Psychological intervention for self-harm: A qualitative review of individual experiences of psychotherapy and a brief case series examination of a cognitive analytic therapy-informed intervention for young people

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Biology, Medicine and Health

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Rebecca E. Haw
School of Health Sciences, Division of Psychology and Mental Health
Department of Clinical Psychology

Table of Contents

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Paper 1 (Systematic Review): *10,176* (entire text); *249* (abstract); *6757* (main text excluding tables, figures and references)
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Paper 3 (Critical Evaluation): *8333* (entire text); *5974* (main text excluding tables, figures and references).

List of Tables, Figures and Appendices

List of Tables

List of Figures

List of Appendices

Thesis Abstract

This thesis investigated the qualitative experiences of psychotherapy for those who self-harm and the feasibility of a brief, cognitive analytic therapy (CAT) informed intervention for young people who engage in non-suicidal self-injury (NSSI). This is presented across three papers: 1) a systematic review and meta-ethnography of the literature; 2) an empirical study evaluating the intervention; 3) a critical appraisal of the research process.

Paper one was a systematic review and meta-ethnography which explored people's qualitative experiences of psychotherapy for self-harm. Four overarching themes were elicited from the synthesis: 'foundations for change,' 'therapeutic relationship as a vehicle for change,' 'development through therapeutic processes' and 'therapy as life changing.' A line of argument synthesis was developed and a conceptual framework around 'recognising the person behind the self-harm' was produced. The main findings illustrated the importance of building a trusting therapeutic relationship which led to empowerment and positive change across the unique domains of an individual's life. Clinical implications include improved understanding of the importance of collaboration and individual tolerance and the recommendation that future research incorporates those from diverse backgrounds.

Paper two investigated the feasibility and acceptability of Cognitive Analytic Therapy for the Containment of Self-Harm in Young People (CATCH-Y); a CAT-informed intervention with a population of young people who had engaged in NSSI. Thirteen participants were recruited from local Child and Adolescent Mental Health Services (CAMHS) for the five-week intervention. There were high rates of referrals and study retention and overall, the intervention was deemed largely acceptable by participants. Secondary outcomes showed preliminary support for positive change in rates of NSSI, urges to self-harm, low mood and personal recovery, although the overall results were mixed and should be interpreted with caution. The results show that future research into the CATCH-Y intervention is warranted with preliminary support found for high levels of engagement and positive change.

The critical appraisal (Paper 3) provides a reflective evaluation of both the systematic review and empirical project. Aspects of the design, implementation and analysis of the papers are reviewed and personal reflections of the researcher's experiences are presented.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

Copyright Statement

Acknowledgements

"I have spent 37 years surviving, and honey, you wouldn't believe the stuff that I have survived from. I want to live. I want the next 37 years of my life to be a part of the human race, because I have a lot to say.... I want to take it and show those morons who abused me that I am the warrior, that I am the victor.... And that's what I have learned."
(Cunningham et al., 2004).

I would like to dedicate this thesis to all of the participants mentioned, who have been kind enough to offer their participation in this research. I will always admire and respect your bravery. Thank you for letting me into your lives and allowing me to be a part of your therapeutic journey.

I would especially like to acknowledge my exceptional supervisors Dr Peter Taylor and Dr Sam Hartley. I can't thank you enough for your expert knowledge, support and compassionate guidance. I'd also like to thank my amazing friend and co-author Molly Marsden for her continued, kind support through the challenges of the thesis, and who this would not have been possible without. I would like to thank Clive Turpin for his fantastic supervision throughout the project, Kate Williams for her guidance on the meta-ethnographic approach, Sarah Trelfa for her contribution to the literature review and Dawn Bennett for her expertise in cognitive analytic therapy.

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Paper 1

A systematic review and meta-ethnography to explore people's experiences of psychotherapy for self-harm.

Haw, R.,[1,2] Hartley, S.,[1,3] Trelfa, S.[4] & Taylor, P.J.[1]

[1]Division of Psychology & Mental Health, University of Manchester, Manchester Academic Health Sciences Centre, UK

[2]Greater Manchester Mental Health NHS Foundation Trust, UK

[3] Pennine Care NHS Foundation Trust, UK

[4]Cheshire East Council, UK

Word count: 10,176 (entire text); 249 (abstract); 6757 (main text excluding tables, figures and references) 7286 (full text).

This paper will be submitted for publishing to the *Journal of Affective Disorders* (word count 8000 for review papers). Author guidelines can be found in Appendix A.
Tables and figures are embedded within the text for ease of reading.

* Corresponding Author: Dr Peter Taylor, Division of Psychology and Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health; The University of Manchester, 2nd Floor Zochonis Building, Brunswick Street, Manchester, M13 9PL, UK
Email address: peter.taylor2@manchester.ac.uk

Abstract

Background: Self-harm is a major public health concern. Lifetime prevalence is high, and rates of self-harm are rising, however available interventions do not benefit everyone with low engagement. Qualitative accounts allow for a greater understanding of what is helpful to individuals. This study aimed to synthesise the experiences of interventions for self-harm, from participants who have participated in these themselves.

Methods: Participants had self-harmed at least once and undergone an individual psychotherapeutic intervention for self-harm. Papers not written or translated to the English language were excluded. Four databases (Medline, CINAHL, Web of Science and PsycINFO) were systematically searched and each paper was assessed using the CASP quality appraisal tool. A meta-ethnographic approach to the synthesis was taken.

Results: Seven studies including 68 participants were included. Four overarching themes were developed and the importance of recognising the person beyond the self-harm emerged through a line of argument synthesis. Building a trusted, therapeutic relationship founded on patience and without judgement was essential for the perceived success of therapy, which was unique to each person and often went beyond reducing self-harming behaviours.

Limitations: The study included a small number of papers and those included showed a lack of diversity with regards to ethnicity and gender.

Conclusions: The findings illustrate the importance of the therapeutic alliance when working with self-harm. Clinical implications of this paper include the importance of utilising key therapeutic competencies which should be considered fundamental to change within psychotherapeutic interventions for self-harm, with the uniqueness of each patient recognised throughout.

Keywords: self-harm, suicide, intervention, psychotherapy, qualitative, systematic review.

Highlights

- Trust and the therapeutic relationship is key within self-harm interventions.
- Client-led therapy and collaboration promotes empowerment.
- Perceived success in therapy is unique and not measured by self-harm reduction.
- Self-harm should be accepted and viewed as an expression of distress.

Introduction

Self-harm can be defined as self-injury or self-poisoning, irrespective of the intent (Hawton et al., 2003). In the UK, this broadly incorporates acts of non-suicidal self-injury (NSSI), including cutting, burning and scratching oneself, as well as suicidal acts that are intended to end the life of the individual carrying them out (National Institute for Health and Clinical Excellence (NICE), 2011). Self-harm with unknown or no intent to die is a major public health concern, with around 8% of the UK adult population having self-harmed at some point during their lifetime (McManus et al., 2014). In the UK, there has been an increase in the lifetime prevalence of non-suicidal self-harm from 2.4% in 2000 to 6.4% in 2014 observable across sexes and age groups (McManus et al., 2019). The most recent UK suicide prevention report showed a significant increase in rates of suicide between 2018-2019 with 10.8 deaths from suicide per 100,000 population (Office of National Statistics, 2019). Self-harm correlates strongly with increased suicide risk in both adolescents and adults, with an increased risk in the first year following an instance of self-harm (Carroll et al., 2014; Mars et al., 2019).

The UK Multicentre Study of Self-Harm (Guelayov et al., 2019) reports that there are around 200,000 hospital attendances for self-harm annually and approximately 50% of those who die by suicide have previously self-harmed. Rising rates of self-harm have also been identified across the globe in countries such as Denmark (Morthorst et al., 2016), Australia (Canner et al., 2018) and Ireland (Griffin et al., 2018), with the World Health Organization (WHO) estimating that rates of self-harm may be as high as 400 per 100,000 (WHO, 2014). Self-harm in adolescence has been found to be a marker for psychosocial difficulties in later life including an increased risk of daily tobacco smoking, substance abuse, heightened emotional distress and comorbid mental health difficulties (Borschmann et al., 2017; Mars et al., 2019). Financial implications are also evident, with UK hospital costs for self-harm estimated at around £162 million per year (Tsiachristas et al., 2017) and with some reporting that this may only account for 3% of the overall yearly economic impact (Kinchin et al., 2017).

A recently published Cochrane review (Witt et al., 2021) identified a small number of studies which provided support for the effectiveness of CBT for reducing self-harm repetition in adults, with small to moderate effects. They also found small reductions in self-harm repetition using Dialectical Behaviour Therapy (DBT) however the low quality of the

available evidence was noted and it was unclear whether this was sustained at longer term follow-up. Conversely, one recent large scale randomised control trial (RCT) found that offering online DBT skills training significantly increased the risk of self-harm (Simon et al., 2022). Other meta-analyses considering the effectiveness of psychosocial interventions for self-harm found benefits associated with any type of psychological or psychosocial intervention, but no strong evidence that any of these interventions improved the overall therapeutic outcome (Hawton et al., 2016; Hetrick et al., 2016). There is preliminary evidence for the potential benefits of several alternative psychotherapies for people who self-harm including Mentalisation-Based Therapy (MBT; Bateman & Fonagy, 2009) and relational approaches such as Psychodynamic Interpersonal Therapy (PIT) or Cognitive Analytic Therapy (CAT; Guthrie et al., 2001; Taylor et al., 2021) however substantially more research into these models is required. Self-harm is a transdiagnostic phenomenon (Selby et al., 2012) and occurs across a diagnostically diverse sample which may account for the lack of compelling evidence for effective intervention and necessitates a deeper exploration into the common therapeutic treatment components that are perceived as successful within this population.

Drawing upon the lived experiences of those who have participated in psychological interventions has been identified as key when designing appropriate, effective care for self-harm (NICE, 2004). The current literature illustrates a lacking evidence base for effective psychotherapeutic intervention, which may be partly due to the lack of consultation with those who have lived experience of participating in these therapies (Hawton et al., 2012). Without co-producing the design and implementation of these interventions, there can be a lack of validity and reduced overall relevance to the intended target group, leading to consequently lower overall therapeutic outcomes (Faulkner, 2009; Kim, 2005). Those who self-harm may also be more likely to disengage with services (Murphy et al., 2010) and frequently report dissatisfaction with immediate and follow-up care following a crisis, which can impact on their willingness to engage with services in the future (Shand et al., 2018). The current understanding around this dissatisfaction is poor, and therefore gaining insight into what those individuals find helpful from services may begin to improve engagement and deepen our understanding of what interventions are useful for those who self-harm.

Although there has been a positive drive towards incorporating service user experiences into the development of services, policy and intervention (O'Connor & Portzky, 2018; WHO,

2010) the literature relating to people's perspectives of interventions for self-harm is still scarce. Examinations of service users' experience of non-specific professional support for self-harm showed quality and genuineness within the therapeutic relationship, non-judgement and confidentiality as consistently important factors (Cooper et al., 2011; Hunter et al., 2013; Lindgren et al., 2018). One systematic review (Winter et al., 2014) examined the barriers and facilitators of effective counselling and psychotherapy in relation to the prevention of suicide alone, highlighting the importance of the therapeutic relationship as well as the therapy techniques, components and theoretical framework used. A recent review (Sass et al., 2022) examined how interactions with health professionals helped individuals to move away from self-harming behaviours. They found the therapeutic alliance to be crucial, however they considered a range of medical disciplines, exploring the positive elements of these interactions in more general terms. A recommendation from this review outlines the need for qualitative research into people's experiences of psychotherapy for self-harm. To our knowledge, no review has specifically collated and synthesised patient's experiences of psychotherapy for self-harm.

Qualitative investigation with those who have lived experience would allow for a further contextualised understanding of the helpful processes that may be accessible across various psychotherapies. This information can then be used to establish mechanisms for developing more effective psychotherapeutic intervention and guide further research in this field. This study therefore uses a systematic review and meta-synthesis to examine the current literature on the helpful and unhelpful aspects of individual psychological therapies for self-harm, as described by those having experienced them. In particular, the review will examine which factors (e.g., therapy approach, technique, context or therapist) were perceived by clients as most beneficial in therapy, and what aspects of therapy were perceived as challenging or problematic. Furthermore, these experiences will be amalgamated and themes drawn out using a meta-ethnographic approach which will consider the common therapeutic processes deemed helpful across psychotherapies. The intention of the meta-ethnography is to produce a new conceptual framework for examining the helpful and unhelpful aspects of psychotherapeutic intervention for self-harm (France et al., 2019).

Method

Search Strategy

The review protocol was registered with the PROSPERO international prospective register of systematic reviews (http://www.crd.york.ac.uk/prospero, registration number CRD42021209322)[1]. A systematic literature search of four key electronic databases (Medline, CINAHL, Web of Science and PsycINFO) was completed from the earliest available date to November 2020. Searches were conducted based on the 'Preferred Reporting Items for Systematic Reviews and Meta-Analyses' guidelines (PRISMA; Moher et al., 2009).

The adapted PICO framework (Population, Intervention, Comparison and Outcome; Richardson et al., 1995), was used to guide the search strategy and search terms were identified in either the title, abstract or keywords of relevant documents (see Table 1). Medical Subject Headings (MeSH) terms that relate to the search terms were also used for each database.

Table 1

Search Terms used on PsycInfo

PICO	Search Terms
Population	"self-harm*" OR "self-injur*" OR "self-mutilat*" OR suicid* OR DSH OR NSSI OR "self-cut*" OR overdose OR parasuicid*
Intervention	trial* OR "randomised control trial" OR RCT OR intervention* OR therapy* OR "case-series" OR "case-stud*" OR "case stud*" OR "case series"
Comparison	qualitative* OR "mixed method*"

The search was conducted by the lead researcher (RH) and duplicates removed. Titles and abstracts of those identified were then screened against the inclusion and exclusion criteria and those that clearly did not meet the criteria were removed. Full texts of remaining studies

[1] Available at https://www.crd.york.ac.uk/prospero/display_record.php?ID=CRD42021209322

were then read and screened for eligibility. The screening of all relevant full texts was completed in full by one researcher (RH) whilst a second researcher (ST) screened 10% of papers. There were identified discrepancies with the eligibility of one paper and an 100% agreement was reached following further screening and discussion. Authors of papers deemed eligible for the review were contacted where possible to inquire about any further eligible papers. Reference lists of included papers were searched and one relevant review (Winter et al., 2014) was screened to identify further relevant papers.

Inclusion and Exclusion Criteria

To be included, papers had to have a sample of participants who i) had at least one self-reported lifetime experience of self-harm; and ii) had undergone an individual psychotherapeutic intervention where self-harm was the primary focus. In addition, papers had to have iii) included a qualitative investigation of the participants' experience of the intervention that they participated in, and iv) be written in or translated into the English language. Papers could be published in peer reviewed articles or in the grey literature (including conference abstracts and dissertations).

Studies were excluded if they i) provided no new data (e.g. reviews, commentaries or discussions), ii) did not give a first-hand account of the participant's experience of self-harm interventions (e.g. accounts given from the perspective of others such as parents, researchers or therapists), iii) analysed existing text such as from internet forums or newspaper articles, iv) used non-descriptive qualitative data (e.g. questionnaires), or v) data was not specific to a participant's experience of psychotherapy.

Quality Appraisal

The CASP checklist (Critical Appraisal Skills Programme, 2018) was used to compare and evaluate the quality of the included papers. The CASP checklist is designed to evaluate each paper on areas including methodological quality, recruitment, data collection and analysis, bias, ethical considerations, findings and the value of the research. It requires assessment of whether each study met, did not meet or it was unclear whether it met the criteria for each quality indicator. Two independent authors (RH, ST) completed this task in parallel and discrepancies identified were resolved through discussion and re-evaluation of the papers. Whilst no papers were excluded on the grounds of poor quality, the risk of bias was considered when interpreting the findings and synthesising the data.

Synthesis

The synthesis was conducted following Noblit and Hare's (1988) seven stages of meta-ethnography. Guidance was also taken from updated versions of these steps (France et al., 2019; Sattar et al., 2021). This method is well established within the literature and used successfully in syntheses of a similar nature (Stänicke et al., 2018; Peel-Wainwright et al., 2021). Stages one and two relate to the formulation, searching and identification of research papers as discussed above.

Following the identification of papers, the lead author began by repeatedly reading the included papers to familiarise themselves with the key concepts and themes in the data. Whilst the lead author completed the analysis alone, regular discussions with the research team took place to ensure that the interpretations of the data were supported. In a meta-ethnography, raw data is extracted verbatim using 'second order constructs' (the authors interpretations of the data) as the focus, alongside the corresponding 'first order constructs' (participants primary data). A data extraction form was used to identify and record first and second order concepts, themes and metaphors from each study using line by line analysis.

The relationships between key concepts across studies were considered to identify common and recurring meaningful ideas. First and second order constructs were reduced from the different studies into relevant categories and given descriptive labels. Noblit and Hare (1988) outline three methods of translation; reciprocal translation (directly comparable studies examining the same concept), refutational translation (contradictory studies) and line of argument translation (a novel interpretation is built as part of a wider social process). Within this review, reciprocal translation was used to compare the similar concepts across studies before a line of argument synthesis was developed.

Reflexivity

The research team have previously completed quantitative and qualitative research relating to self-harm and suicidality. The potential for bias given their pre-existing research and knowledge in this area was mitigated using a reflective log and regular research supervision.

Results

Search Results

A PRISMA flow diagram (Page et al., 2021) of the search process is presented in Figure 1. Seven eligible papers (Colbert, 2002; Craigen, 2006; Cunningham et al., 2004; Long et al., 2016; Persius et al., 2003; Ross, 2002; Walker et al., 2016) with a total of 68 participants were identified and used in the final synthesis.

Study Characteristics

Study characteristics are reported below (see Table 2). A range of psychological therapies were included, with three studies looking at dialectical behaviour therapy (DBT), two at counselling and two at psychodynamic interpersonal therapy (PIT). Five studies looked at community samples, one looked at inpatient populations and one looked at prison populations. Only one study used mixed gender samples, whereas the remaining six studies used female only samples. Whilst the search included both adult and child populations, only one study looked at adolescent populations, with the rest looking only at adults. Included papers were conducted across four countries.

Quality Appraisal

Results of the quality appraisal using the CASP are outlined in Table 3. One of the studies included in the review was considered to be of lower quality due to a lack of clarity on ethical issues, data analysis and the relationship between the researcher and respondents. All other studies showed good quality across most of the ten areas of the CASP quality checklist. In three studies, the relationship between the researcher and participants was not adequately considered which means it may be unclear how this relationship may have impacted on the results of these studies. There was an initial agreement of 88.2% between the two independent researchers completing the ratings, but following discussion and re-evaluation, this rose to 100%.

Figure 1

PRISMA Diagram

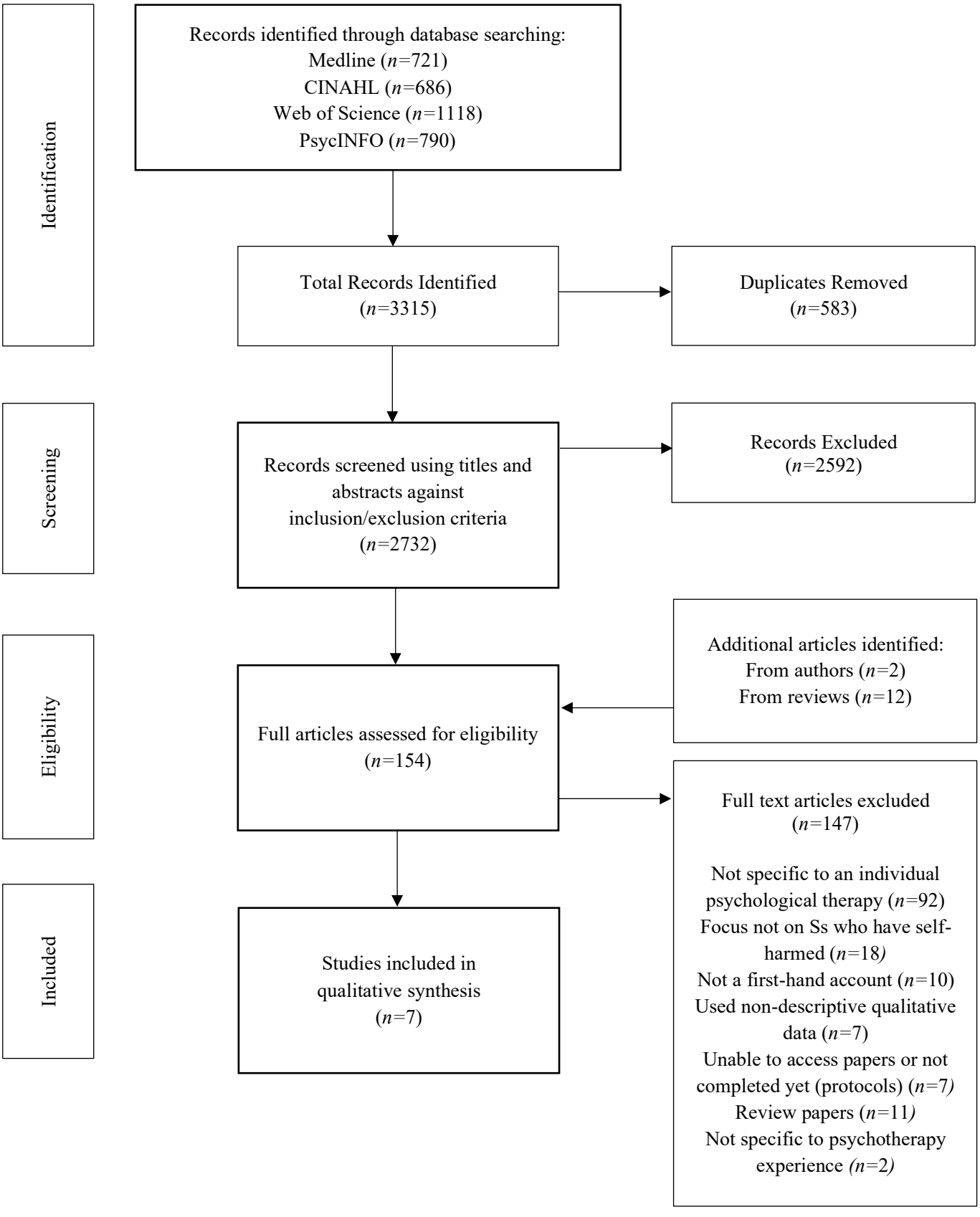


Table 2

Study Characteristics

Author	Country	Therapy type and duration	Design	Participant Characteristics	Analysis Type
Colbert (2002)	UK	Psychodynamic Interpersonal Therapy (4 sessions)	Case study. Semi-structured interview.	N = 7 Gender = Female Ethnicity = White British (n=6), Mixed Race (n=1) Age = >25 (n=4), 36-45 (n=2), 55+ (n=1)	Grounded theory
Ross (2002)	UK	DBT (7 months - 2.5 years)	Semi-structured interviews.	N = 4 Gender = Female Ethnicity = n/a Age = 16-18	Interpretative phenomenological analysis
Perseius et al. (2003)	Sweden	DBT (minimum 12 months)	Focussed Interviews.	N = 10 Gender = Female Ethnicity = n/a Age = 22-49 (mean = 27)	Content Analysis.
Cunningham et al. (2004)	USA	Dialectical Behaviour Therapy (3 months - 6 years, average 15 months)	Ethnographic. Open ended, semi-structured interviews	N = 14 Gender = Female Ethnicity = n/a Age = 23-61 (mean = 38.7)	Ethnographic. Interpretive analysis.

Craigen (2006)	USA	Counselling (minimum 5 sessions)	Phenomenological. Semi-structured interview.	N=10 Gender = Female Ethnicity = n/a Age = 18-23	Inductive Phenomenological Categorical Analysis
Long et al. (2016)	Northern Ireland	Counselling (ongoing)	Qualitative with grounded theory approach. Semi-structured Interviews.	N = 10 Gender = Female (n=8), Male (n=2) Ethnicity = Northern Ireland residents Age = 19-42 (mean = 31)	Grounded Theory
Walker et al. (2016)	UK	Brief Psychodynamic Interpersonal Therapy (4 - 8 sessions)	Semi structured interview	N = 13 Gender = Female Ethnicity = White (n=12), Mixed Race (n=1) Age = 18-35+	Thematic analysis

Table 3

Quality Appraisal

Author	1. Aims	2. Qualitative Methodology	3. Research Design	4. Recruitment	5. Data Collection	6. Relationship	7. Ethical Issues	8. Data Analysis	9. Findings	10. Value
Colbert (2002)	✓	✓	✓	✓	✓	✓	✓	✓	×	✓
Ross (2002)	✓	✓	✓	✓	✓	✓	✓	✓	?	✓
Perseius et al. (2003)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cunningham et al. (2004)	✓	✓	✓	✓	✓	×	×	?	✓	✓
Craigen (2006)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Long et al. (2016)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓
Walker et al. (2016)	✓	✓	✓	✓	✓	×	✓	✓	✓	✓

Note: ✓denotes this criteria was met; ×denotes this criteria was not met; ? denotes that there was not enough evidence provided to assess this criteria. Full questions from the CASP; 1. Was there a clear statement of the aims of the research?, 2. Is a qualitative methodology appropriate? 3. Was the research design appropriate to address the aims of the research? 4. Was the recruitment strategy appropriate to the aims of the research? 5. Was the data collected in a way that addressed the research issue? 6. Has the relationship between researcher and participants been adequately considered? 7. Have ethical issues been taken into consideration? 8. Was the data analysis sufficiently rigorous? 9. Is there a clear statement of findings? 10. How valuable is the research?

Translation and synthesis

Summaries of the studies and the themes can be found in appendix B. Four themes were identified; 'foundations for change,' 'the therapeutic relationship as a vehicle for change,' 'development through therapeutic processes' and 'therapy as life changing.' The overarching themes encompass the experiences of psychological interventions undertaken by participants who have self-harmed and whilst separate, the successful use of each theme within the therapeutic process is reliant on the effective implementation and maintenance of the preceding themes. Additional illustrative quotes can also be found in Appendix C.

Overarching theme one: Foundations for change

Building up trust and feeling safe: The process of developing trust was described as a complex, non-linear process. Participants required time and patience to feel safe, where they would test the boundaries to establish safety within a therapeutic relationship; "once I connect I'll back off because I get scared… it's a scary thing to be so open with someone and tell them your deepest darkest secrets," (Long et al., 2016, p43). A feeling of safety was described as being built due to "a lack of derogation or intrusion in the behaviour of the therapists," (Colbert, 2002, p3.17) which illustrates the importance of patience and validation as a key component of establishing trust. Allowing for choice over the location of therapy developed trust, with some noting the importance of this in the context of maintaining privacy in their lives. Without a trusting relationship, the therapeutic space was perceived as unsafe and participants would either withhold information or disengage from the therapy. This could lead them to delay disclosing their self-harming behaviours to their therapist, therefore increasing their risk. The safety of the relationship could be particularly fragile when trust had previously been broken by a therapist; "[the therapist] started rhyming off a list of why people self-injure and she said 'a lot of people self-injure for sexual gratification.' What… I've been raped how many times… so it was a long time then before I trusted anybody" (Long et al., 2016, p43). Some learnt not to disclose information about their self-harming to counsellors they had not built a trusting relationship with; "I had one convinced that I was fine… it was great, except I was getting worse," (Craigen, 2006, p138).

Relationship with change: Therapy was described by participants as limited help for those who did not yet feel ready to confront their self-harm and associated difficulties, with barriers identified as fear of beginning recovery and the implications of change to a sense of identity (Craigen, 2006; Ross, 2002). An ambivalence to change often reflected the internal

conflicts of those entering therapy, and reiterates the importance of giving space to explore the commitment they are about to embark on; "sometimes it is hard to change and I didn't wanna just change all of a sudden and start dealing with all my problems… just 'cos I'm scared of change," (Ross, 2002, p13).

Adaptations throughout the therapy, dependent upon the participant's tolerance at any given moment, allowed for constant review of how therapists can constructively challenge, with patients recognising the importance of this balance with their therapist; "he is getting to know my strengths and weaknesses and how far he can/should push… we butt heads but that's good because that's when we get things done," (Cunningham et al., 2004, p251). When a balance between patients feeling comfortable and being challenged by their therapists was not met, there were negative impacts on the therapy, the relationship and considerable emotional distress experienced in sessions (Craigen, 2006; Cunningham et al., 2004). The privacy of self-harming behaviours, frequently attached to feelings of shame and embarrassment, increased the need for trust and safety within the sessions. When therapists failed to recognise this and challenged their patients' self-harming behaviour incongruously, it often led to disengagement, selective disclosures within therapy and poorer outcomes.

Overarching theme two: The therapeutic process as a vehicle for change

Validating environment: All papers reflected on the importance of a validating and accepting therapy environment and many identified specific factors which were instrumental in the process of change. The importance of a human connection between the therapist and the patient was widely recognised leading to a contained space which lessened feelings of ostracization. Participants who perceived a felt connection with their therapist reported this as normalising, and described "thus no longer feeling marginalised" (Long et al., 2016, p44) which served as a reminder that they "are not alone… and I'm not getting the 'oh you're a freak' reaction" (Long et al., 2016, p44). Conversely, where participants felt that their therapist had failed to normalise their experiences, this maintained feelings of shame and embarrassment (Craigen, 2006). Those who felt they lacked an authentic connection with their therapist described feeling alone within the therapy and embarrassed about behaviours that they felt unable to speak about (Colbert, 2002).

Some spoke of being understood and respected (Persius et al., 2003) which allowed participation in an open and meaningful way without fear of punishment or rejection (Cunningham et al., 2004; Long et al., 2016). Others specifically referenced 'cutting' and the importance of therapists understanding and accepting this behaviour. Walker et al. (2016)

describes the goodbye letter as "written affirmation of being heard" (p103) which had a powerful impact on the women who received them. It appeared that when the relationship felt free of judgement, participants were able to speak openly and in turn, feel understood by their therapist when they were met with a validating response. The quality of the therapist-patient relationship was associated with positive outcomes, with participants who reported a positive working relationship achieving better overall outcomes (Cunningham et al., 2004).

Power and collaboration: Six of the studies considered client-led therapy to be imperative to making progress, where clients found it more comfortable to move at their own pace. Positive relationships were often defined by the participants' perception of power in the relationship and those participants that perceived an equality between themselves and the therapist were empowered to take on more responsibility within the therapy. This is portrayed by a participant from Cunningham et al. (2004) who summarises the partnership; "my other therapist would talk about what he wanted to talk about, [my current therapist and I] talk about what we want to talk about" (p252). Being on the same level, both the patient and therapist were "working towards the same goal" (Cunningham et al., 2004, p251), which appeared to be closely linked to the emergence of self-belief in the change process (Ross, 2002). Craigen (2006) reported "it was like a partnership of the two of us against the cutting" (p253) whilst others described how power inequalities within the relationship and the expert stance taken by the therapist left them feeling inadequate; "I just felt like her child, her failure child at that," (Craigen, 2006, p277).

Some described negative experiences when their therapy was not a collaborative process, with it appearing as though therapists in these circumstances were driven by theory rather than their patient. In these cases, it was the patient's perception that their therapist struggled to understand them as a unique person and instead, "put words in your mouth so you sort of fit their category" (Craigen, 2006, p138) or "tried to make me fit a mould… because she only understood the mould," (Craigen, 2006, p198). Some even felt that therapists changed their approach to the therapy once they learnt that they were a 'cutter,' which led them to feel dismissed and unimportant within the relationship.

Overarching theme three: Development through Therapeutic Processes

Awareness and understanding: Building understanding helped to integrate experiences and frame difficulties in a different way which supported patients to build compassion for themselves; "so I don't hate myself anymore, I know my reasons as to why I

did it… I can understand it," (Long et al., 2016, p44). Walker et al. (2016) also reported how the therapy goodbye letter acted as a written reminder of their experiences and the patterns of relating that were brought into their awareness throughout the therapy process. Some spoke of the importance of developing awareness as part of the journey which incorporated learning how to cope in different ways; "I think you need to understand the past and I think you need to apply the DBT principles for how to handle yourself with the feelings that come up, and how to run your life," (Cunningham et al., 2004, p251).

Moving beyond self-harm: Participants described how they were unable to stop self-harming until they had "dealt with the issues that were underneath" (Long et al., 2016, p44) and that "if [the therapist] focuses on the cutting, then nothing is getting fixed," (Craigen, 2006, p281). For some, therapists focussing on self-harming behaviours was in contrast to the goals of patients and they "really resented attempts to get [them] to stop cutting" (Long et al., 2016, p44). This was experienced as coercive and compounded feelings of helplessness experienced elsewhere. An acceptance of self-harming behaviours as functional coping strategies until participants felt able to consider alternative methods improved the therapeutic relationship and allowed for a space to focus on the underlying reasons for their behaviours. Whilst the focus of underlying issues dominated in patient's preference, providing alternative strategies before targeting underlying issues that would reduce self-harm was described as helpful, with one participant stating that "you can't strip someone of their old clothes until you have a new set available," (Craigen, 2006, p281).

Therapeutic techniques: A band aid approach?: Each participants' experience of the techniques employed within the therapy was unique. Largely, patients reported alternative strategies to be helpful, but alone not enough to produce meaningful change. A wide variety of specific therapeutic techniques were named, with many perceived as helpful by some participants (e.g., mindfulness, distraction, positive self-talk) but at times also seen as unhelpful by others. The variation in reported helpfulness of techniques showed the uniqueness of each person's therapeutic journey, that was most successful when the therapist was attuned to the emotional experience of their patient. An exploration of strategies incorporating their personal preferences allowed participants to be actively engaged in sessions and gave them realistic alternatives to self-harming (Craigen, 2006). Structured practice of skills learnt was described as helpful to "integrate skills into patterns of living" (Ross, 2002, p12) and to "get into the right tracks of thinking so you can use the skills to

handle it yourself" (Persius et al., 2003, p223). Some argued that alternative strategies were only short-term solutions to self-injury and described them as a "band aid approach" (Craigen, 2006, p290) to managing self-injury and "terribly simplistic behaviours that were short term answers" (Craigen, 2006, p305). Telephone coaching as an adjunct to DBT was considered a "crucial crisis support" (Persius et al., 2003, p223) from most of those who had experienced it, which helped patients through distressing moments, whilst also building up a sense of personal responsibility around expressing their needs (Cunningham et al., 2004).

Overarching theme four: Therapy as life changing

Across different therapeutic approaches there were consistent reports of reduced impulses to self-harm, self-harming behaviours and suicidal ideation, with previous acts of self-injury being described as "a past life kind of thing" (Ross, 2002, p8) and therapy having "brought them back to life," (Persius et al., 2003, p221). Three studies reported on the 'life saving' nature of therapy.

Interpersonal Change: Reflective thinking about instances of self-harm and control over impulses and emotions appeared important when considering the day-to-day positive impact of therapy; "the ability [for patients] to control their emotions allows them to weather moments of crisis rather than escaping through parasuicidal behaviour or drug use," (Cunningham et al., 2004, p255). Gaining control over both their urges to self-harm and response to these urges where they can "handle situations… without being self-destructive," (Persius et al, 2003, p222) helped participants to better manage interpersonal exchanges, controlling their emotions in interactions and improving relationships. Use of interpersonal skills learnt within therapy led to strengthened relationships with others that it may have not been possible to share with before; "I talk to my mom about a lot of things now," (Craigen, 2006, p279). Assertiveness, increased tolerance of others through emotion regulation and conflict management skills were consistent factors that illustrated perceived success in relationships as an outcome of therapy. Whilst many acknowledged that self-harming behaviours and fluctuations in mood were still a part of their life, a sense of hope was described by the majority of participants who had experienced therapy as positive; "I feel like my future is going to be great. Like I have the chance to become something… I feel like I have always wanted that anyway; I just didn't have the tools to do it, so now I know. I have great hope," (Cunningham et al., 2004, p255).

Intrapersonal Change: There was a strong sense of change for participants within themselves following a successful therapeutic outcome. Developing understanding and making meaning of their difficulties, participants were able to integrate their experiences and build an identity that endures without the need to self-harm, "It's something that helped make me stronger, if it never happened I probably wouldn't be the person I am today… I like who I am today, so I want to keep it that way." (Long et al., 2016, p44). The therapy also supported patients to develop an acceptance of themselves and their feelings, as well as the feelings of others; "being able to accept that life can feel like shit for one day, without cutting myself to pieces…" (Persius et al., 2003, p222). For some participants, their beliefs of the attained positive changes made within themselves was confirmed when identified by others; "it's definitely nice when people say 'oh you're much happier than you used to be'… 'cos that's like how I've always wanted to be but I'm like that now," (Ross, 2002, p10).

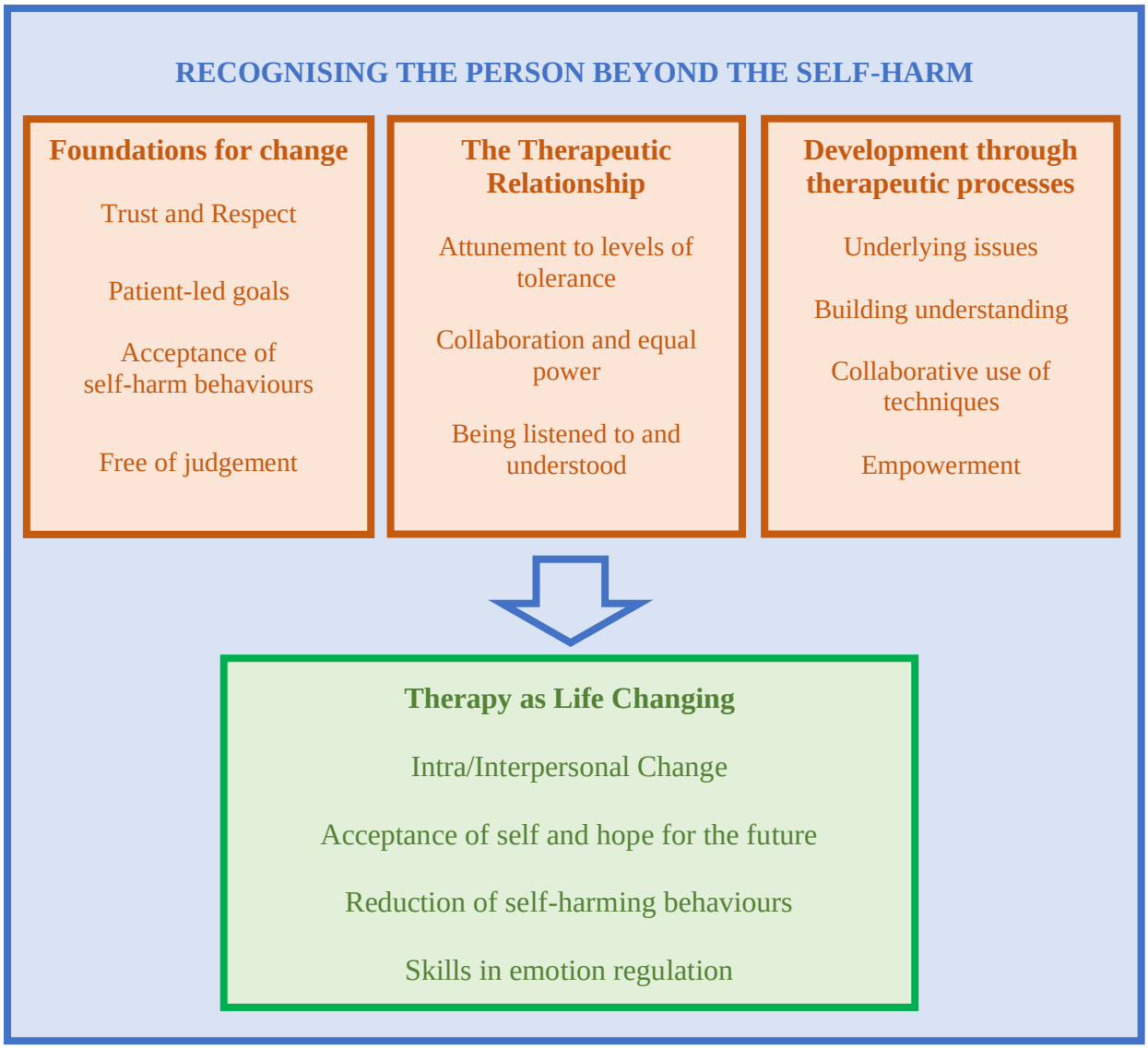
Powerful messages of how therapy was empowering for participants were consistently found alongside the importance of personal responsibility. Participants' perceived gains made within therapy acted as a motivator throughout, building a sense of pride in themselves and their accomplishments; "I can look at my scar and say that I'm proud that I got through it, that I survived, and that I'm still surviving in every single day that I go along" (Long & Tracey, 2016, p44). The focus of participants' own responsibility, both for therapy and their own lives, had a valuable impact on their progress including expressing needs, problem solving and skill application; "how I progress is up to me. I've waited my whole life for this but the pride, the accomplishment, is mine because I did it. And that's what this program is geared to do. It gives you the information, they do their damnedest to keep you on the right track but where you go with it is up to you." (Cunningham et al., 2004, p251).

Line of Argument Synthesis

Underlying all four themes was the importance of recognising the person beyond the self-harming behaviour. In line with the uniqueness of the functions, motives and methods of self-harm, the way that therapy was approached for participants needed to centre around the uniqueness of each individual. This understanding developed into the model that can be seen in Figure 2.

Figure 2

Line of Argument Synthesis Model



The narratives elicited from participants showed that giving space and time to recognise them as an individual separate to the self-harm enabled them to develop a strong rapport with their therapist and sense of trust within the therapeutic process, increasing the likelihood that they felt safe enough to critically consider their ways of coping and disclose their most private fears and experiences. Consistently, there was a clear preference for self-harming behaviours to be accepted as an understandable way of coping with distress, with an acknowledgment given to the feelings of shame and privacy that those who self-harm often hold. Successful, trusting relationships were developed within a validating environment, eliciting a genuine human connection between the dyad which served to destigmatise the self-harm and allowed

the parties to navigate the therapeutic processes together, where the pace of therapy moved at the rate that was tolerable for the individual. Led by the patient's goals, which often went beyond the scope of self-harm reduction, the therapist had to incorporate an appreciation of the complex and individualised needs of the self-harming patient, with a focus on tackling the underlying difficulties that led them to the point of harming. When the therapist's agenda differed from that of the patient, the lack of attunement within the relationship led to patients feeling unheard, misunderstood and unimportant, resulting in a rupture within the therapeutic relationship and creating a barrier to accessing therapeutic skills and techniques.

Therapists that were attuned to the emotional needs of the patient (including their level of established trust and tolerance for change) were able to collaboratively navigate which specific therapeutic techniques could be useful for their patients, if any, and recognise when they weren't ready to access them. It was important to participants that they perceived there to be a genuine, compassionate understanding of them as unique, rather than being reduced to merely 'fit the mould' of a theoretical model or stereotyped assumption that exists around the concept of 'cutting.' Through the developing understanding of their difficulties and a positive therapeutic relationship, participants described an increase in self-compassion and acceptance of their experiences, which helped them to develop a positive relationship with themselves and others outside the therapy room. Seeing the individual behind the self-harm helped participants to become more accepting of their own identity and their relationship with self-harm which incorporated a sense of empowerment in the aspects of their life that were uniquely important to them.

Discussion

This study reviewed seven qualitative studies, including a total of 68 participants, with the aim of collating and synthesising the experiences of those who have participated in psychological therapy for self-harm. Four overarching themes ('foundations for change,' 'therapeutic relationship as a vehicle for change,' 'development through therapeutic processes' and 'therapy as life changing') and nine subthemes emerged from the data. Synthesising the available qualitative research highlighted the importance of trust and safety within the therapeutic relationship as a prerequisite for perceived successful therapeutic outcomes. Recognising the individual as separate to their self-harming behaviours was illustrated across all four themes, with an acknowledgement given to the power of acceptance of self-harm and the attunement to an individual that can lead to empowerment and autonomy. There has shown a critical need for collaboration in therapy, where progression is made within the capacity of a patient's tolerance, and success is measured on a level of meaningful change within the uniqueness of an individual's life.

Within a successful therapeutic space, participants reported that their self-harming behaviours were accepted as a means of coping with distress. Those engaging in self-harm often experience strong feelings of shame (Sheehy et al., 2019), leaving them acutely sensitive to any perceived judgements from their therapist. A strong relationship incorporates a therapist who is attuned to the extent that a patient can tolerate these strong emotions and adjusts their approach as and when the patient's tolerance expands. Vygotsky (1978) referred to this concept as 'the space between a patient's actual learning developmental level and their level of potential development,' naming this as the zone of proximal development (ZPD). As illustrated in this study, direct references to stopping self-harming behaviours may have led patients to feel overwhelmed and move outside of their ZPD, meaning they are unable to access the therapy. Some therapies consider the ZPD as focal to the therapy, for example cognitive analytic therapy (CAT; Ryle & Kerr, 2002); a relational therapy that collaboratively explores the relationships one holds with themselves and others. In addition to the need to work within an individual's ZPD, improvements in intra/interpersonal relationships largely dominated the narratives of perceived success within this study and therefore the use of CAT-informed approaches may warrant further investigation as a treatment for self-harm, such as the brief CAT-informed intervention described in Sheard et al. (2000).

The findings highlight how a successful therapeutic relationship is fundamental to the perceived effectiveness of a psychotherapeutic intervention and is strongly supported in previous literature (Fluckiger et al. 2018; Wampold & Imel, 2015). Aversive relational dynamics where individuals are found in a disempowered position can often be present for those who engage in self-harm (Peel-Wainwright et al., 2021). These dynamics have the potential to emerge within the therapeutic relationship, particularly when clinicians hold pejorative attitudes (Saunders et al., 2012) which perpetuate the shame and stigma often felt by those who self-harm (Mitten et al., 2016). Compassionate and gentle care has been found to alleviate feelings of shame in those that self-harm (MacDonald et al., 2020) with positive therapist qualities being reliable indicators of successful outcome, independent of the therapeutic approach (Norcross & Lambert, 2018). Within this study, the human connection elicited through a trusted and collaborative partnership made way for a safe therapeutic space where patients felt comfortable to disclose their experiences without fear of judgement. Barriers to the development of a positive therapeutic relationship can arise from a lack of knowledge and confidence in clinicians (Fortune et al., 2021) yet staff training in self-harm has been found to increase perceived competence and reduce apathy in clinicians (Patterson et al., 2007). Whilst formal training in the management of self-harm is a requirement within NICE guidelines (NICE, 2004), there is no agreed framework for this training and therefore the development of an education programme which prioritises the unique individual within a collaborative, therapeutic relationship may enhance compassionate care.

In this review, therapists' efforts to challenge or remove self-harming behaviours were met with resistance and perceived as coercive and intrusive, whereas validating and non-judgemental responses allowed patients to feel empowered within the relationship. In most therapies, self-harm is considered a high risk behaviour (Lewis & Hasking, 2021) which drives clinicians to attempt to reduce self-harming behaviours as a priority. Contrastingly, those who have participated in therapeutic interventions for self-harm consistently report that reduction in frequency of typical self-harming behaviours are alone, not enough to indicate improvement to their lives and mental wellbeing (Owens et al., 2020). This study found that when the therapy requires patients to confront or eradicate self-harming behaviours before trust has been established, a conflict can occur within the therapeutic relationship which can lead patients to withhold information or disengage from the therapy. Perceived success was viewed by patients as meaningful changes within relationships with the self and others, as well as an improvement in their ability to regulate their emotions. In practice, careful

consideration should be given when collaboratively determining the goals and structure of the therapy to reduce the likelihood of conflicts that could impact on therapeutic outcomes (Taylor et al., in press). Based upon these results, it is recommended that all patients should be given the opportunity to discuss their goals and expectations throughout therapy, with the focus of therapy reflecting this and consideration from clinicians given to resist the pull to reduce self-harming behaviours as a priority where it conflicts with the patient's goals.

This study included seven papers within the analysis. Whilst this could be considered a limitation, the meta-ethnographic approach necessitates a detailed synthesis which provides deeper insights into the conceptual ideas studied (Nobilt & Hare, 1988) and the inclusion of a smaller number of studies has been found to achieve a higher degree of conceptual development (Campbell et al., 2012). This has been attained within this paper through a thorough and systematic search of the field, resulting in a comprehensive picture of the available research and is therefore a strength of the study. Similar reviews that have studied support for self-harm (Winter et al., 2014) have included a comparable number of papers, which may be reflective of the scarcity of evidence currently available within this field. Of the seven papers, three were considered to have a high risk of bias when considering the relationship between researcher and respondent. Future research should attempt to mitigate this through further bias considerations and accurate reporting. One paper (Cunningham et al, 2004) was also deemed to be lower quality than the other papers due to a lack of clarity around risk of ethical issues and analysis methods, however the findings of this study largely echoed that of the higher quality papers and therefore the risk of bias was not considered to be substantial.

Of the 68 participants included within this review, 66 of these participants were female. The existing research highlights inconsistencies in the prevalence of self-harm across genders (Whitlock et al., 2011) with generally higher rates in women but with the effect size of this difference often being small (Bresin & Schoenleber, 2015). Males are significantly underrepresented within both research and clinical practice (Kimbrel et al., 2017) which currently serves to maintain the disparity between distress and receiving appropriate support, therefore future research should strive to include males and diverse genders within qualitative research. Another limitation of the included studies was the paucity of reporting and inclusion of diverse ethnicities, where most papers (n=5) did not identify an ethnicity and with the large majority of identified ethnicities being white. Whilst white populations have

been found to have the highest rates of hospital admissions for self-harm (Polling et al., 2021), community surveys identify lower rates of professional support seeking and mis-classification of self-harming behaviours due to uncommon presentations of self-harm within minority populations (Crawford et al., 2005; Rockett et al., 2010). It is therefore imperative to include diverse populations in future research to ensure that appropriate considerations are made that fulfil the needs of a wider population.

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Paper 2:

A brief cognitive analytic therapy informed case series for young people that have self-injured (CATCH-Y)

Haw, R.,[1,2] Marsden, M [1,2,] Hartley, S.,[1,3] Turpin, C.,[2] & Taylor, P.J.[1]

[1]Division of Psychology & Mental Health, University of Manchester, Manchester Academic Health Sciences Centre, UK

[2]Greater Manchester Mental Health NHS Foundation Trust, UK

[3] Pennine Care NHS Foundation Trust, UK

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This paper will be submitted for publishing to the *Journal of Psychopathology and Clinical Science* (word count 9000). Author guidelines can be found in Appendix D.
Please note, some deviation from the guidelines is evident for example, not all appendices included in this thesis will be submitted for publishing, but are included here for context. Tables and figures are embedded within the text for ease of reading.

* Corresponding Author: Dr Peter Taylor, Division of Psychology and Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health; The University of Manchester, 2nd Floor Zochonis Building, Brunswick Street, Manchester, M13 9PL, UK
Email address: peter.taylor2@manchester.ac.uk

Abstract

Background: Non-suicidal self-injury (NSSI) presents an increasingly prevalent problem for young people, however there remains a scarce evidence base for effective, scalable treatments for adolescents. This study aimed to assess the feasibility and acceptability of a brief, cognitive analytic therapy (CAT) informed intervention for young people who engage in NSSI (CATCH-Y).

Methods: A case-series design recruited thirteen young people who met the inclusion and exclusion criteria to participate in the five session intervention. Eligible participants were aged 13 – 17 years (M = 15.15, SD = 1.28) and had engaged in NSSI at least once in the past 6 months. Feasibility and acceptability were measured via recruitment, retention, qualitative feedback and missing data. Secondary outcome measures of personal recovery and motivation were administered pre- and post-assessment, with measures of low mood and urges to self-harm completed weekly.

Results: The intervention was found to be largely feasible and acceptable with high rates of recruitment, retention and pre/post-assessment data completeness. Measures showed preliminary support for positive change in rates of NSSI, urges to self-harm, low mood and personal recovery, although results were mixed.

Limitations: A small sample size and missing data on weekly measures means that findings should be interpreted with care. The successful use of CAT-informed practitioners shows promise for the wider dissemination of CATCH-Y within healthcare settings.

Conclusions: The findings of this study support further evaluation of the CATCH-Y intervention on a larger scale.

Keywords*: self-harm, non-suicidal self-injury, cognitive analytic therapy, adolescents, brief intervention.*

Introduction

Non-suicidal self-injury (NSSI) can be defined as the direct and intentional infliction of damage to one's own body tissue without the intention of suicide and not consistent with cultural expectations or norms (Klonsky, 2007; Nock et al., 2006). NSSI arguably differs from suicidal behaviour in intent, function, frequency, method and severity (Muehlenkamp, 2005) with the UK definition of self-harm being inclusive of both suicidal and non-suicidal acts (Hawton et al., 2003). Typical methods of NSSI include cutting, hitting or burning oneself, with many of those who engage in NSSI doing so across multiple methods (Lloyd-Richardson et al., 2007).

Whilst people may engage in NSSI at any age, adolescents report the highest rates of NSSI, with a lifetime prevalence of around 17% (Swannell et al., 2014). Prevalence rates have increased in the UK from 2.4% in 2000 to 6.4% in 2014, with the most substantial rise found in females aged 16-24, from 6.5% in 2000 to 19.7% in 2014 (McManus et al., 2019). Harmful relationships, particularly parental maltreatment and bullying, have been found to be highly associated with engagement in self-harming behaviours (Kaess et al., 2013; Klomek et al., 2016). Engaging in NSSI is a risk factor for both future NSSI and suicide (Castellví et al., 2017; Ribeiro et al., 2016), which is currently the second leading cause of death globally for those aged 15-29 (World Health Organisation, 2018). Not only does self-injury increase the risk of suicide, it can also result in other serious consequences such as scarring, infection, accidental death and heightened emotional distress (Nock, 2010).

Whilst there is currently no guidance for the treatment of NSSI, the recommended intervention for self-harm in the UK is '3-12 sessions of a psychological intervention that is specifically structured for people who self-harm' (NICE; National Institute for Health and Care Excellence, 2011) with new guidance expected to be released in 2022. Despite the growing prevalence of young people that self-injure, few studies have examined NSSI-specific therapeutic interventions with rigour and there is no universally agreed treatment for those who engage in NSSI (Ougrin et al., 2015). A recent Cochrane review compared the effectiveness of various psychosocial interventions for young people who self-harm (with or without suicidal intent) finding evidence in support of the effectiveness of dialectical behaviour therapy for adolescents (DBT-A; Witt et al., 2021). No significant reductions in self-harming behaviours were found for Cognitive Behavioural Therapy (CBT) or

Mentalisation Based Therapy (MBT). A meta-analytic review of DBT-A for NSSI and depression also found a significant reduction in NSSI and improvement in depressive symptoms when applying the intervention (Cook & Gorraiz, 2016) however another review on self-harm in adolescents concluded that no psychological intervention was superior than TAU (treatment as usual) when NSSI is considered alone (Ougrin et al., 2015).

Research has shown that engaging in NSSI fulfils both intrapersonal and interpersonal functions. Intrapersonal functions often include emotional self-regulation (both inducing positive states and escaping aversive states) and self-punishment, whilst interpersonal functions involve meeting essential needs by exhibiting control over their social context, eliciting care and support and communicating powerful emotions to others (Peel-Wainwright et al., 2021; Burke et al., 2021; Taylor et al., 2018). Whilst intrapersonal reasons for self-injuring are commonly cited, the two overarching functions are not distinct but instead interwoven, as difficult interpersonal experiences are frequently drivers for the aversive emotional states that NSSI serves to regulate (Peel-Wainwright et al., 2021). Studies have consistently identified interpersonal reasons for self-injury, such as social rejection, limited social support and bullying amongst others, and therefore understanding and working with the relational contexts in which NSSI occurs is key (Cawley et al., 2019; Karanikola et al., 2018).

As a reported function and consequence of NSSI, relational difficulties could be considered an important risk factor for engaging in self-injury. One relational therapeutic approach that could therefore be effective in reducing NSSI is Cognitive Analytic Therapy (CAT; Ryle & Kerr, 2002). CAT is a relationally-based psychological therapy, which focuses on how patterns of relating to oneself or to other people can develop over time and maintain psychological problems. Self-injury may emerge as part of procedures (chains of aim-directed actions) that function to reduce distress or help someone escape from aversive relational roles (e.g., feeling criticised or ignored), but which ultimately maintains their difficulties. CAT has been found to produce faster improvements compared to good clinical care when used with young people with a diagnosis of borderline personality disorder; a diagnosis that incorporates self-harm as a symptom (Chanen et al., 2008). Furthermore, preliminary evidence from pilot trials have shown brief CAT interventions to be helpful when working with individuals that self-injure (Ourgin et al., 2008; Sheard et al., 2000). Those that engage in NSSI often have poor adherence to treatment which is associated with poor

treatment outcomes (Murphy et al., 2010; Ougrin et al., 2012). Using a CAT-based initial assessment within Children and Adolescent Mental Health services (CAMHS) for young people who self-harm has shown preliminary support for improved adherence to follow-up and treatment engagement (Ougrin et al., 2011).

Child and Adolescent Mental Health Services (CAMHS) have been under pressure in recent years with a marked increase in referrals from 2019 to 2021 of 68% (NHS Digital, 2021) and increased numbers of young people presenting to accident and emergency departments having self-harmed (Hawton et al., 2012). It has been reported that only 25% of children and young people that need specialist support are able to access it and those accepted can be waiting up to 10 months for an appointment (Department of Health and Social Care, 2018). The serious risk that self-harm poses, significantly heightened within the first months after an episode of self-harm (Chitsabesen et al., 2003), means that a timely intervention is crucial. Whilst DBT-A for NSSI could be a promising treatment with regards to the evidence base, it is a demanding therapy that is intensive for those participating in it as well as for those training to deliver DBT-A and the services providing it (Comtois, 2002; Comtois & Linehan, 2006). Furthermore, a recent large scale randomised control trial (RCT) found online DBT to increase the risk of self-harm in adults (Simon et al., 2022). DBT-A initially targets the elimination of high-risk behaviours such as NSSI, before moving toward a more intensive treatment for additional symptoms of 'borderline personality disorder' (Rathus & Miller, 2002). As NSSI is a transdiagnostic phenomenon (Bentley et al., 2017), less intensive and more easily accessible therapies which can reach more young people are essential when considering the rapidly increasing rates of CAMHS referrals for self-harm.

Brief interventions for young people could be considered a promising approach for increasing accessibility to evidence-based interventions in many healthcare settings (Glenn et al., 2019). Clinicians often report a scarcity of knowledge or training around the treatment of NSSI (Flaherty, 2018) however the use of briefer interventions may require less staff training than more traditional therapies. A number of studies across different brief therapeutic approaches have shown promising initial results for young people who self-injure (Kaess et al., 2020; Andover et al., 2017).

Members of the research team recently completed a feasibility study investigating a brief, two-session CAT-informed intervention (Cognitive Analytic Therapy for Containing Self-

Harm; CATCH) for adults who have engaged in NSSI (Peel-Wainwright et al., in prep) and found the intervention acceptable to this population. Following this initial success and with there being early support for the use of CAT-informed interventions with young people (Ougrin et al., 2011), the CATCH intervention has been adapted for use with young people (Cognitive Analytic Therapy for Containing Self-Harm in Young People; CATCH-Y). Consultations with clinicians, young people and carers within CAMHS services led to adaptations of the CATCH intervention including an increase in session number, reduction in session length, flexibility in location, explicit use of psychoeducation and an emphasis on systemic factors.

According to the Medical Research Council (MRC) and National Institute for Health Research (NIHR) complex intervention development framework, the feasibility and piloting of a new intervention is key to exploring uncertainties in the design and changes should be trialled before embarking on larger scale research (Skivington et al., 2021). A smaller case series feasibility study will expose whether major challenges in recruitment and retention would limit the feasibility of a larger trial (Bugge et al., 2013). To our knowledge, the CATCH-Y intervention had not yet been evaluated and therefore, the current study investigated the feasibility and acceptability of CATCH-Y, a brief CAT-informed intervention for young people that have engaged in NSSI. Feasibility was measured through recruitment rates, retention rates and data completeness whilst acceptability was assessed by attendance of participants, as well as their feedback on their experience. The secondary aim of the study was to investigate whether the CATCH-Y intervention showed preliminary evidence for change across measures of mood, urges to self-harm, motivation to change and personal recovery.

Method

Ethics

This research was granted ethical approval from the University of Manchester Sponsorship panel (see appendix E) and the NHS Research Ethics Committee (see appendix F). Recruitment took place within two local NHS trusts who also issued local approval. The research was completed as part of a trainee clinical psychologist's thesis project and received funding from the University of Manchester. Additional funding was also issued by the Association of Cognitive Analytic Therapists (ACAT) to cover clinical supervision fees (see appendix G). A second trainee clinical psychologist also worked on the project and aspects of the study are relevant to their thesis only. Both trainees held dual researcher-therapist roles throughout the study.

Study Design

An AB design with follow-up assessment was used. The study took an idiographic approach to the evaluation of the intervention. The study was pre-registered with clinicaltrials.gov (NCT04708262).

Study inclusion criteria were intentionally broad to reflect the nature of CAMH services and increase the likelihood that outcomes could be translated into practice contexts. Participants were included in the trial if they a) were between the ages of 13 – 17; b) had self-injured at least once in the six months prior to screening and had a lifetime history of two or more episodes of NSSI; c) had a clinician allocated to them within a mental health service (including NHS or third sector services); d) had access to the internet. Participants were excluded if they a) were receiving alternative psychological therapy at the time of screening; b) had ever received CAT before; c) had a severe intellectual disability which would impair their ability to participate without considerable adaptations being made to the intervention; d) had insufficient English-language speaking skills to participate in talking therapies in the English language (time and resource restraints meant it was not possible to hire an interpreter); e) were judged to be at high risk of harm to themselves, operationalised as having current suicidal thoughts with a high intent or active plan to end their life. A sample size of eight was sought in line with similar case-series in the field (Searson et al., 2012; Taylor et al., 2019). With an estimated attrition rate of 1/7 predicted based upon the outcomes of the CATCH study (Peel-Wainwright, in prep), the study aimed to recruit nine participants.

Measures

Feasibility and Acceptability

The primary aim of this study was to assess the feasibility and acceptability of CATCH-Y in a population of young people who have self-injured. The following hypotheses around feasibility and acceptability were tested: i) over 50% of those referred to the study and eligible to participate would consent to take part; ii) at least 70% of those recruited would attend all five intervention sessions; iii) missing outcome data on clinical outcomes (for those still retained in the study) would not exceed 20% per assessment.

The acceptability of the study was also explored using an adapted version of the Client Satisfaction Questionnaire (CSQ-8; Larsen et al., 1979). This was used to gain feedback on the helpful/unhelpful aspects of the intervention upon completion. The CSQ-8 has good internal consistency and is a widely used measure for therapeutic outcome (Attkisson & Zwick, 1982). Higher scores indicated higher levels of satisfaction and there was also space for participants to comment descriptively on their experiences (see appendix H for the adapted CSQ-8).

Secondary Outcome Measures

All secondary outcome measures can be found in appendix H with the measures and time points administered outlined in Table 4. All measures were completed either face to face or via an online survey platform. In addition to the measures below, self-reported rates of non-suicidal self-injury were analysed pre and post assessment.

Self-Injurious Thoughts and Behaviours Interview (SITBI): In this study, the self-injurious behaviour subsection of the SITBI was used to identify participants' self-injury history. The SITBI is a structured interview which assesses the frequency and characteristics of NSSI in young people (Nock et al., 2007). The SITBI has been evaluated with a population of adolescents who self-injure and has been shown to have comprehensive validity and reliability. It is now widely used in research into NSSI.

Motivation for Youth Treatment Scale (MYTS): The MYTS evaluates a young person's motivation to change and desire to find solutions to difficulties (Bickman et al., 2010). A psychometric evaluation of the MYTS conducted with young people aged 11-18 found it to

be a reliable tool for assessing important dimensions of intrinsic treatment motivation (Breda & Riemer, 2012).

Recovery Questionnaire (ReQuest-YP): The ReQuest-YP examines recovery of functionality and outlook post-treatment (John et al., 2015). An evaluation of the psychometric properties of the ReQuest-YP with 65 young people (including those self-injuring) showed good internal consistency and test-retest reliability (Bentley et al., 2019).

Alexian Brothers Urges to Self-injure scale (ABUSI): The ABUSI is a measure to assess the frequency, intensity and duration of the urge to self-injure (Washburn et al., 2010). The ABUSI has shown good internal consistency and reliability (Chavez-Flores et al., 2019) and validity in a population of students who self-injured (Dimitrova et al., 2019).

Patient Health Questionnaire for Adolescents (PHQ-9A): The PHQ-9A is a low mood clinical evaluation which has been modified for adolescents (Kroenke & Spitzer, 2002; Johnson et al., 2002). An examination of the PHQ-9A completed by 442 young people, showed positive validity of the measure (Richardson et al., 2010). Clinically significant change was also measured in line with the clinical scoring used in the authors' original paper (Kroenke & Spitzer, 2002).

Procedure

Participants were recruited from two CAMH services in North West England. Clinicians identified potentially appropriate referrals to the study and contacted a member of the research team. After gaining consent to contact from the young person (and their carer if they were under 16), a member of the research team contacted the young person to complete the screening appointment. Within the screening appointment, eligibility was checked and a brief risk screening assessment was completed. If the young person met the criteria, a mutually convenient time, date and location was set for the first research session. Eligibility and risk were also explored with the young person's allocated clinician prior to acceptance to the study.

Caregivers were required to be present within the first research session for those under the age of 16. Consent was taken from both parties and baseline assessment measures completed.

Participants attended a second research session where they completed a repertory grid as part of the second trainee's project (MM).

Table 4

Measures and time points

Measure	Pre-therapy	Weekly	Post-therapy	Follow up (for 4 weeks)
SITBI	✓			
Repertory Grids	✓		✓	
MYTS	✓		✓	
ReQuest-YP	✓		✓	
ABUSI	✓	✓	✓	✓
PHQ-9A	✓	✓	✓	✓
CSQ-8			✓	

Note: SITBI: Self-Injurious Thoughts and Behaviours Interview; ABUSI: Alexian Brothers Urge to Self-Injure Scale; PHQ-9A; Patient Health Questionnaire for Adolescents; ReQuest-YP; Recovery Questionnaire for Young People; MYTS: Motivation for Youth Treatment Scale; CSQ-8: Client Satisfaction Questionnaire.

Participants then completed the CATCH-Y intervention which ran over five sessions, each lasting around 30-40 minutes. Two measures (ABUSI, PHQ-9A) were completed weekly either via an online survey platform or within the face to face session. Approximately one week following the final CATCH-Y session, participants were asked to complete a final research session where they repeated the repertory grid task and the post-therapy assessment measures. They were asked to complete weekly measures online for four weeks after the completion of therapy. Participants were reimbursed with a £30 shopping voucher for their participation. Full study protocol is available in appendix I.

CATCH-Y

Researchers followed the CATCH-Y therapy guidance which can be found in appendix J. As final year trainee clinical psychologists, both researchers delivering the intervention (RH, MM) had significant experience working therapeutically with young people who engaged with self-injury and were familiar with CAT. They also underwent 3 additional training sessions in CAT with a CAT-qualified practitioner prior to delivering the intervention. The two researchers received fortnightly supervision from a qualified CAT practitioner and supervisor. In addition, they received intermittent supervisory support from senior clinical psychologists within the research team.

CATCH-Y is a brief psychological intervention for young people who self-harm which intends to support young people to make sense of their behaviours in the context of their relational patterns. It could be utilised as a brief therapeutic intervention or a facilitator for developing an initial understanding before further therapeutic work follows. It is modelled on the CATCH intervention (Peel-Wainwright et al., in prep) which was based upon a previous brief CAT manual (Sheard et al., 2000) and informed by guiding principles of cognitive analytic therapy (Ryle & Kerr, 2002). In the first and second session, the focus was on the process of 'mapping,' where there is an emphasis on forming a collaborative understanding of the young person's relational, experiential and coping patterns, in a sequential diagrammatic reformulation (SDR) or 'map.' In sessions three and four, where indicated by the young person's therapeutic zone of proximal development (ZPD; Vygotsky, 1978), the focus shifts towards identifying exits (or ways of breaking out of unhelpful patterns) that can be applied by the young person. A goodbye letter which captured the SDR was written and shared with the young person within the fourth session. The final session was a consultation session which focussed on consolidating and sharing the collaborative understanding of the young person. If acceptable to the young person, the key clinician and/or caregivers would be invited to attend the session. Participants were encouraged to keep the SDR to reflect on and share with other professionals following the end of the sessions.

Data analysis

To evaluate the primary aims of acceptability and feasibility, descriptive statistics were used to outline recruitment, retention, attendance and data completeness. Frequency statistics and percentages were calculated to determine whether the hypotheses were met.

Whilst the study was not expected to produce statistically significant changes with the small participant number, meaningful data was explored and trends over time were examined for all measures. Means, standard deviations and confidence intervals were calculated and analysed to determine pre/post-assessment treatment effect sizes as well as changes over time. Clinically significant change was also calculated using the Reliable Change Index (Jacobson & Truax, 1991) to assess the clinical impact of the intervention.

Results

Participant Characteristics

Thirteen participants were recruited from May 2021 to December 2021. Participant ages ranged from 13 – 17 at the time of screening, with a mean age of 15.15 (*SD* = 1.28). Participant characteristics can be seen in Table 5.

Table 5

Participant characteristics

Characteristics	n (%)
Gender	
Female	7 (54%)
Male	4 (31%)
Non-binary	1 (8%)
Prefer not to say	1 (8%)
Ethnicity	
White	7 (54%)
Black	3 (23%)
Mixed	1 (8%)
Asian	1 (8%)
Other (British Pakistani)	1 (8%)
Mental Health Diagnosis	
Anxiety	1 (8%)
None	12 (92%)
Medication	
Antidepressant	2 (15%)
Sleep medication	1 (8%)
None	10 (78%)

NSSI subscale of the Self-Injurious Thoughts and Behaviours Interview (SITBI):

All 13 participants that consented to participate in the study completed the SITBI. 100% of participants had engaged in cutting or carving the skin, with 85% (*n*=11) having engaged in more than one form of NSSI. None of the young people had received medical treatment for harm caused by self-injury (although the majority reported having received medical attention for suicide attempts). All participants had engaged in NSSI in the past month, with 54% (*n*=7) having self-injured within the week prior to assessment. Full results from the NSSI subscale of the SITBI can be found in appendix K.

Feasibility and Acceptability

Recruitment, Retention and Attendance

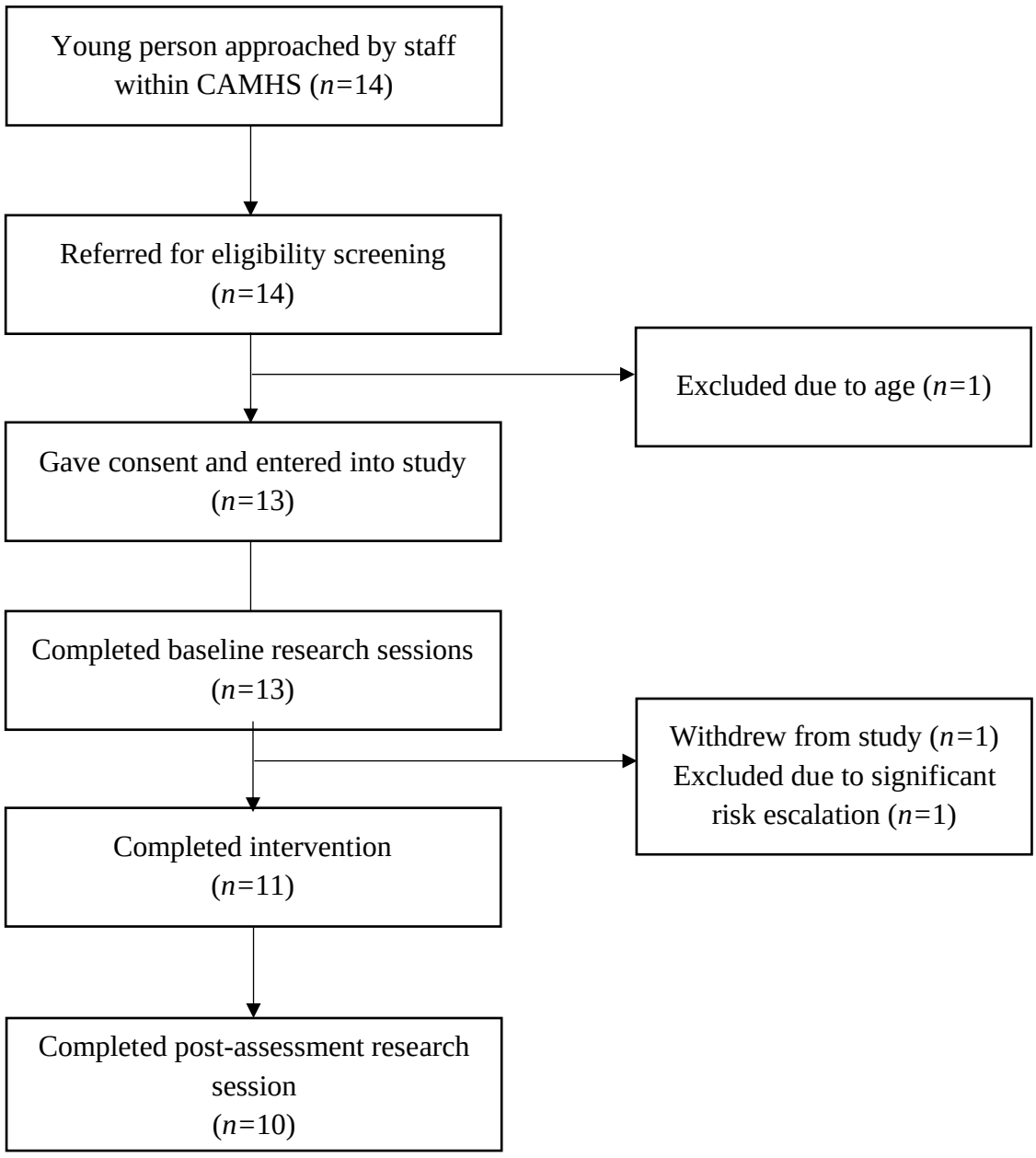
The number of participants at each stage of the study is outlined in the CONSORT diagram below (see figure 3). All 14 young people that were approached about participation in the study agreed to take part. One person did not meet eligibility criteria and therefore was excluded at the screening stage. The 13 remaining young people gave consent to participate and all completed the two baseline research sessions. Before the intervention began, one participant withdrew from the study and one was excluded due a significant escalation in risk, therefore neither of these participants completed any of the intervention sessions. Eighty-five percent (*n*=11) of those who consented to participate in the study attended all five intervention sessions, with all 11 of the participants who began the intervention completing all five sessions.

Referral rates

Fourteen individuals were referred to the study however when screened for eligibility, one was excluded due to being outside of the age limits. All of the remaining 13 participants consented to participate in the study. Furthermore, clinicians reported that 100% of those that they approached to participate in the study gave consent to progress to the screening stages.

Figure 3

Consort diagram of participants per referral stage



Missing Data

Outcome data from the 11 participants who remained in the study was analysed. One participant did not complete any pre-assessment, post-assessment or weekly measures due to difficulties with accessing emails. Following this, an amendment was made to the study procedure so that measures could be completed in person as well as via the online survey platform. Outcome data per measurement can be seen in table 6 below. Follow up data (four

weeks after the post-therapy assessment) was collected however due to the large scale of missing data (87%), this was not analysed.

Pre-assessment and post-assessment measures were completed by 10 of the 11 participants (91%). Weekly outcomes (ABUSI, PHQ-9) were completed 51% of the time, with missing data totalling 49% overall for each measure. Post-amendment, 100% of all the pre/post-assessment measures were completed across all outcomes with 56% of the weekly measures being completed.

Table 6

Outcome data completion per measure

Measure	Pre-therapy assessment (PA)	Post-therapy assessment (PA)	Weekly (PA)
SITBI	100% (100%)	n/a	n/a
ABUSI	91% (100%)	91% (100%)	51% (56%)
PHQ-9	91% (100%)	91% (100%)	51% (56%)
ReQuest-YP	91% (100%)	91% (100%)	n/a
MYTS	91% (100%)	91% (100%)	n/a
CSQ-8	n/a	91% (100%)	n/a

Note: n/a: not applicable; PA: post amendment; SITBI: Self-Injurious Thoughts and Behaviours Interview; ABUSI: Alexian Brothers Urge to Self-Injure Scale; PHQ-9A; Patient Health Questionnaire for Adolescents; ReQuest-YP; Recovery Questionnaire for Young People; MYTS: Motivation for Youth Treatment Scale; CSQ-8: Client Satisfaction Questionnaire

Acceptability

Acceptability was measured using the adapted CSQ-8. All information attained from the adapted CSQ-8 can be found in appendix L. A majority of the participants reported that they found the therapy at least partly helpful (n=9) and a positive experience (n=8). Most participants felt that it was at least partly true that they could speak safely within sessions (n=8), their worries were taken seriously (n=8) and that the therapist knew how to help them (n=8). When recommending a friend to undertake this intervention, 8 participants rated

'certainly true' or 'partly true', with two reporting 'don't know.' Six participants reported that they felt at least partly hopeful about the future, with two reporting this not to be true and two reporting that they didn't know.

An additional space was given for participants to report what they liked and disliked about the intervention as well as additional comments. Four participants described the visual mapping process helpful;

'Setting everything out in a map format allowed me to understand my problem more.'
'[I liked] writing it down'
'I liked how it visualised a map of emotions which made it easier to understand.'
'The map of the roles I switch between.'

Positive qualities within the therapeutic relationship were also commonly identified;

'I felt like I could open up about anything and I wasn't scared to talk about my problems.'
'[It was] nice having my thoughts taken seriously'
'I liked the therapist a lot who really understood my problems and treated me like an actual person. She helped me better understand my problems and helped me understand why I felt terrible all the time, I've seen my life improve since seeing her and I really don't know if I would have felt this comfortable if it was anyone else.'

They were also asked to describe what they disliked about the therapy. Five participants could not identify anything that they disliked about the therapy. Two participants disliked that they found the therapy to be repetitive;

'I felt it was sort of repetitive, especially to the counselling I have.'
'It felt a little repetitive.'

Some described not liking the research measures that they were asked to complete as part of the research project but separate to the intervention itself;

'The surveys and other questions such as the rep grid were quite complicated to fully grasp properly and although helpful I feel like they could be improved.'
'The measures have been a bit much - too many.'

One participant reported that they found the intervention unhelpful, not a positive experience and felt as though they were not taken seriously by the therapist. When asked what they liked and disliked about the therapy, they reported that they disliked '*everything'* and liked *'nothing but missing school.'*

Secondary Outcomes

The data from one item on one measure was missing and therefore mean imputation was used to input the score. One participant provided no pre-assessment or post-assessment data and two participants withdrew from the study prior to the intervention beginning and therefore provided no post-assessment data.

Rates of NSSI

A majority of participants reported either a decrease or no change in self-reported rates of NSSI, pre/post-assessment. A reduction in NSSI was evident in 40% (n=4) of participants, 40% (n=4) reported no change and 20% (n=2) reported an increase in NSSI. The mean change in NSSI frequency was -2 (SD=1.48*).* Scores can be found in appendix M.

Pre-post outcome measures

Descriptive statistics for each of the secondary outcome measures (ABUSI, PHQ-9, ReQuest-YP, MYTS) are outlined in Table 7. Outcomes showed a trend with moderate effect size towards improvement pre-post in subjective personal recovery (ReQuest-YP) and an improvement in mood (PHQ-9A) with a small effect size. An apparent reduction in motivation to change (MYTS) was found over time with a small effect size; a large effect size was indicated for a reduction in readiness to participate in treatment (MYTS treatment readiness subscale) whilst there was no change in recognition of difficulties (MYTS problem recognition subscale). It was noted that those who reported better outcomes at the end of the study saw a reduction in problem recognition. No difference was found in scores on the ABUSI over the two time periods.

Table 7

Secondary Outcome Measures

Measure	Pre-therapy assessment mean (SD)	Post-therapy assessment mean (SD)	Mean change (95% CI)	Standardised mean change
ABUSI	14 (4.64)	14.2 (8.75)	0.2 (6.8, -6.2)	0.02
PHQ-9	16 (5.23)	13.3 (8.41)	-2.7 (3.42, -8.82)	-0.32
ReQuest-YP	35.4 (9.62)	40.1 (15.2)	4.7 (10.45, -1.05)	0.58
MYTS	3.9 (0.39)	3.76 (0.38)	-0.11 (0.15, -0.37)	-0.31
PR Subscale	4.03 (0.67)	4.04 (0.86)	0.015	0.02
TR Subscale	3.73 (0.42)	3.4 (0.38)	-0.325	-0.92

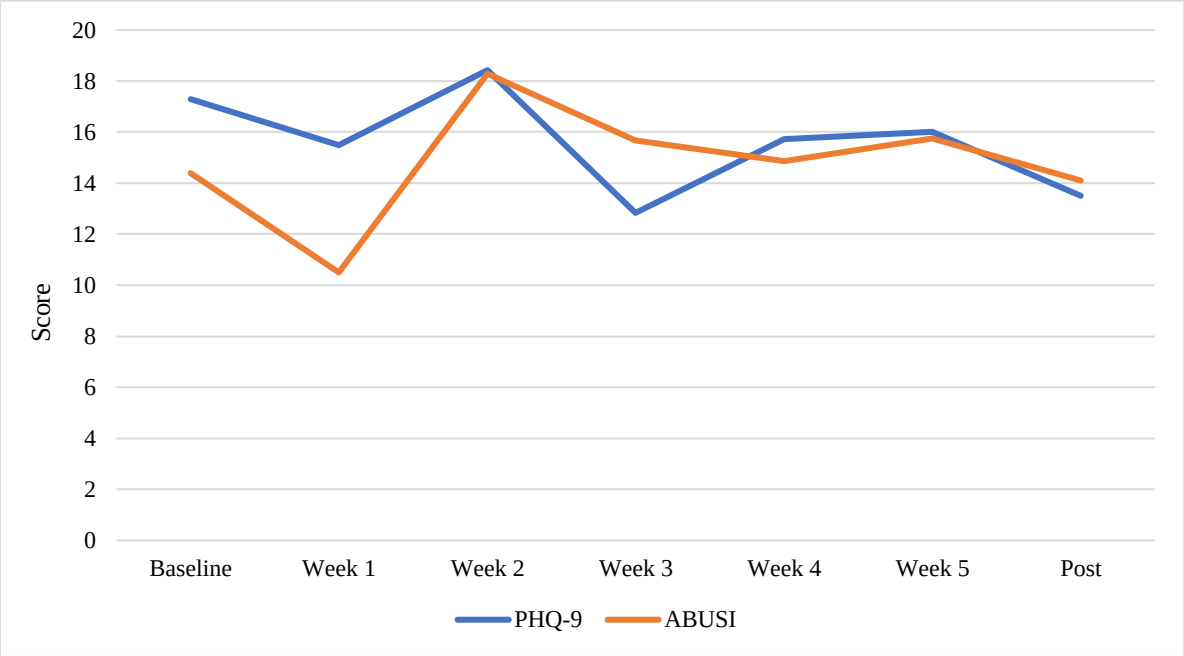
Note: SD: Standard Deviation; SITBI: Self-Injurious Thoughts and Behaviours Interview; ABUSI: Alexian Brothers Urge to Self-Injure Scale; PHQ-9A; Patient Health Questionnaire for Adolescents; ReQuest-YP; Recovery Questionnaire for Young People; MYTS: Motivation for Youth Treatment Scale; PR: Problem Recognition Subscale; TR: Treatment Readiness Subscale.

Weekly measures

Both the PHQ-9 and ABUSI were administered weekly throughout the intervention. There was an overall trend towards a reduction in symptoms of low mood (PHQ-9A) but no evidence of reductions in urges to self-injure (ABUSI) as illustrated in Figure 4. Missing data for these measures was 51% and therefore trends should be interpreted with caution. Amongst those measures completed, there appeared to be an initial fluctuation in low mood (PHQ-9) and urges to self-harm (ABUSI) which plateaued in the later stages of the therapy. Individual graphs of change graphs can be found in appendix N.

Figure 4

Graph to show the weekly outcome data



Note: ABUSI: Alexian Brothers Urge to Self-Injure Scale; PHQ-9A; Patient Health Questionnaire for Adolescents.

Reliable change

Reliable change was calculated using the reliable change index (RCI; Jacobsen & Truax, 1991) and scores can be seen in Table 8. Reliable improvement was most common for low mood (PHQ-9A) and personal recovery (ReQuest-YP). A number of participants showed a deterioration across each measure. On the PHQ-9, of the five that showed an improvement, one participant showed an improvement spanning three clinical categories (severe to mild), one showed an improvement spanning two clinical categories (moderate severe to mild) and three showed an improvement across one clinical category (moderate severe to moderate).

Competency of Cognitive Analytic Therapy (CCAT) Rating

Adherence to a CAT approach within the therapy was measured using the CCAT. A qualified CAT practitioner rated the recordings of 10% (n=4) of all individual therapy sessions. They found the therapists to be compliant with the CAT model of therapy.

Table 8

Reliable Change Index scores

Measure	Cronbach's alpha (α)*	Improvement (n)	Deterioration (n)
ABUSI	0.92	3	3
PHQ-9A	0.89	5	2
ReQuest-YP	0.95	4	3

Note: ABUSI: Alexian Brothers Urge to Self-Injure Scale; PHQ-9A: Patient Health Questionnaire for Adolescents; ReQuest-YP: Recovery Questionnaire for Young People; a: Cronbach's alpha, n: number of participants.

**Cronbach's alpha was taken from Washburn et al., 2010 (ABUSI), Kroenke and Spitzer, 2002 (PHQ-9) and John et al., 2015 (ReQuest-YP).*

Discussion

This study aimed to assess the feasibility and acceptability of a brief, CAT-informed intervention (CATCH-Y). Findings suggest that CATCH-Y is largely feasible and acceptable with young people who have self-injured, and therefore larger scale evaluation is warranted. The results showed high recruitment rates, with 100% (n=13) of those eligible giving consent to participate in the study. Furthermore, 85% (n=11) of those that consented completed the intervention, with 100% of those that began the intervention completing all five sessions. Rates of recruitment and retention therefore exceeded the expected hypotheses. High levels of satisfaction were reported on the CSQ-8 with a majority of the participants describing the intervention as helpful and positive, reporting that they felt taken seriously and safe to speak about their difficulties within the sessions. Whilst there were high retention and recruitment rates, there were high levels of missing weekly data and a small number of participants did not find the intervention helpful or positive, therefore the results of the study could be considered somewhat mixed.

Clinicians reported that 100% of young people approached about study participation consented to participate, with the referrals received being over the capacity of the study, which may be reflective of increasing rates of referrals to CAMHS (NHS Digital, 2021) without the equivalent resources required to meet young people's needs (Falissard, 2018). Whilst participation in the study was highly sought after, CAMH service demands meant that referring clinicians were often unavailable for liaison and information sharing during the therapy period. Future research should reflect upon the capacity of clinicians whilst considering the importance of service involvement when managing the risk presented by the young people. Missing data rates were low (9%) on outcome measures pre-post assessment which met the study hypothesis of data incompleteness not exceeding 20%, however there was 49% of data missing on weekly measures and therefore this did not meet the expected hypothesis. Weekly measures continued to be completed both in person and online following the study amendment, with high in-person completion rates but with large quantities of missing data from online measures. There were also very high missing data rates for the weekly post-therapy follow-up online assessments which were unable to be analysed. This suggests that online measures are not a feasible or acceptable method of data collection within this population. Future research should consider participant outcome completion within sessions to ensure data completeness.

The secondary aim of the study was to investigate whether the intervention produced preliminary evidence of change. Overall, the study showed mixed results, with trends found for reductions in rates of NSSI, improvements in mood (PHQ-9A) and perceived personal recovery (ReQuest-YP). No change was shown in urges to self-harm (ABUSI) and there was a trend towards a reduction in motivation to change (MYTS). On the weekly measures, there appeared to be improvements over time in mood (PHQ-9) but no change in urges to self-harm (ABUSI). Due to missing data on weekly clinical outcomes and the inability to demonstrate statistical efficacy due to a small sample size, this data should be interpreted cautiously. The lack of a comparator also means that change cannot be attributed to the intervention itself and may be due to extraneous factors. Reductions in motivations to change (MYTS) may be understood as an increase in the participants' understanding of their difficulties and means of coping as a result of the intervention, in line with the primary aims of CAT (Ryle & Kerr, 2002), thus perceiving there to be less requirement for further therapy. Nevertheless, the decrease may instead be explained by participants' negative experience of the intervention which whilst possible, seems unlikely due to the overall positive acceptability of the intervention reported within the CSQ-8. Given the mixed results presented within this study and the smaller case series design, conclusions cannot be drawn and outcomes should be examined further in a larger scale study.

Unique to each individual, successful therapeutic outcomes have been found to be perceived as meaningful change within relationships with the self and others, as well as an improvement in their ability to regulate their emotions (Haw et al., in press). Qualitative investigation has consistently found a reduction in self-harm repetition to be a low priority for those who have undergone interventions for self-harm (Owens et al., 2020) however successful outcomes in clinical trials are still typically quantified by reductions in self-harm (Witt et al., 2021). Whilst nomothetic approaches cannot capture every aspect of an individual's experience, the ReQuest-YP examines domains that are underpinned by evidence based qualitative research and theory (John et al., 2015) such as personal meaning and understanding, social connectedness, empowerment and control. For the purposes of comparability, rates of NSSI were examined within this thesis alongside the ReQuest-YP, and although there was a trend toward reductions in self-harm, it would arguably be more useful to give more weight to the improvements in perceived personal recovery which is likely to reflect the priorities of the participants.

An important aspect of acceptability and feasibility within this group is engagement. Adolescents who engage in NSSI often have poor adherence to treatment (Murphy et al., 2010) which acts as a large obstacle to positive outcomes. Qualities of the patient-therapist relationship were described positively which is in line with established research showing a good therapeutic relationship is crucial for positive outcomes (Shirk et al., 2011) and may have contributed to the high rates of engagement with the intervention. A majority of participants recounted a positive and helpful experience, reporting increased understanding of their difficulties and notably, the usefulness of the sequential diagrammatic formulation. The positive aspects of the intervention described relate closely to the CAT model, which aims to improve understanding of problematic behaviours and reciprocal roles using the specific therapeutic relationship as a vehicle for change (Ryle & Kerr, 2002). Previous research showing improved engagement with treatment following a CAT-informed therapeutic assessment (Ougrin et al., 2011) is supported by this study, both by reported positive experiences of CAT-informed processes and high levels of engagement with the intervention.

A number of participants did report less helpful experiences with the study. One participant in particular found the intervention difficult, often being unable to express themselves within sessions and reporting an overall negative experience. Upon reflection, it could be hypothesised that this young person felt pressures within their care system to participate in the intervention with pre-assessment outcome measures indicating that the young person did not want to attend. Understanding the reasons why some young people find the intervention helpful or more difficult through further qualitative investigation would be helpful in future research.

These results have implications both clinically and for future research, however consideration must also be given to the strengths and limitations of this study. The low sample size and lack of comparative control group used in a case series design may limit the ability to generalise findings, however it has been deemed appropriate to use a case series design when piloting new interventions (Skivington et al., 2021) and the sample size of this study is similar to that of others in the field (Taylor et al., 2019). Following the positive findings of acceptability and feasibility within this trial, future research may consider expanding to a larger sample and using a comparative control to evaluate the CATCH-Y intervention with scientific rigour. A further limitation of this study could be the quality of the intervention delivery. The researchers delivering the therapy did not hold recognised CAT qualifications, however had a

wealth of therapeutic experience and brief training in the model. The quality of CAT session delivery was also evaluated using the CCAT, which indicated a good quality of CAT-informed practice.

Whilst the usefulness of alternative psychotherapies such as DBT-A in this population is acknowledged (Witt et al., 2021), the cost and length of training is widely recognised as a barrier to access of these treatments (Comtois & Linehan, 2006) with new research indicating that DBT could increase self-harm (Simon et al., 2022). Brief interventions have been suggested as a focus for research in the field of adolescent self-injury (Glenn et al., 2019) and whilst in the initial stages of development, preliminary findings from the current study show trends towards reductions in NSSI and improvements in key areas of mood and recovery. Due to the risks associated with NSSI such as an increased risk of suicide (Castellví et al., 2017), a brief intervention such as the CATCH-Y model could be introduced as an approach specifically aimed to reduce NSSI that can be easily delivered on a wider scale, benefitting both services and young people who may struggle to access longer scale treatments (Gulliver et al., 2010). Preliminary support for brief psychotherapeutic interventions for young people who self-injure in comparison to TAU has previously been found (Andover et al., 2017) as well as equivalent rates of success to longer psychotherapies (Kaess et al., 2020). For some, CATCH-Y may also be useful as an initial therapeutic intervention to develop initial understanding and insight into NSSI behaviours, with the potential to reduce immediate risk and distress in individuals and facilitate further therapeutic work or care delivery in a person-centred, relationally-informed way. The indication of good quality delivery, acceptability and trends toward positive change found in this study could therefore support the concept that clinicians could be trained to deliver CATCH-Y successfully in a shorter time frame, suggesting that it could be utilised as a brief, scalable intervention for clinicians working within the NHS.

This study of the CATCH-Y intervention showed a largely feasible process and indicates acceptability to develop the intervention through larger scale evaluation. Improvements were indicated across measures of mood and personal recovery, however there was no reduction in urges to self-harm and a reduction in motivation to change. Whilst some positive change has been indicated within this study, care should be taken when interpreting the results due to missing data, indications that some young people did not improve and mixed results. Future research could consider adjustments to the delivery of intervention; alternative methods of

gathering data to ensure data completeness (such as in-session measures); structured involvement from clinical services for safety and information sharing; larger sample sizes and comparative controls to evaluate the efficacy when judged against TAU or longer-term psychotherapies. Qualitative data should also be gathered from participants to explore the personal processes in which meaningful change occurs.

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Paper 3

Critical Appraisal

Rebecca E. Haw

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This paper is not intended for publication.

Introduction

The following paper provides a critical reflection of the research completed within this thesis. Both the empirical paper and the meta-synthesis will be critically examined, with consideration given to the design and implementation of the research as well as the interpretations of the data gathered. Strengths and limitations will be discussed and overall personal reflections of the research will also be provided.

The project took place between January 2020 and April 2022, in which time the COVID-19 global pandemic led to three national lockdowns which significantly altered the delivery of mental health services across the UK. At the time that recruitment for the empirical study began (May 2021), the third lockdown had just ended. A large scale living review (John et al., 2020) into the global impact of COVID-19 on self-harm and suicidal behaviour has reported there to be thus far, no clear evidence of an increase in either. Whilst the research indicates no increase in self-harm, the findings from the systematic review outline how the complex and individualised needs of each person should be recognised, which led the researcher to be mindful of each individual's lived experience of the pandemic. For instance, whilst some young people described the lockdowns as difficult and distressing, others welcomed the time at home or away from school. The researcher therefore tried to maintain an open, curious stance when exploring participants' experience of the pandemic, and recognised the importance of giving time to this within the therapeutic space.

It was also important for the researcher to reflect on the impact of the global pandemic on themselves. The uncertainty around whether it would be feasible to go ahead with the design of the project led to more anxiety for the researcher, however frequent discussions within the research team meant that contingency plans could be drawn up which reassured them of the stability of the project. Fortunately, the COVID-19 restrictions were largely withdrawn by the point of recruitment and therefore the study was able to go ahead as initially planned, with appropriate personal protective equipment in place. Whilst the restrictions initially led to uncertainty, the researcher also felt that the additional time they were able to spend on the project due to the lockdowns was beneficial and led to project advances such as early ethical approval which put them in an advantageous position later on.

Paper 1: Systematic Review

Topic Selection

The initial topic considered for the review was a qualitative investigation of interventions for self-harm in young people. The treatment for self-harm in young people is a reasonably under-researched area, with no universally agreed treatment yet established (Ougrin et al., 2015). As there were increasing attendances at accident and emergency for adolescent self-harm before the COVID-19 lockdowns (Morgan et al., 2017) yet low engagement with follow-up self-harm interventions (Murphy et al., 2010), it was felt that building a comprehensive picture of young people's experiences could provide useful clinical insights and give direction for future treatment developments. Following an initial scoping search, only a very limited amount of available literature could be identified. Attention was then given to how to broaden the search criteria, such as the inclusion of all psychotherapies for young people, however, an examination of the literature identified this to be too expansive. The scope appeared broader when considering qualitative research into self-harm interventions for both adult and child populations and therefore, with the need for the development of accessible and efficacious interventions in both populations (Witt et al., 2021a, 2021b), the decision was made to widen the scope of the literature review to incorporate both adults and young people.

Self-harm is a transdiagnostic phenomenon (Selby et al., 2012) that can occur across a range of psychiatric disorders. With such diagnostically diverse samples, current UK National Institute for Health and Care Excellence (NICE) guidelines recommend offering 3 to 12 sessions of an unspecified psychological intervention, which aims to reduce self-harm (NICE, 2011). The current literature into interventions for self-harm shows some evidence for a range of treatments such as Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy for Adolescents (DBT-A; Witt et al., 2021b) however the common components of psychotherapies that are effective are largely unknown. It was therefore concluded that exploring these components through collation of the helpful or unhelpful elements, as described by those who have taken part in psychotherapy for self-harm, would identify common treatment factors relevant to the transdiagnostic nature of self-harm.

Inclusion and Exclusion Criteria

Research into self-harm has arguably been stunted by the challenges of conceptualising and defining the behaviour across the globe (Slesinger et al., 2019). In the USA, non-suicidal self-injury (NSSI) is separated from suicide attempts, based upon the intent to die as a result of the act (American Psychiatric Association, 2013). Conflictingly, the UK definition of self-harm incorporates both suicidal acts and NSSI, irrespective of the motivation (NICE, 2011). Whilst NSSI is now widely considered different to suicidal acts with regards to function, method and outcome (Mars et al., 2014), it is a risk factor for future engagement in self-harm and suicidal acts (Castellví et al., 2017; Ribeiro et al., 2016). After deliberation, it was decided that due to the global prevalence of inconsistent terminology within the literature, this review would cover all acts of self-inflicted harm (and the associated labels), with or without intent to die, under the term 'self-harm.'

The inclusion of grey literature improves the reliability of findings by reducing publication bias within systematic reviews (Higgins & Green, 2018). Using the retrieval systems available on two of the databases (PsychInfo, Medline), grey literature was searched and three dissertations were used within the analysis. In addition, only studies written in or translated to the English language were included within the review due to the resource and time limitations of the thesis. Whilst studies have found no evidence of systematic bias from the use of language restrictions within medical fields (Morrison et al., 2012), it is recognised that using studies in the English language alone may introduce a language bias and could therefore be considered a limitation of this paper.

Search

The PICO framework (Population, Intervention, Comparison, Outcome; Richardson et al., 1995) was used to structure the design of the search terms, with the removal of outcome as an appropriate modification due to the lack of relevance to the research question. Synonyms for 'self-harm,' 'intervention' and 'qualitative' were generated alongside any additional words that were identified through Medical Subject Headings (MeSH) terms, truncation and wildcards. Finally, identified search terms were shared with the research team, who held specialist expertise in the field, to incorporate any that may have been overlooked, which resulted in two additional words being added ('self-mutilate' and 'parasuicide').

The reference lists of two reviews of a similar nature (Sass et al., 2022; Winter et al., 2014) were examined and a further three papers were identified. Both reviews examined similar topics but with fundamental differences to the research question posed within this paper. Sass et al. (2022) examined the qualities of professional support (including all clinical staff) perceived as helpful for those who self-harm, whereas Winter et al. (2014) looked at participants' experiences of counselling and psychotherapy for the prevention of suicide alone. Findings from both reviews identified the therapeutic relationship as central to positive change, with Sass et al. (2022) recommending the exploration of participants' experiences of psychotherapy delivered in a clinical setting to support the shaping of available treatments. The findings of the current paper reiterate the importance of the therapeutic relationship, trust and add specific recommendations around the acceptance of self-harm and focus on underlying issues within psychotherapy and therefore strengthen the arguments proposed within the available research base.

Quality Assessment

The quality appraisal of data contributing to a systematic review is a key step, common to all systematic reviews, qualitative or quantitative (Noyes et al., 2018). Whilst there is little consensus within the literature around what constitutes 'quality' (Johnson et al., 2020), there is a growing expectation for researchers to demonstrate a more objective rigour within qualitative research (Research Excellence Framework, 2019). The CASP is the most commonly used tool for quality assessing within qualitative research (Dalton et al., 2017) and has been found to give a good indication of the reported procedural aspects of a study (Dixon-Woods et al., 2007).

Removing papers on account of low methodological quality or risk of bias can lead to selection bias within systematic reviews (Stone et al., 2019) yet retaining these studies within the analysis can result in a lack of precision in any conclusions drawn (Higgins et al., 2011). After deliberation, it was decided within the research team that one paper deemed to be of lower quality would still be included within the overall synthesis to ensure transparency of quality assessment and reduction of selection bias, however this was explicitly discussed and appropriate considerations given to the weighting of this study within the analysis. After a comprehensive examination of the data, it was deemed unlikely that this paper affected the findings in a meaningful way due to the common findings seen within this paper and the others included.

Papers

Whilst the meta-ethnographic approach provides a comprehensive synthesis of this information, there was a notable lack of diversity in the data, with limited input from males, young people and those from diverse backgrounds. [2] Notably, only one study looked at adolescents aged 16-18 years old (Ross, 2002) whereas all other papers looked at those over 18. Professional support is not commonly sought by young people (Doyle et al., 2015) yet rates of self-harm are higher than most other age brackets (Geulayov et al., 2019). Young people's expectations of therapeutic support is an influential factor when they are considering whether to seek help (Rickwood et al., 2005) which emphasises the importance of a well-informed intervention and the significance of young people's contributions to research around the design. Reflecting upon the lack of diversity in the study sample, it seems that there is little to be gained from generalising the results to populations that were omitted. Instead, it is likely more valuable to highlight the need for future research into the experiences of these individuals to uphold the aims of developing and delivering appropriate, accessible and client-led support to all those that self-harm.

The review synthesised seven papers including 68 participants. Incorporating a smaller number of studies can elicit a deeper conceptual understanding (Campbell et al., 2012) which is essential within the meta-ethnographic approach (Noblit & Hare, 1988). The researcher had hoped to extract more studies from the search which initially identified 3315 papers, however the small number of appropriate studies identified from the thorough search reflects the scarcity of qualitative evidence available within the field, despite recommendations for its inclusion within UK guidance (National Collaborating Centre for Mental Health UK, 2004). There are a number of ways in which more papers could be identified for analysis such as widening the inclusion criteria to include group therapy, examining the experiences of both therapists and participants or the inclusion of those diagnosed with borderline personality disorder. Whilst this would produce a larger search pool, all three options would arguably lead to the conclusions drawn from the findings to be non-specific to the research question asked within this study. Within the search, seven papers were identified as appropriate

[2] Lack of diversity within gender and ethnicity is discussed within the discussion section of Paper 1 and therefore will not be discussed further here.

however were either inaccessible to the researcher (despite contacting authors) or not yet complete. Repeating the same search in a number of years may therefore produce more papers, improving the validity of conclusions drawn.

Synthesis

This review amalgamates all of the known qualitative research into individual psychotherapeutic intervention for self-harm, as described by those having experienced it. The aim of this review was to collate the experiences of individual psychotherapies for self-harm, with the purpose of providing conceptual contributions to the existing research base and generating evidence that can be used to inform healthcare policy development and practice. The meta-ethnographic approach (Noblit & Hare, 1988) was chosen as it is the most commonly used method of qualitative synthesis in healthcare research (Hannes & Macaitis, 2012) and offers not only a descriptive collation of information, but a deeper conceptual understanding of a particular phenomenon, in line with the purpose of this review. Whilst a new method for the researcher, immersion in the data and continued learning through extensive reading and guidance on the approach led the researcher to appreciate the value of the translational processes. At first, the synthesis elicited important ideas around building trust and the therapeutic relationship however the translation gave rise to a deeper understanding around recognising the person behind the self-harm, which offers a useful conceptual framework for working specifically with those who self-harm.

Whilst completing the synthesis was the most challenging aspect of the review, the researcher felt that this was also the most rewarding. Immersing themselves in the data was a powerful experience, where the direct quotes of participants having overcome significant hurdles in their lives were moving. One particularly pertinent example being the following;

"I have spent 37 years surviving, and honey, you wouldn't believe the stuff that I have survived from. I want to live. I want the next 37 years of my life to be a part of the human race, because I have a lot to say.... I want to take it and show those morons who abused me that I am the warrior, that I am the victor.... And that's what I have learned."

(Cunningham et al., 2004).

The provocation of hope within participants' narratives instilled strong feelings within the researcher at a time where they felt substantial demands from the project. This empowered them to work hard on the review, with a new personal objective of sharing the courageous

stories of the participants in a comprehensive and useful way that represented them wholly. Counter-transference responses (as likely described here) have been described as common in response to emotionally sensitive topics when conducting qualitative research (Gemignani, 2011). Whilst an important motivator within the literature review, the researcher was mindful of their emotional response impacting upon the objectivity of the data analysis and therefore the power of this response was discussed within supervision to mitigate the effects.

Clinical Implications and Future Research

NICE guidance on the management and treatment of self-harm is currently being updated and due to be published after the submission of this thesis (NICE, in prep). The new draft guidance places more emphasis on the need for safety, collaboration and the development of a therapeutic relationship, both when assessing and providing intervention for those who self-harm. Considering the findings from this paper, this is a welcomed change. One research recommendation within the NICE guidance draft is the examination of specific psychological interventions in different populations and settings. Whilst this review was completed before the draft guidance was published, the findings from this study can be used to contribute to the qualitative research base that will be invaluable when examining the effectiveness of specific psychological therapies for self-harm. The findings may also give rise to a more explicit consideration of the importance of the relationship within any given intervention and provide future research direction into relevant therapeutic approaches for those who self-harm (for example psychoanalytic therapy or cognitive analytic therapy) where the relationship is largely the focus throughout.

Specific guidance was elicited from the dominant narratives of participants, which illustrated the adverse effect of pursuing behavioural change (such as self-harm cessation) rather than the therapeutic objectives held by each unique individual. This understanding reiterates the importance of recognising self-harm as a way of coping with psychological distress that may be problematic to withdraw before robust change has occurred in other aspects of a person's life. This understanding led the researcher to reflect on the importance of accurate and meaningful outcome reporting for those participating in interventions for self-harm and the impact that the lack of meaningful outcome measurement may have on the research base. Not only is there a lack of consensus on the use of terminology for self-harm within the field (Slesinger et al., 2019) but also in the lack of clarity around what interventions are designed to do and what outcomes are appropriate to measure them (Owens et al., 2020). Within

clinical trials for self-harm, successful outcomes are typically quantified by reduction of self-harm, Accident and Emergency attendances and improvements on mood scales (Witt et al., 2021a, 2021b). Including patient and public involvement at the earliest stages of research design could improve the efficacy of research by gaining an insight into what outcomes are considered meaningful to those who self-harm. Considering the results from this study, these may centre more around quality of life, self-acceptance and social functioning. Future research to develop a battery of relevant outcome measures from key stakeholders (incorporating patient involvement) for those who self-harm could increase the comparability and relevance of findings, as previously seen in other clinical specialities (Williamson et al., 2012).

Paper 2: Empirical Paper

Topic Selection

As the rationale for the research topic has been comprehensively discussed within Paper 2, this will not be repeated in such detail here to avoid repetition. Approximately 17% of adolescents engage in non-suicidal self-injury (NSSI) during their lifetime (Swannell et al., 2014) with substantial rises in prevalence rates occurring in the UK (McManus et al., 2019). NSSI fulfils both intrapersonal and interpersonal functions (Taylor et al., 2018) with harmful relationships being associated with engagement in self-harming behaviours (Kaess et al., 2013). Whilst there is some evidence for the effectiveness of Dialectical Behaviour Therapy for Adolescents (DBT-A; Witt et al., 2021a) for young people who engage in NSSI, it is an intensive therapy that is demanding for both young people and services (Comtois & Linehan, 2006). Access to effective treatment is often restricted due to limited resources and a shortage of trained clinicians (Andreasson et al., 2016) and therefore there is a need to develop less intensive, effective treatments that are accessible to a wider scope of young people. Brief interventions have shown promise for young people who self-injure (Andover et al., 2017; Kaess et al., 2020) and the use of brief relational based approaches such as Cognitive Analytic Therapy (CAT; Ryle & Kerr, 2002) in emergency departments has led to increased engagement (Ougrin et al., 2011).

Whilst the review and the empirical paper were completed in parallel and therefore one could not inform the other, similarities can be drawn between the papers and the results of the literature review have implications for the design and implementation of the CATCH-Y study. The results of the literature review show the importance of intra/interpersonal change as an indicator of successful outcome for those participating in a therapeutic intervention for self-harm, rather than a reduction in self-harm repetition. CAT is a relational therapy that focuses on the relationship one holds with the self and others with an emphasis on the importance of building trust within the therapeutic relationship (Ryle & Kerr, 2002). Reflecting upon the delivery of the CATCH-Y intervention as a clinician, the acceptance of self-injury and focus upon the underlying drivers for this behaviour appeared to allow participants to explore their patterns of relating to themselves and others without fear of judgement or pressure to eradicate the behaviour. This may have contributed to the positive therapeutic relationship that the majority of participants described following the intervention.

Another finding from the review was the importance of recognising the unique individual with unique goals for the therapy they were undertaking. Whilst the study looked at the ReQuest-YP (John et al., 2015) as a measure which encapsulates known aspects of meaningful change, having more explicit conversations regarding the participants' goals for the therapy may improve the relationship and ensure a collaborative therapeutic experience. Consideration of an person-centred measure of change, such as goal based outcomes (Law, 2011), may further bolster the participants' perceived success of the intervention whilst also accounting for the need for standardised measures within a research setting for effective evaluation.

Design

The current study aimed to investigate the feasibility and acceptability of a brief, CAT-informed intervention (CATCH-Y) in a population of young people who have self-injured. Recently updated guidance (Skivington et al., 2021) from the Medical Research Council (MRC) and National Institute for Health Research (NIHR) recommends piloting a new intervention before embarking on larger scale research to support progression by optimising design and estimating rates of recruitment which usually requires both qualitative and quantitative investigation. In line with this, the current study used a case-series design, with analysis based largely on quantitative data and with some input of qualitative feedback on the acceptability of the intervention. Having elicited useful data which can be used to adapt the CATCH-Y intervention for future use, in line with the aims of the study, the case series design incorporating quantitative and some qualitative feedback has been deemed appropriate.

Within the early development of the project, it was anticipated that the execution of a robust study which recruits an appropriate number of participants would be demanding for one trainee and therefore the decision was taken for the project to be undertaken by two trainees. Whilst each trainee designed and analysed their own parts of the project, the implementation was shared between the two trainees. This resulted in more manageable demands for each trainee and led to the development of team working and communication skills which will likely be of benefit within their future careers. Whilst the emotional and practical support of a peer was of huge value to the researcher, compromises also had to be made with regards to the project. Initially, the participants' perceptions of the acceptability of the study was going to be evaluated within a post-intervention interview, however the participant burden

associated with numerous assessment sessions pre/post-intervention led to the decision that this would be completed via online survey platform instead. Valuable information was gathered through this questionnaire and therefore this was considered to be a useful and reasonable compromise. Upon reflection, this gave the researcher valuable insights into the practicalities of navigating the research processes as part of a team which will be particularly useful when working in research contexts in the future.

Consideration was given to whether or not the use of a multiple baseline design would allow for greater validity of the design and support a more substantial demonstration of any changes associated with the CATCH-Y intervention. A multiple baseline design offers a control for the effects of time and can lead to a more confident observation that the changes are as a result of the intervention offered (Barlow & Nock, 2009). Following these discussions, the idea was shared with a young person who reported that whilst possible, the length of time involved within the study when including follow up assessments may lead to fatigue and possible disengagement. Furthermore, the primary focus of the intervention was determining the feasibility and acceptability of CATCH-Y. After deliberation, the added risk to feasibility surrounding the uncertainty of the impact of COVID-19 at the time, as well as the input from the young person, led to the decision that a single baseline design would be adequate at this stage of development. Upon reflection, the low completion rates of online measures within this group led the researcher to believe that the single baseline design was an appropriate decision and further measures prior to the start of the intervention may have led to difficulties with recruitment and retainment.

To reduce bias and ensure that the intervention was kept separate from the research elements of the study, the initial procedure proposed that the two researchers delivering the intervention (MM, RH) would alternate between the roles of researcher and therapist. During the early stages of the study, it became apparent that this was difficult to maintain due to the time restraints of the study period, balancing other placement commitments and the impact of COVID-19 and therefore an ethics amendment was made so that the researchers were holding a dual researcher-therapist role for each participant. Psychologists must remain aware and mindful of their ethical responsibility to clients when conducting research in a dual psychologist-researcher role (Yanos & Ziedonis, 2006). To mitigate the conflicts associated with this role, clear boundaries were explained around the expectations of each role and the limits of confidentiality and full informed consent of each process was given by participants.

The boundaries of these roles were, at times, challenging when participants were eager to share their difficulties with the therapist whilst they were in a researcher role.. On these occasions, the researchers gave gentle reminders of role difference and signposted to participants' named clinicians where necessary. Whilst every effort was made to minimise the chance of misconception or rupture between the therapist and the participant, the dual role may have impacted on both the therapeutic relationship and the validity of evaluating the intervention as separate from the research.

Measures

Measures used within the study can be seen in Table 9. Outcome measures were refined within the design of the study to reduce burden for participants and to maximise data collection and retainment. This was determined with the support of a young person who reviewed and provided feedback on the utility of the measures and the number of measures to be included. Within the acceptability questionnaire administered at post-intervention, a commonly cited (n=3) dislike from participants about their participation was the frequency of measures completed. When planning for future research, it would be helpful to further consult with young people with experiences of self-harm around the content, frequency and length of measures included.

Table 9

Measures and time points

Measure	Pre-therapy	Weekly	Post-therapy	Follow up (for 4 weeks)
Self-Injurious Thoughts and Behaviours Interview (SITBI)	✓			
Repertory Grids	✓		✓	
Motivation for Youth Treatment Scale (MYTS)	✓		✓	
Recovery Questionnaire for Young People (ReQuest-YP)	✓		✓	
Alexian Brothers Urge to Self-Injure Scale (ABUSI)	✓	✓	✓	✓
Patient Health Questionnaire for Adolescents (PHQ-9A)	✓	✓	✓	✓
Client Satisfaction Questionnaire (CSQ-8)			✓	

Prior to the development of the project, members of the research team that developed the CATCH-Y intervention met with a group of young people to consult on the most appropriate concepts that could elicit meaningful change, with motivation being an important concept described by the young people. Research has shown that enhancing motivation is a key

component for effective treatment in adolescent populations (Lambie & Sias, 2006). Whilst the CATCH-Y intervention can be considered a standalone treatment for some, many may require further treatment following the end of sessions. CATCH-Y is a collaborative approach which aims to develop a young person's motivation to engage in further support where indicated. Young people who self-harm can often find it difficult to engage with services (Murphy et al., 2010) however CAT-informed approaches have shown increased engagement in this population (Ougrin et al., 2011).

Within this study, results from the MYTS saw a small significant reduction in motivation to change. These findings may reflect accurate results in the reduction of motivation as a result of the intervention, or may be more representative of the weak validity of the MYTS when used to measure motivation within this population. Reflecting upon the lack of clarity gained from these results, the researcher felt that an alternative measure for assessing motivation may be useful in future research. The Treatment Support Measure for Youth (TSM-Y; Warren et al., 2008) is a 40-item youth self-report measure which assesses across multiple domains, with good demonstration of sensitivity to change. Whilst it appears to be a more inclusive and robust measure of motivation, the clinical use of the TSM-Y could also improve the delivery of CATCH-Y. After identification of potential obstacles within the initial completion of the TSM-Y, clinicians could adjust their therapeutic approach in order to improve motivation and engagement for young people which may increase the likelihood of improved motivation within the intervention and sustained motivation following completion.

Acceptability and feasibility

The study aimed to recruit nine participants in line with other similar case-series in the field (Searson et al., 2012; Taylor et al., 2019), with an expected attrition rate of 1/7 based upon the outcomes of the CATCH study (Peel-Wainwright, in prep). In practice, the referral rates for the study were high, with clinicians referring more participants than the study capacity as well as reporting that 100% of those young people that they approached gave consent to progress to the screening stage. Given that young people don't often seek professional support for self-harm for a multitude of reasons (Doyle et al., 2015), the high referral rates were surprising to the researchers. In response, they were able to expand their capacity for the study and accept 13 participants. The initial hypothesis stated that 'over 50% of those referred to the study and eligible to participate would consent to take part,' which was largely surpassed and overall rates of referral for the study were 100%. Upon reflection, the

researchers felt that the ability to adapt to greater demands within the study was a strength, and improved their ability to negotiate time management and organisation skills which will be important when practising clinically in the future.

The study hypothesised that at least 70% of those recruited would attend all five intervention sessions. Adolescent disengagement from therapy is common in community mental health services, with estimated dropout rates between 16% and 72% (De Haan et al., 2013). Within this study, one participant withdrew participation following the initial research sessions and one was excluded due to a significant escalation in risk prior to the start of the intervention. The remaining 11 participants completed 100% of the five intervention sessions, meaning the hypothesis was met and exceeded. A strong predictor of therapy completion in young people is the therapeutic alliance (O'Keefe et al., 2018), with a positive therapeutic alliance also being associated with improvements in self-harming behaviours (Dunster-Page et al., 2017). Positive aspects within the therapeutic relationship were identified qualitatively by participants in this study and 80% reported that they felt at least partly safe, taken seriously and had confidence in their therapists. The importance of the therapeutic relationship is acknowledged in cognitive analytic therapy (Ryle & Kerr, 2002) and taking this into account, it seems likely that a positive therapeutic relationship was at least partly responsible for the high retainment rates in the study which can be understood as a strength of the project and the CAT approach.

Data analysis

One challenge faced by the researcher within the study was the collection of outcome data. In developing the CATCH-Y intervention, discussions with young people with lived experience prompted a reduction in standard session length to reduce burden. Considering the importance of acknowledging and practicing within the scope of a young person's tolerance, it was decided that the weekly measures would be completed by participants via online survey platform rather than within the shorter intervention session. Every effort was made to encourage participants to complete measures, such as text or email reminders and prompts within sessions, however online measure completion was still low. As a result of low completion rates from the first participant and difficulties in accessing emails, an amendment to the study design was made to allow for completion of measures within sessions as well as online, at the choice of the participant. Upon reflection, changing all measure completion to

within sessions at this point may have reduced levels of missing data and increased the overall validity of the design.

Furthermore, follow-up outcome measure completion was very low (13%) and therefore analysis could not be completed on this data. Long follow-up periods have been found to result in particularly low response rates (Mackinnon et al., 2008) and whilst this follow-up period was relatively short, it was almost the same length as the intervention which may have led participants to feel fatigued and reduce measure completion. Scores for all participants that completed the PHQ-9A pre-assessment indicated at least 'mild depression,' with 80% of participants scoring in or above the 'moderate depression' range. Depression has been identified as an influential factor for low response rates (Proudfoot et al., 2013; Brueton et al., 2014) which may therefore have led to lower response rates in this study. Strategies for increasing response rates to follow-up questionnaires have been found to be effective, such as giving advance notice of upcoming measures and using colour photographs on questionnaires (Edwards et al., 2009). Whilst the low levels of weekly and follow-up measure completion was disappointing to the researcher, they were able to reflect on the utility of this information as valuable to the feasibility and acceptability of the study within the scope of further research. Higher rates of completion were evident when measures were completed in person and future research may wish to consider this to increase the likelihood of increased data completeness. Furthermore, the strategies illustrated above may elicit better completion rates and could also be incorporated into future research.

Risk

As NSSI is considered a high risk behaviour, it was crucial to develop a detailed risk management plan prior to the commencement of the study as it was anticipated that elevated risk and possible safeguarding concerns could occur. A comprehensive risk protocol was used, adapted from the CATCH intervention study with adults (Peel-Wainwright et al., in prep). This protocol was co-developed with someone with lived experience of NSSI and further examined by a psychologist at one of the research sites being recruited from. Adaptations to the protocol were made based upon their recommendations, including an agreement made at the start of the intervention that a young person would disclose to the researcher if they felt their risk was escalating. Young people were explicitly informed of the limits to confidentiality and the occasions where others (including parents) would be informed of disclosures regarding risk. The two trainees delivering the intervention also

attended additional child safeguarding training provided by the university to ensure increased knowledge and skill for if risk occurred and their overall competence in risk management was deemed to be a strength within the study.

The CATCH-Y intervention was currently in the initial stages of development and therefore any negative impacts resulting from the intervention were unclear. Within the scope of the thesis and due to providing therapeutic support within a research capacity, it was deemed appropriate to exclude the highest risk participants from the study. This was explicitly stated within the exclusion criteria, and determined within the screening appointment, where young people were asked about the presence of a plan and any intent to end their lives. If they held a plan and had high intent, this information was shared with their named clinician and their participation in the study was withdrawn. Whilst this necessary precaution was in place, escalating risk was observed prior to and during the study period. Increasing rates of referrals (NHS Digital, 2021) without the equivalent resources required to meet need (Falissard, 2018) means that CAMH services are seemingly required to allocate care to those with the highest level of need. It could therefore be presumed that the higher level of risk seen in the current study is reflective of not only the population group, but also of the current national context of CAMH services. Nevertheless, the acceptability and high rates of attendance observed show not only good engagement from a typically hard to reach group (Murphy et al., 2010), but also preliminary evidence for the usefulness of CATCH-Y with high-risk young people within the national context where this is crucial.

Future Directions

The aim of this study was to investigate the feasibility and acceptability of the CATCH-Y intervention in a population of young people that have engaged in NSSI, with the purpose of evaluating its utility within a larger scale trial. Positive participant feedback on the intervention as well as high referral and retention rates suggest that larger scale evaluation of the approach is feasible. In line with MRC guidance (Skivington et al., 2021), the next step when developing and evaluating the CATCH-Y intervention will be a larger scale feasibility trial. Suggestions made as a result of the current study will help to inform further the implementation of CATCH-Y on a wider scale, alongside further consultation with public and patient involvement to consider measures of meaningful change.

Personal Reflections on Thesis

As the researcher hopes to work within children's mental health services in the future, the study provided useful experience of working with young people experiencing significant distress and gave rise to an advancement of skills, particularly that in CAT-informed approaches which will be invaluable in future clinical settings. The prospect of developing these skills motivated the researcher to work hard early on in the project to educate themselves in CAT processes and techniques, reading extensively and engaging in further training to enhance their practice. Being able to execute this approach and to study in such detail the experiences of those who self-harm gave the researcher a strong sense of pride in what they had achieved.

Balancing the commitments of the ClinPsyD whilst undertaking an emotionally and practically demanding thesis project was, at times, challenging for the researcher. Managing the risks that emerged within the project were tackled with the support of the research team, supervision and the second trainee working on the project, which helped the researcher to feel reassured and constructively reflect upon the challenges faced. Earlier logistical tasks such as ethics applications were tackled with willingness and enthusiasm, however as broader commitments became more taxing, the amount of expendable time and energy that could be easily given to the project reduced. Nevertheless, this taught the researcher valuable lessons in efficiency, organisation and time management which were essential for the successful completion of the project.

Engaging in supervision with a CAT-trained supervisor allowed for further reflection on the often complex and challenging presentations that the young people brought to the therapy. The trainee felt that this support was invaluable throughout the therapy period, but in particular as they first began to deliver CATCH-Y where they felt less experienced and needed support to translate their acquired knowledge into practical skills. The space given within this supervision allowed for reflection on both research cases and their own emotional response to the young people they were seeing. They felt that this broadened their ability to relate to the individuals they were working with, both in the research setting and within their other clinical work, resulting in a heightened interest in psychoanalytic and relational ways of

working that has since influenced their personal preferences when delivering psychological therapies. This was further influenced with the findings of the literature review, where the views of participants reiterated the importance of relating to individuals through a genuine, human connection within therapy.

Dissemination

It is the intention that the findings of each of these papers will be submitted for publication within the coming months. Paper one will be submitted to Archives of Suicide Research whilst Paper 2 will be submitted to the Journal of Psychopathology and Clinical Science. All young people who consented to receive the findings of the study will be sent a lay summary of the results. It is also the aim that lay summaries will be published on relevant social media pages to ensure a wider dissemination scope. The findings will be presented at the University of Manchester LSRP research conference in 2022 and lay summaries sent to each recruitment site for sharing within the service.

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Appendix A – Journal of Affective Disorders Author Guidelines

JOURNAL OF AFFECTIVE DISORDERS

Official Journal of the International Society for Affective Disorders

AUTHOR INFORMATION PACK

TABLE OF CONTENTS

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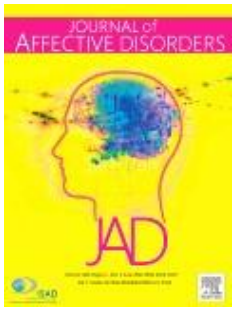

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The Journal of Affective Disorders publishes papers concerned with affective disorders in the widest sense: depression, mania, mood spectrum, emotions and personality, anxiety and stress. It is interdisciplinary and aims to bring together different approaches for a diverse readership. Top quality papers will be accepted dealing with any aspect of affective disorders, including neuroimaging, cognitive neurosciences, genetics, molecular biology, experimental and clinical neurosciences, pharmacology, neuroimmunoendocrinology, intervention and treatment trials.

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Description

The Journal of Affective Disorders publishes papers concerned with **affective disorders** in the widest sense: **depression, mania, anxiety and panic**. It is interdisciplinary and aims to bring together different approaches for a diverse readership. High quality papers will be accepted dealing with any aspect of affective disorders, including biochemistry, pharmacology, endocrinology, genetics, statistics, epidemiology, psychodynamics, classification, clinical studies and studies of all types of treatment.

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Appendix B – Themes and subthemes

Table 1

Themes elicited per paper

	Foundations of change	Therapeutic Relationship as a vehicle for change	Development through Therapeutic Processes	Therapy as life changing
Colbert (2002)	✓	✓	✓	✓
Ross (2002)	✓	✓	✓	✓
Persius et al. (2003)	✓	✓	✓	✓
Cunningham et al. (2004)	✓	✓	✓	✓
Craigen (2006)	✓	✓	✓	✓
Long et al. (2016)	✓	✓	✓	✓
Walker et al. (2016)	✓	✓	✓	✓

Table 2

Subthemes elicited per paper

	Building up trust and feeling safe	**Relationship with change**	**Validating environment**	**Power and collaboration**	**Therapeutic techniques: a band aid approach?**	**Moving beyond self-harm**	**Awareness and Understanding**	**Interpersonal change**	**Intrapersonal change**
Colbert (2002)	✓		✓	✓		✓		✓	
Ross (2002)	✓	✓	✓	✓	✓	✓		✓	✓
Persius et al. (2003)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cunningham et al. (2004)	✓	✓		✓	✓	✓	✓	✓	✓
Craigen (2006)	✓	✓	✓	✓	✓	✓		✓	✓
Long et al. (2016)	✓	✓	✓	✓	✓	✓	✓		✓
Walker et al. (2016)		✓	✓				✓	✓	

Appendix C – Illustrative Quotes per Theme and Subtheme

Theme	Subtheme	Additional Example First or Second Order Constructs
1. Foundations for change	1.1. Building up trust and feeling safe	"Establishing trust in counselling was a complex albeit imperative process, which facilitated the disclosure of self-injury" (Long et al., 2016). "I felt like I had to earn her trust and she had to earn my trust. It was a trust issue, I guess." For Kylie, she eventually would show this counsellor her scars, after cutting. She shared, "By that time, by the time we starting doing that, we had gotten to the point where I had trusted her a lot, and that is why I would show her" (Craigen, 2006).
	1.2. Relationship with change	"I used to sit on my hands and I didn't want to get better, because I was this crazy girl and I liked it" (Ross, 2000). "Self-injury was an extremely private behavior, often associated with shame and even embarrassment. This theme of privacy definitely translated into the counseling relationship. Many of the women didn't want to talk about this behavior with their counselor. Consequently, they would avoid it, lie about it, or even "manipulate" their counselor into thinking that they were no longer harming themselves." (Craigen, 2006). "The clients feel that within these relationships, where balance has been achieved, they are comfortable enough to express themselves freely while at the same time having their behavior challenged and being challenged to work harder" (Cunningham et al., 2004).
2. The therapeutic process as a vehicle for change	2.1. Validating Environment	"The participants all conveyed the importance of human contact, provided in an accepting and validating counselling relationship, when they worked through both their self-injury and the associated underlying issues" (Long et al., 2016). "… it's the understanding, to be taken seriously, met with respect…" (Persius et al., 2003). "All seven participants felt that the therapist got to know them a lot as a person. The service users reported that the opportunity to talk with someone who was non-judgemental was very important" (Colbert, 2002). "She got me to a T" (Walker et al., 2016). "Non-judgemental and validating are two therapist qualities consistently mentioned as being necessary to create the proper environment for DBT (Cunningham et al., 2004).
	2.2. Power and Collaboration	"She asked [about the self-injury and the depression]. She didn't know and she asked. And she tried to understand, and then she did her own little research to understand it, and she realized that she wasn't the authority.. .1 was.. .And I could help educate her. She really showed an effort" (Craigen, 2006). An effective trainer must simplify and clarify the basics of the skills for those clients who are new to the therapy or who are slower to learn, while at the same time challenging those clients who are more advanced. This requires the trainers to possess a thorough comprehension of the skills as well as each client's abilities" (Cunningham et al., 2004).
3. Development through	3.1. Awareness and understanding	"Naming experiences and patterns helped them bring thoughts, feelings and responses into awareness as opposed to being overlooked or avoided" (Walker et al., 2016).

therapeutic processes		"Findings demonstrated that the ultimate goal of counselling was developing the capacity to make meaning from the experiences that led to and maintained the participants' self-injury" (Long et al., 2016).
	3.2. Moving beyond self-harm	"The general consensus was that it was most helpful to focus on the underlying issues, rather than the outer "symptoms," or the actual act of cutting. many of the women didn't like the fact that their counselors focused primarily on their self-injury" (Craigen, 2006). "One participant disclosed that experiences of counselling that involved a direct attempt to stop her self-injury were experienced as coercive. This approach to counselling compounded her feelings of helplessness at living with ongoing abuse in her family home and ultimately intensified the level of injury" (Long et al., 2016).
	3.3. Therapeutic techniques: A band aid approach?	"Some believed the alternatives were helpful, while others found them to be unhelpful. Some of the women expressed competing thoughts about alternative behaviors for self-injury" (Craigen, 2006). "Each client's experience with the skills is unique, especially for those skills that move beyond daily survival into behavior and thought modifications" (Cunningham et al., 2004).
4. Therapy as life changing	4.1. Interpersonal Change	"The integration of experiences was expressed as pivotal in the creation of a healthier relationship with themselves and others" (Long et al., 2016). "I can go on vacation or go on an outing and enjoy it, not be angry at the way every single person in the place looked at me or . . . bumped into me" (Cunningham et al., 2004). "I can now handle situations that I couldn't have done some years ago, without being self-destructive…" (Persius et al., 2003). "This process of integration, which unfolded through interactions in the therapeutic encounter, enabled the person to make meaning and gain understanding of themselves in the social context of their lives" (Long et al., 2016).
	4.2. Intrapersonal Change	"That's the greatest thing about DBT. DBT is about me solving my problems. It's about me getting off my ass and getting my shit together, not a counselor doing it for me, and that's why it works" (Cunningham et al., 2004). "The patients also narrated the pattern of self-hate and the tendency of always condemning their own thoughts, feelings and efforts as bad or not good enough, and also the tendency to condemn other people in the same way. The therapy has, however, helped them accept themselves better, condemning neither themselves nor others the same way as before" (Persius et al., 2003). "Among the many achievements gained from DBT, participants believe the greatest is pride in themselves and hope for the future" (Cunningham et al., 2004).

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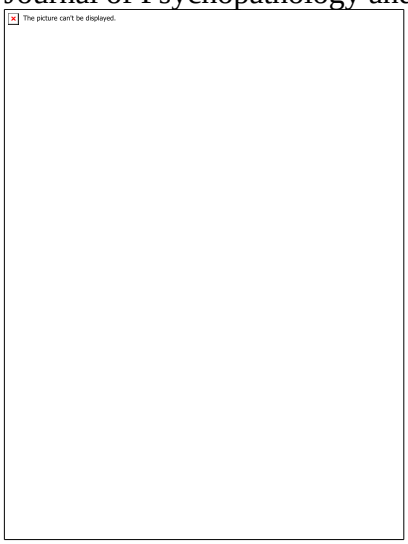

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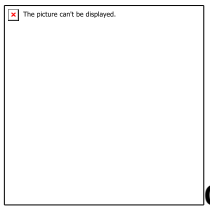

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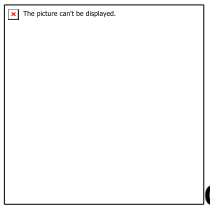

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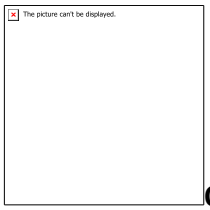
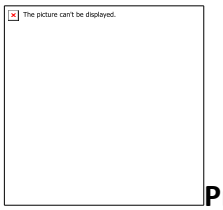
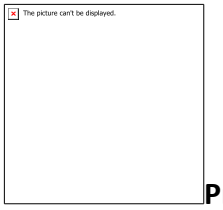


Open Materials:
All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.



Preregistered:
At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.



Preregistered+Analysis Plan:

At least one study's design has been preregistered along with an analysis plan for the research—and results are recorded according to that plan.

Note that it may not be possible to preregister a study or to share data and materials. Applying for open science badges is optional.

Manuscript preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In online supplemental material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the text of the article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's insert table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Academic writing and English language editing services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting supplemental materials

APA can place supplemental materials online, available via the published article in the PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Author contribution statements using CRediT

The *APA Publication Manual (7th ed.)*, which stipulates that "authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study." In the spirit of transparency and openness, the *Journal of Psychopathology and Clinical Science* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.

Submitting authors will be asked to identify the contributions of all authors at initial submission according to the CRediT taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an author contributions statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.

CRediT includes 14 contributor roles, as described below:

Conceptualization: Ideas; formulation or evolution of overarching research goals and aims.

Data curation: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use.

Formal analysis: Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.

Funding acquisition: Acquisition of the financial support for the project leading to this publication.
Investigation: Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.
Methodology: Development or design of methodology; creation of models.
Project administration: Management and coordination responsibility for the research activity planning and execution.
Resources: Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.
Software: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
Supervision: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
Validation: Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
Visualization: Preparation, creation and/or presentation of the published work, specifically visualization/data presentation.
Writing—original draft: Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
Writing—review and editing: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision: including pre- or post-publication stages.
Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author.

General Scientific Summaries

Please provide a General Scientific Summary (GSS) of the paper on the manuscript file below the abstract.
This should be a brief (2–3 sentences) statement that, in nontechnical language, explains the contributions of the paper.
This is not a simplified version of the abstract, which highlights the details of your study and its findings for other specialists who know the history of the research, will be able to comprehend a description of methodology, and can determine the significance of your results amidst more technical language.
Rather, assume that the reader is an intelligent, interested individual who might know something about abnormal psychology, but may not know technical terms or abbreviations such as ERP, SEM, endophenotype, error-related negativity, or mediation.
Examples are included below:
"This study suggests that some approaches to subtyping eating disorders in adolescence, specifically those that include _____, _____, and _____, may be more useful than _____in predicting outcomes in young adulthood."
"Decreased motivation to seek out rewarding experiences is a key symptom in depression. This study supports the notion that for depressed individuals, this decrease in motivation is more likely due to lower anticipation that an activity will be pleasurable than by the ability to actually experience pleasure during the activity itself."

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the references section.

Examples of basic reference formats:

Journal article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an edited book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

All data, program code and other methods must be appropriately cited in the text and listed in the references section.

Data set citation

Alegria, M., Jackson, J. S., Kessler, R. C., & Takeuchi, D. (2016). Collaborative Psychiatric Epidemiology Surveys (CPES), 2001–2003 [Data set]. Inter-university Consortium for Political and Social Research. https://doi.org/10.3886/ICPSR20240.v8

Software/Code citation

Viechtbauer, W. (2010). Conducting meta-analyses in R with the metafor package. *Journal of Statistical Software*, 36(3), 1–48. https://www.jstatsoft.org/v36/i03/

Wickham, H. et al., (2019). Welcome to the tidyverse. *Journal of Open Source Software, 4*(43), 1686, https://doi.org/10.21105/joss.01686

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, please see the general guidelines.

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

$900 for one figure

an additional $600 for the second figure

an additional $450 for each subsequent figure

Journal Article Reporting Standards

Authors must adhere to the APA Style Journal Article Reporting Standards (JARS) for quantitative, qualitative, and mixed methods. The standards offer ways to improve

transparency in reporting to ensure that readers have the information necessary to evaluate the quality of the research and to facilitate collaboration and replication.
The JARS:
recommend the division of hypotheses, analyses and conclusions into primary, secondary, and exploratory groupings to allow for a full understanding of quantitative analyses presented in a manuscript and to enhance reproducibility;
offer modules for authors reporting on replications, clinical trials, longitudinal studies, and observational studies, as well as the analytic methods of structural equation modeling and Bayesian analysis; and
include guidelines on reporting on of study preregistration (including making protocols public); participant characteristics (including demographic characteristics; inclusion and exclusion criteria) psychometric characteristics of outcome measures and other variables, and planned data diagnostics and analytic strategy.
The guidelines focus on transparency in methods reporting, recommending descriptions of how the researchers' own perspectives affected the study, as well as the contexts in which the research and analysis took place.

Transparency and openness

APA endorses the Transparency and Openness Promotion (TOP) Guidelines developed by a community working group in conjunction with the Center for Open Science (Nosek et al. 2015). Effective February 1, 2022, empirical research, including meta-analyses, submitted to the *Journal of Psychopathology and Clinical Science* must at least meet the "requirement" level for all aspects of research planning and reporting. Authors should include a subsection in the method section titled "Transparency and openness." This subsection should detail the efforts the authors have made to comply with the TOP guidelines. For example:
We report how we determined our sample size, all data exclusions (if any), all manipulations, and all measures in the study, and we follow JARS (Kazak, 2018). All data, analysis code, and research materials are available at [stable link to repository]. Data were analyzed using R, version 4.0.0 (R Core Team, 2020) and the package *ggplot*, version 3.2.1 (Wickham, 2016). This study's design and its analysis were not pre-registered.
Links to preregistrations and data, code, and materials should also be included in the author note.

Data, materials and code

Authors must state whether data and study materials are available and where to access them. If they cannot be made available, authors must state the legal or ethical reasons why they are not available. Recommended repositories include APA's repository on the Open Science Framework (OSF).
In both the author note and at the end of the method section, specify whether and where the data and material will be available or include a statement noting that they are not available. For submissions with quantitative or simulation analytic methods, state whether the study analysis code is available, and, if so, where to access it. For example:
All data have been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].
Materials and analysis code for this study are available by emailing the corresponding author.
Materials and analysis code for this study are not available.
The code behind this analysis/simulation has been made publicly available at the [repository name] and can be accessed at [persistent URL or DOI].

Preregistration of studies and analysis plans

Preregistration of studies and specific hypotheses can be a useful tool for making strong theoretical claims. Likewise, preregistration of analysis plans can be useful for distinguishing confirmatory and exploratory analyses. We encourage investigators to preregister their studies and analysis plans prior to conducting the research (e.g., ClinicalTrials.gov or the Preregistration for Quantitative Research in Psychology template) via a publicly accessible registry system (e.g., OSF, ClinicalTrials.gov, or other trial registries in the WHO Registry Network).

Articles must state whether or not any work was preregistered and, if so, where to access the preregistration. Preregistrations must be available to reviewers; authors may submit a masked copy via stable link or supplemental material. Links in the method section and the author note should be replaced with an identifiable copy on acceptance. For example:

This study's design was preregistered; see [STABLE LINK OR DOI].

This study's design and hypotheses were preregistered; see [STABLE LINK OR DOI].

This study's analysis plan was preregistered; see [STABLE LINK OR DOI].

This study was not preregistered.

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APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

Download Disclosure of Interests Form (PDF, 38KB)

In light of changing patterns of scientific knowledge dissemination, APA requires authors to provide information on prior dissemination of the data and narrative interpretations of the data/research appearing in the manuscript (e.g., if some or all were presented at a conference or meeting, posted on a listserv, shared on a website, including academic social networks like ResearchGate, etc.). This information (2–4 sentences) must be provided as part of the Author Note.

Authors of accepted manuscripts are required to transfer the copyright to APA.

For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK

Publication Rights (Copyright Transfer) Form (PDF, 83KB)

For manuscripts funded by the Wellcome Trust or the Research Councils UK

Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment. Please include in the Author Note information regarding your research ethics committee approval (i.e., institution granting approval, study name, or study #).

Download Certification of Compliance With APA Ethical Principles Form (PDF, 26KB)

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on itsr website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611

Appendix E – University of Manchester Sponsorship Letter

Faculty of Biology, Medicine & Health
The University of Manchester
Oxford Road
Manchester M13 9PT

www.manchester.ac.uk

16 December 2020

To whom it may concern

Sponsor Reference: NHS001785

Role of the Research Sponsor under the UK Policy Framework for Health and Social Care (2017) and the Medicines for Human Use (Clinical Trials) Regulations 2004 (SI2004/1031)

I hereby confirm that the University of Manchester would be prepared to accept the role of research sponsor as currently defined in the *UK Policy Framework for Health and Social Care (2017)* and the *Medicines for Human Use (Clinical Trials) Regulations 2004 (SI2004/1031),* in relation to the study:

A Case-Series of a Brief CAT-Informed Intervention for Young People (CATCH-Y)

I have been informed that this study will be led by **Dr Peter Taylor** of The University of Manchester.

Sponsorship is subject to the following conditions:

1) The lead investigator for the study must be an employee of the University of Manchester. For student research the academic supervisor is considered to be the lead investigator.
2) An appropriate contract must be agreed between the University and the funding body.
3) The research must be reviewed and approved by appropriate ethics, NHS and regulatory bodies and registered in accordance with University insurance requirements.

To enable the sponsor to meet their responsibilities as listed in section 9.10 of the UK Policy Framework for Health and Social Care (2017), Chief Investigators are asked to adhere to the responsibilities as outlined in section 9.2 of the UK Policy Framework for Health and Social Care (2017) (available at: https://www.hra.nhs.uk/documents/1068/uk-policy-framework-health-social-care-research.pdf). In line with this requirement **Dr Peter Taylor** must ensure that all involved in the research project understand and discharge their responsibilities in accordance with the agreed protocol and any relevant management, ethical and regulatory approvals.

If you have any queries about sponsorship of this project then please address them to Ms Lynne MacRae, Faculty Research Practice Manager, University of Manchester, 5.012 Carys Bannister Building, Dover Street, Manchester M13 9PT, or email fbmhethics@manchester.ac.uk.

Yours Faithfully,

Lynne MacRae

Lynne MacRae
Research Practice Governance Manager
Faculty of Biology, Medicine and Health

Dated: **16 December 2020**

Appendix F – HRA Ethical Approval Letter

Dr Peter Taylor
Senior Clinical Lecturer and Clinical Psychologist

The University of Manchester
Division of Psychology & Mental Health, School of Health Sciences
Faculty of Biology, Medicine and Health, Zochonis Building, Room 2.33, University of Manchester
M13 9PL

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

24 February 2021

Dear Dr Taylor

HRA and Health and Care

Study title:	**A Case-Series of a Brief CAT-Informed Intervention for Young People who self-injure (CATCH-Y)**
IRAS project ID:	**287611**
Protocol number:	**N/A**
REC reference:	**21/NW/0019**
Sponsor	**The University of Manchester**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

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

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **287611**. Please quote this on all correspondence.

Yours sincerely,

Natalie Marking
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Lynne MacRae* **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [COVID Restart Checklist for Face to Face Work]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Complete insurance certificate]		07 January 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University of Manchester Insurance Documents]	1	01 June 2020
IRAS Application Form [IRAS_Form_06012021]		06 January 2021
Laboratory Manual [Therapeutic Manual for CATCH-Y]	1	02 July 2019
Letter from funder [Letter from Funder - ACAT]		20 October 2020
Letter from sponsor [Sponsor Letter Confirmation - The University of Manchester]		16 December 2020
Non-validated questionnaire [Demographic Questionnaire (Tracked Changes)]	2	15 February 2021
Non-validated questionnaire [Demographic Questionnnaire]	2	15 February 2021
Organisation Information Document		18 December 2020
Other [Data Management Plan]	2	15 February 2021
Other [Phone Screening Script (Tracked Changes)]	1	04 December 2020
Other [Text Reminder for Online Measures ((Tracked Changes)]	2	15 February 2021
Other [Safeguarding Approval from Safeguarding Lead]	1	15 February 2021
Other [Remote Therapy and Procedure Guidance (COVID-19)]	1	15 February 2021
Other [Phone Screen Script]	2	15 February 2021
Other [Text for messages/emails]	2	15 February 2021
Other [CATCH-Y Protocol]	2	15 February 2021
Other [REC Panel Responses]	1	15 February 2021
Other [Example of a Repertory Grid]	1	03 December 2020
Other [University of Manchester Insurance Assessment Form]	1	05 November 2020
Other [University of Manchester - Insurance Confirmation Letter]	1	16 December 2020
Other [Email from NHS Trust confirming Consent to Contact Responsibility]	1	12 December 2020
Other [Response Text for Consent Not Given]	1	28 October 2020
Other [Risk Protocol]	1	04 December 2020
Other [Study Risk Assessment]	1	04 December 2020
Other [Signposting for Participants]	1	03 December 2020
Participant consent form [Consent Form - Child (Online) Tracked Changes]	2	09 February 2021
Participant consent form [Consent Form Child Online]	2	09 February 2021
Participant consent form [Consent Form Child Paper]	2	15 February 2021
Participant consent form [Consent Form Parent Online]	2	15 February 2021

Participant consent form [Consent Form Parent Paper]	2	15 February 2021
Participant consent form [Consent Form - Child (Paper) Tracked Changes]	2	15 February 2021
Participant consent form [Consent Form - Parent (Online) Tracked Changes]	2	15 February 2021
Participant consent form [Consent Form - Parent (Paper) Tracked Changes]	2	15 February 2021
Participant information sheet (PIS) [Participant Information Sheet 13 - 15 (Tracked Changes)]	2	15 February 2021
Participant information sheet (PIS) [Participant Information Sheet 13-15]	2	15 February 2021
Participant information sheet (PIS) [Participant Information Sheet]	2	12 February 2021
Participant information sheet (PIS) [Participant Information Sheet 16-17 Tracked Changes]	2	12 February 2021
Participant information sheet (PIS) [Participant Information Sheet Parent (Tracked Changes)]	2	12 February 2021
Participant information sheet (PIS) [Participant Information Sheet for ages 16-17]	2	12 February 2021
Referee's report or other scientific critique report [Confirmation of proceedings from The University of Manchester Research Subcommittee after evaluation]		04 December 2020
Research protocol or project proposal [Protocol (Tracked Changes)]	2	15 February 2021
Schedule of Events or SoECAT [Schedule of Events]	1	03 December 2020
Summary CV for Chief Investigator (CI) [CV - Peter Taylor]		03 December 2020
Summary CV for student [CV - Rebecca Haw]		03 December 2020
Summary CV for student [CV - Molly Marsden]		03 December 2020
Summary CV for supervisor (student research) [CV - Sam Hartley]		03 December 2020
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [University of Manchester - Insurance and Exclusions]	1	05 November 2020
Summary of any applicable exclusions to sponsor insurance (non-NHS sponsors only) [University of Manchester - Sponsor Conditions]	10	09 October 2020
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Brief Summary Sheet]	1	04 December 2020
Validated questionnaire [Validated online outcome measures during study (ABUSI, PHQ-9) (Tracked Changes)]	2	15 February 2021
Validated questionnaire [Online Measures]	2	15 February 2021
Validated questionnaire [Pre and Post Outcome Measures (MYTS, ReQuest-YP) (Tracked Changes)]	2	15 February 2021
Validated questionnaire [Pre and Post Measures]	2	15 February 2021
Validated questionnaire [ReQuest-YP]		
Validated questionnaire [SITBI]		
Validated questionnaire [Client Satisfaction Questionnaire (Adapted)]		

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Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
All organisations will be conducting the same activities as per the protocol and Organisation Information Document. Therefore, there is one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	An organisation information document has been submitted and the sponsor is not requesting and does not expect any other site agreement to be used.	No funding is being provided to participating sites by the sponsor.	A Principal Investigator should be appointed at study sites.	For the interventional aspects of the study, where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain an honorary research contract from one NHS organisation (if university employed), followed by Letters of Access for subsequent organisations. This would be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm enhanced DBS checks, including appropriate barred list checks,

					and occupational health clearance. For the questionnaire aspects of the study, where arrangements are not already in place, research staff not employed by the NHS host organisation undertaking any of the research activities listed in the research application would be expected to obtain a Letter of Access based on standard DBS checks and occupational health clearance.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they intend to apply for inclusion on the NIHR CRN Portfolio

Appendix G – ACAT Funding Confirmation Email

From: Alison Jenaway [mailto:alisonjenaway@googlemail.com]
Sent: 20 October 2020 19:35
To: Peter Taylor; Louise Barter
Cc: HARTLEY, Samantha (PENNINE CARE NHS FOUNDATION TRUST); DUDLEY, Jay (DEVON PARTNERSHIP NHS TRUST)
Subject: Re: Research funding agreed by Trustees

Dear Peter, I am pleased to let you know that the Board of Trustees of ACAT were pleased to agree to your funding request of £1125 for "A Case series of a Brief CAT - informed Intervention for young people who have self injured". Please invoice Louise Barter who i have copied in and please acknowledge the funding from ACAT in any publication or publicity about the study.
Best wishes, Alison jenaway (previous Chair of ACAT).

Dr Alison Jenaway
Consultant Psychiatrist in Medical Psychotherapy, CAT Therapist and Supervisor
07771 596594
alisonjenaway@googlemail.com
Collaborate

Appendix H – Outcome Measures

Self-Injurious Thoughts and Behaviours Interview (SITBI)

A Case-Series Examination of a Brief CAT-Informed Intervention for Young People that have Self-Injured.

These questions ask about your thoughts and feelings of self-injurious behaviours. Please response as accurately as you can by writing your answer or ticking the box.

1. Have you ever actually purposely hurt yourself without wanting to die?
    a. [ ] no
    b. [ ] yes

2. How old were you the first time you purposely hurt yourself without wanting to die?

    _____

3. How old were you the last time?

    _____

4. Now I'm going to go through a list of things that people sometimes purposely do to harm themselves without wanting to die. Please let me know which of these you've done:
    a. [ ] cut or carved skin
    b. [ ] burned your skin (i.e., with a cigarette, match or other hot object)
    c. [ ] inserted sharp objects into your skin or nails
    d. [ ] picked areas of your body to the point of drawing blood
    e. [ ] hit yourself on purpose
    f. [ ] gave yourself a tattoo
    g. [ ] scraped your skin to the point of drawing blood
    h. [ ] other (specify):_____

5. How many times in your life have you purposely hurt yourself without wanting to die?

(Please give your best estimate)

How many times in the past year? _____

How many times in the past month? _____

How many times in the past week? _____

6. On average, how long have you thought of purposely hurting yourself without wanting to die before actually doing it?
    a. [ ] 0 seconds
    b. [ ] 1–60 seconds
    c. [ ] 2–15 minutes
    d. [ ] 16–60 minutes
    e. [ ] less than one day
    f. [ ] 1–2 days
    g. [ ] more than 2 days
    h. [ ] wide range (spans > 2 responses)

7. Have you ever received medical treatment for harm caused by purposely hurting yourself without wanting to die?
    a. [ ] no
    b. [ ] yes

8. On a scale of 0 to 4, what do you think the likelihood is that you will purposely hurt yourself without wanting to die in the future? _____

0	1	2	3	4
Not at all	A little bit	Somewhat	Very Much	Extremely

Thank you for completing the questionnaire.

For the researchers: individual participant reference number

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

Alexian Brothers Urge to Self-Injure Scale (ABUSI)

The questions below apply to **the last week**. Place an "X" in the box next to the most appropriate statement

1. **How often have you thought about injuring yourself or about how you want to injure yourself?**
   - ☐ **Never**, 0 times in the last week
   - ☐ **Rarely**, 1 -2 times in the last week
   - ☐ **Occasionally**, 3 – 4 times in the last week
   - ☐ **Sometimes**, 5 – 10 times in the last week, or 1 -2 times a day
   - ☐ **Often**, 11 – 20 times in the last week, or 2 – 3 times a day
   - ☐ **Most of the time**, 20 – 40 times in the last week, or 3 – 6 times a day
   - ☐ **Nearly all of the time**, more that 40 times in the last week, or more than 6 times a day
2. **At the most severe point, how strong was your urge to self-injure in the last week?**
   - ☐ **None** at all.
   - ☐ **Slight**, that is, a very mild urge.
   - ☐ **Mild** Urge.
   - ☐ **Moderate** Urge.
   - ☐ **Strong** Urge, but **easily** controlled.
   - ☐ **Strong** Urge, but **difficult** to control.
   - ☐ **Strong** Urge **and would have self-injured if able to**.
3. **How much time have you spent thinking about injuring yourself or about how you want to injure yourself?**

☐	☐	☐	☐	☐	☐	☐
None.	Less than 20 min.	21-45 min.	46-90 min.	90 min to 3 hrs.	3-6 hrs.	More than 6 hrs.

4. **How difficult was it to resist injuring yourself in the last week?**

☐	☐	☐	☐	☐	☐	☐
Not difficult at all	Very mildly difficult	Mildly difficult	Moderately difficult	Very difficult	Extremely difficult	Was not able to resist

5. **Keeping in mind your responses to the previous questions, please rate your *overall average* urge or desire to injure yourself in the last week.**
   - ☐ **Never** thought about it and **never** had the urge to self-injure.
   - ☐ **Rarely** thought about it and **rarely** had the urge to self-injure.
   - ☐ **Occasionally** thought about it and **occasionally** had the urge to self-injure.
   - ☐ **Sometimes** thought about it and **sometimes** had the urge to self-injure.
   - ☐ **Often** thought about it and **often** had the urge to self-injure.
   - ☐ Thought about self-injury **most** of the time and had the urge to do it **most** of the time.
   - ☐ Thought about self-injury **nearly all** the time and had the urge to do it **nearly all** the time.

Motivation for Youth Treatment Scale (MYTS)

How You Feel About Counseling

Below are statements about how youths might feel about their lives and about counseling. For each statement, please think about how you CURRENTLY feel and place an 'X' in the one box that best describes how much you agree or disagree with each one. There is no right or wrong answer.

		Strongly Disagree	Disagree	Neither Agree Nor Disagree	Agree	Strongly Agree
1.	My behavior is causing problems at home, school, with my friends, or in other places.	☐	☐	☐	☐	☐
2.	My behavior is making my life worse.	☐	☐	☐	☐	☐
3.	Some of my feelings are really bothering me.	☐	☐	☐	☐	☐
4.	I want help finding solutions for my current problems.	☐	☐	☐	☐	☐
5.	Getting counseling seems like a good idea to me.	☐	☐	☐	☐	☐
6.	If I attend counseling I think my life will get better.	☐	☐	☐	☐	☐
7.	I am getting counseling because I want to.	☐	☐	☐	☐	☐
8.	My feelings are causing problems at home, school, with my friends, or in other places.	☐	☐	☐	☐	☐

Patient Health Questionnaire modified for Adolescents (PHQ-9A)

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Recovery Questionnaire for Young People (ReQuest-YP)

QUESTIONNAIRE FOR YOUNG PEOPLE (RE-QUEST YP)

We would like you to tell us how much you agree with the statements listed below. To tell us how much you agree, we'd like you to use this scale:

0 = Not at All
1 = A little
2 = A lot
3 = Completely

For example, if we asked you how much you agree with the statement – "I enjoy summer time" - then:

If you circle the **0**, this means that you **do not agree at all** with the statement, you do not enjoy summer time at all.
If you circle the **1**, this means that you **agree with the statement but just a little,** you enjoy summer time a little.
If you circle the **2**, this means that you **agree a lot with the statement,** you enjoy summer time a lot.
If you circle the **3**, this means that you **completely agree with the statement**, you enjoy summer time completely.

So, we would like you to circle the number that best describes how much you agree with each of the statements below. When thinking about each statement, try to think of **what your experience has been over the past week. There are no right or wrong answers**, it is what you think that is important. Please try to answer all of the questions.

So, here are the statements. How much do you agree with them?

	Not at All	A little	A lot	Completely
I enjoy being with my friends.....	0	1	2	3
Talking about my problems makes me feel better.....	0	1	2	3
My problems will always ruin my life.....	0	1	2	3
I do not see my friends because of how I feel	0	1	2	3
Knowing that there are people my age with similar problems makes me feel better	0	1	2	3
I am too frightened to do anything	0	1	2	3
I can see how my life could be better.....	0	1	2	3
I do not feel alone any more	0	1	2	3
I have a better understanding of my problems	0	1	2	3

Please turn over the page

How much do you agree with the statements below?

	Not at All	A little	A lot	Completely
I have no life.....	0	1	2	3
My problems are not affecting me as badly as before	0	1	2	3
I have abilities and talents.....	0	1	2	3
I find ways to be with my friends.....	0	1	2	3
I feel quite alone because nobody understands me	0	1	2	3
I cope with my problems much better than before.....	0	1	2	3
I do not know who I am any more	0	1	2	3
I wish I could be like other people my age	0	1	2	3
I am hopeful about my future	0	1	2	3
I look for people to talk to about my problems.....	0	1	2	3
I believe in myself	0	1	2	3
I am not different to other people my age.....	0	1	2	3
I understand my problems.....	0	1	2	3
I have no confidence in myself.....	0	1	2	3
I do not understand my problems at all.....	0	1	2	3
I have learnt ways to manage my problems.....	0	1	2	3
I like who I am.....	0	1	2	3
People around me understand and can help me.....	0	1	2	3
I try my hardest and, if it fails, I try again.....	0	1	2	3
I try not to share my problems with anybody.....	0	1	2	3
I can enjoy my life despite having my problems.....	0	1	2	3

That is the end of this questionnaire. Thank you!

Adapted Client Satisfaction Questionnaire

Using a Cognitive Analytic Therapeutic Informed Approach for Young People who Self-Injure: A Repertory Grid Study

Thank you for participating in the CATCH-Y study. We are asking participants to complete a questionnaire to gather feedback on their experience of the study.

Please read the questions and circle or write in the box your answer to the question.

Assessment sessions:

1. I understood how to complete the repertory grid

   Certainly True *Partly True* *Not True* *Don't know*

2. I found the repertory grid easy to complete

   Certainly True *Partly True* *Not True* *Don't know*

Therapy sessions:

3. I found the therapy sessions a positive experience

   Certainly True *Partly True* *Not True* *Don't know*

4. I found the therapy sessions helpful

   Certainly True *Partly True* *Not True* *Don't know*

5. I felt I could speak about my difficulties safely within the sessions

   Certainly True *Partly True* *Not True* *Don't know*

6. My views and worries were taken seriously by the therapist

Certainly True *Partly True* *Not True* *Don't know*

7. I felt the therapist knew how to help me

   Certainly True *Partly True* *Not True* *Don't know*

8. I feel more hopeful about the future

   Certainly True *Partly True* *Not True* *Don't know*

9. If a friend needed this sort of help, I would suggest to them to do this therapy

   Certainly True *Partly True* *Not True* *Don't know*

Was there any thing you liked about the therapy?
(Please write your answer in the space below)

Was there any thing you disliked about the therapy?
(Please write your answer in the space below)

Any additional comments?
(Please write your answer in the space below)

Thank you for completing the questionnaire.

For the researchers: individual participant reference number

Appendix I – Study Protocol

RESEARCH PROTOCOL

A Case-Series of a Brief CAT-Informed Intervention (CATCH-Y) for Young People that have self-injured.

Contents

1) RESEARCH TEAM & KEY CONTACTS

Chief Investigator: Name: Dr Peter Taylor Address: Division of Psychology & Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, Zochonis Building, Room 2.33, University of Manchester Brunswick Street M13 9PL Email: peter.taylor-2@manchester.ac.uk Telephone: 01613060425	***Co-Chief investigator(s):*** Name: Dr Samantha Hartley Address: Division of Psychology & Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, Zochonis Building, Room 2.33, University of Manchester Brunswick Street M13 9PL Email: samantha.hartley2@nhs.net Telephone: 01613060425
Sponsor(s): Name: The University of Manchester Sponsor contact: Ms Lynne Macrae, Faculty Research Practice Governance Coordinator Address: Faculty of Biology, Medicine and Health 5.012 Carys Bannister Building University of Manchester M13 9PL Email: FBMHethics@manchester.ac.uk Telephone: 0161 275 5436	***Lead R&D Trust contact(s):*** Name: Mr Simon Kaye Address: Pennine Care NHS Foundation Trust, Trust Headquarters, Research and Innovation Department, 225 Old Street, Ashton-under-Lyne, Lancashire OL6 7SR Email: researchdevelopment.penninecare@nhs.net Telephone: 0161 716 3993
Researcher: Name: Rebecca Haw Address: Division of Psychology & Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, Zochonis Building, Room 2.33, University of Manchester Brunswick Street M13 9PL Email: rebecca.haw@postgrad.manchester.ac.uk Telephone: 01613060425	***Researcher:*** Name: Molly Marsden Address: Division of Psychology & Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, Zochonis Building, Room 2.33, University of Manchester Brunswick Street M13 9PL Email: molly.marsden@postgrad.manchester.ac.uk Telephone: 01613060425

2) INTRODUCTION

Non-suicidal self-injury (NSSI), the term used for when somebody purposefully hurts themselves without intending to end their life. Often, it suggests that there are other difficulties going on in someone's life. Talking therapies can be offered to help however currently there is little evidence to

show which therapies help most. CATCH-Y (Cognitive Analytic Therapy for Containing Self-Harm in Young People) is a brief talking therapy which has been created to support young people who self-injure. It aims to help young people and those around them build to a shared understanding of their difficulties. Previously a group of adults, who have a history of self-harm, have engaged in a trial version of CATCH-Y for adults, in which it was found to be positive, safe and feasible.

The study will aim to recruit nine young people who have self-injured in the past. Participants must be aged between 13 - 17 years old and have self-injured within the last six months. They will be recruited from local Child and Adolescent Mental Health Services (CAMHS). The therapy is five sessions long, with two assessment sessions before the therapy begins and one assessment session post-therapy. Online assessments will be completed throughout. CATCH-Y involves working with the therapist to understand a young person's past and current experiences, linked to their self-injurious behaviours. We believe that this individualised approach would benefit these young people.

As a novel treatment, and in accordance with the medical research council (MRC) framework, the feasibility and acceptability of CATCH-Y should be considered before progressing to a larger trial. In this study, we are examining the feasibility and acceptability of the CATCH-Y intervention through attendance and retention rates, data completion and intervention acceptability. As a secondary measure, we are looking at whether CATCH-Y shows preliminary evidence for positive change. Questionnaires can often limit participant's responses as they use set questions and move away from the intended personalised approach. Therefore, in addition to feasibility measures, repertory grids will be used as an alternative assessment measure to look at personal change. The measure may gather more meaningful outcomes from therapy. The repertory grid will be developed with the young person based on their own thoughts about themselves, others and their current difficulties. The study plans to use these grids to measure changes before and after the therapy.

The findings from this study will help to develop the therapy and improve further testing in larger studies. If this is successful, CATCH-Y could be available as a treatment for young people who self-injure.

3) BACKGROUND

Non-suicidal self-injury (NSSI) can be defined as "directly and intentionally inflicting damage to one's own body tissue without intention of suicide and not consistent with cultural expectations or norms" (Nock, Joiner, Gordon & Lloyd-Richardson, 2006, p.1). It can be differentiated from "self-harm", which also encompasses suicidal behaviours. Often, NSSI is indicative of underlying emotional difficulties and predictive of later psychological problems (Daukantaite et al., 2020). Rates of NSSI have increased from 5% in 2000, to 14% in 2014 in the UK (McManus et al., 2019). Furthermore, adolescents have a greater lifetime prevalence of self-injury than adults, with non-suicidal self-injury rates of 17% in adolescents, 13% in young adults and 6% in adults (Swanell et al., 2014). Whilst there is some evidence for NSSI leading to a higher risk of suicide (Wilkinson et al., 2011), it is distinct in its function, intent and epidemiology and can have other serious consequences such as scarring, infection and accidental death, as well as evoking complex feelings of shame and guilt (Butler & Malone, 2013). With suicide being the leading cause of death for young people in England in 2015,

interventions for young people who self-harm, including those who engage in NSSI, is now a national health priority (McPin Foundation, 2018).
Current reviews of the support available for young people who have self-injured show the sparsity of evidence based-interventions (Turner, Austin & Chapman, 2014). This may be partly accounted for with the diversity of reasons for self-injury (Taylor et al., 2018), which necessitate a more individualised approach. One review of interventions for NSSI found that structured therapeutic approaches focussing on collaborative therapeutic relationships, motivation to change and directly addressing NSSI behaviours the most effective however the evidence currently available is of low quality (Turner, Austin & Chapman, 2014). Whilst there are significant differences in the functions of self-injurious behaviours, commonly reported reasons are largely interpersonal or intrapersonal (Taylor et al., 2018). Relational approaches to intervention may therefore be appropriate when working with young people who self-injure, due to the emphasis being on making sense of inter/intrapersonal patterns of relating.
Cognitive analytic therapy (CAT) is a relational therapy, which suggests an internalisation of relational patterns from childhood that may manifest themselves throughout a lifetime, influencing relationships towards the self and others. Pilot trials have shown that CAT may be helpful when working with individuals who self-injure (Sheard et al., 2000; Ourgin et al., 2013). Widely documented issues of access to interventions within CAMHS services (Department of Health, 2017) mean that brief interventions could be accessed and implemented more widely than their longer-term counterparts.
Cognitive Analytic Therapy for Containing Self-Injury (CATCH) is a brief intervention based upon CAT principles aimed at those who self-injure. A feasibility trial of CATCH found evidence that the intervention is acceptable to participants and safe (Peel-Wainwright et al., in prep). This intervention has been adapted for the needs of young people and adolescents (CATCH-Y; Taylor, Turpin & Hartley, 2019). CATCH-Y is a brief intervention that uses a collaborative, relational approach. With early evidence showing that young people who self-harm respond well to CAT (Sheard et al., 2000; Ougrin et al., 2013), and the need for timely intervention, CATCH-Y could have both therapeutic and service level benefits. No study to date has looked at CATCH-Y with young people.
According to the Medical Research Council (MRC) Complex Intervention Development Framework (2019), the first step in progressing with CATCH-Y is assessing the feasibility of the intervention by exploring whether it is safe and acceptable through a case-series. This will determine the plausibility of larger trials, through evaluation of the attendance, recruitment and retention of participants. Therefore, this study will be a case-series which evaluates the feasibility and acceptability of the CATCH-Y intervention for young people who self-injure. If outcomes indicate plausibility, a randomised control trail (RCT) will determine the clinical benefits of implementing the CATCH-Y intervention.

4) STUDY OBJECTIVES

4.1 Primary Question/Objective:

The primary aim of this study is to assess the feasibility and acceptability of a brief, five-session CAT intervention (CATCH-Y) in a population of young people who have self-injured.

- Is CATCH-Y a feasible and acceptable intervention for young people who have self-injured?

4.2 Secondary Question/Objective:

The potential benefits of the intervention are assessed as a secondary aim to determine whether there is preliminary evidence of change over the course of therapy.

- To investigate how young people's personal constructs change following attending CATCH-Y.
- To explore whether there is preliminary evidence showing improvements in affect, motivation, self-injury urge severity and perceived recovery.

A tertiary aim is to determine the feasibility of employing the repertory grid technique to examine the construal of young people who self-injure.

5) STUDY DESIGN & PROTOCOL

5.1 Participants

Participants will be young people aged 13 to 17 years with a recent history of NSSI. This will be defined as one or more episodes of non-suicidal self-injury in the past six months, with a lifetime prevalence of two or more episodes of NSSI. A sample size of nine will be used which is in line with other case-series in the field (Taylor et al., 2019; Searson, Mansell, Lowens, & Tai, 2012). An attrition rate of 1/7 is also predicted, based upon the outcomes of the CATCH study (Peel-Wainwright et al., in prep) and therefore we are aiming to recruit nine participants, expecting that eight will complete the study.

5.2 Study Intervention and/or Procedures

This study is part of wider research that encompasses two trainee projects. Both researchers will receive fortnightly supervision from a qualified CAT practitioner plus fortnightly supervision from internal research supervisors (PT and SH) whilst conducting the intervention.

Whilst the intention is to conduct the stated sessions face-to-face, the current Covid-19 restrictions may warrant remote online delivery of these sessions, in which case we would use an appropriate web platform (such as Zoom or Microsoft Teams). If the intervention is completed remotely, the 'remote therapy and procedure guidance – COVID-19' would be followed to ensure that the therapy is delivered safely. To reduce bias, one researcher will conduct phase 1 and 3. Another researcher will conduct phase 2.

Phase 1: Baseline

Appointments will be conducted face-to-face at a mutually convenient location or via a video conferencing platform (e.g. zoom). Caregivers will be present in appointments for participants under the age of 16 (16-17 years old at their discretion).

Consent: Whilst gaining face to face consent is preferable, this will be dependent upon whether circumstances such as the presence of COVID-19 related restrictions mean that only remote contact is possible. In the procedure where face to face meeting is possible, the researcher would share the PIS again, giving the opportunity for young people/their caregivers to ask any questions. Written consent will be gathered from all young people and caregiver where the child is below 16. For young people under the age of 16, we will not use Gillick competence in the absence of caregiver consent. For participants aged 16-17, we will encourage informed consent is gathered from caregivers but not essential. Young people who do not consent to take part would not be involved even where a caregiver provides

consent. Seeking consent rather than assent from young people is consistent with the Nuffield Bioethics committee recommendations (2015).
Where only remote contact is possible, young people and their caregivers will be sent a digitally generated version of the consent form using the University of Manchester survey platform. Participants would be provided a link to this form and asked to complete the questions along with their name and the date of submission. The researcher would be available remotely at this time to answer any queries that the young person or their caregiver may have. The same age-dependent rules would apply for the remote consent form.
Following consent, the baseline assessments will be administrated (demographic information, SITBI and repertory grids) in two 30-60-minute appointments. Burden will be monitored and breaks provided. Participants will be asked to complete outcome measures online one week prior to the intervention starting. A link to select survey, where participants can complete the measures, will be sent via email, once a date for the first therapy session is arranged. Consideration will be given to any foreseeable delays that might prevent a timely start to the intervention and the baseline session adjusted accordingly so that the intervention is able to start within a week of the baseline measures.

Phase 2: Intervention
One week after baseline, the intervention delivered by the researchers will start. The intervention will run over five sessions, each lasting around 30 - 40 minutes and delivered within seven weeks (allowing for cancellations).
Researchers will follow the CATCH-Y manualised treatment guide. CATCH-Y is a brief, five session psychological intervention based upon CAT principles and designed to help young people who have self-injured.
Sessions 1-3: Focuses on the process of mapping or 'reformulation,' where the emphasis is on forming a collaborative understanding of the young person's behaviour patterns.
Sessions 3-4: The focus begins to shift towards identifying exits (or ways of breaking out of unhelpful patterns), which can be applied by the young person.
Session 5: The final session is a 'consultation' session, which focuses on consolidating what has been learned within the therapy collaboratively with another key individual such as parent or clinician. This key individual will be invited to the session at the participant's discretion.

After each intervention session, participants will be asked to complete outcome measures online. A link to a University of Manchester approved online survey platform, where participants can complete the measures, will be sent every Friday throughout the intervention period via email. There will also be the option of completing these measures by phone where issues arise in using the online platform. This will start after the first intervention session and continue until four weeks after the completion of or withdrawal from therapy.
The therapy will be delivered by two trainee clinical psychologists. Previous research has shown trainee clinical psychologists can be successfully trained to deliver CAT informed therapies for people who self-injure (Peel-Wainwright et al., in prep). The trainee providing therapy would not be the same that undertakes research assessments. Therapists will receive regular group clinical supervision every two weeks. One supervision session every

four-weeks will be delivered by a CAT accredited supervisor. Other clinical supervision will be delivered by clinical psychologists with an understanding of CAT informed approaches. Therapy sessions one to four will be audio-recorded with the consent of the participants and caregivers (where participants are aged under 16 years). This will be done using an encrypted recording device. All audio recordings will be saved as pseudonymised data and saved on a University of Manchester secure shared drive. A subset of 10% (~ 4 sessions) will be rated independently using the Competence in Cognitive Analytic Therapy (CCAT; Bennett & Parry, 2006) tool to evaluate adherence to the approach.

Phase 3: Follow-up

One week after completing or withdrawing from the intervention participants will be invited to a follow up assessment (either in person or via zoom) to complete a repertory grid for the second time. Participants will also be asked to complete the post-intervention measures online using The University of Manchester's survey platform, including the adapted client satisfaction questionnaire.

Participants will be sent a written debriefing sheet in the post, including researchers contact details. Participants will be able to still seek further interventions via CAMHS. Participants will be reimbursed with a shopping voucher (£30).

6) STUDY PARTICIPANTS

6.1 Inclusion Criteria:

- Participants will be between the ages of 13 – 17 years.
- Participants will have self-injured at least once in the past six months and have a lifetime history of two or more episodes of NSSI.
- Participants will have a clinician allocated to them within a CAMHS service.
- Participants will have access to the Internet.

6.2 Exclusion Criteria:

- Participants will be excluded if they are currently receiving alternative psychological therapies from a mental health professional. Participants may be receiving other forms of ongoing contact and support that do not constitute a formal psychological therapy.
- Participants will be excluded if they have a severe intellectual disability, which would impair their ability to participate without considerable adaptations being made to the intervention.
- Participants will be excluded if they have inadequate English-language speaking skills due to limitations in their ability to engage with talking therapies in the English language.
- Participants will be excluded if they are judged at high risk of harm to themselves, operationalised as having current suicidal thoughts with a high intent or active plan to end their life.

6.3 Recruitment:

The recruitment pathway outlined will require participants under the age of 16, to provide consent to contact and consent to participate from both young person and caregiver. Participants over the age of 16, who can be seen alone, will not require caregiver consent, only consent from the young person. We will still advise that consent to contact from caregivers is desirable, but not essential.

We will recruit from Child and Adolescent Mental Health Services (CAMHS) within Greater Manchester Mental Health NHS Foundation Trust and Pennine Care NHS Foundation Trust (see appendix A).

Phase 1: Advertising

Service managers will be contacted and researchers will attend the above services to inform teams of the study, detailing the referral process and to inviting them to refer. Researchers will be in regular contact by phone/face to face to collect referrals.

Phase 2: Consent to contact

Clinicians from the above services will identify young people appropriate for the study from caseloads using the criteria provided. They will provide the young person and parent/carer with an information sheet. If interested in partaking in the study, clinicians from trusts that are willing to take responsibility of data sharing will ask young people and their parent/carer for their verbal consent to contact to share their contact details with the research team. If aged 15 or under, verbal consent to contact will be required from both young person and caregiver. If they are unable to take this responsibility, they will share the contact details of the research team with the potential participants and details of how to contact. If a young person contacts the research team, this will be considered consent to contact. The research team will liaise regularly with clinicians by phone, video call or in person, and will collect contact details of potential participants who have given consent to contact at these times.

Phase 3: Screening

A researcher will then contact the young person via phone call to confirm interest (if contact has not already been made by the young person). Verbal consent will be requested to talk with the young person's clinical team. An initial eligibility screening will then take place over the phone where the young person and their caregiver is asked questions around their NSSI. If the young person is 15 and under, then these conversations will be required to take place with both the young person and their caregiver. If the inclusion criterion is met, they will then be invited to participate in the study and a face-to-face appointment organised.

6.5 Participants who withdraw consent:

Participants can withdraw consent at any time without giving any reason, as participation in the research is voluntary, without their care or legal rights being affected.

7) OUTCOME MEASURES

Primary Outcome Measures

The primary aim of this study is to assess the feasibility and acceptability of a brief, five-session CAT intervention (CATCH-Y) in a population of young people who have self-injured. This will determine whether it is viable to deliver and evaluate the therapy in a larger RCT. Feasibility will be assessed through recruitment rates and data completeness. The attendance and retention of participants, as well as feedback of their experience will determine acceptability.

Retention rates: Attendance at each session will be recorded to determine whether over 70% of participants will be retained from baseline to the end of the study.

Referral rates: Referrals will be recorded to test the hypothesis that >50% of those who are referred to the study and are eligible to participate, consent to take part.

Measurement data: Completion of measurements will be analysed to test whether the level of missing data exceeds 20% per assessment.
Acceptability: An exploration of factors that influence engagement (including what was helpful/unhelpful) will be determined in the adapted version of the client satisfaction questionnaire.

Secondary Outcome Measures

Self-Injurious Thoughts and Behaviours Interview (SITBI): The SITBI is a structured interview, which assesses the frequency and characteristics of NSSI in young people (Nock et al., 2007). These authors evaluated the SITBI with a population of adolescents who self-injure and found comprehensive validity and reliability. It is now widely used in research into NSSI. In this study, the self-injurious subsection will be used. This measure will be used at baseline only.
Repertory grids: The repertory grid will be used to explore changes in participants' perceptions of the self, others and their experiences of NSSI. Participants will be asked to complete them prior to, and following, completion of CATCH-Y. This assessment will be completed as a structured interview, with one of the researchers talking through and explaining each step. The repertory grids will be developed following established techniques (Jankowicz, 2003). Previously repertory grids have been used with adolescents (Sewell, 2020). These measures will be used pre and post intervention.
Motivation for Youth Treatment Scale (MYTS): This evaluates motivation to change and desire to find solutions to difficulties in youths and their caregivers. A psychometric evaluation of the MYTS conducted with young people aged 11-18 found it to be a reliable tool for assessing important dimensions of intrinsic treatment motivation (Breda & Riemer, 2012). This measure will be assessed online using select survey, pre and post intervention.
Recovery Questionnaire (ReQuest-YP): Examines recovery of functionality and outlook post-treatment. An evaluation of the psychometric properties of the ReQuest-YP with 65 young people showed good internal consistency and test-retest reliability (Bentley, Bucci & Hartley, 2019). This measure will be assessed online using select survey, pre and post intervention.
Alexian Brothers Urges to Self-injure scale (ABUSI): A measure to assess the frequency, intensity and duration of the urge to self-injure. The ABUSI has shown good internal consistency and reliability (Chavez-Flores et al., 2019). In addition, a recent study found that the ABUSI provided valid information in a population of students who self-injured (Dimitrova, Radkova, Stoyanov & Petrov, 2020). This measure will be assessed online using select survey, pre, post and weekly during the intervention. It will also be assessed for four weeks post-intervention.
Patient Health Questionnaire for Adolescents (PHQ-9A): Low mood clinical evaluation. An examination of the PHQ-9A completed by 442 young people, showed positive validity of the measure (Richardson et al., 2010). This measure will be assessed online using select survey, pre, post and weekly during the intervention. It will also be assessed for four weeks post-intervention.
Client Satisfaction Questionnaire (CSQ): An adapted version of this questionnaire (Attkinsson & Zwick, 1982) will be used to gain feedback and measure aspects of the acceptability of the intervention. This measure will be assessed online using select survey, post-intervention.

Measure	Pre-Intervention (Online and F2F)	During (Online)	Post-Intervention (Online)	Follow up (4 weeks post-intervention)
SITBI	Y			
Repertory Grids	Y		Y	
MYTS	Y		Y	
ReQuest-YP	Y		Y	
ABUSI	Y	Y	Y	Y
PHQ-9	Y	Y	Y	Y
Client Satisfaction Questionnaire			Y	

Benefits and implications of answering the research question

NSSI is a concern for young people, for who it causes significant distress (Hawton, Sanders & O'Connor, 2012) and heightens their risk of death by suicide (Colman et al., 2004). With suicide being the leading cause of death for young people in England in 2015, interventions for young people who self-harm, including those who engage in NSSI, is now a national health priority (McPin Foundation, 2018).

Current reviews of the support available for young people who have self-injured show the sparsity of evidence based-interventions (Turner, Austin & Chapman, 2014). This may be partly accounted for with the diversity of reasons for self-injury (Taylor et al., 2018), which necessitate a more individualised approach. Widely documented issues of access to interventions within CAMHS services (Department of Health, 2017) mean that brief interventions could be accessed and implemented more widely than their longer-term counterparts.

CATCH-Y is a brief intervention that uses a collaborative, relational approach. With the need for timely intervention and early evidence showing that young people who self-harm respond well to CAT (Sheard et al., 2000; Ougrin et al., 2013), CATCH-Y could have both therapeutic and service level benefits.

According to the Medical Research Council (MRC) Complex Intervention Development Framework (2019), the first step in progressing with CATCH-Y is assessing the feasibility of the intervention by exploring whether it is safe and acceptable through a case-series. This will determine the plausibility of larger trials, through evaluation of the attendance, recruitment and retention of participants. If outcomes indicate plausibility, a randomised control trail (RCT) will determine the clinical benefits of implementing the CATCH-Y intervention. Such studies may improve the treatment options and increase the accessible service provision available for young people who self-injure.

8) DATA COLLECTION, SOURCE DATA AND CONFIDENTIALITY

Participant's phone numbers will be used in this study to contact for arranging appointments, recruitment and screening purposes. Their email addresses will also be used to send out weekly online assessments. This information will be stored on an electronic file on a secure University of Manchester shared drive, only accessible by members of the research team. Participants will be allocated a unique ID number and this will be used for all data management and linking purposes. A separate document containing participant's name and their associated ID numbers will be created and kept only on a secure shared drive at the University of Manchester. Data relating to age, gender, nature of difficulties and other demographic information will also be collected. These details will be stored on a secure, University of Manchester shared drive, with non-identifiable unique ID numbers.
During the study, participants will be asked to complete weekly online assessments, which will be done through the online survey platform select survey. Participants will not be asked to input any identifiable information and instead, they will each be sent an email containing a link to a standardised survey which is specific to them. The online assessments will be hosted on a University of Manchester approved, secure platform (e.g. select survey).
Therapy sessions one to four will be audio recorded using an encrypted recording device, or password-protected computer. Audio recordings will immediately be transferred to a University of Manchester secure drive upon completion of the session. No audio recordings will be left stored on the computer or recording device. Upon completion of data collection, a subset of 10% of recorded sessions will be selected at random to be rated using the CCAT tool by a qualified member of the research team. Upon completion of the ratings, all audio recordings will be destroyed.
During the study, any hard copies of data (e.g. questionnaires, repertory grids) will be stored in a secure site file, which will be kept locked in secure filing cabinets at the University of Manchester. Paper consent forms (if the procedure followed is face to face) will also be kept a secure storage facility, separate to that of questionnaires or any other participant identifiable data. At the end of the study, data will be archived and stored in secure filing cabinets in a locked office with a senior member of the research team (Dr Peter Taylor) at The University of Manchester. If the procedure followed is remote, then any remote confidential consent information will be stored on an electronic file on a secure University of Manchester shared drive, only accessible by members of the research team. Upon completion of the 'phone screen script,' it would be immediately transferred to the secure UoM shared drive and no copies would be saved elsewhere. Data will be stored in compliance with The University of Manchester's Standard Operating Procedure 'Information Security Classification, Ownership and Secure Information Handling'.
Details regarding clients' presentation will be included in the write-up of the study. This may also include the publication of direct quotes. However, all information will be appropriately anonymised to ensure that no specific individuals can be identified from this material. No identifiable data will be written up for the doctoral thesis or for publication.
To comply with the University of Manchester's research storage policy, consent forms will be retained as essential documents for a period of 5 years after the end of the study. However, information such as participant contact details will be deleted as soon as they are no longer needed. Data will be anonymised at the earliest opportunity and anonymous data will be stored for at least 5 years after the date of any publication, which is based upon it. This is to comply with the University of Manchester policy on research data storage. After

this period, all paper documents will be shredded and electronic files will be deleted from the server.

Breaking confidentiality

The participant information sheet will clearly state that the information collected in the study will be confidential unless participants indicate any possible risk to themselves or others. The researcher will reiterate this at the beginning of the study. If a possible risk or safeguarding issue is raised during the study, the researcher will restate the boundaries of confidentiality and the possible consequences of making a disclosure. If risk/safeguarding issues or indicators of other unknown mental health difficulties arise during the study, the participant's case clinician will be notified and will follow these up appropriately. Immediate risk will be handled in accordance with local service policy. Throughout, a previously developed risk management protocol will be followed.

9) STATISTICAL CONSIDERATIONS

9.1 Statistical Analysis

Primary Outcomes

Descriptive statistics will be used to summarise feasibility aspects of the study (recruitment, retention and data completeness). The statistical programming package R will be used to carry out the analysis. Frequency statistics and percentages will be calculated to determine whether the hypotheses related at recruitment, missing data and attendance rates, have been met.

To explore the acceptability of the study, mean scores and standards deviations will be calculated for the appropriate items on the adapted client satisfaction questionnaire. All data will be presented in graphs and explored to better the understanding of the acceptability of the intervention.

Secondary Outcomes

Whilst the study is not expected to produce statistically significant changes over the short study period, meaningful data will be explored and trends over time will examine for all measures. Means and standard deviations will be collected, with 95% confidence intervals where appropriate, for the outcome measures. All measures will be analysed to determine the pre-post treatment effect sizes as well as changes over time and whether the effect is maintained at follow-up.

Trends will be examined and mean changes over time will also be calculated for the ABUSI and PHQ-9A which are administered weekly throughout the study period. This data will be plotted on graphs to identify any trends toward significance. Individual graphs will also be produced to examine individual change and to consider inflexion points. Clinically significant change will also be calculated using the Reliability Change Index (Jacobson & Truax, 1991) for all of the secondary outcomes. The Standardized Individual Difference (SID) will also be used as an alternative to the RCI that is more conservative but better protects against false positives (Ferrer & Pardo, 2014).

Repertory Grid Analysis: Individual participant repertory grid data will be analysed using IDIOGRID version 2.4 (Grice, 2002).

Stage one: Analysing relationships within a single grid

Principle component analysis will be conducted on individual grids to generate a two-dimensional visual plot of how that person construe's themselves and others. The loading of elements and constructs on the principal components will be used to plot a 'map' of the

subjects construct system. The 'maps' will indicate graphically how the elements and constructs are semantically clustered in a two-dimensional space (Euclidean distance). The analysis will also highlight the degree of interrelatedness of the individual's constructs, suggesting the extent to which their construing is tight or rigid (Winters, 1992).

Stage two: Analysing multiple grids

The second stage will involve analysis to explore change in individual personal constructs across pre and post repertory grid. The same elements and constructs will be used at post-assessment, enabling the difference or change in repertory grid metric to be calculated. Distances between elements of interests (Euclidean distance) will be obtained. The individual difference in element distances will be reported, sample mean change, standard deviations, and effect size, this will highlight whether there are any group trends. The reliability of the individual's grid change will be determined using the Standardized Individual Difference (SID) (Ferrer & Pardo, 2014). This will allow random variation to be distinguished from reliable change.

Stage three: Content analysis

Content analysis is a way of grouping the information present in a large set of repertory grids, by collecting and categorising the different forms of construal present in the set. The main points of information from each grid will be compared systematically, comparing and contrasting, and drawing inferences from sample. Qualitatively we will look for evidence for any broader structural changes in the grids.

Stage four: Feedback questionnaires

Feedback questionnaires will be analysed using descriptive level information regarding how they found completing the repertory grids and CATCH-Y (e.g. were they easy to complete and an understandable tool). Open-ended questions will be analysed to explore themes and which components of the repertory grids were well received and which were less well received or understood.

9.2 Sample Size:

The target sample size is n=9 who will all receive the CATCH-Y intervention. A feasibility study on the CATCH intervention found 1/7 participants did not complete the study (Peel-Wainwright et al., in prep) and therefore it is expected that we will recruit nine participants and complete the intervention with eight. If a participant no longer wants to continue at the baseline stage, another eligible participant will be recruited. If a participant drops-out during the intervention stage another participant will not replace them. As the aims of the study were not statistical inference but acceptability and feasibility in the form of recruitment, retention and missing data outcomes, the sample size was similar to other case series in the field (Taylor et al., 2019; Searson, Mansell, Lowens, & Tai, 2012) and no power calculation is required. Other research has administrated repertory grids to small-scale case design for as low as 2 participants (McNair, Woodrow, & Hare, 2016). The sample is reflective of the time and resource limited nature of the project, with the goal of gaining preliminary evidence to support the progression and development of a larger scale RCT.

10) DATA MONITORING AND QUALITY ASSURANCE

The study will be subject to the audit and monitoring regime of the University of Manchester.

11) SAFETY CONSIDERATIONS AND ADVERSE EVENTS

NHS Research Ethics Committee approval will be obtained before commencing research. The study will be conducted in full conformance with principles of the "Declaration of Helsinki", Good Clinical Practice (GCP) and within the laws and regulations of the country in which the research is conducted.

It is unlikely that there will be any adverse events/risks associated with participation in this study, as these have not been evident in the previous adult trials of CATCH. Adverse and Serious Adverse Events will be monitored during the course of the study. If an adverse event is deemed to be directly related to the participation of the study (i.e. an adverse reaction) project activities for that participant would be paused and the research team would review whether the participant should be withdrawn from the study, and whether the project as a whole should continue or be halted.

There is a possibility that safeguarding or other risk issues will arise during the participation of the study. To combat these issues, study information including the potential risks will be explained in a clear and age appropriate way at the start of the study. We will work alongside clinicians and clinical services, liaise regularly and keep them informed as needed where risk becomes apparent. We know from past research that research participation is largely experienced as positive, even where the focus is self-injure, and distress is rare (Biddle, 2013). Our current risk management protocol (developed collaboratively with those with lived experience of self-harm and clinical psychologists) will be reviewed to reflect CAMHS procedures/population e.g. how/when to involve caregiver.

12) PEER REVIEW

This project has been independently peer reviewed by the The University of Manchester research sub-committee for the DClinPsy Programme.

13) ETHICAL and REGULATORY CONSIDERATIONS

13.1 Approvals

NHS Research Ethics Committee approval and HRA approval will be obtained before commencing research. The study will be conducted in full conformance with all relevant legal requirements and the principles of the Declaration of Helsinki, Good Clinical Practice (GCP) and the UK Policy Framework for Health and Social Care Research 2017.

13.2 Risks

Concerns from service-users about the implications of participating in the research and talking openly about their behaviours (such as fear of hospital admission or judgement from researchers) could be apparent. To mitigate this, we aim to familiarise service-users with the research team, with photographs of the researchers in correspondence. We will also ensure that all study information is clear and accessible to young people, and have utilised PPI consultations to incorporate the best ways of doing this.

Whilst conducting the therapy, it may become apparent that there are safeguarding risks to the young people or those around them. It would be the duty of the researchers to report

these risks to the CAMHS workers who would deal with this appropriately, or to safeguarding teams. If the risk was immediate, researchers would assess and manage the risk appropriately and in line with local policies and the risk management protocol. A risk management protocol (developed with clinical psychologists and experts by experience) has been adapted from past research for use in this study. To ensure that there is an open line of communication with regards to risk, all-young people participating in the study will require a key worker at a CAMHS service. Furthermore, all young people will be informed of the bounds of confidentiality around contacting their parent/carer if the researchers feel that it is necessary. This will be made explicit from the start.

14) STATEMENT OF INDEMNITY

The University has insurance available in respect of research involving human subjects that provides cover for legal liabilities arising from its actions or those of its staff or supervised students. The University also has insurance available that provides compensation for non-negligent harm to research subjects occasioned in circumstances that are under the control of the University.

15) FUNDING and RESOURCES

Completion of this project is in partial fulfilment of the Doctorate in Clinical Psychology Qualification. As such, the researcher will receive a £400 research budget from The University of Manchester to be used towards the completion of this research (e.g. for purchasing of measures).

16) PUBLICATION POLICY

The results of the study will be written up in two forms, for the doctoral theses of Rebecca Haw and Molly Marsden. The results will also be prepared for publication in an academic journal. Contact details for the trainee are provided on the participant information sheet, explaining that participants can get in touch if they would like to receive a written summary of the results and/or relevant publications upon request.

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Appendix J – CATCH-Y Guidance Manual

COGNITIVE ANALYTIC THERAPY APPROACH TO CONTAINING SELF-HARM IN YOUNG PEOPLE (CATCH-Y)

MANUAL

Peter Taylor

Clive Turpin

Samantha Hartley

The initial CATCH intervention was largely based upon: Sheard, T. , Evans, J. , Cash, D. , Hicks, J. , King, A. , Morgan, N. , Nereli, B. , Porter, I. , Rees, H. , Sandford, J. , Slinn, R. , Sunder, K. and Ryle, A. (2000), A CAT-derived one to three session intervention for repeated deliberate self-harm: A description of the model and initial experience of trainee psychiatrists in using it. British Journal of Medical Psychology, 73: 179-196. doi:10.1348/000711200160417
The approach was adapted initially to 1) shift the focus from overdoses to self-harm more broadly, 2) move away from a hospital based context for the intervention, 3) reduce the number of sessions to two.

In revising the intervention for young people (CATCH-Y), we sought the views of young people who have utilised Child and Adolescent Mental Health Services (for difficulties including self-harm) in both the community and inpatient settings. We also consulted clinicians who work in this area. The main changes were: 1) Increase of session number to 5, with the 5th session incorporating a handover to coordinating clinician and/ or family member; 2) Reduction in standard session length to 60 minutes and flexibility in this; 3) To include explicit provision of psychoeducation where appropriate; 4) Flexibility in the location of sessions; 4) Emphasis on systematic factors/ opportunities as part of the reformulation and potential exits (e.g. family-based treatment/ social care involvement).
The terms ‘young person’ and ‘client’ are used interchangeably throughout this document.

OVERVIEW

This manual gives a brief overview of a five-session (four plus one) Cognitive Analytic Therapy (CAT) intervention aimed at young people (aged 13-17) with experiences of self-harm. This manual assumes an existing knowledge of CAT and does not provide a detailed

definition of CAT concepts and ideas. CAT is a personalised and idiosyncratic therapy that is guided by the reformulation and therapeutic relationship created between therapist and client. Therefore, the manual offers guidance to core elements of consideration, rather than a 'how-to' or 'step-by-step guide'. Practitioners using this approach should already have a good grounding in CAT, experience of working with young people in a clinical capacity and appropriate clinical supervision structures in place to support the dynamic and formulation-driven adaptation and implementation of the guidance.
The intervention is based around five face-to-face sessions, preferably spaced a week apart. The intervention centres on developing a shared, collaborative, relational understanding of a client's selfharming behaviour, drawing upon the Cognitive Analytic Therapy (CAT) framework for making sense of these experiences. Broadly the goals of the intervention are to:

- Develop a shared relational understanding of the client's experience of self-harm, capturing the antecedents, consequences and patterns related to this behaviour.

- Using CAT constructs of 'Reciprocal Roles' and 'Procedures' (see below) to help develop clients' awareness, and understanding of these experiences. These concepts do not necessarily need to be named in the therapy but should be used where appropriate by the therapist to help explore, develop and elaborate on the client's understanding of their experiences.

- Provide an initial exploration of how a client might start to use their developed awareness to prevent a repeating pattern escalating or pause to create a space to reflect. This may include developing basic 'Exits' with the client and/or the system supporting them, based on the formulation that is developed.

- Roles, procedures and exits should include explicit consideration of systemic influences and opportunities, such as relationships with systems in the young person's life (e.g. school) and potential options for service-level exits (e.g. liaison with social care), alongside the individual young person's active role.

- Share this understanding with the young person's coordinating clinician and/ or family members to handover this understanding in the hope it will engender greater relational understanding of their self-harm, inform care planning and highlight and/or avoid any potential blocks to effective care.

Introducing the Intervention

As this is a short intervention it is necessary to be mindful of clients' expectations about the intervention and transparent about the aims and potential benefits. It is important to be clear about the length of the sessions and the intervention from the start, and may be helpful to remind clients of this as work progresses and use the brevity to aid focus.

Clients will be made aware at the baseline assessment that the intervention is part of a research trial. If directly asked about the impact/helpfulness of the intervention, it can be stated that you are hoping to find out whether this sort of brief intervention can be helpful for people who self-harm, and that you know anecdotally that many people appear to value and benefit from this sort of intervention, although cannot give assurance.
When introducing the therapy it could be suggested that the goal of the intervention is to develop a way of understanding why the person self-harms, that looks at the patterns that people can get stuck in, rather than necessarily coming up with solutions or new ways to cope. The emphasis is on understanding why a young person self-harms – how it is useful or important to them in relation to their other difficulties and not to provide a 'quick-fix' solution to stopping it; if the young person doesn't yet want to stop self-harming, that's ok. The intervention could be introduced as an opportunity to think about these experiences and highlight how developing an understanding of them could support future change.
The content of therapy should be briefly discussed; i.e. it will involve discussing experiences and ideas, and drawing out patterns of how the self-harm happens. Emphasis should be placed on doing what works for that young person and figuring that out together during therapy- i.e. in the relative balance of mapping and talking, questions and hypotheses. At this point the therapist might explore previous experiences or discussions related to self-harm and what has felt helpful/ unhelpful.

Therapist Style

In line with a standard CAT approach the therapist should aspire to adopt the following therapeutic manner:

- Working collaboratively, getting alongside the client to try and understand their world and their experiences.
- Being aware of the inherent power imbalance between therapist and client but also between adult and child, and working with an awareness and mitigation of its impact.
- Being curious and open minded.
- Showing appropriate empathy and concern (avoiding alarmist or judging comments).
- Within CAT therapists can be proactive, making suggestions or suggesting hypotheses, sharing their thoughts. However, this should be carefully paced in light of the client can take in, to avoid running ahead of them or leaving them feeling overwhelmed or pressured to respond in a certain way. Particular care should be taken to work within a young person's Zone of Proximal Development (ZPD) in terms of their emotional and relational literacy.

Session structure

Most therapeutic approaches, including CAT, place value on the 'therapeutic frame'. Alongside this, young people value flexibility and adaptability in terms of session location and length. It is therefore important that the therapist balances these competing demands and takes time to explore with the young person; a) where therapy would be best located (default is at a clinic location but options might include school, home or GP surgery) and b) how long therapy lasts (maximum is 60 minutes per session but a minimum of 30 minutes is acceptable). Exploration and contracting around these elements should occur prior to session one and be finalised there. Within the following sessions the agreement about location of the

sessions should be adhered to, but the length of the session might be increased (e.g. from 30 to 60 minutes) if re-contracted in the previous session.

Session one and an overview of key therapeutic processes

The initial session should last around 60 minutes, and include:

- Provide a brief introduction to what the therapy involves (see above), including the number and duration and focus of the conversation, checking how this sounds to the client and fits with their expectations. (5 minutes)
- Reiterate requirements around risk and confidentiality (this will have been covered in their previous meeting with the researcher) including briefly referring back to the plan discussed in their first meeting about what might be done if there is a concern about risk of harm to themselves or others. (2 minutes)
- Exploration of sharing information with parents in line with the young person's age and competence. Where competent, the young person can decide for no information from therapy to be shared with parents (aside from that pertaining to risk, which would be done by the care coordinator).

Self-Harm Self-Help file

Participants can be sent the Self-Harm Self-Help file (see Appendix I) by post or email following randomization, to complete before the first therapy session. If clients have not completed this it can be done at the start of the session. If completed in the session this can be done in an interactive manner, asking the client the questions verbally, with the file visible to both therapist and client. It is not essential to complete the File. It may be that in starting a session there is already important content to pick up on and that going through the File would only disrupt this process. However, if the File has been offered (whether completed or not) then it should always be discussed (otherwise the client may feel they are being asked to do something which is not important).

If the File is completed then the client's responses on the File should be discussed. The goal of this activity is not to collect data or get to a "correct" answer, but to open a discussion about the client's experiences of self-harm. It should be explained that the file is not an exhaustive list and won't fit for everyone.

The therapist should explore with the client if any of the feelings or patterns covered in the File seem particularly relevant to their self-harm. Where this is the case, it can provide a potential starting point in mapping out the client's experiences of self-harm. For example the therapist can start this process by writing out the states/feelings on a separate sheet of paper. Where feelings or patterns listed in the File have some relevance, but do not seem to capture the client's experience fully, this is an opportunity to try to further elaborate on the client's own experience (e.g., "So the feeling is not quite like X, how would you say it is different? Is it more like …"). This would be another starting point for formulation.

If clients struggle to engage with the File or identify any feelings or patterns that fit for them, it is important to reflect that this is fine, the ideas in the File will not fit for many people. This is then a starting point to suggest working together to try and better understand the client's own experiences around self-harm.

Mapping

The remainder of the session should then focus on the process of formulating or 'mapping' the client's experiences around self-harm. This should involve an active, collaborative discussion between the therapist and client, with the therapist drawing out a visual representation of the client's experiences as the discussion develops, taking care to use the client's own words (e.g. Figure 1).

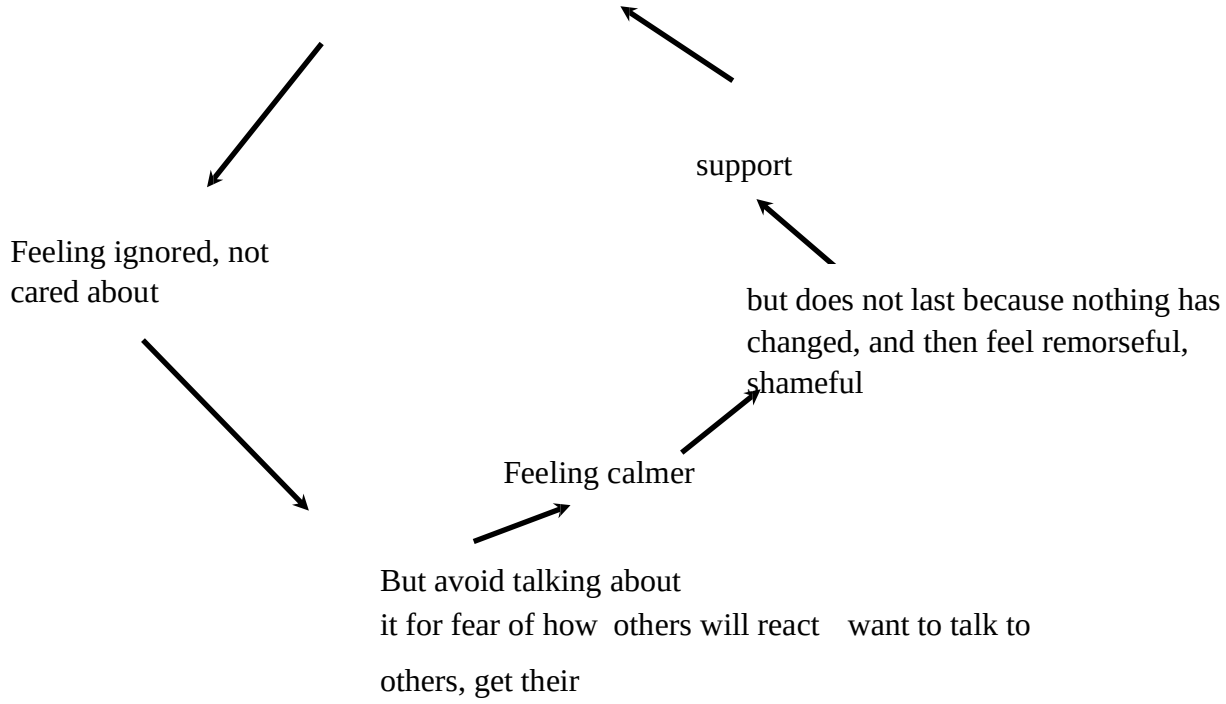


Figure 1: A simple map outlining hypothetical pattern of events around self-harm. See other examples in Sheard et al (2000).

A typical starting point would be to begin with self-harm itself on the diagram, and then to either track backwards or forwards in time, asking about the events that precede or follow self-harm. Clients can be given the choice about the direction they would like to focus on. An exception might be where a client already strongly identifies with an item in the Self-Help File and this may become the natural starting point for mapping. When tracking it is

preferable to start with a single (but typical) recent experience, rather than to talk in generalities (the latter may lead to overly vague and less personally meaningful content).
In tracking a client's experiences it is likely that gaps will occur (e.g. going straight from an event or feeling into self-harm). The therapist should work with the client to identify and try and fill these gaps. Symbols such as question marks can be used on the diagram to indicate areas or places where the client is not sure what goes there. Where clients describe a sudden shift in feeling, leading up to self-harm, it may help to draw out this shift (see Figure 2) as a means of exploring intervening states. A client might be asked at which point along this arrow would they be likely to self-harm, and what the feelings might be called that precede or follow this point.

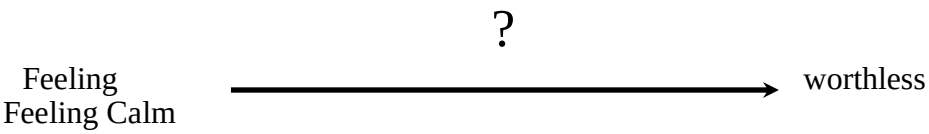


Figure 2: Mapping sudden shifts in state

Alexithymia is commonly associated with self-harm, and as such it is possible that clients may struggle with the labelling and naming of emotional states or feelings. Young people might especially be limited in their emotional literacy or delineation. Suggestions can be provided by the therapist in a curious and open manner ("I wonder if the feeling is a bit like … or more like …"). Where possible it is good to use the client's own language and wording in drawing out the visual map. Where a feeling is not easily labelled, it might help instead to ask about where it is felt in the body, or even see if the client is able to draw a representation of the feeling (could draw it onto an outline of a person).
Where clients do not explicitly refer to others or systems (e.g. school) in their lives it might be helpful to explicitly inquire about what others are doing or not doing at a particular point. Where clients struggle to identify states preceding or following their self-harm, another approach may be to ask about what the place or state or feeling they are trying to get away from when the self-harm occurs, and likewise, what the state they are trying to get to is like.
The process of mapping should focus on typical experiences relating to self-harm. It will usually be helpful to begin by focussing on a specific incident of self-harm, but where this is done the therapist would then check whether this is pattern that typically occurs for other instances of self-harm. It is possible that for some clients there is no single pattern that fits every case and the focus may be on mapping out one or two commonly occurring patterns.
Young people can especially struggle with questioning. Where this is either observed or explicitly stated, the therapist can offer guesses or hypotheses and request feedback/ elaboration/ clarification from the young person. This process – of offering guesses rather than questioning but needing the young person's input to ensure accuracy - should be made explicit.
Appendix II provides a series of example diagrams that capture particular, general patterns (adapted from Sheard et al., 2000). These are intended as a guide for therapists and should typically not be used in therapy in the first instance, but may be helpful in some situations. For example, these diagrams can be considered where a client describes experiences that appear to match one of these diagrams. This may be helpful where a client is struggling to elaborate on their experiences. However, caution should be taken to try to avoid the situation where a client agrees a diagram fits their experience out of acquiescence. This might be avoided by being clear it is unlikely the standard diagram will fully match the client's

experiences, and using it as an opportunity to then explore what might be different for the client.

The pacing of the mapping process should be largely led by the client. Based on CAT theory, different clients will have different Zones of Proximal Development (ZPD; the area between what they might achieve alone, and what they are able to do, accommodate or tolerate with the therapist's help). As such some clients will be less able to develop and elaborate an understanding of their experiences than others. The goal of the therapist is to work within their ZPD, rather than to bring all clients to the same point (e.g. a fully completed and worked out map). It is also important to remain mindful of the client's window of emotional tolerance in order to maintain reflective capacity. It might be useful to have a discussion at the start of therapy as to how client and therapist will be aware of when the tolerance threshold is being reached and how they can check-in on that during the course of therapy and manage it. An example might be checking-in on a 0-10 scale as to how overwhelmed the client feels and where this increases above 6, the therapist and client will dial-down the emotional focus of the conversation. The therapist should maintain an awareness of how information related to this process might inform the reformulation or understanding of enactments, while also considering the ZPD and working to engage the young person within their current ZPD. Some different ways clients might respond to the intervention are outlined below:

- Clients wishes to move too fast, sharing their experiences and insights but with little elaboration or connection with these experiences. For these individuals the job of the therapist is to slow the pace of the work and focus on deepening the shared understanding of the feelings and experiences linked to their self-harm. The above stance may also apply to clients who appear very avoidant of emotional content.

- Client is demanding rescue and expresses overwhelming, difficult feelings that flood the session. Therapist would try to adopt a more cognitive stance, identifying and labelling relevant emotions/feelings without exploring these and focus on how this link together within the map/diagram.

- Client wants to push on to solutions to their problems before an understanding of their selfharm has been developed. Therapist may respond by slowing the pace, re-iterating the focus on understanding their self-harm, and the value of this. In some cases a client's need for quick solutions may even form part of the map (e.g. look for quick solutions but ultimately feel disappointed when these do not emerge or do not help) but this would need to be done carefully to avoid client feeling judged.

Identification of Reciprocal Role Procedures

During the process of mapping the therapist can begin to work with the client to identify particular Reciprocal Roles (RRs) that are linked to a client's experiences of self-harm. RRs are discussed in detail elsewhere (e.g. Rykle & Kerr, 2002). Briefly, they represent internalised patterns of relating, that have emerged as a result of earlier experiences, and guide the way the individuals relate to themselves and others. RRs are bipolar (e.g. see Figure 3) and tend to capture three forms of relating: self-to-self; self-to-other; other-to-self. Thus an individual may feel rejected or shamed in response to a rejecting other (other-self), but they

may also become rejecting and shaming to themselves, for example as part of negative inner dialogue (self-self).

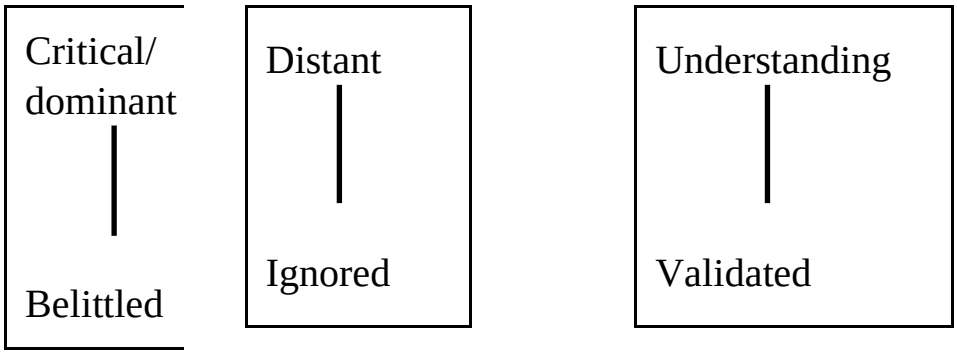


Figure 3: Example Reciprocal Roles

One method to help identify RRs is to focus on the following questions:

- How did you feel towards yourself at this time?
- How did you feel towards others at this time?
- How did you feel others were relating to you at this time?
- How did you feel you were being treated by that system (e.g. school) at that time

It may also help to begin by identifying how the client felt in a given situation, before moving on to ask about what the other person was doing or not doing (or what they were doing to themselves) that led to feeling this way. By doing this the two poles of the RRs can be elucidated. When identifying RRs it is important that the pole labels are meaningful to clients and ideally deepen their awareness of the feelings present during that time. It is tempting for therapists to assume what the opposite pole will be (rejecting to rejected, abusing to abused) but these poles do not necessarily cooccur and client's experiences may differ (rejecting to ignored/uninterested or crushed). Hence RRs should match client's experiences as closely as possible. Therapists should provide some brief, accessible psychoeducation around RRs when they arise in the formulation, e.g. we learn how people relate to us and vice versa when we are young and then we tend to relate to ourselves and others in similar ways, often creating difficult feelings that we try and cope with but we can end up getting stuck.

Problem Procedures

Within CAT a number of commonly occurring, problematic procedures have been noted. Whilst these procedures do not describe every pattern a client might struggle with, they apply to some clients. Where present it may be helpful for the therapist to comment on these emerging patterns. ● **Traps**: Where negative expectations lead to behaviour which ends up confirming these expectations (I know she won't care so I avoid her and end up feeling like she does not care)

- **Snags**: Where a particular aim is abandoned because of expected negative consequences (I do not ask for help because I know they will react negatively)
- **Dilemmas**: Where a client's feelings are caught between two alternatives (either I am a push-over and do what others tell me, or I kick back and get angry), black or white.

It is important to identify these patterns not by their conceptual labels, but in terms of the client's own experiences, incorporating psychoeducation relating to that individual cycle (e.g. 'have you noticed that the way you tend to cope with feeling anxious actually leads to more anxiety?').

Identifying Patterns in the Room

Whilst CAT often focuses on identifying problematic patterns and RRs within the therapy relationship, this may not be possible within the short duration of this intervention, and is not expected. Nonetheless, there may be times where it is helpful to make links between the client's experiences and their relationship with yourself.

- Where patterns are apparent that seem likely to affect a client's likelihood of attending the next session (e.g. a pattern of feelings other cannot help and cutting off contact from them). ● Where client's way of relating is creating a barrier to progressing with the intervention (e.g. unwilling to engage in the intervention for fear that it might not help) it may help to reflect on how this process seems very difficult for them and ask about whether this feels like a barrier in other contexts.
- Where clients reflects positively on the experience of the intervention it may helpful to explore how their interaction with yourself differs to others they have captured in the mapping.
- Where an example from the therapy room might be more within the client's ZPD than one outside (e.g. 'sometimes I guess you might think I don't really get what you're saying- like I'm not listening properly, like it feels with school', rather than 'do you sometimes feel like your mum doesn't listen either'- which the client might not be ready to explore)

Ending Session One

Endings are an important focus in CAT. Whilst this intervention is brief, it may be helpful to reiterate towards the end of the initial session that three more (plus one extra with their clinician/ family member) remain and reflect on feelings relating to this. It might be helpful to discuss what the client would like to get from the following sessions, or how they would like to approach them, based on session 1 and their hopes/ expectations. The brevity of this intervention may be challenging or difficult, which can be acknowledged (see below "Negative reactions to short intervention"). For some clients, where endings or related experiences (e.g. perceived rejection) have emerged as relevant feelings, it may be useful to link the ending of the session to this observation. In these instances it may help to explore how the client typically responds to endings and also how this (the next intervention session) could be an opportunity to do something differently. This may include thinking aloud about why it might be difficult to attend the next session.

Following sessions one, two and three, a relevant between-session activity should be set for the young person to do in the week before the next session. The activity should link to the content of that particular session, but they would tend to involve either a) reflecting on mapping and reformulation; b) focus on monitoring for patterns or difficulties in everyday life; c) practicing or trying out potential exits or ways of doing something differently.

Planned activities should be discussed and agreed collaboratively within the session, and space should always be allowed to review how this went at the subsequent session. As with all other aspects of the intervention, the between-session activity should work within and stretch slightly the client's ZPD; i.e. if the young person is able to reflect on patterns then an activity could be to spot and note them in action, whereas if a young person finds this too much then noting instances of self-harm might be less taxing while still facilitating more focused discussion in the subsequent session.

Clients should be encouraged to reflect on the initial session and try to keep formulations or relational patterns in mind to support the work in the following session, for instance, what are the things that you'd like to take away from our conversation. For clients where a map has started to be developed they could be asked to reflect upon it and make notes on recognition and/or add to it. If the map has been developed further it can be used more actively to recognise relational pulls, patterns and new ideas of strategies that have occurred between the sessions. The client should take a copy of the map or encouraged to use their phone (if present) to take a photo to improve the availability of it.

The final 10 minutes should be kept aside to reflect on the conversation and content and help ease the transition from the session back to everyday life. This is particularly important for clients who experience distress during the session, allowing space for these clients to return to a less distressed state before the session is closed. This might be achieved through validation and normalisation that this psychological work can be difficult, and non-problem talk on non-arousing subjects or an activity (e.g. a brief card game).

Session Twos-Four

Sessions two-four should be 60 minutes long or shorter where this has been contracted. Once again the last 10 minutes can be set aside as time to wind-down and help the transition from the intervention to everyday life.

Session two should begin with a review and recap of the ground covered in session one, using the diagram(s) or map(s) developed in the first session as a prompt. Also of any homework tasks set in the last session are reviewed. Where homework is not undertaken the reasons why, including whether this work was difficult or challenging, should be discussed. The diagram or map may help facilitate and exploration of the reasons behind not completing tasks. Using the map in this way may help these discussions feel non-judgemental or less emotionally charged.

The focus of the second session and beyond will then depend on the progress made in and between sessions, and may involve further development of the mapping process or a move to focus on exits (see below).

Exits

Once a map has been collaboratively developed the next task is to consider how the client might use a developed relational awareness to pause and reflect on the identified pattern and explore what alternatives might exist, avoiding any explicit push towards change where this is not yet welcomed. For example this could involve stepping out of a situation, sharing their thoughts or feelings, asserting themselves, or if change is restricted/limited/minimal how acknowledging this might be helpful.

It is important not to move on to exits too soon, before a shared and valid understanding of a client's self-harm has been developed (though there may be an implicit or explicit pressure from some clients to do this) and before motivation to change self-harm is enhanced (if this was limited to start with).

Given the short duration of this intervention, identified exits are likely to be limited in their complexity. Within the context of this intervention exits can also be presented as a starting point for longer-term change, for example, engaging with further psychotherapy as a means of changing the way they respond in a particular situation or providing them with additional coping resources. Helping develop a client's motivation and hope in relation to further therapy is a valid outcome to the intervention. Using the formulation map to guide the coordination of care (i.e. is individual therapy the right thing yet/ do other services need to be involved/ is family-based treatment required) might also be possible. It is desirable to find a middle ground between the onus of change being on the client and the system, exploring and offering exits that sit with both the young person and the people around them (e.g. family members, clinicians, teachers). Exits might include enhancing understanding by sharing the reformulation, thus reducing RRs such as blaming/assuming-misunderstood and blamed.
In developing exits a starting point would be to go through the map and ascertain where the client feels they are most likely to be able to notice what is going on, and stop, or pause, the pattern. This includes recognising there will be places where difficult states or feelings are too strong for the client to step out of the pattern, but there may be points where this is more possible. Symbols such as a pause sign can be added to the diagram to help indicate these points in the cycle. The therapist can then explore with the client what they might be able to do differently at this point and how others can help with this. Potential ideas for exits are listed below:

- Options for experimenting with different ways of seeking help or support that might break old patterns (e.g. patterns of avoidance).
- Client works on better identifying and reflecting on the pattern they are caught in, possibly cycling forward to where they know they are likely to end up, and using this knowledge as motivation for trying to halt the process.
- Use of flash cards or other visual aids or reminders to help halt or pause the process.
- Exits drawing on existing support network and coping skills.

Exits can be added visually to the diagram. The map should be framed as a tool the client can take home after the therapy to help them in the future. Identification and discussion of potential exits might also provide information that leads to the elaboration of reciprocal roles and procedures, such as when blocks to solutions are encountered.

Ending & Goodbye Summarising

Time should be given to discussing the ending of the intervention, including any positive or negative feelings this generates. For clients with high or idealised expectations of change disappointment is likely, and time should be given to explore these feelings. Where appropriate links might be made back to the map that has been developed (e.g., "I wonder if you're feeling a little let down even? If we look at the map I notice there has been a common pattern of feeling this way"). Clients could be encouraged to think about what they usually do with these feelings and what they could possibly do differently. Reflecting on the sessions as a whole helps to consolidate understanding and awareness and thinking about how this might continue, such as returning to the map and holding some of the conversations in mind, using writing might also help promote ongoing reflection.
In Session four, it will be helpful to allow space for the therapist to summarise and share their understanding of the young person's difficulties, drawing together the work that has been done across the four sessions. This summary can take the form of a written 'Goodbye letter', as in traditional CAT, but it might also be a verbal summary. A formal goodbye letter is not

required for CATCH-Y, but some form of 'goodbye summary' is. The goodbye summary should encompass a) key patterns or procedures linked to self-harm, b) key reciprocal roles or relational patterns, c) any potential exits that have been discussed or practiced, d) wider reflections (as appropriate and bearing in mind the client's ZPD) on any challenges within the therapy, including, for example, difficult enactments of roles, with a particular focus on important steps or gains the young person has made (e.g. "I know that opening up and talking about these experiences has been incredibly hard for you; I think it says a lot about your inner strength that you have been able to overcome these barriers and start to share these experiences with me"). The summary should be offered tentatively, allowing for adjustment or correction by the young person. Following this summary, it is important to allow time for the young person to comment on what has been said and offer their own reflections.

Negative Reactions to Short Intervention

From qualitative research we have seen that some individuals view their difficulties as very entrenched and can be sceptical of the idea that a short intervention will be of any use. If such concerns arise it can be noted to emphasise that such concerns are understandable, and whilst this five session intervention may not be enough to resolve or work through all of the difficult experiences they might have faced, it may nonetheless be a useful stepping stone, perhaps starting some helpful processes or changes in how they think about their experiences that could lead to bigger changes in the future. It might be worth highlighting that things have been tried before, possibly over longer time periods, and not yet been effective, and therefore the current intervention is to try and ensure any future care is worth the young person's time and effort.

For some clients the brevity of the therapy may activate or bring to the surface negative feelings about treatment (e.g. that this intervention can't help or that nothing will help) or the possibility of change more generally (e.g. that nothing will help). Where such feelings are apparent it may be possible to comment on these and being them into the therapy room. Such feelings may be a useful indicator in thinking about patterns with others that are linked to their self-harm (e.g. they feel let down by others who cannot help and this feeling leads into self-harm). In these cases links could be made between the feeling in the therapy room and these wider patterns. However, care should be taken that this does not feel blaming or judging, and is done in a curious and open-minded way.

Negative feelings may also be apparent towards the end of a session, and it may be helpful to explore where these typically lead and how this situation could be different (e.g. feeling it won't help so maybe they will miss the next session altogether, but what might it be like if they attend the next session despite this feeling).

The fifth session

The nature and purpose of session five should have been alluded to from the start of therapy and highlighted again and planned for during session three. The therapist and the young person will discuss the importance of handing over their joint understanding to the coordinating clinician and a family member (the latter where the young person consents) with the aim of sharing understanding and thus facilitating more effective care. The therapist will invite those appropriate and discuss with the young person in advance how this session will be managed(e.g. who will speak about which aspects, what aspects of the map will be emphasised, will questions be fielded and by whom). There should be an emphasis on empowering the young person to share their own map, coupled with an awareness of their

ZPD and the inherent challenges of power imbalances in this process. It may help to focus this discussion on the plan for session five around what feels most helpful to the young person and to think together, using the map as a guide, around what might be useful. It will also be important to avoid generating unrealistic expectations about what might be achieved in this fifth session, whilst still keeping an optimistic focus on what change might be possible (e.g. it is unlikely that a parent's whole approach to parenting could be altered).

Session five should be around 60 minutes in length. Where possible it may be helpful to begin the session with the young person, to briefly recap on what will be discussed and how, and to check how they feel about the session. By involving them in this way at the start, it may be possible to help them feel like they have a role in guiding and directing the conversation based on their own needs, rather than just being a subject to be discussed by adults (a feeling they may have experienced before). Depending on the client it may also be helpful to agree on a plan around what to do if they become overly distressed or need to take time out form the session (how this might be communicated and acted on). The other attendees, who may include (but not limited to) parents, clinicians, social workers, and teachers can then be invited in, and the session proper started.

The therapist should take the role of facilitating the discussion. The session should begin by discussing the purpose of the session (which will focus primarily on how the young person is best supported and helped) and also key ground rules or boundaries for the session, especially around confidentiality. The first part of the session proper can then be spent summarising the reformulation or map that has been developed with the young person. It should be explained that the map essentially captures the feelings and relational experiences form the young person's perspective. In this sense the discussion should not be about whether the map is right or wrong, the map captures the young person's experience, and this is valid, even if it differs to how others experience the same situations.

The therapist should check in regularly with the other attendees to ensure they understand and to clarify any uncertainties. Depending on the stage the young person is at, it may be beneficial to allow them space to introduce and explain some aspects of the map. The discussion is focused on summarising the work and looking ahead, but done to also include wider systems and to think more specifically about their role in helping the young person. The second part of the session should focus on a review of planned exits or recommendations for future support, and a discussion of these within the group.

It is possible that the content of the map may directly relate to individuals invited to the fifth session. This issue needs to be managed with care due to the potential for some individuals to feel blamed or judged (e.g. parents who feature heavily in the map as rejecting or unsupportive). There may be times where due to the nature of a person's impact on the client it would not be appropriate to have them present at the meeting. In other situations, making it clear the map reflects the young person's personal experience within a range of relationships, reflecting that this may at times be difficult to hear, and keeping the focus on the young person and how they're to be best supported, may help.

A good conclusion to the fifth session may be to produce, in addition to the existing maps, a list of recommendations, exits, or plans, for helping the young person in the future, with actions identified for the young person as well as others they interact with. This list or plan could be typed and shared, with a copy kept in the young person's notes along with the map.

Appendix I

Self-Harm Self-Help File

The Self harm self help file

This booklet is yours to complete prior to the first session with the therapist. It can help to share how things are for you and start the conversation without too many questions. It is meant as a first step towards understanding the patterns of thinking, feeling and behaviour that lead to you harming yourself.

We try to sort out our problems in our life and in our relationships but sometimes the ways we cope leave us even more stressed or things keep going wrong. Most of our ways of coping are habits that have developed over a long time. Sometimes they start off as useful but now lead to stress and suffering. Sometimes the habits are so familiar it is difficult to put them into words. This file is designed to help recognise some of the habits and patterns that you notice in your life.

Through completing the booklet and conversations with your therapist, we hope it will give you a chance to take a step back and see

- If your ways of coping are not working well or are adding to your stress
- If so, how you might begin to change with the support of those around you

Part One: Confusion caused by changes in how we feel towards ourselves and other people

Some of us change a lot in the way we feel towards ourselves and other people from day to day, or moment to moment. When in these different states of mind we may have very strong feelings or feel completely unemotional.

Here are some examples of different states of mind which can happen sometimes or often in our lives, can you mark in the boxes which of these you experience and how strongly?

++ means you feel it definitely and strongly applies to you
+ means it applies to you but not strongly
0 means it does not apply to you

1.	Feeling or expecting to be let down, rejected, hurt	++	+	0
2.	Feeling or hoping to feel very safe, cared for, and perfectly close	++	+	0
3.	Feeling angry with myself and wanting to harm myself	++	+	0
4.	Feeling emotionally very calm or cut off and wanting to harm myself	++	+	0
5.	Feeling or expecting to feel punished	++	+	0
6.	Feeling guilty, bad, unworthy of love and care	++	+	0
7.	Feeling I've always got to do things for others, that it's too much, tired out	++	+	0
8.	Feeling very angry with others, and maybe wanting them to suffer	++	+	0
9.	Feeling no one cares, feeling rejected, abandoned, very alone	++	+	0
10	Wanting to give perfect love and care to another person	++	+	0
11	Being very busy, full of energy, cut off from emotions	++	+	0

12	Feeling let down, cheated, and that other people owe me something	++	+	0
13	Feeling numb, emotionally blanked off or cut off from myself and others	++	+	0

These changes in how we feel towards ourselves and other people can be very confusing. Which of the following descriptions below best suits how you feel about yourself?

1.	The way I feel about myself and others is usually always the same	++	+	0
	The way I feel about others is constantly changing, but this does not affect how I feel about myself	++	+	0
2.	The way I feel about myself and others is constantly changing	++	+	0

Part Two: Vicious circles

Sometimes we seem to go round in circles. We try and help ourselves but end up in just the same position or in an even worse one. It is as if we are trapped in a vicious circle. We can call this pattern a **trap**; here are some examples.
Can you mark in the boxes which, if any apply to you **in your daily life**?

Avoidance trap

I feel unable to cope with certain situations, feelings or people. I try to avoid these things, for example, by pretending they are not happening or distracting myself. Avoiding them makes me feel better for a little while, but the problem or feelings are still there and get even worse.

Do you do this?
Often □
Sometimes □
Never □

I must please others trap

I want to be liked by others, so I try to be nice and avoid upsetting anyone. But I end up becoming a bit of a *pushover*, someone who gets bossed around or taken advantage of by others. Because of this I become angry with other people or I try to avoid or run away or avoid these people. Other people then become cross or upset with me.

Do you do this? Often
□
Sometimes □
Never □

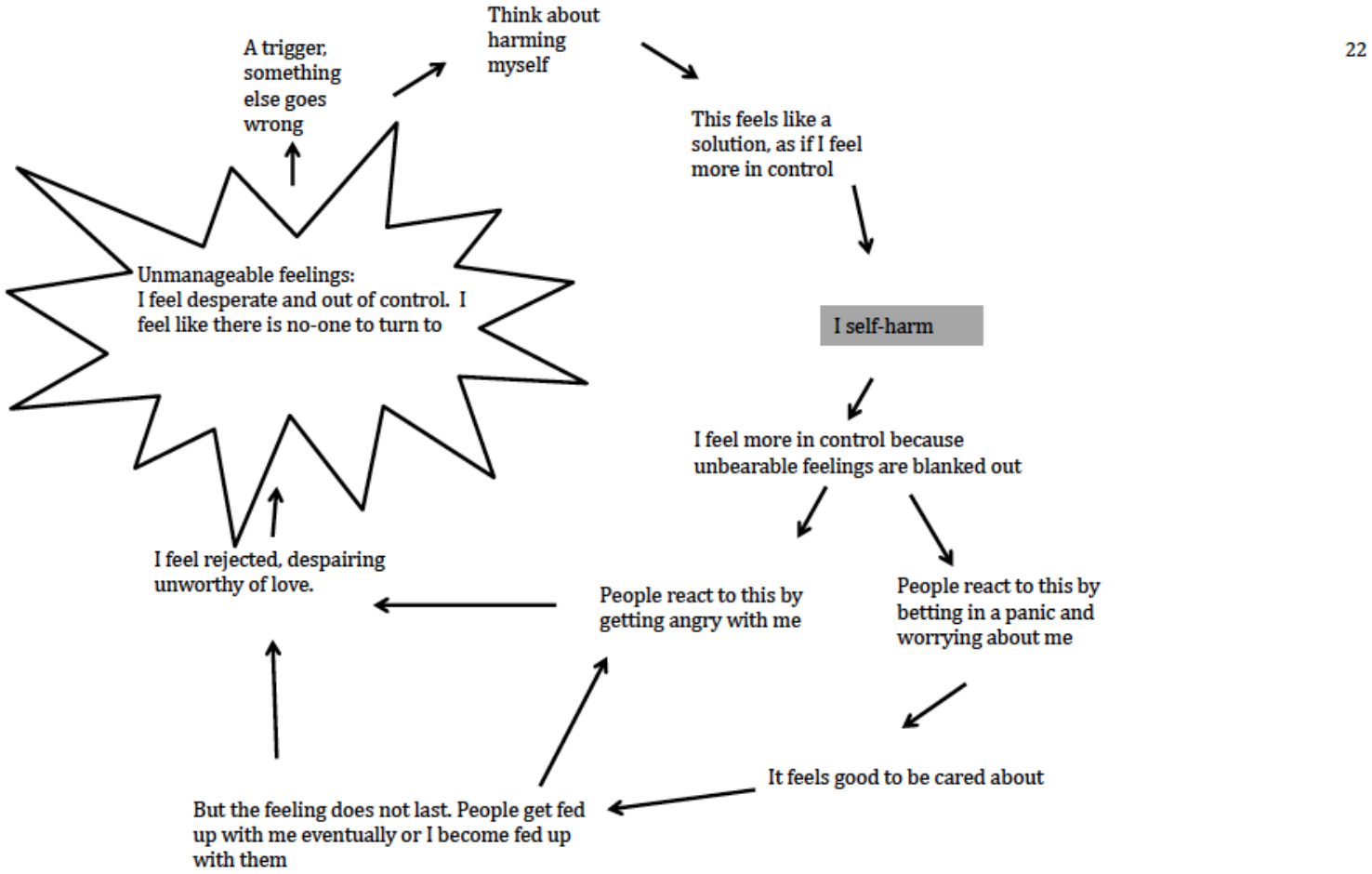
‘I’ll only do it badly’ trap

I expect that I will do things wrong or handle things badly. This could be in relationships, at school or at home. Because of this I give up easily, or I think a lot about how what I have done could be better. This leaves me feeling like a failure or unhappy.

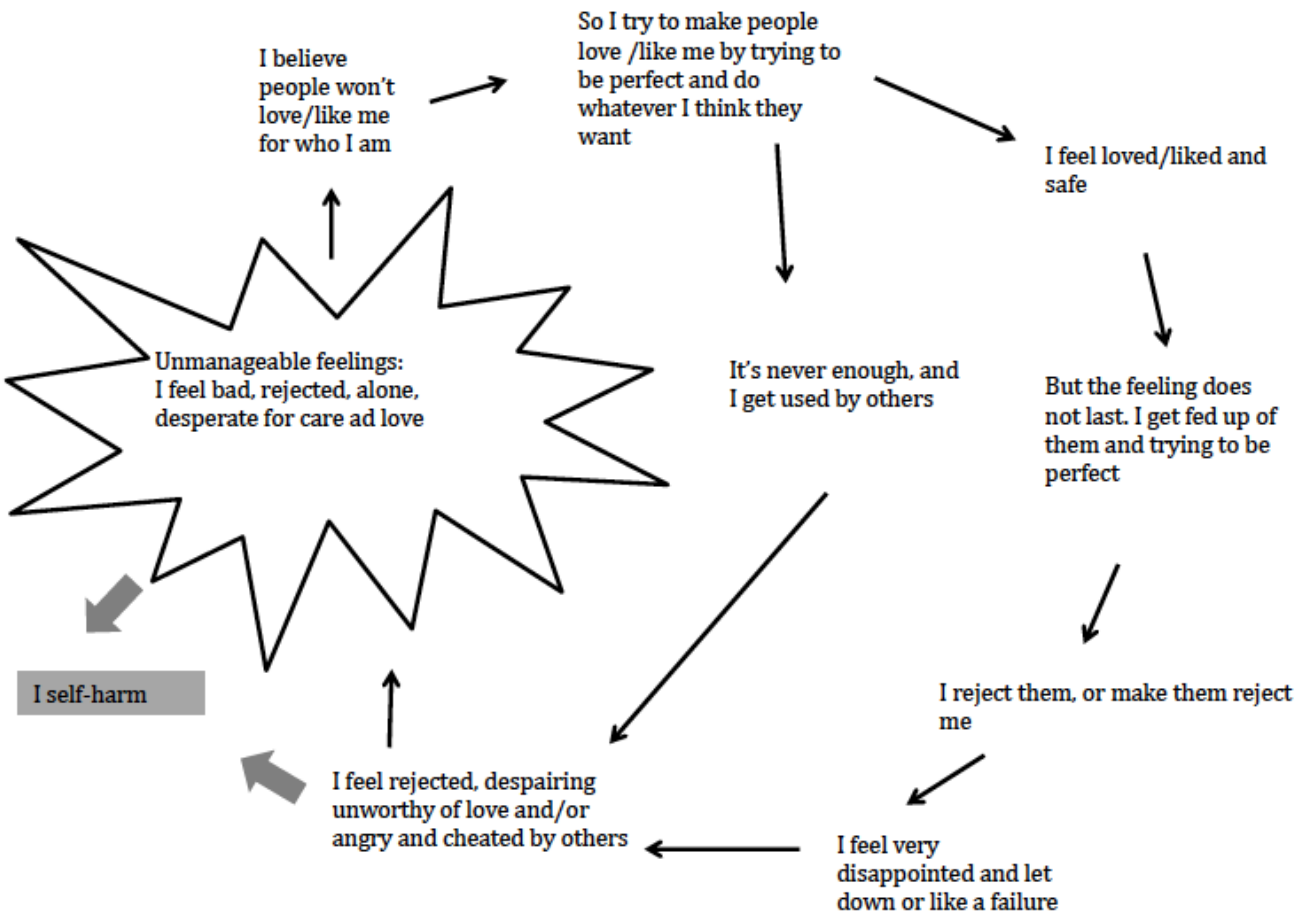
Do you do this?

Often □
Sometimes □
Never □

Template Diagrams

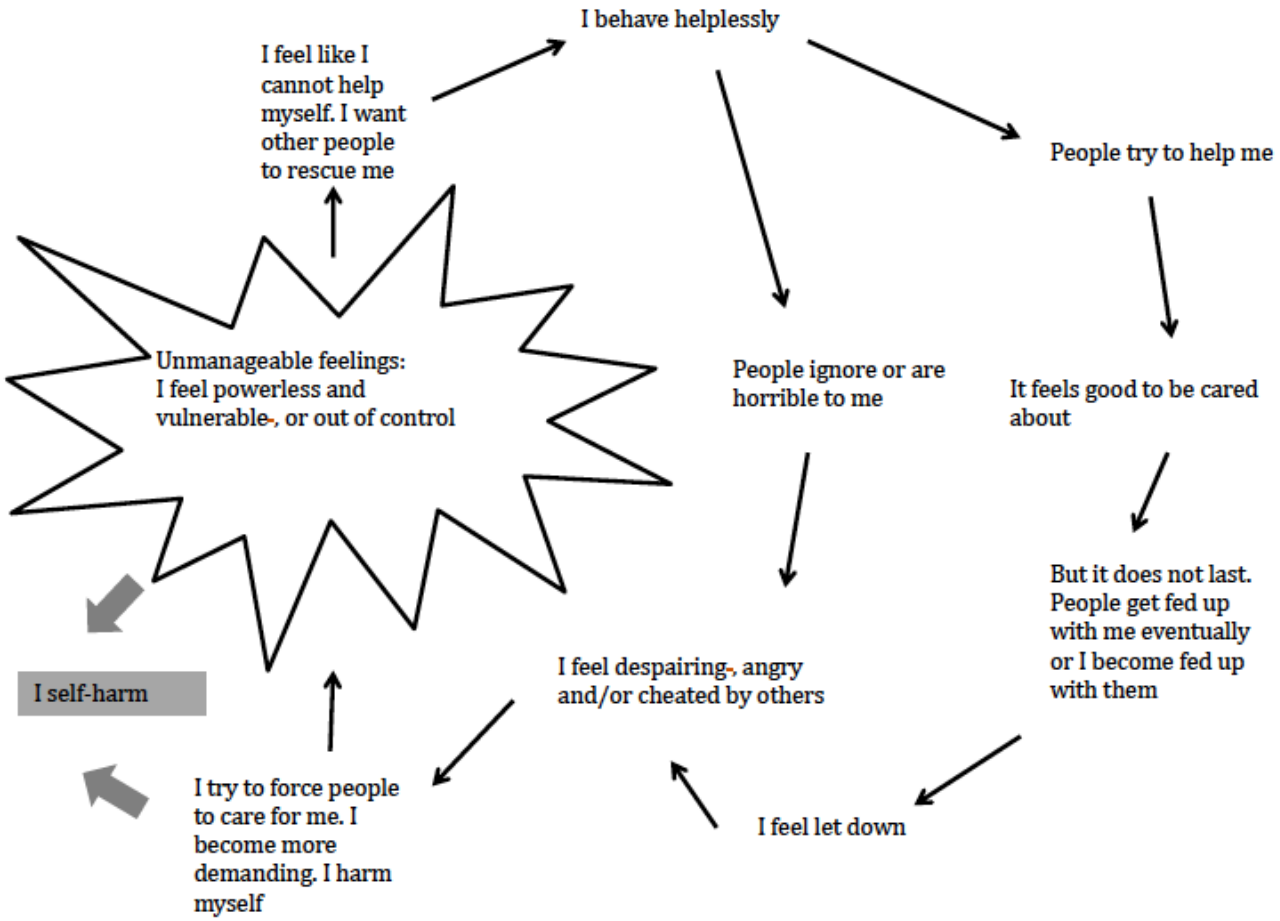


'Feeling out of control' Map



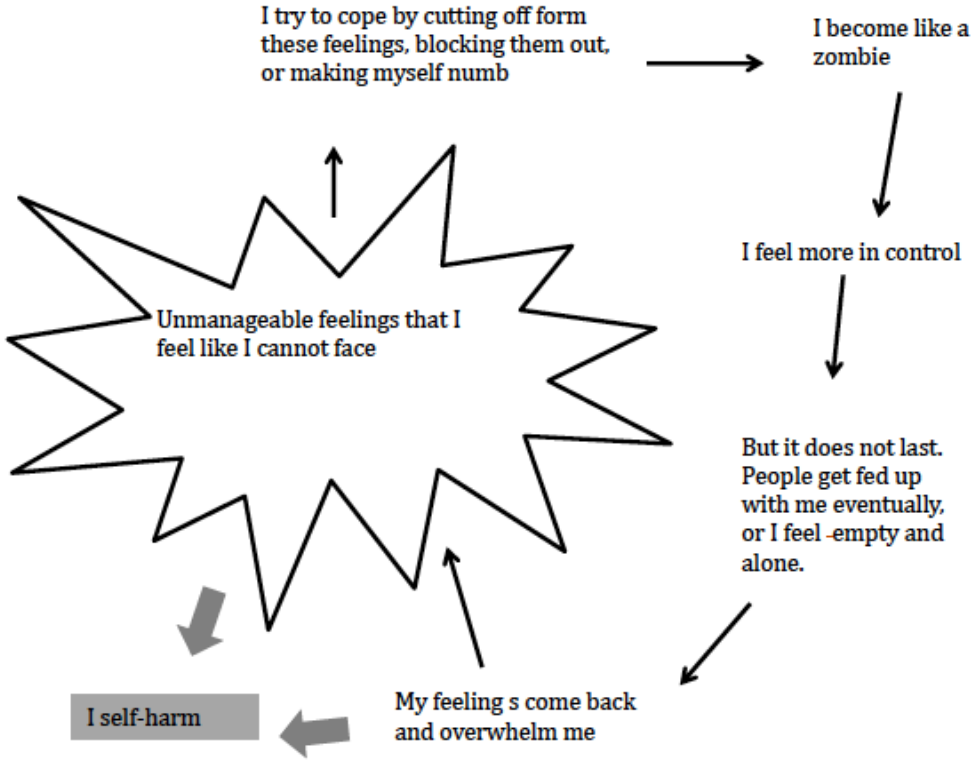
'Wanting others to like or love me'

Map



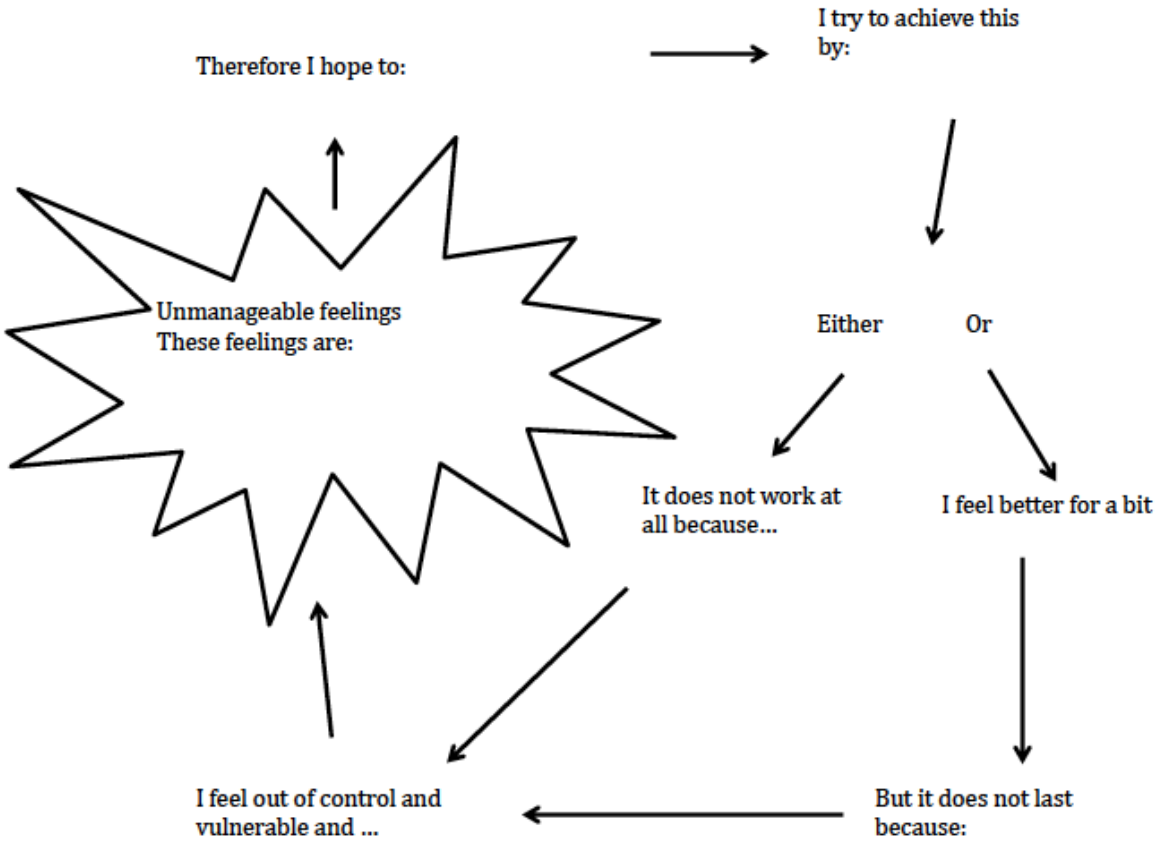
'Feeling helpless' Map

25



'Cutting off from feelings' Map

26


I try to achieve this by:
Therefore I hope to:
Unmanageable feelings
These feelings are:
Either
Or
It does not work at all because...
I feel better for a bit
I feel out of control and vulnerable and ...
But it does not last because:

Blank Map

Appendix K – NSSI Subscale of the SITBI

Characteristics	n (%)
Age first engaged in NSSI	
15	2 (15%)
14	2 (15%)
13	6 (46%)
12	1 (8%)
11	2 (15%)
Form of NSSI	
Cut or carved skin	13 (100%)
Hit self on purpose	9 (69%)
Picked areas of the body to the point of drawing blood	6 (46%)
Scraped Skin	6 (46%)
Burned skin	3 (23%)
Gave self a tattoo	3 (23%)
Inserted sharp objects into skin or nails	2 (15%)
Lifetime Prevelance of NSSI	
51+ times	3 (23%)
31 - 50 times	6 (46%)
11 - 30 times	4 (31%)
Number of times in past year	
51+ times	1 (8%)
31 - 50 times	5 (38%)
11 - 30 times	7 (54%)
Number of times in past month	
6 - 10 times	3 (23%)
1 - 5 times	10 (78%
Number of times in past week	
1 - 5 times	7 (54%)
0 times	6 (46%)
Average amount of time thought about NSSI before engaging in it	
1 - 60 seconds	2 (15%)
16 - 60 minutes	2 (15%)
Less than 1 day	2 (15%)
1 - 2 days	1 (8%)
Wide range (spans >2 responses)	6 (46%)
Have you ever received medical treatment for harm caused by NSSI?	
No	13 (100%)
What is the likelihood that you will engage in NSSI in the future (0-4)?	
4	7 (54%)
3	5 (38%)
2	1 (8%)

Appendix L – Full results of the CSQ-8

		I found attending the sessions a positive experience	I found the therapy sessions helpful	I felt I could speak about my difficulties safely within the sessions	My views and worries were taken seriously by the therapist	I felt the therapist knew how to help me	I feel more hopeful about the future	If a friend needed this sort of help, I would suggest to them to come here
Number of participants	Certainly true	6	6	6	7	7	2	5
	Partly true	3	2	2	1	1	4	3
	Not true	1	1	1	0	1	2	0
	Don't know	0	1	1	2	1	2	2

What did you like about the therapy?	What did you dislike about the therapy?	Any additional comments? Please leave any additional feedback on your experience.
It was short. Change of pace. Nice having my thoughts taken seriously.	Not really.	The measures have been a bit much - too many.
I liked how it visualised a map of emotions which made it easier to understand.	n/a	n/a
setting everything out in a map format allowed me to understand my problem more		
Writing it down	I felt it was sort of repetitive, especially to the counselling I have	Nothing
the way they help	missing some lessons i like	
nothing but i liked missing school	everything	no additional comments
I Liked the therapist a lot who really understood my problems and treated me like an actual person. she helped me better understand my problems and helped me understand why i felt terrible all the time, ive seen my life improve since seeing her and i really dont know if i would have felt this comfortable if it was anyone else.	The surveys and other questions such as the rep grid were quite complicated to fully grasp properly and although helpful i feel like they could be improved.	Thank you for giving me the chance to improve.

I felt like i could open up about anything and i wasn't scared to talk about my problems.	Nothing.	No.
the map of the roles i switch between.	it felt a little repetitive.	no
i like how the therapy is very interactive and you get to see how you were when first starting compared to how you are when finishing i also liked the group session in the way it helped talk about my problems and with my family	im not sure	

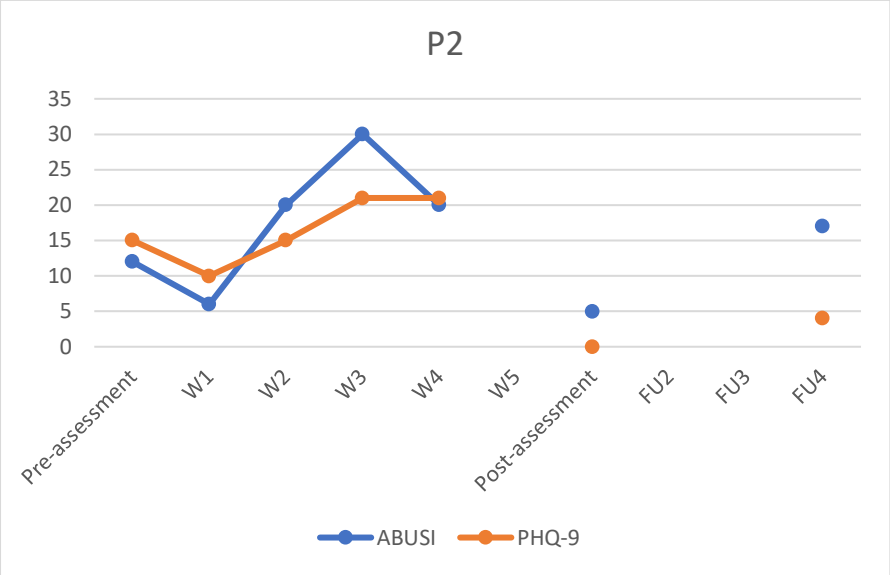
Appendix M – NSSI Scores

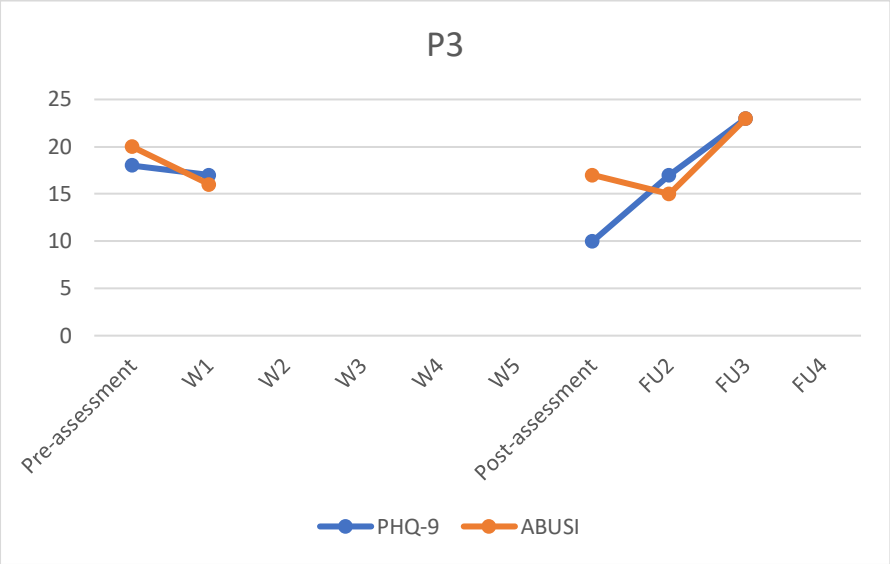
Table 1

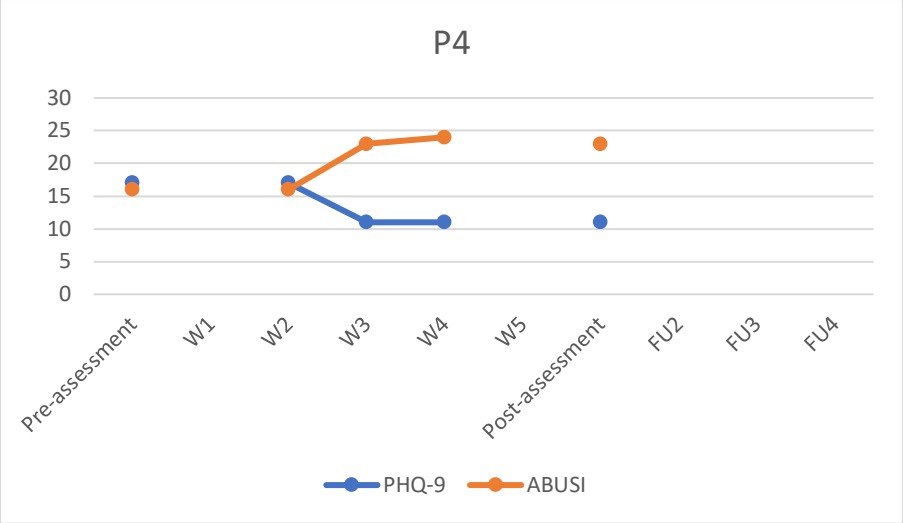
Number of times during the past week that participants engaged in NSSI, pre-therapy assessment and post-therapy assessment.

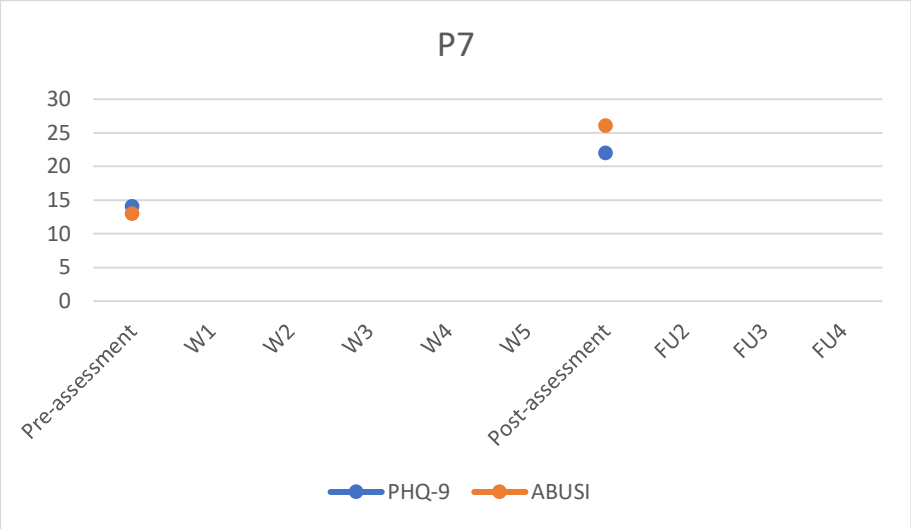
Participant number	Pre-therapy assessment score	Post-therapy assessment	Mean difference
P2	1	0	-1
P3	4	1	-3
P4	2	2	0
P7	1	0	-1
P8	0	0	0
P9	0	2	2
P10	0	0	0
P11	0	0	0
P12	2	4	2
P13	1	0	-1
Total	**11**	**9**	**-2**
Mean	**1.1**	**0.9**	**-0.2**
Standard deviation	**1.29**	**1.37**	**1.48**

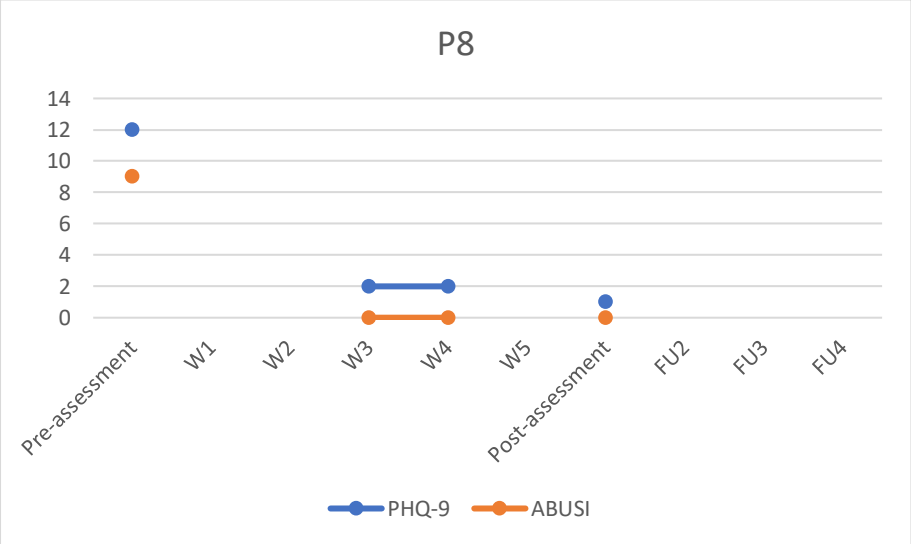
Appendix N – Individual Change Graphs

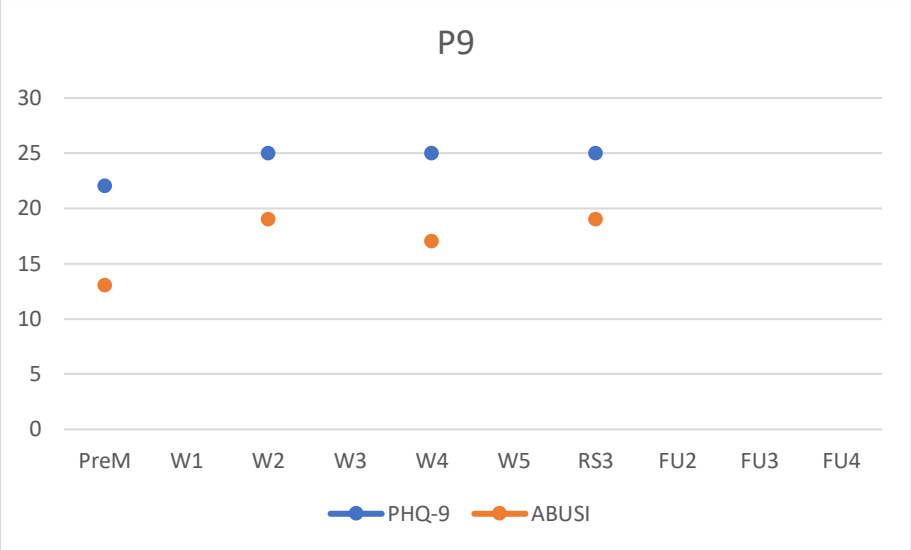


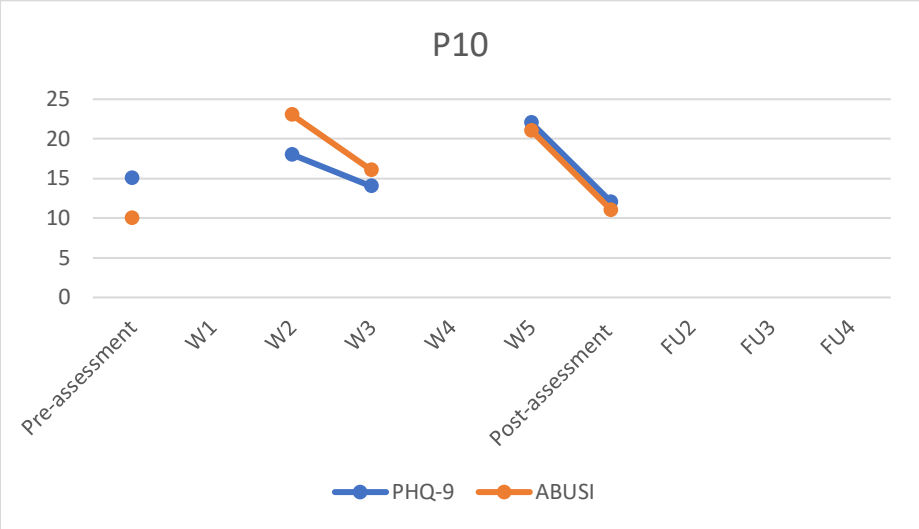


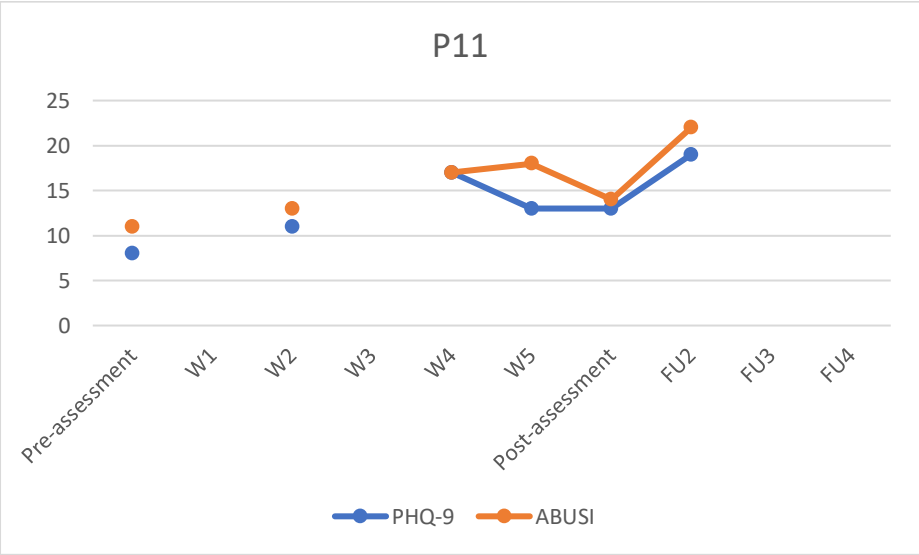

P4
30
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI

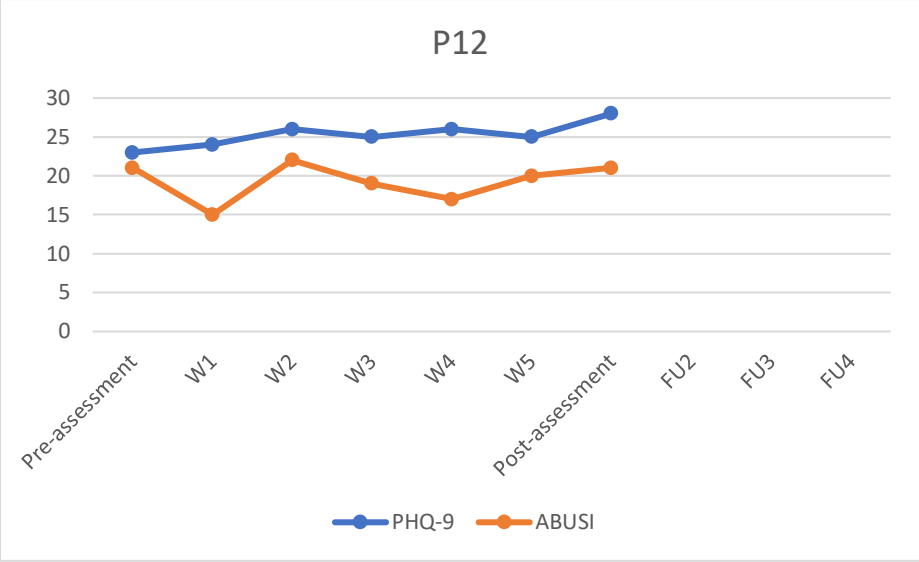

P7
30
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI

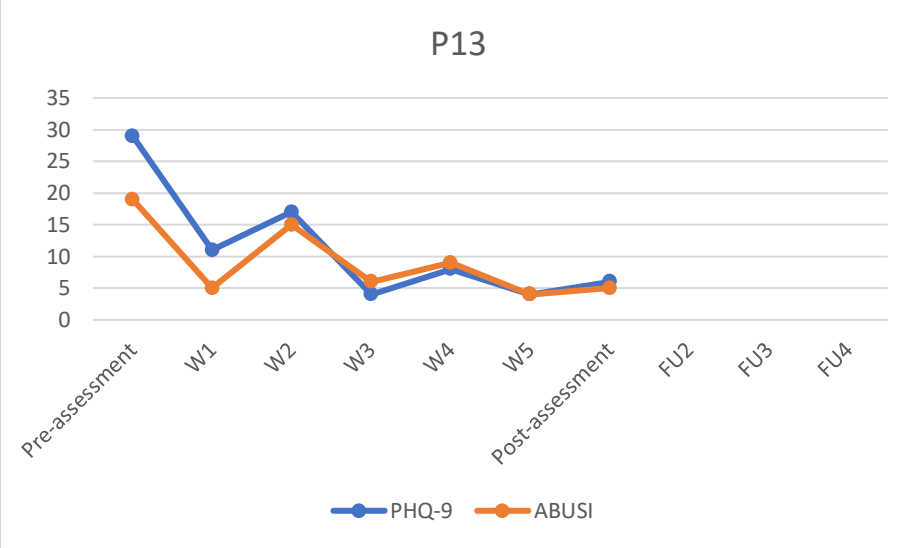

P8
14
12
10
8
6
4
2
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI


P9
30
25
20
15
10
5
0
PreM
W1
W2
W3
W4
W5
RS3
FU2
FU3
FU4
PHQ-9
ABUSI


P10
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI


P11
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI


P12
30
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI


P13
35
30
25
20
15
10
5
0
Pre-assessment
W1
W2
W3
W4
W5
Post-assessment
FU2
FU3
FU4
PHQ-9
ABUSI