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New Strategies for Practice Based Evidence: A focus on self–harm

Sam Warner and Helen Spandler

Abstract

This paper suggests new ways of approaching clinical-based research in an era of evidence based practice. Using the example of self-harm, we identify three distinct problems with current dominant approaches to research in this area. These include insufficient clarity about target issues; an over-reliance on predetermined outcomes which prioritise *behavioural* measures (such as self-harm *cessation*); and an undue focus on treatment techniques. We argue that clinical research requires flexible, user-centred and practice-based methods, informed by a focus on principles instead of techniques. Therefore, we outline key practice based principles that we argue need to be embedded within clinical research strategies. We then demonstrate how traditional behavioural approaches to research can be enriched with more qualitative cognitive and emotionally-based data. We conclude that such strategies provide thickened, meaningful and context-specific research which is more relevant for service commissioners, clinicians and service users.

Key words (5-10 words): Clinical psychology; evaluation; self-harm; harm minimisation; outcomes; evidence based practice; practice-based evidence.

New principles for clinical research: A focus on self–harm

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Introduction

Although there is an established tradition for conducting research in clinical psychology, much of this research has been under-utilised by clinicians. It has been argued that, at least in part, this is because clinical research tends to favour large scale studies that identify general trends, but fail to inform day-to-day practice with individual clients. As such, it has also long been argued that smaller scale, qualitative studies may be better suited to meeting the everyday concerns of service providers and users (e.g. Harper and Warner, 1993). However, such research still carries less weight in the development of government policies and clinical guidelines. There are therefore, and unsurprisingly, significant tensions between policy makers, practitioners and service users in respect of the merits of different types of 'evidence'. In addition, irrespective of the type of research of evidence used, its applicability is always limited by the quality of the thinking that various stakeholders bring to bear on it (Tanner and Turney 2003). Notwithstanding these evident tensions, there is growing emphasis on evaluating the impact of services and clinical interventions, typified by the evidence based practice (EBP) agenda.

According to proponents of EBP, clinical practice should be validated and directed by reliable and robust, usually quantitative, research evidence. Clearly, an agenda that routinely favours large-scale quantitative studies poses a number of challenges for qualitative, user-centred and/or more 'critical' approaches to clinical research (Newnes 2001; Hollway 2001; Burton and Chapman 2004). Nevertheless, although we may want to challenge the form of research which tends to be prioritised in EBP, and we may prefer clinical practice to be exploratory and in-depth, we do accept the need for clinically relevant research to be robust, applicable, and credible. Whilst recognising that research, policy and clinical fashions are tightly intertwined, it is important to ensure that clinical practice has some basis in good research and 'evidence' rather than being imposed by clinical doctrine or subject to the whims of Government policy (Cooper 2003; Pope 2003). However, there are multiple methods for generating 'good quality evidence'; there is more than one form of evidence that can be utilised to validate good practice; and 'practice-based evidence' can offer a bottom-up

approach of gathering data from everyday practice, using the expertise of practicing clinicians and service users to inform policy and practice (e.g. Morgan 2002; Margison et al 2000; Lucock et al. 2003).

Taking self-harm as an exemplar, we present an approach to generating a range of qualitative and quantitative data to help inform, evaluate and validate clinical practice. First, we identify problems with current approaches to research in this area, which tend to focus on assessing particular intervention techniques, using structured, and primarily behavioural, outcome measures. Rather, we argue that research should be informed by effective *principles for practice.* This means that research should incorporate service users' own values and aspirations and provide more holistic and contextual understandings of clinical practice. This focus on meaning is typically characteristic of qualitative approaches to research. To achieve this, we propose a way of conceptualising research which combines the collection of cognitive, emotional *and* more nuanced behavioural data. We argue that research carried out in this way should elicit information which is meaningful to practitioners and service users, and produce 'evidence' which is also robust enough for policymakers and commissioners. The terms 'research' and 'evaluation' are used interchangeably in recognition of their necessary overlap, especially in relation to clinical practice. In our paper, we argue that a qualitative focus on meaning should be incorporated into both the ongoing process of evaluating clinical practice, and the larger scale scope of formal clinical research.

Identifying problems with current research: Questioning the questions

The merit of any methodology depends not only on the type and quality of 'data' that is collected, but also on the questions we ask and assumptions we make when we do so. In the following sections, we consider three distinct, but interrelated, problems with current research that is used to inform clinical practice and policy in the area of self-harm. These problems include a lack of definitional specifically (for example, a failure to differentiate between self-harm as a coping strategy and as a means of suicide); an over-reliance on predetermined outcomes (such as cessation of self-harm); and a focus on techniques rather than principles (for example, cognitive behavioural therapy rather than harm minimisation). These are now discussed in turn.

Defining meaning and challenging the confusion between coping strategy and attempted suicide

As noted, certain forms of research are prioritised in the current evidence-based policy agenda. For example, large scale outcome or prevalence studies are usually seen as more objective and reliable in making generalised conclusions and service recommendations. However, whilst these can be useful in identifying trends, there are a number of problems when seeking clinical guidance from such studies. First, the conceptualisation and classificatory systems used in such studies varies enormously from study to study: for example, what is included as 'self-harm' (Laye-Gindhu and Schonert-Reichl 2005). In particular, such studies rarely explore *intent* or *meaning*, despite the fact that these issues are central to service users' understanding of their experience (Lefevre 1996; Pembroke 1994; Spandler 1996). Qualitative research in the area of self-harm, for example, has consistently demonstrated the importance of the unique, complex and shifting meanings associated with the experience of self-harm and the various functions it serves in the context of a person's life (e.g. Spandler 1996; Simpson 2006; Rameshwari 2006).

Despite the widespread recognition of the significant difference between self-harm as a means of coping with unbearable distress and attempted suicide, many studies fail to make this distinction and frequently use data on these interchangeably (Simpson 2006). For example, the authors of the recent 'Cochrane review' of research into the efficacy of psycho-social and pharmacological treatments for self-harm (Hawton et al 2007) acknowledge that the 'dependent variable' (repetition of self-harm) was not consistently defined and measured in the studies included in their review, yet this lack of clarity is repeated in the review itself. As a result of this confusion, in effect, the main outcome measure appears to be suicidal behaviour. It is highly problematic to draw specific conclusions and recommendations for treatments for people who *self-harm* on the basis of a review which primarily considers *suicidal* behaviour. Whilst it is important to acknowledge the *potential* relationship between self-harm and suicide, and its actuality in a minority of cases, it is not necessarily justifiable to use this partial relationship as a basis for service recommendations for *everyone* who self-harms (regardless of intent) (Spandler and Warner 2007; Warner and Feery, 2007).

In addition, most large scale research on self-harm has been carried out on self poisoning, not self injury. For example, the UK National Institute for Clinical Excellence (NICE) review on self-harm collapsed self injury with self poisoning (NICE 2004; Barker and Buchanan Barker 2004). Whilst some people may use self poisoning and self injury for similar reasons, and to achieve similar effects, they obviously involve different physical strategies. Both strategies can be used to cope with overwhelming feelings, for example through distraction (cutting versus getting 'high') or dissociation/interfering with consciousness (blood-letting versus taking tablets). Alternatively, both can be used to end life. Hence, we cannot treat them as if they are the same, or assume an a priori meaning, but must explore the specific meaning and intent further. Such problems are not confined to large scale studies but are also evident in smaller service-based outcome studies and evaluations which often collapse self injury, self poisoning *and* attempted suicide (see for example, Wheatley and Hollin 2005).

It can be argued that the lack of specificity in defining meaning and intent in respect of self harm is reflective of categorical approaches to understanding mental health problems, typified by the medical model. Categorical systems tend to collapse the range of physical, cognitive and emotional 'symptoms' an individual might display into a pre-determined set of core disorders, via the practice of diagnosis. Diagnosis thus provides a broad-brush approach to understanding mental distress, which necessarily invites static understandings of symptoms. If symptoms are used solely to categorise there is little need to search for individual meanings: we simply assume symptoms, as de facto indicators of pathology, are abnormal and undesired. When the assumption is made that symptoms have a singular negative meaning this leads to a corresponding and premature predefinition of recovery whereby recovery is understood to be a state in which a person is necessarily 'symptom-free'. Freeing clients of their symptoms thus becomes the focus of intervention. Hence, in the area of self-harm, self-harm *cessation* becomes the primary goal of treatment. As such, the use of pre-determined outcome measures in research on self-harm is just as problematic as failing to differentiate self-harm as a coping strategy from a means to end life.

Identifying the restrictions of pre-determined outcomes

In formal evaluations of interventions, assumptions about outcomes are rarely debated. However, service user-defined goals (which may change and evolve) often differ

considerably from funders and service provider- defined goals (Perkins 2001). In relation to self harm, outcome-focused evaluations tend to concentrate almost exclusively on the actual occurrence or repetition of self-harm in a designated follow-up period and few studies use other outcome measures apart from repetition rates (NHS Centre for Reviews and Dissemination/ NHSCRD, 1998; Hawton et al. 2007). Although the NICE guidelines do recommend that research uses a broader range of outcomes (such as 'quality of life'), in relation to self-harm itself, NICE guidelines still only recommend reduced occurrence of incidents of self-harm as the assessed outcome (NICE 2004). Whilst this may make some sense in relation to attempted suicide, it is less appropriate for outcomes in relation to self-harm as a coping strategy - where there are number of potential problems.

First, it is over-simplistic to assume that particular *behaviours* are necessarily proxy indicators of 'success' or 'progress' without taking into account contextual considerations and clients' own goals and circumstances. In addition, a lot of incidences of self-harm will go unreported, especially as most self-harm occurs in private. Further, we cannot know whether people have taken up alternative methods of harming themselves (for example using drugs or alcohol). Lastly, a focus on pre-determined outcomes does not alert us to any unintended negative effects of the treatments themselves. For example, one study which found that depot neuroleptic medication reduced repetition of self-harm did not take into account the many negative side effects of such medication (Montgomery 1979, in Hawton et al. 2007). As such, the use of self-harm as *the* outcome measure in research on self-harm has been described as 'largely nonsensical' (Allen 2007: 175). Despite these problems (or perhaps because of them) attempts to assess the likelihood of 'repetition' of self-harm have failed to produce any meaningful information (NHSCRD, 1998).

Although clinical psychologists are encouraged to make a functional analysis of problems rather than diagnose disorder, funded research often demands that proposals, methods and outcomes are couched in familiar medical, diagnostic and treatment terms. A consequence of this reductive approach to problems is that the use of predetermined outcomes leads to a narrowed focus on treatments that aim to address these outcomes. Other interventions are then ignored and research becomes narrow in focus as investigation is orientated solely towards determining which techniques and interventions best meet these predefined set of goals: anything else is deemed to be irrelevant.

Refusing to focus on techniques and treatments

With such blunt instruments and simplistic outcome measures, it is perhaps not surprising that the effectiveness of particular interventions have been hard to ascertain. Yet, despite the elusiveness of finding effective treatment techniques through such methods, researchers and policy makers still recommend *larger trials* to work out which treatments are related to reduced rates of self-harm (Hawton et al 2007; Burns et al 2005). There is, however, a more fundamental problem with this approach. Attempts to validate the use of particular techniques for particular problems or symptoms assume that particular techniques will work for all those who share relevant symptoms. However, if there is no single meaning for any particular 'symptom', then there cannot be a single best technique for treating the problem.

This is one of the problems with what Bracken (2007) has called the 'technological paradigm' which dominates in mental health. This paradigm assumes that there are a set of interventions that can be applied, studied and assessed independently of context, relationships and values. As a result, individuals are grouped together (through symptoms or diagnosis, for example) and offered interventions that seem to have the best results for the majority – the 'best average' - at the expense of individualised, flexible and tailor made support (Bola and Mosher 2002). We have already seen how the 'similarity' of clients may be problematic when, for example, self-harm as coping strategy and as attempted suicide are left undistinguished. In addition, studies rarely take into account other social inequalities such as social class, age, gender, sexuality and ethnicity, despite the fact that these are heavily correlated with long term mental health problems (Rogers and Pilgrim 2003) and self harm in particular (SDC & RUHBC, 2005).

Indeed, research methods which include narrow, pre-determined outcomes are effectively favouring *particular* models of intervention over others, because they prioritise interventions that have simple goals and which are amenable to formal measurement. In the context of self-harm, it is perhaps not surprising that reviews of such research tend to result in recommending practices such as Dialectical Behaviour Therapy because this intervention specifically tries to reduce self-harming *behaviour*, thus directly coinciding with the outcome measures used (NICE 2004). Despite the emphasis on particular treatments, research which compares the impact of different psychotherapies has demonstrated that different models often have similar outcomes and that 'common factors' (such as the therapeutic alliance)

might be more important than specific techniques (Horvath and Symonds 1991; Bolsover 2007). Similarly, a recent qualitative study about self-harm (Simpson 2006) highlighted the necessity of support which combines sympathy, tolerance and solidarity: features which are not necessarily dependent on particular *models* of intervention, but rather on the quality of relationships and values that underpin support. For these reasons, the focus of most research on comparing the relative merits of different treatment models is not necessarily helpful. Rather, as we have argued elsewhere, it may be more productive to identify effective *principles* for working with people who are in mental distress and/or who exhibit difficult behaviours - such as self-harm (Spandler and Warner, 2007). In the following section we describe how this approach can be used to inform evaluation strategies.

Identifying key practice principles

We have argued that much of the outcome-focused research in self-harm has provided 'thin' descriptions of clinical issues by reporting 'facts, independent of intentions or circumstances' (Denzin 1994: 505). In contrast, a 'thick' description "gives the context of an experience, states the intentions and meanings that organised the experience, and reveals the experience as a process" (ibid, 1994: 505). If, as we argue, the aim of clinical research is to provide *thickened descriptions* of clinical relevant issues, the quality of these descriptions depends upon the understandings and meanings we use to interpret such data. Therefore, we argue that it is important to focus on principles rather than particular methodological or treatment techniques. These principles can then be used as a framework to guide the methodological and treatment techniques that are being applied or evaluated. Hence, the identification of principles must precede the identification of techniques and not the other way round. In *Beyond Fear and Control* (Spandler and Warner, 2007), we identified five principles that can be used to guide work with (young) people who self-harm. We believe these principles have wider application within the field of adult mental health.

Our first principle is based on the understanding that mental distress (such as that associated with self-harm) is rooted in negative, oppressive and/or abusive experiences in the social world (SDC and RUHBC, 2005). Because people experience oppression and abuse differently, it follows that individual meanings are paramount. Hence, according to our

second principle, it is crucial to recognise the specific *meaning* the person themselves attaches to their behaviour. This means making a distinction between self-harm as a coping strategy and as a means of ending life and recognising that self-harm can have both positive and negative effects within and between people at different times (Spandler 1996; Pembroke 1994; Rameshwari, 2006). Because of the need to recognise individuality, our third principle holds that we should not assume the focus of intervention (or clinical research) should be 'stopping' the target behaviour at the expense of other considerations, values and goals which are important to the service user (Pembroke 2007; Shaw and Shaw 2007). As such, our fourth principle requires being service-user-focused (or in the case of younger clients, young person-centred). In the case of research, this means working within a broad spirit of service-user-focused monitoring (e.g. Rose et al. 1998). Finally, the development of good clinical research based on these principles is at least in part dependent upon workers (clinicians, researchers and evaluators) being adequately supported to work in this way – so the need for good support represents our fifth principle (Babiker and Arnold, 1998). Having a principled beginning does not automatically include or exclude any particular therapeutic interventions or research methodologies. Rather, it places these *secondary* to the central principles, outlined above, which can be summarised as relating to issues of power, meaning, context and values (Bracken 2007). Therefore, the following section describes an approach to data collection which can be adapted and used across a range of different methods (from structured questionnaires to unstructured in-depth interviews) and clinical contexts.

A holistic approach to research

We have argued that traditional methods of research are seldom sufficiently complex, flexible and individualised enough to be meaningful or applicable to individuals who self-harm. More nuanced means are necessary to capture the complexity of people's experiences of using self-harm. In order to achieve this, it is necessary to utilise a more complex, flexible and holistic framework. Being more complex, however, does not mean that research has to be over-complicated. Rather, a framework is required which invites consideration of all matters that are potentially clinically relevant to the service user(s), rather than a framework that predetermines the importance of one aspect, usually the physical act, over all others.

We suggest using a simple communication framework made up of three components: a person's feelings, thoughts and behaviour. Warner (2000; & *in press*) triangulates the

relationship between thoughts, feelings and behaviour in order to draw attention to how thoughts, feelings and behaviour influence each other, and to emphasise the need to consider all three aspects when developing assessment, intervention *and* research strategies.

Whilst a focus on thoughts, feeling and behaviour might seem like a mainstay of psychology, it is worth noting that most clinical psychological interventions tend to prioritise one of these elements (e.g. psychodynamic, behavioural or cognitive therapies) or, more recently, two (e.g. cognitive analytic, cognitive behavioural therapies) rather than integrating all three. Similarly, research tends to reflect this by focusing on outcomes relating to one of these elements (usually behavioural). Whilst we recognise that the distinctions we might make between behaviour, thoughts and feelings are not absolute, they can be used as a strategic device to help organise the range of information we are interested in generating and exploring. This framework is used here precisely because it holds that thoughts, feelings and behavioural are *all* important in making sense of the individual in the social world. This is not simply in terms of communication with others, but also in terms of people's relationships with themselves: any external behaviour is only meaningful when the specific and associated thoughts and emotions are explored (the same act of self-harm can mean different things to different people). The emphasis on *communication* also encourages the need to explore and connect 'external' social processes (such as the relationships and service dynamics involved in clinical practice) with the more 'internal' processes of individual thoughts and feelings that bring meaning to behaviour. It is precisely this focus that gets left out of outcome-focused research (that is, research that focuses on *what* has changed, but not *how* or *why*).

This framework can be used to help identify the various components that could be considered when researching the benefits of particular clinical interventions or services. For example, when developing evaluation strategies of services for people who self-harm, it is important not only to consider the physical act of self-harm (the behaviour: the traditional focus of self-harm outcomes studies), but also what people think *and* feel about their actions, themselves and their lives. Extending the focus beyond the behavioural allows issues to emerge that may have remained hidden within a more restricted framework. For example, concentrating on behavioural measures of self-harm cessation would not necessarily enable evaluators to recognise when a successful 'harm minimisation' approach had been implemented.

There are a variety of ways of making sense of the process of data collection. However, we argue that this framework provides a comprehensive, yet simple; flexible, yet robust approach to collecting data relevant to clinical practice. Whilst currently fashionable ideas like 'recovery' and 'well-being' may also offer ways to do clinical research, in practice such notions can be nebulous, hard to define or translate into measurable 'outcomes' (Turner-Crowson and Wallcraft, 2002). This is why drawing distinctions between thoughts, feelings and behaviour can be beneficial because it is in breaking down these components that concepts like recovery and well-being become operational. This is because any notion of recovery and/or well-being has behavioural, cognitive, and emotional elements. For example, in order to assess changes in well-being, what people do (behavioural measures); how people understand the behavioural and emotional changes they have made (cognitive factors); and how people feel about the changes they have made in their behaviour and thoughts (emotional factors) are all relevant.

In the following sections we suggest a range of questions that could be posed when using this framework to design a research or evaluation study. The questions and issues we raise are far from exhaustive and may be reflexively extended, employed (or rejected) depending on context. Ideally, any specific research questions should be developed with input from service users and clinicians, so that indicators of change within the study are meaningful within that context (Rose, 2003). This process of consultation enables key principles to be extended, amended and translated into specific evaluation strategies for particular groups of individuals and/or services. This should provide greater specificity (research tailored to the particular service or treatment setting); greater collaboration (research questions developed with service users and not just providers); and ultimately greater depth (behavioural measures are extended to include more qualitative data).

Behavioural aspects of evaluation: FINDing what matters

We have argued that the dominant focus on particular *behavioural* manifestations of distress (e.g. incidences of self-harm) is severely limited. Nevertheless, just because the behavioural aspect of self-harm is displaced as the *primary* concern in our formulation, it does not mean it entirely disappears. A focus on behavioural change can offer us a way of assessing whether services are beneficial, as long as we a) do not consider behaviour in isolation from the cognitive and emotional context *and* b) ensure that we consider a *variety* of possible

behavioural dimensions of change in relation to actual self-harm. One possible way of achieving the latter is by considering the frequency, intensity, number and duration of self-harm (this can be remembered by using the mnemonic/ memory aid acronym 'FIND') (for example, Warner, 2000, in press), see Box 1.

Box 1: FIND

1. **F**requency: how often?
2. **I**ntensity: how severe? (immediate harm and long term damage; need for medical intervention, hospital visit etc)
3. **N**umber: how many times?
4. **D**uration: how long does each particular incident of self-harm last?

Focusing on one of these factors in isolation can present a distorted picture. But assessing a *combination* of these should give a more accurate picture of whether services are having a positive impact. For example, entering into an intensive therapeutic relationship may result, at least in the short term, in the **F**requency or **I**ntensity of self-harm increasing as clients begin to talk about painful memories and underlying difficulties. However, over the long term, the **F**requency, **I**ntensity, **N**umber and **D**uration of the harm may all alter, depending on the nature of the individual's circumstances. To make matters even more complex it is important to recognise that different forms of self harm may have different *meanings* to people. In other words, we cannot assume that all forms of self harm are, by definition, similarly harmful.

It will help to illustrate this with an individual case study. For Saira, a young woman who has self-harmed for many years, cutting and taking tablets have two distinct, if sometimes, overlapping meanings, and hence serve different functions in relation to the wider context of her life. Cutting is often associated with Saira's angry feelings, whilst her drug intake is often associated with feelings of sadness and a desire to stop feeling. During the course of therapy, Saira's overdosing decreased in **I**ntensity (that is, it became less serious in consequence), **F**requency (it reduced from twice a week to once a month), **N**umber (she took fewer tablets) and **D**uration (she spent less *time* taking the tablets). Here, on all **FIND**

measures Saira demonstrated decreases over time. By contrast, over the course of therapy – as Saira felt less sad about her life (indicated through reduced use of tablets), she felt increasingly angry about the way she had been treated in her family and this led to an increased **F**requency in cutting. However, whilst the frequency increased, and continued to stay at this level for some time, the **I**ntensity (severity) of her self-harm; the **N**umber of times she cut in any one period of self harm; and the **D**uration over which she cut, decreased over time. If the only measure used was frequency, it would only be possible to see that improvements had occurred in respect of overdosing, but not in terms of her cutting. Yet, Saira was using significantly 'safer' cutting than when she cut less frequently (which then often resulted in visits to the hospital).

Hence, the mnemonic 'FIND' enables a more comprehensive understanding of the behavioural impact of interventions. It also allows records to be used that can indicate the success of a 'harm reduction' approach which services can use to validate its practices. As such, this approach can be used to evaluate individual and ongoing clinical practice and interventions. Additionally, more nuanced behavioural data like this can also be incorporated into more general, systematic research and evaluation studies. As argued, detailed *behavioural* data can be further enriched by a consideration of cognitive and emotional factors.

Intellectual aspects of evaluation: Rethinking our practices

Whilst there is a strong tradition of using cognitive-focused measures in clinical psychology as standardised evaluation tools, such as Beck's depression scale (Beck 1996), our interest in cognitive factors is not about developing better standardised tools, but is about inviting a more qualitatively informed interest in the development of understanding and knowledge about the particular issue under scrutiny. For example, the aforementioned general 'principles for practice' can be made operational by transforming them into a specific knowledge-base that has direct relevance for particular peoples' lives. This knowledge-base may include information people have about themselves, their life circumstances and experiences, and their means of coping. In order to evaluate whether the person's knowledge-base about themselves has increased over the course of an intervention it is necessary to consider the knowledge/cognitive *content* of intervention (the process of delivery is also relevant, and this is discussed next in the 'emotional' section) (also see Warner 2009). Box 2

presents some relevant questions about the practical knowledge that might be necessary to minimise the harmful effects of self-harm and to understand whether individual sense of power and volition are enabled.

Box 2: Practical Knowledge

- Does the individual have sufficient information about how their body works?
- Are they aware of the immediate and long term effects of the particular forms of self-harm they practice?
- Do they know how to care for their injuries and when to seek medical assistance?
- Can they identify the particular 'triggers' to their self-harm?
- Do they have the opportunity to discuss alternatives to self-harm?
- Do they have access to less harmful alternatives?
- Do they know where to go for particular information and support?
- Have they had the opportunity to discuss and draw up any forward planning tools about their treatment e.g. advanced directives, living wills, crisis plans etc (Amering et al. 2005)?
- Is there anything else important that should be asked about?

These questions can be used to assess whether a specific individual's particular needs are being met within a service. They can also be refined to generally evaluate the quality of care services provide to all the individuals in a particular service (a monitoring/evaluation study). Hence, conducting this kind of review across a service enables service-providers to identify if there are consistent gaps in service provision (for example, no-one has a forward-planning

tool such as an advanced directive) or if there are individual's who lack specific information (for example, particular individuals have not been offered an advanced directive). Provision can then be adapted accordingly. Positive benefit may also be indicated by behavioural change and hence it is important to also record relevant 'FIND' information on behaviours thought to be affected by the intervention (for example, different forms of self harm). Furthermore, such questions can also be considered for inclusion within more general research studies (both qualitative and quantitative). Finally, any of these methods should also explore the emotional impact of services and interventions.

Emotional aspects of evaluation: Making more of feelings

A focus on principles rather than techniques invites us to consider not only *what* is done but also *how* it is done: the emotional 'principles for practice'. If researchers, as well as practitioners, started their work by considering how interventions, assessments, or evaluation might be *experienced* in the context of a person' life, it is possible to develop more sensitive and appropriate methods of intervention, assessment and evaluation (Warner, in press). It is therefore, important to identify particular *emotional* components of a principle-led practice. In terms of self-harm work this means identifying and evaluating specific practices that enhance well-being and minimise harm. This aspect of evaluation is important because if we ignore the emotional component of service delivery we may compound (emotional) harm precisely because we re-invoke the same difficult feelings that underlie the need to self-harm in the first place.

There are a range of different emotions that could, and perhaps should, be explored in relation to the impact of particular clinical interventions in relation to self-harm. However, given the sense of powerlessness and lack of control that seems to frequently underlie the use of self-harm it makes sense to explore a range of areas that specifically relate to self efficacy (or power and control). Relating back to our 'principles for practice', this sense of powerlessness often relates to underlying social causes of distress (past experiences of neglect, abuse, institutionalisation, oppression etc). Therefore, we can assume that an increased sense of control over one's body, life and immediate social world reflects amore general benefit in relation to the emotional components of self-harm. With this in mind, we will concentrate on questions relating to power and control in order to illustrate questions relevant to the emotional components of research.

A sense of 'control' will change according to context and the particular life circumstances of the individual client (or service). For example, people using a community based service will have different things they can exert control over than people detained in a mental hospital, prison or secure unit. Nevertheless, despite obvious limitations, there are still multiple choices either individual can make. If we accept the centrality of issues of power and control, we can develop relevant questions for the particular research studies. For example, Babiker and Arnold (1998: 97) have identified questions relevant to illuminating how particular environments support or undermine clients' sense of power and control (see Box 3).

Box 3: Questions for services about power and control

- Are service users being made to feel helpless, vulnerable and controlled?
- Is self-injury the only circumstance under which people are taken seriously and listened to?
- Are service users being harassed, oppressed, assaulted (by other clients or staff?)
- Is self-injury the only available means of expressing distress, anger or of releasing tension?
- Are clients bored, under-stimulated or isolated?
- In what ways does the [service] replicate the cultural context - with regard to gender, race, sexual orientation and class - in which individuals may develop self-injury?

As the above box suggests, the emphasis here is less on evaluating 'individuals' and predetermined 'outcomes' and more on ensuring that services provide the necessary conditions for effective and principled practice. Again, these questions can be asked in order to evaluate practice on a case-by-case basis in order to monitor progress. These questions could also be asked within a service or across a range of service contexts in order to validate

good practice and/or identify service gaps and shortfalls. And again, the subsequent identification of relevant issues arising from these questions can be feed into broader research studies.

Without reference to a combination of all three aspects (behavioural, cognitive and emotional), an impoverished data set is provided. Therefore, and in addition, this information can be 'triangulated' to provide a comprehensive, robust and meaningful picture of the particular service or intervention under scrutiny. Such triangulation requires critical evaluation in order to highlight areas of potential conflict, imbalance or gaps in service provision (Denzin, 1970).

Conclusion: Utilising holistic data in practice

In summary, our approach to data collection can be applied in a number of distinct, but interrelated ways. This multi-level approach reflects a blurring of boundaries between research, evaluation and clinical practice. First, the information generated can be collected as part of individual case studies and used as way of monitoring and evaluating the impact of clinical interventions – a way of embedding qualitative data in everyday clinical practice. This kind of individual case study approach can then be used as a form of 'micro-evidence' (Adams, 2008) which identifies 'practice derived evidence' and points out areas for future development and change. In addition, this approach can be extended to include all service-users involved in a particular intervention. Ideally, studies of this kind would be informed by an 'action research' approach where data collection is ongoing and clinical interventions remain open to being informed and shaped by what the evaluation indicates. The process provides a means of evaluating innovative practice as it develops, rather than waiting for some mythical end point when a therapy or intervention has been extensively used and applied and can now be NICE-trialled (Adams, 2008). Finally, at least some of the same type of data could be usefully incorporated into large-scale research studies. After all, it is these studies which often directly influence policy and practice. Whilst we have focused here on one area of practice (self-harm), the framework we have outlined could potentially be adapted to other areas of clinical practice and inquiry, such as in respect of services for people who hear voices and see visions. Research and clinical practice into hearing voices has also tended to concentrate on overly simplistic measures of change which assume that

outcomes should be based on stopping these experiences, rather than developing different relationships with them (Knight 2008; May 2004).

In conclusion, traditional interventions with people who self-harm have frequently compounded, rather than alleviated, suffering by undermining people's ability to take control of their bodies and their lives. Unfortunately, traditional approaches to research can make things worse, by further denying individual goals and desires and using crude and impersonal measures of change. If services are to be improved, we need to re-evaluate the questions we ask; challenge the assumptions we make; and question the blunt measures we use to measure change. Research does not need to be standardised and turned into 'tick boxes' and formulaic assessment tools in order to demonstrate quality, meaning and utility. Good research, like good practice, needs to be embedded in a principled approach that is flexible and user-centred. This enables multiple research strategies to be developed and we have suggested some ways of measuring and recording change which reflect the diversity of client's needs and circumstances. The challenge in the current context is to find ways of incorporating such research strategies within the broader lexicon of 'what counts' within the dominant evidence based practice agenda. However, if we want to develop truly innovative and compassionate strategies of support and care, clinical research must move beyond overly restrictive frameworks and instead find new ways to explore, critique and/or validate current practices.

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