECIPHer research centre at Cardiff University (https://decipher.uk.net/public-health-improvement-research-networks-phirns/public-involvement-alpha/).

The children and young people's interview schedule, in addition to that of the parents and carers, focused on their previous experiences of seeking and receiving treatment for self-harm. The professionals' topic guide centred on the experiences of service provision. Important for the present paper, is to note that questions were not always explicitly framed around how self-harm might be prevented, but they did reflect the assumptions of the research. These assumptions were primarily that negative experiences of seeking help may lead to future self-harm, and so understanding how provision is experienced and might be improved may enhance future prevention efforts. There were more direct questions about how participants felt the experience of self-harm management and prevention provision would influence possible future self-harm, and this data was central to the study exploring how effective prevention activities could be enacted in future. The interview schedules are included as Appendix A.

Interviews with children, young people, parents and carers were conducted in the family home. Interviews with professionals were undertaken at their place of work. They varied in length from 30 mins to 120 mins. Interviews were digitally recorded and stored securely. All interviews were anonymised and transcribed by a professional transcription agency, and checked for accuracy by the research team. They were conducted between September 2018 and March 2019.

2.5. Ethical Procedures

Participants were provided with study information in advance of interview and any questions were discussed prior to obtaining informed consent. Although evidence reports that discussion of self-harm for research purposes does not confer significant harm or distress (Blades et al., 2018), we were mindful of the potential emotional impacts of the interview experience. All participants were provided with a list of support resources for follow-up as required. For children and young people, the CAMHS Crisis Liaison Team made a follow-up contact after the interview to check their wellbeing and to link them into services as necessary. Ethical approval was provided by the NHS Research Ethics Committee to ensure the project was conducted in accordance with National Research Ethics Services (NRES) Standard Operating Procedures and the Governance Arrangements for Research Ethics Committees (GafREC) (Ref: 18/WA/0066).

2.6. Analysis

For the original analysis, we employed a thematic analytical approach, derived from the principles of grounded theory (Strauss and Corbin, 1990). The full approach is detailed in a related study publication (MacDonald et al., 2020a). Following the central analysis, and for the purposes of this paper, we returned to the data for re-analysis. There were two key features that we attended to when re-coding them: 1) How participants relate to and talk about the notion of self-harm prevention and management, and how the use of interactional strategies (e.g. rhetorical devices) can reveal a layer of meaning and perspective that is often not attended to; and 2) How participants undertake identity work in relation to the interviewer within the interview space, and how this offers important insights into the complexity and challenges of interactions in relation to self-harm management and prevention.

To code the data, we used a combination of inductive and deductive coding, starting with an open exploration of interactions and language, before searching for the commonality of certain interactional repertoires or linguistic devices within and across participant accounts. In the first instance transcripts were coded individually, then considered by group of participants to identify any distinctness (e.g. carer or professional). At the final stage codes were integrated and examined across the different groups of participants to generate the two discursive considerations, while aiming to retain any particularly for each group. Memos served to capture changing researcher interactions with the transcripts and variations between coders. Coding was undertaken by CS, who conducted all of the interviews, and was checked by a second researcher (RE). We used NVivo10 software to support the analysis and storage of data.

3. Results

The results are presented in two sections. First, they explore how participants relate to and talk about the notion of 'prevention'. This unearths a central ambiguity over its meaning and hence highlights the challenge of drawing recommendations for enhancing self-harm management and prevention. Second, they consider how the interview site encourages meaningful identity work for participants, particularly in relation to the notion of 'competence', revealing a range of tensions, challenges and unmet needs.

3.1. Rendering prevention intelligible: Problematizing self-harm as a preventable phenomenon

The first discursive consideration relates to participants' understanding of self-harm as preventable. As noted already, in alignment with our study aims and research questions,

the interview topic guides were clearly orientated to improving the quality and nature of hospital-based provision, so as to prevent recurrent self-harm (Appendix A). Yet, despite discussion ostensibly exploring this subject matter, our revisiting of the data revealed a lack of intelligibility about the very prospect of prevention, which mainly seemed to come from ambiguity over the construct of self-harm.

Re-engagement with the interviews drew out numerous attempts by the researcher to question how the quality of prevention and management provision for self-harm among children and young people may be better enacted. Such questions rarely seemed answerable to participants in situ and responses were often characterised by queries, non-sequiturs or exploration of the wider context of prevention. For example, accounts about improving care quality relapsed into considerations of self-harm itself, including how it had been caused, who was concerned, and when it had been noticed. One parent's interview frequently returned to wider reflections about their daughter's self-harm when asked about the impacts of professional decision-making as part of treatment:

> Interviewer: *How did you feel about that decision that* [child] *stay in?*
>
> Participant: *I think I was in a bit of shock because you know, I know she'd been feeling down and I was aware that she'd hurt herself previously but I thought we were dealing with it and I think it was a bit of a, for me personally that I'd let my daughter down I hadn't spotted the signs properly. So there was a bit of denial I think, like does my daughter really need to be here, what are you doing that I'm not doing you know but she was in the right place and I had to, I did feel I couldn't say anything*. (Parent and Carer: Six)

Tracing the origins and subsequent unfolding of interview interactions, we often returned to participants' uncertainty and ambiguity. Self-harm in particular was seen as an amorphous and elusive construct. On the surface level, discussions acknowledged it as an act, or series of acts, that possess materiality and thus can be technically managed or treated. Such sentiments were notably present within the accounts of healthcare professionals. Often, we heard how an individual's presentation to an emergency room with a physical injury allows self-harm to be definitionally brought into being through clinical classification, with frequent reference to the means through which the body was harmed:

> *Also with medication, that can be so, so dangerous because a young person could take quite a lot of tablets and go to the hospital, but come out relatively unscathed, but they might take a much smaller amount, think I'll be fine and then that might be, so accidental suicide is always at the forefront of our minds here* (Healthcare and Affiliated Professional: Four)

For many participants however, self-harm was not conceived as an event or act that can be simply presented and communicated to others. Accounts often lacked chronological sequences that characterised a child or young person's history of self-harm, and there was no clear moment of origin where it commenced. Rather for many it appears to exist outside of any clear sense of space and time.

Young people in particular presented fractured histories of self-harming journeys, with descriptions of their experiences often being de-contextualised. One young participant spoke of the difficulty of recalling events, but remembered there being a preceding and unpredictable loss of control, where the compulsion to self-harm would emerge from

nowhere and then it 'just clicks' (Child and Young Person: One). Meanwhile, this participant's parents presented a protracted and conflicted domestic situation characterised by anger, escalating physical assaults and threats of violence to their other children. Although these were acknowledged as suggesting a complex family dynamic, they had been increasingly accepted as part of their normality. However, this all changed when their child's behaviour was classified as part of their self-harm by clinicians, when they indicated an intention to hurt them self at school. The parents' accounts listed the behaviours that were now being interpreted as symptoms or acts of self-harm, co-constructing a narrative within the interview about what actions were now being deemed problematic or not:

> Interviewer: *Yeah. So it seemed more like tantrums at first, rather than any* [self-harm]
>
> Participant*: He's never actually threatened to harm himself until recently, but he's always lashed out at us and everything around him … Yes, we've had windows smashed, we've been attacked with everything, poles to whatever else he can get his hands on at the time. It doesn't matter what it is, he doesn't think, he doesn't understand. I mean, he'll dart across a road, and he would do that now if he was in a bad mood, without even looking to see if there was a car coming. He has no sense of danger or what he's doing. It's like he's out of control.* (Parent and Carer: Two)

This re-imagining of the family history and future, where self-harm now claimed ownership of historical and possible events, periods and relationships, was evidently confusing and destabilising for their narrative. As such, the notion of there being a point at which their child's self-harm 'started', and thus could have been prevented, became increasingly unclear and even senseless.

Similarly, there was often a lack of certainty about self-harm reaching a conclusion. Across accounts, there was a sense that while physical injuries could be attended to, self-harm had a disruptive and transformative impact on a myriad of relationships, drawing everyone into a new state of being. Parents and carers in particular spoke of relational dynamics within families being permanently ruptured by their child's experiences, and hence while future episodes of self-harm may be avoided, its impacts could not be prevented. One parent in particular discussed how tentative they had become in their relationship with their child, amidst fear of repeat self-harm:

> *So when they released her the first time I felt I couldn't say anything or do anything to upset her you know and they put a plan in place for children and young people and you've got to follow that plan and I'm like well no because you're not listening so why should I follow that plan if you're not doing your half, but CAMHS said. So it was almost as if they'd given her a free rein to do what she wanted to do because it was written down on paper*. (Parent and Carer: Six)

Located somewhere between these blurred timepoints is also the situational variability, wherein self-harm becomes visible or is rendered invisible depending on the interactional context. One young person, for example, explored the judgement involved in identifying as someone who experienced self-harm, depending on the social spaces and peer groups that were being occupied:

> *It really is an issue in my old school because not that I would necessarily feel like I'm depressed or anything but you know people who are actually depressed and I could see people when I go round the school flaunting it* [self-harm]. *So they sit in classes and they're like look at this and it would get me really annoyed but I wouldn't say*

> *anything but like in my school now you wouldn't know that anything's going on because people who genuinely are depressed themselves like are low down… I'm not saying I'm cold hearted but I'm just saying I wouldn't necessarily believe it as much if it was kind of, I'd see it more as attention seeking but in this school I'd see it more as like a genuine thing* (Child and Young Person: Two).

Within the context of tracing boundaries around self-harm, it is apparent that some of our questioning around improving the quality of self-harm management and prevention was potentially constricting. Enquiring about how to best intervene presupposed (even implicitly) that there is a knowable object or event that may be avoided in future. Indeed, in our original analysis the line of questioning risked masking the fractured meanings ascribed to the phenomenon and the continued work being undertaken to construct it within every interactional context.

In reflecting on the risks of artificially drawing parameters, our re-analysis also elicited important insights into how individuals might experience scenarios of self-harm management and prevention in practice. In particular, accounts revealed parents of children feeling dissatisfied with entrenched approaches for being insensitive to the complex, messy and volatile edges of self-harm. Indeed, the extended impact of their child's behaviours often felt crudely truncated to the immediate physical event, leading to a sense of being misunderstood or under supported. One parent in particular considered how the wider social history of self-harm had been routinely overlooked in favour of the immediate medical aspects of their perceived problem. In this instance the interview was undertaken jointly between the child and parent, with their reflections responding to an earlier question by the interviewer of '*if there was something that you have* [to help], *what would it be to support?':*

> *Yes a normal doctor don't understand the situation, the young person is in … They're the first to tell you when they come, because to me it's a waste of their time, coming to us, for a medical reason, she hasn't got a medical reason, it's an issue she's got.* (Parent and Carer: Nine)

From such responses then, it is important that we remind ourselves within the interview space that there will likely be cleavages in sense-making between the interviewer and the interviewee as both relate to an amorphous contrast that may have no clear definition to anyone. These cleavages can reveal a glimpse into the challenges around 'real-world' interactions if we look closely enough, offering a rich understanding of the needs of different individuals who may be the subject of prevention.

3.2. *Co-constructing 'prevention' personas: Surfacing identity work*

The second discursive consideration to emerge in relation to self-harm management and prevention was identity work. Surfacing this work revealed potentially unmet support needs and unresolved tensions that are often elided and left unaddressed.

While the concepts of management and prevention lacking intelligibility for many participants, largely due to lack of definition around self-harm, they still served as key anchors within accounts. Indeed, while not always coherent, much of the narrative touched on the need to minimise or resolve self-harm among children and young people in some way, while also exploring a fear of 'relapse' or repetition. On the surface level, the need for prevention seemed couched in a clear set of motives, with participants wanting to convey to the interviewer the importance of ensuring the wellbeing of the young person and minimising potential distress.

Yet beneath this was a more complex array of motivations and an intricate process of identity work at play. For many it seemed that self-harm had disrupted their biographies, fracturing and even undermining their sense of self. Interviews then became a site for participants to restore some biographical coherency. Perhaps more importantly, they seemed an opportunity to signal that participants previous identity had not been completely shattered, and that the individual had retained, and could still competently, perform aspects of themselves that they considered valuable.

For parents in particular, there was exploration of how their child's self-harm disrupted the identity of 'parent', eroding any previous sense of capability within the relationship and rendering many skills impotent. Accounts considered how parents were thrust into new ways of being that they were ill prepared for. This was particularly problematic as the causes and consequences of self-harm began to transgress the private confines of the home, moving into public spheres such as schools and hospitals, which exposed parents and carers to the judgement of others.

Within this context, participants appeared to invest significant effort within interview interactions to undertake biographical work, seemingly to restore this lost identity of parent. This sometimes entailed performing parenting capabilities for the interviewer, with participants referencing stories of responding in a pro-active and responsible manner to self-harm. For example, some individuals focused on seeking professional help so that they could manage the risk and ensure the wellbeing of other children in their family, hence allowing the perceived parental responsibility of protection to be enacted:

> *We did go on the, the first time it was on a weekend and he was so out of control here it wasn't safe for the younger ones. They were all watching him and he had a knife to himself and everything. He was attacking us and everything else around him. And that's the first time we said, "Right, we can't have him at home right now, we've got to do something now."* (Parent and Carer: Two)

Beyond efforts to actively perform certain skills and knowledge, was also recognition of the absence of old competencies. Stories then became one of loss, guilt and shame, with parents signalling that they knew what good parenting should be but how it was no longer available to them. There was often a focus on assuming responsibility for their child's self-harm, and rhetorical devices included negatively appraising themselves against a standard of parenting they had once achieved. In this instance, accounts centred on the shock at not being aware that their child had been experiencing difficulties, and the perceived skills deficit at not being able to manage the situation at hand, or their own emotions. One parent reflected on the lack of self-belief they now felt, stating that *'I don't feel safe in myself'* (Parent and Carer: Nine), while others maintained that they felt a failure. A further participant, who in this case was a grandparent, reflected that they no longer were able to perform the parenting role they had previously enacted, and were struggling to construct and negotiate a new self:

> *Yes I did lose, I just thought, I think I lost myself I didn't know if I was doing the right thing and I was afraid to say something and it did make me lose my confidence quite a bit in that sense.* (Parent and Carer: Six)

Meanwhile, one parent, who had also previously been a foster carer, maintained that it had '*taken me a while to believe*' that her own child was experiencing self-harm, and once she had come to terms with it she was challenged in embodying the identity of a mother:

> *It's very stressful, parenting now, than I ever had to do, and I think because I don't understand what's going on, I can't predict what's going to happen. I did safeguarding and that with the fostering training and stuff like that, but when it's your own child, it does not feel like a job, and* [if] *it was a foster child, it was kind of like a bit of a mother but more of a job, so I think you're in a different mindset*. (Parent and Carer: Five)

Healthcare and affiliated professionals demonstrated a similar need to find ways to restore the increasingly fragile identity of a competent person, although their constructed accounts were more clearly couched in the performance of professional expertise. This often entailed a regular deferral to 'other' experts, who were perceived to have more relevant knowledge and experience of managing and preventing self-harm. Here we sensed a need to inscribe clear boundaries around participants' own expertise, minimising the risk of moving into more uncertain territories that might expose their limitations. A number of professionals, when asked about their role in treating and preventing future self-harm, had a clear sense of being ineffectual:

> Interviewer: *Yeah so people are looking for help, but you feel that they've come to the place [speaking over each other at this point]?*
>
> *Participant: There's always a lot of like, that what we do is helpful to the journey, I feel like we make an assessment which can be helpful if somebody is, if they've taken an overdose or they've hurt themselves and need treatment for that, we can sort that out. We can make an assessment, a brief assessment to whether we think they are at risk of further harm, but then we're not offering anything to treat that, we're not actually offering anything for a problem that they're coming in with.* (Healthcare and Affiliated Professional: Two)

While reflecting on the fear of not being able to manage mental health, accounts often sought to emphasise where clinicians possessed expert knowledge, notably in relation to presentations of physical ill health. Sometimes participants spoke personally, sometimes reflecting on the experiences of others, but in both instances they drew upon physical illnesses as a frame of meaning and reference:

> *I don't know about A&E but up here obviously it's different to if they've got tonsillitis or something like that yes. I'm not sure really, obviously there's something emotional going on there that you can't always see it can you like a physical illness but obviously there's something going on. So like when the teenagers come in a lot of people don't they're scared and they don't know what to say to them and that, when they come in they'd rather look after somebody who's got tonsillitis* (Healthcare and Affiliated Professional: Three).

Interviews with young people themselves, while few in number, provided some of the most compelling examples of identity work. While parents and professionals often seemed to relate to a need to somehow restore personal lost skills or confidence, for young people this work was more directly related to meeting the needs and expectations of others. In these instances, participants often reached for descriptions of how they were developing a sense of control and ownership over self-harm, formulating a repertoire of strategies to help them manage difficult situations. One young person presented a range of harm minimisation strategies they had adopted, on the suggestion of a clinician, even though they felt them to be largely ineffectual:

> *The safety plans don't work, we've got them, we've got like over three sheets of paper with different, like fifty different things on them, and we try them together, so I thought well I'm not going to try any of them, because it's not going to work with everyone, so I picked one, and stuck with that, which is music and colouring and then that seemed to, that works … It works for like a couple of hours, and that's it and then I still feel the same* (Young Person Three)

Reflecting on the accounts provided by young people, they seemed to hold an underlying assumption that self-harm management is something they must take personal responsibility for and that their new identity was linked to notions of self-control and self-management.

Within this complex nexus of interactions, and the biographical work performed, we were left with the question of why competence features. While we had no definitive interpretation, these motives and moments appear important as they surface how destabilising the phenomenon of self-harm can be for an individual's sense of self. It can transform and threaten previously taken for granted relationships and identities. The performance of competency then appears to be a situational response to the vulnerability and uncertainty being experienced. From here then, we may suggest identity work to be part of a concerted effort to seek safety. It is a persuasive performance for the interviewer, often signalling that the aspects of their identity that they had valued have not been fully lost. But it is also an opportunity for the participant to find assurance and legitimisation for themselves. As a result, we might consider interview interactions around prevention to not be so much a negotiation about how to best prevent self-harm, but a set of discursive repertoires through which individuals can find meaning, security and even approval in regard to the complexity of experiences they are encountering.

4. Discussion

4.1. Overview and Implications

The present paper provided an opportunity to revisit the data generated as part of a hospital-based case study exploring the experience of receiving or delivering self-harm management and prevention provision. A primary consideration to emerge, is the importance of integrating critical perspectives into research on self-harm prevention, and recognising the dominant discourses and value systems that inscribe our research foci and priorities. This can be supported by drawing upon ideas expressed within the expansive literature aligned with 'critical studies in suicide' (White et al., 2016, Hjelmeland, 2016, Marsh, 2016), and extend to radical critiques of qualitative methods (Atkinson, 2004, Atkinson and Silverman, 1997, Silverman, 2017).

Reflecting on the research of our primary study, and on closer examination of the data, we recognised the strength of our own latent assumptions around the desirability of prevention. In drawing forth these assumptions, which were somewhat hidden at the outset, we were able to see their impact on the interactions with participants and the resulting data. In particular, they may have given some false sense of coherence to the findings from our study. In our original analysis we treated discrepancies in perspectives about prevention as an issue of degree; we saw it as matter of participants having different views over how management and prevention provision could be improved to reduce future self-harm. But in actuality there was likely a more fundamental incongruence between accounts, as neither prevention nor self-harm were seen as unified or intelligible constructs. This gap in understanding between researcher

and participant highlights the need to remain vigilant in recognising the phenomenon under examination, realising that it is being reflexively co-constructed in situ and should not really be seen as fully defined and described. Moreover, the lack of shared meaning regarding fundamental constructs, may provide a momentary glimpse into the challenges of interacting in relation to self-harm and prevention.

As part of the focus on understanding how prevention is rendered intelligible, we further sought to reflect on the interview method in detail. Our re-analysis kept in mind the radical critiques of the method, and the tendency to see it as portraying the interiority of social actors and their external social world (Hammersley, 2003, Willis, 2019, Whitaker and Atkinson, 2019, Atkinson, 2013). As a result, we worked with the idea that interviews offer sites of constitutive work, whereby participants deploy rhetorical devices and practices in order to accomplish a desired identity (Whitaker and Atkinson, 2019, Blakely and Moles, 2017). While not providing a complete representation of the work participants were undertaking to construct an identity they deemed socially desirable, our re-analysis did offer some insights into the nature of work that may occur. In particular, we observed that for many participants, children and young people's self-harm was highly disruptive to their previous identity, where they may have felt secure in their personal or professional skills. However, their competency had now been brought into dispute, and much of the identity work seemed to focus on restoring and performing proficiency for the interviewer. This observation resonates with Atkinson's earlier experience of clinician professionals' effort to articulate '*contours of competence'* (Atkinson, 2004). To date there have been somewhat limited reflections on identity work in relation to research on self-harm, but it is important in a field that can be characterised by uncertainty.

The two central discursive considerations encourage us to reflect on the process of undertaking research in relation to self-harm, and even suicide prevention and management. First, and most evident, it the need to articulate and reflect upon the underlying assumptions of the research from the outset, ensuring that they are understood and challenged at the point of formulating research questions, developing interview schedules, conducting analysis and framing the results Sustained and rich co-production with different groups of participants have much to offer here, particularly around the interrogation of assumptions . Second, is integrating more critical perspectives into discussion around the prevention agenda both within research, and in the wider policy and practice context. In particular, this study responded to the expressed needs of health professionals to improve their prevention and treatment provision. On reflection, we might have engaged and collaborated in ways that did not foreground our shared pursuit of prevention, even though shared goals can feel important in creating research relationships. Instead, we might have been more conscious and active in creating space to explore the contested nature of the constructs we were working with, allowing more opportunity to critically appraise the assumptions of all stakeholders. Third, and more related to the interview method, is recognising the full impact of the process on participants. While there is extensive consideration of the risk of distress, we might also understand that where extensive identity work is undertaken, and where biographies are potentially destabilised in situ, the interview may be fundamentally impactful and emotional for some. Responses to this may include a more explicit focus on the interactions in ethical considerations and planning, alongside post-interview support that explores related issues.

4.2. Limitations

The original study was not intended as a methodological critique, and hence there are limitations in the reflections presented. The most apparent constraint is that the questions guiding the re-examination of data were conceived by the principal investigator and first author (RE). Meanwhile interviews were conducted by another member of the research team (CS). As such there was work in ensuring that the team's exploration of discursive considerations was fully grounded in the data. To support this, re-analysis was led by the researcher who undertook the interviews. Additionally, when reflecting on the lack sense-making around central constructs, such as prevention, it is important to consider alternative explanations. In this paper we have interpreted the challenges in thinking about prevention as being a result of ambiguity about the phenomenon it is intended to prevent, namely self-harm. But it might be that participants did not recognise activities or provision that were intended as preventative.

We also recognise the limitations associated with the primary study. First, the case study comprises one urban hospital setting, and so many of the experiences and perspectives of prevention were likely dominated by this particular system of healthcare. In drawing out certain ideas in this paper, notably the lack of intelligibility around the notion of prevention, we note that this may not be a general occurrence beyond the case. Regardless, our central point remains that the latent, or even explicit assumptions of the research can lead us to overlook ambiguity and conflict in accounts. Second, as recognised in the methods section, there was a relative lack of children and young people participating in the study. In reflecting on the method, there remains significant work to be undertaken in exploring the construction of the phenomenon and the constitution of identities with the diverse range of individuals that are 'children and young people'.

4.3. Conclusions

This paper has re-examined data from a hospital-based case study of the experience of receiving or providing provision for the management and prevention of self-harm. Its aim was to question and disrupt the latent assumptions underpinning the authors' research, and self-harm and suicide research more broadly, namely the prioritisation of prevention. This is not to suggest that we want to undermine or reject prevention efforts, but rather think more critically about extant approaches. Centrally, our re-analysis revealed the reflexive construction of prevention in situ, with ambiguity and uncertainty linked to self-harm being experienced as an unbounded and often undefinable phenomenon. We also explored the biographical work performed within the interview context, with participants seeking to enact authenticity and contours of competence. Together, these findings encourage us to continue to meaningfully engage with the construct of prevention, whilst also appraising and problematising the qualitative methods used and the nature of data generated. In continuing to move toward a more nuanced approach we can keep seeking to develop a rich understanding of what diverse individuals, across disparate contexts, mean and need when they talk about self-harm prevention.

5. References

ALLEN, D. 2001. Narrating nursing jurisdiction:“atrocity stories” and “boundary-work”. *Symbolic interaction,* 24**,** 75-103.

ATKINSON, P. 2004. The discursive construction of competence and responsibility in medical collegial talk. *Commun Med,* 1**,** 13-23.

ATKINSON, P. 2013. Ethnographic Writing, the Avant-Garde and a Failure of Nerve1. *International Review of Qualitative Research,* 6**,** 19-35.

ATKINSON, P. & SILVERMAN, D. 1997. Kundera's Immortality: The Interview Society and the Invention of the Self. *Qualitative Inquiry,* 3**,** 304-325.

BAMBERG, M. G. 1997. Positioning between structure and performance. *Journal of narrative and life history,* 7**,** 335-342.

BANTJES, J., NEL, A., LOUW, K.-A., FRENKEL, L., BENJAMIN, E. & LEWIS, I. 2017. 'This place is making me more depressed': The organisation of care for suicide attempters in a South African hospital. *Journal of health psychology,* 22**,** 1434-1446.

BANTJES, J. & SWARTZ, L. 2017. The cultural turn in critical suicidology: What can we claim and what do we know? *Death studies,* 41**,** 512-520.

BERNHARD, S. 2015. Forms of identities and levels of positioning: A practice theoretical approach to narrative interviewing. *Narrative Inquiry,* 25**,** 340-360.

BLADES, C. A., STRITZKE, W. G. K., PAGE, A. C. & BROWN, J. D. 2018. The benefits and risks of asking research participants about suicide: A meta-analysis of the impact of exposure to suicide-related content. *Clinical Psychology Review,* 64**,** 1-12.

BLAKELY, H. & MOLES, K. 2017. Interviewing in the ‘interview society’: making visible the biographical work of producing accounts for interviews. *Qualitative Research,* 17**,** 159-172.

CASSELL, C. 2005. Creating the interviewer: identity work in the management research process. *Qualitative Research,* 5**,** 167-179.

CHARMAZ, K. 2006. Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.

CROWE, S., CRESSWELL, K., ROBERTSON, A., HUBY, G., AVERY, A. & SHEIKH, A. 2011. The case study approach. *BMC Medical Research Methodology,* 11**,** 100.

EDMONDSON, A. J., BRENNAN, C. & HOUSE, A. O. 2018. Using photo-elicitation to understand reasons for repeated self-harm: a qualitative study. *BMC Psychiatry,* 18**,** 98.

EVANS, R. E. 2018. Survival, Signaling, and Security: Foster Carers' and Residential Carers' Accounts of Self-Harming Practices Among Children and Young People in Care. *Qualitative health research,* 28**,** 939-949.

FITZPATRICK, S. J. & RIVER, J. 2017. Beyond the Medical Model: Future Directions for Suicide Intervention Services. *International Journal of Health Services,* 48**,** 189-203.

GIBB, S. J., BEAUTRAIS, A. L. & SURGENOR, L. J. 2010. Health-Care Staff Attitudes Towards Self-Harm Patients. *Australian & New Zealand Journal of Psychiatry,* 44**,** 713-720.

HAMMERSLEY, M. 2003. Conversation Analysis and Discourse Analysis: Methods or Paradigms? *Discourse & Society,* 14**,** 751-781.

HJELMELAND, H. 2016. A critical look at current suicide research. *In:* WHITE, J., MARSH, I., KRAL, M. J. & MORRIS, J. (eds.) *Critical suicidology: Transforming suicide research and prevention for the 21st century.* UBC Press.

HUGHES, J., HUGHES, K., SYKES, G. & WRIGHT, K. 2020. Beyond performative talk: critical observations on the radical critique of reading interview data. *International Journal of Social Research Methodology,* 23**,** 547-563.

HUNTER, C., CHANTLER, K., KAPUR, N. & COOPER, J. 2013. Service user perspectives on psychosocial assessment following self-harm and its impact on further help-seeking: a qualitative study. *Journal of affective disorders,* 145**,** 315-23.

JAMES, K., SAMUELS, I., MORAN, P. & STEWART, D. 2017. Harm reduction as a strategy for supporting people who self-harm on mental health wards: the views and experiences of practitioners. *Journal of Affective Disorders,* 214**,** 67-73.

JENNINGS, S. & EVANS, R. 2020. Inter-professional practice in the prevention and management of child and adolescent self-harm: foster carers' and residential carers' negotiation of expertise and professional identity. *Sociology of Health & Illness,* 42**,** 1024-1040.

KAPUR, N., COOPER, J., O'CONNOR, R. C. & HAWTON, K. 2013. Non-suicidal self-injury v. attempted suicide: new diagnosis or false dichotomy? *British Journal of Psychiatry,* 202**,** 326-328.

MACDONALD, S., SAMPSON, C., BIDDLE, L., KWAK, S. Y., SCOURFIELD, J. & EVANS, R. 2020a. Theorising health professionals' prevention and management practices with children and young people experiencing self-harm: a qualitative hospital-based case study. *Sociology of Health & Illness*.

MACDONALD, S., SAMPSON, C., TURLEY, R., BIDDLE, L., RING, N., BEGLEY, R. & EVANS, R. 2020b. Patients' Experiences of Emergency Hospital Care Following Self-Harm: Systematic Review and Thematic Synthesis of Qualitative Research. *Qualitative Health Research,* 30**,** 471-485.

MARSH, I. 2016. Critiquing contemporary suicidology. *In:* WHITE, J., MARSH, I., KRAL, M. J. & MORRIS, J. (eds.) *Critical suicidology: Transforming suicide research and prevention for the 21st century.* UBC Press.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE 2004. Clinical Guidelines (CG16): Self-harm in over 8s: short-term management and prevention of recurrence. London.

NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE 2013. Self-harm Quality Standard. London.

OWENS, C., HANSFORD, L., SHARKEY, S. & FORD, T. 2016. Needs and fears of young people presenting at accident and emergency department following an act of self-harm: secondary analysis of qualitative data. *British Journal of Psychiatry,* 208**,** 286-291.

PRATO, L., LINDLEY, L., BOYLES, M., ROBINSON, L. & ABLEY, C. 2019. Empowerment, environment and person-centred care: A qualitative study exploring the hospital experience for adults with cognitive impairment. *Dementia,* 18**,** 2710-2730.

ROBINSON, J., BAILEY, E., WITT, K., STEFANAC, N., MILNER, A., CURRIER, D., PIRKIS, J., CONDRON, P. & HETRICK, S. 2018. What works in youth suicide prevention? A systematic review and meta-analysis. *EClinicalMedicine,* 4**,** 52-91.

SAUNDERS, B., SIM, J., KINGSTONE, T., BAKER, S., WATERFIELD, J., BARTLAM, B., BURROUGHS, H. & JINKS, C. 2018. Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality & Quantity,* 52**,** 1893-1907.

SAUNDERS, K. E., HAWTON, K., FORTUNE, S. & FARRELL, S. 2012. Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. *J Affect Disord,* 139**,** 205-16.

SILVERMAN, D. 2017. How was it for you? The Interview Society and the irresistible rise of the (poorly analyzed) interview. *Qualitative Research,* 17**,** 144-158.
STAKE, R. E. 1995. *The art of case study research,* London, Sage Publications Ltd.
STRAUSS, A. & CORBIN, J. M. 1990. *Basics of qualitative research: Grounded theory procedures and techniques,* Thousand Oaks, CA, US, Sage Publications, Inc.
WHITAKER, E. M. & ATKINSON, P. 2019. Authenticity and the interview: a positive response to a radical critique. *Qualitative Research,* 19**,** 619-634.
WHITE, J. 2016. Reimagining youth suicide prevention. *In:* WHITE, J., MARSH, I., KRAL, M. J. & MORRIS, J. (eds.) *Critical suicidology: Transforming suicide research and prevention for the 21st century.* UBC Press.
WHITE, J., MARSH, I., KRAL, M. J. & MORRIS, J. 2016. Introduction: Rethinking suicide. *In:* WHITE, J., MARSH, I., KRAL, M. J. & MORRIS, J. (eds.) *Critical suicidology: Transforming suicide research and prevention for the 21st century.* UBC Press.
WHITE, J. & MORRIS, J. 2010. Precarious spaces: Risk, responsibility and uncertainty in school-based suicide prevention programs. *Social Science & Medicine,* 71**,** 2187-2194.
WILLIS, R. 2019. The use of composite narratives to present interview findings. *Qualitative Research,* 19**,** 471-480.
ZALSMAN, G., HAWTON, K., WASSERMAN, D., VAN HEERINGEN, K., ARENSMAN, E., SARCHIAPONE, M., CARLI, V., HÖSCHL, C., BARZILAY, R. & BALAZS, J. 2016. Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry,* 3**,** 646-659.