Author's response to reviews

Title: Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users views

Authors:

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Author's response to reviews: see over
Dear Sir/Madam

We were pleased to receive the very constructive peer review feedback on our article ‘Appropriate interventions for the prevention and management of self-harm: a qualitative exploration of service-users’. Please accept the following amendments to our paper, which address the reviewers’ comments.

Reviewer 1: Judith Green

Minor Essential Revision:

1. “The process [open coding] described seems to be a fairly standard thematic analysis rather than a real attempt at open coding, and it may be sensible to reword. Ditto on axial coding”.

Page 6, paragraph 1 of Data Analysis. We recognise this is misleading and have emphasised that we drew broadly on the techniques of grounded theory, rather than applying them rigidly.

Discretionary Revisions:

1. “Abstract … could be more specific on findings. One key finding was that many patients wanted to learn to manage their self-harm rather than stop”.

Abstract, page 2, Results: We agree with this revision, and have added this important finding to the results section of the abstract.

2. “The data here seems rather under-analysed in terms of constant comparison, and it may be worth toning down, for instance the claims in the discussion for aims of theoretical and conceptual generalisation”.

Page 6, paragraph 1 of Data Analysis: We have removed the reference to constant comparison as a methodology, instead referring to “repeated comparison of emerging ideas within the expanding dataset”. This may have been overstated. The second part of the revision is addressed in response to Allan House’s revisions.

3. “One example (of over-interpretation in the contextual accounts) where alcohol dependent interviewees are described as dissatisfied with encounters because of their drunken behaviour”

Page 19, paragraph 2 of Main Findings: We have clarified the fact that the role of “drunken behaviour” was stated by the interviewee as straining the situation with staff, fuelling their dissatisfaction, rather than an interpretation by the interviewer.

4. “These are patients whose accounts are characterised by referrals to psychiatric illness, rather than necessarily whose personal circumstances are characterised by this experience? … Presumably ALL of your sample may have had some experience of psychiatric illness – all we (as reader) or you as researcher have access to is how many utilised this within the interview”.

According to information provided by study patients, only a minority had been given a formal diagnosis of psychiatric illness or received treatment from specialist psychiatric services.

5. “It is claimed that there is an ‘overall preference for community interventions’ yet 7 (?50%) are described as wanting admissions. This is unclear.”

Page 15, paragraph 3: This is clarified in the amended paper. The desire to be admitted, displayed by 7 patients, is emphasised as ‘on occasion’, and then reference to ‘most notably seen amongst the patients characterised by psychiatric illness’ is removed here to avoid confusion. On page 20, paragraph 1, this is developed: “some patients whose personal circumstances were characterised by the experience of psychiatric illness expressed a desire, on occasion, to be admitted to hospital”. It is made clear that these patients shared the overall preference for community based intervention, but sometimes wanted to be admitted to the hospital.

6. “How did the interviewer introduce herself?”
   “Where in the hospital was the interview done, and when?”.

Page 6, paragraph 2: These points are addressed and the possible implications of these issues are discussed in the on page 21.

Reviewer 2: Allan House.

Major Compulsory Revisions:

1. “The research question is not highly specified and the analysis is described as being based on grounded theory. However the results don’t introduce a new conceptual categorisation and rather suggest that a sort of framework analysis was used. The authors should indicate the topics used in the original interview and how subsequent analysis (especially axial coding) changed their approach”.

As stated above (minor revision 1, Judith Green), we have emphasised that the approach and analysis was not intended to be a rigid adherence to grounded theory, instead drawing on some of its principles and practices. In our amended paper we have introduced our use of ‘seed categories’ to inform the research questions, interview questions and early analysis. This clarifies how we identified the topics for interview, and how during analysis the seed categories became less important, and the subsequent interviews and analyses were informed by the emerging data. This use of seed categories is discussed on page 5 (Data Collection) and on page 6 (Data Analysis).

2. “The early results section describes characteristics of the sample … These aren’t new and the whole section doesn’t add either to our knowledge about self harm or to the framework within which the results are discussed. I’d drop it”.

We feel that this section is important. In a small scale study such as this, it is important to illustrate that out sample was not exceptional or unusual.

Page 8, paragraph 1: “The characteristics of the sample as a whole did not differ significantly from those of repetitive self-harmers reported in the literature”. We believe this is of significance, and the description of patient characteristics is of interest to the reader.
3. “The finding that the majority had a preference for community-based services seems to clash with your findings that 7/14 valued hospital care. It needs rewording for clarification”.

This point was addressed above (Discretionary revision 3, Judith Green). We have clarified that the desire to be admitted to hospital was sometimes felt by the patients, but on the whole they shared the feelings that community-based services were preferable. Hence it holds as the majority opinion.

4. “The discussion raises ... a false dichotomy between usual care and a proposed approach that takes account of the clinical heterogeneity”

It is true that the ‘usual’ approach to care for people who self-harm is characterised, at least in theory (as illustrated by guidelines) by an approach which acknowledges clinical heterogeneity. This required clarification in our paper.

Page 19, Discussion paragraph 1: We clarify that our findings serve to confirm the already existing view that services for self-harm are often tailored to the individual in this way (and cite the Barnes Unit, Oxford, as an example). This is also addressed in the last paragraph of the conclusion.

5. “There is no reference to the existing literature (much based on personal testimony and available via the internet) on service user perspectives on services”.

Page 3, last paragraph: We refer to the body of patient testimonies, using SIARI as an example, and indicate that this has not however contributed to the formal evidence base.

6. “The authors’ assertion that their “principal pursuit was for theoretical or conceptual generalisation” is at odds with the rest of reporting of the results which is theory-free and implicitly claims empirical generalisability. This contraction needs resolution by either 1] a statement of the theory/conceptualisation being proposed or b] sticking with empiricism and stating what’s new about the finding”.

We have removed this statement, and in the discussion of study limitations (page 21) we refer to the limits of our sample size in terms of generalising the findings, the need for further research to (dis)confirm our results, and consequently the significance of our hypotheses.

Reviewer 3: Linda L. Gask

Minor but essential revisions:

1. “I think there should be discussion of the impact of the service provision for self-harm in Edinburgh on this sample recruited. Were the subjects admitted to the same unit at the ERI as was the case in the past? This would have an impact on the experiences of services”

The precise implications of this comment are unclear, but we have addressed the point that all of the patients were admitted to the same unit in the same hospital (and this is only hospital service provider for self-harm in adults in Edinburgh City) on Page, 6 paragraph 2.

2. “I would like to see more discussion of the potential motives for the interviewees in telling their stories’ in this setting and whether these should be taken entirely at face value of examined for other potential meanings in the context of this study”.
For example, “a highly dramatised story. Was this explored further? Were interviewees pushed to say more about what services has been offered, whether they were able to take up such offers and if not, why not?”.

**Page 21, paragraph:** This point has been addressed on page 21.

Page 21: The latter point is acknowledged as a valuable area for future research; discussion of the limitations of single interviews.

3. “I would like to know if an opportunity has been taken to test out the validity of the conclusions- perhaps by a member check with interviewees or a service-user group”.

Page 21, paragraph 1: This is an important point. We have developed this and suggested it is an important aspect of any subsequent research.

**Discretionary Revisions:**

1. “Why was there a cut-off at age 50? Was this arbitrary?”

**Page 4:** This point is addressed in the text in ‘recruitment and sampling’ on page 4.

2. “I don’t like the phrase ‘three claimed they were depressed’ – is there a better way or wording this – it seems to be judgemental in tone”.

**Page 8, paragraph 1:** ‘Claimed’ has been substituted for ‘reported’, which we believe is less judgemental but still maintains it was the patient’s report, rather than an formal diagnosis confirmed by a professional.

3. “I am left wondering about the person who could not be assigned to one of three themes”.

**Page 8, paragraph 2:** The patient who could not be classified is now accounted for.

4. “The comment by M37 is intriguing – did the interviewee want the interviewer to be sacked? This is unclear!”

**Page 13:** This quotation has been clarified. The patient was referring to the staff rather than the interviewer!

We look forward to hearing your response.

Yours sincerely

Megan Hume     Stephen Platt