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1 **An interpretative phenomenological analysis of young people’s self-harm in the context of**  
2 **interpersonal stressors and supports: parents, peers and clinical services**

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**Abstract**

**Rationale:** Self-harm in young people is of significant clinical concern. Multiple psychological, social and clinical factors contribute to self-harm, but it remains a poorly understood phenomenon with limited effective treatment options. **Objective:** To explore young women’s experience of self-harm in the context of interpersonal stressors and supports. **Method:** Fourteen adolescent females (13 – 18 years) who had self-harmed in the last six months completed semi-structured interviews about self-harm and supports. Interpretative phenomenological analysis was undertaken. **Results:** Themes identified were: 1) Arguments and worries about family breakdown; 2) Unhelpful parental response when self-harm discovered and impact on seeking support; 3) Ongoing parental support; 4) Long-term peer victimization/bullying as a backdrop to self-harm; 5) Mutual support and reactive support from friends (and instances of a lack of support); 6) Emotions shaped by others (shame, regret and feeling ‘stupid to self-harm’); and 7) ‘Empty promises’ - feeling personally let down by clinical services. These themes were organised under two broad meta-themes (psychosocial stressors, psychosocial supports). Two additional interconnected meta-themes were identified: Difficulties talking about self-harm and distress; and Impact on help-seeking. **Conclusion:** Parents and peers play a key role in both precipitating self-harm and in supporting young people who self-harm. The identified themes, and the apparent inter-relationships between them, illustrate the complexity of self-harm experienced in the context of interpersonal difficulties, supports and emotions. This has implications for improving support from both informal and clinical sources.

**Keywords:** UK; self-harm; adolescence; clinical services; qualitative methods; interviews.

64 **An Interpretative Phenomenological Analysis of Young People’s Self-harm in the Context**  
65 **of Interpersonal Stressors and Supports: Parents, Peers and Clinical Services**

66 Self-harm, defined as self-injury or self-poisoning regardless of intent (National Institute  
67 for Clinical Excellence, 2004), is a common and significant clinical concern in young people  
68 (Shanmugavadivel et al., 2014; Stafford et al., 2014). However, most self-harm does not come to  
69 the attention of clinical services, with young people primarily seeking help from family and  
70 friends (Fortune et al., 2008; Michelmore & Hindley, 2012). For those reaching clinical services,  
71 attitudes towards self-harm can be negative (Saunders et al., 2012) and young people can feel not  
72 listened to or understood (Storey et al., 2005). It is thus crucial to improve our understanding of  
73 the difficulties experienced by young people who self-harm, to better tailor interventions and  
74 supports.

75 Current theoretical accounts of self-harm, focusing on psychological mechanisms,  
76 suggest a potentially important role for relational factors in the development and continuation of  
77 self-harm. Nock (2009) suggests that self-harm serves both intrapersonal functions (e.g. affect  
78 regulation) and interpersonal functions (e.g. communicating the need for help). Self-harm is  
79 maintained because it allows for immediate regulation of aversive emotional and social  
80 experiences, in the context of poor communication skills or emotional dysregulation. Laboratory  
81 and self-report studies indicate that negative affect occurs prior to self-harm and decreased  
82 negative affect and relief are experienced after self-harm, with alleviating negative affect  
83 reported as a main function served by self-harm (Klonsky, 2007). Importantly, these changes in  
84 emotional experience predict lifetime frequency of self-harm, suggesting that they reinforce and  
85 potentially maintain the behaviour (Klonsky, 2009). Furthermore, the Experiential Avoidance  
86 Model states that reengagement with self-harm (without suicidal intent) occurs as negatively

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87 reinforced strategy for avoiding or escaping unwanted negative emotional experiences (Chapman  
88 et al., 2006). Thus, relational problems such as family conflict or bullying are stimuli that cause  
89 unwanted aversive emotions, with self-harm understood as an attempt to gain relief or release  
90 from these interpersonal emotional experiences, possibly in the context of existing vulnerabilities  
91 such as poor emotion regulation or social communication skills (Chapman et al., 2006; Nock  
92 2009). This contrasts with conceptualising self-harm as a way of addressing interpersonal  
93 stressors directly through interpersonal influence (eliciting help/attention, stopping conflict or  
94 otherwise influencing a person's behaviour) – for which there is less empirical support (e.g.  
95 Klonsky 2007). Through affect regulation, self-harm is reinforced and so these models suggest  
96 that the behaviour can be readily maintained as a way of coping with social stressors.

97         Studies of patients (15 years and above) attending general hospital suggest self-harm  
98 occurs in the context of multiple life problems, particularly relationship difficulties (Haw &  
99 Hawton, 2008; Townsend et al., 2016). In adolescents who self-harm, frequent interpersonal  
100 problems with family, friends, peers (including bullying) and romantic partners are reported  
101 (Hawton et al., 2003; McLaughlin et al., 1996; O'Connor et al., 2009), with increased severity of  
102 self-harm history being associated with increased prevalence of relationship problems (Madge et  
103 al., 2011). These quantitative studies strongly indicate that relational difficulties and  
104 interpersonal stressors are associated with self-harm episodes. These broad associations also  
105 indicate the need for future research to closely examine the impact of relational difficulties on  
106 self-harm, taking into account the severity, specificity and temporal sequencing of these  
107 stressors, along with the potential protective role of social factors (Madge et al., 2011; Michelson  
108 & Bhugra, 2012; Townsend et al., 2016). Qualitative research is well-placed to do this.

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109           The developing body of qualitative research on self-harm offers a more nuanced look at  
110 the potential role of interpersonal stressors. A US qualitative interview study of six young  
111 women found that all participants reported self-harm in response to ‘pain’ or ‘anger’ due to  
112 family problems and relational difficulties (Abrams & Gordon, 2003). An interpretative  
113 phenomenological analysis (IPA) of seven young people found that several interpersonal factors  
114 were reported to predispose, trigger or maintain self-harm, in particular emotional turmoil or  
115 ‘trauma’ involving family conflicts and bullying (McAndrew & Warne, 2014). A thematic  
116 analysis of 20 UK adults’ retrospective accounts of self-harm found that unpredictability and a  
117 perceived lack of control in family lives were associated with their earlier self-harm, and that the  
118 resolution of their chaotic family environment was linked to stopping self-harm (Sinclair &  
119 Green, 2005).

120           The important role of family and friends in *supporting* young people who self-harm also  
121 features in the qualitative literature. An interview study with six US college students reported  
122 that support from parents, friends and romantic partners was vital, providing someone to rely on,  
123 emotional connectedness and the validation of distress (Shaw, 2006). Two larger studies using  
124 content analysis found support from family and friends could be a catalyst for stopping self-harm  
125 and was more pertinent than care or therapy (Gelinias & Wright, 2013; Rissanen et al., 2013).

126           The present study extends this emerging body of qualitative research, which (except for  
127 McAndrew & Warne, 2014) has not examined the role of interpersonal stressors and supports  
128 experienced by UK adolescents who self-harm. This focus on teens in the UK (including their  
129 social context, e.g. school and peer relations) is timely as self-harm is a common reason for  
130 young people to be presenting to emergency departments (Hawton et al., 2011) and general  
131 practice data indicates an increased prevalence of self-harm over recent years, particularly in



154 Larkin, 2009). Qualitative findings from other sub-samples from the wider study focus on the  
155 experiences of young adults (19-21 years) and of young people who had been looked-after in  
156 care, are reported elsewhere.

157 **Participant characteristics.** The participants ( $N = 14$ ) were aged between 13 and 18  
158 years, with a mean age of 16.00. All participants were female (one male was recruited to this  
159 group but was not included in the analysis to focus on the experiences of young women). Most  
160 of the group (85.7%) were of white British ethnicity. Individual participant characteristics are  
161 given in Table 1. Nine participants were recruited from Child and Adolescent Mental Health  
162 Services (CAMHS), and the remaining five self-referred from the community.

163 <INSERT TABLE 1 ABOUT HERE>

#### 164 **Data Collection**

165 **Procedure.** The participants completed semi-structured interviews with the first author in  
166 2014 at a location of the participants' choosing (e.g. at home, college, a volunteer centre).  
167 Participants and their parents (in the case of under 16s) provided informed consent. Ethical  
168 approval was given by the Social Care Research Ethics Committee (NHS Health Research  
169 Authority) and the departmental ethics committee. In the unlikely event that participants became  
170 distressed during the research, a referral path to clinical support was available.

171 **Interviews.** Background demographic information regarding age, ethnicity and  
172 education/employment status was collected (Table 1). Details about the participants' self-harm  
173 history (methods, age started, frequency), contact with clinical services and mental health  
174 diagnoses were self-reported.

175 The semi-structured interview, developed for this study, comprised open-ended questions  
176 focusing on 1) accounts of first episode of self-harm, 2) accounts of most recent episode of self-

177 harm, 3) perceptions and experiences of self-harm maintenance, stopping and recovery (e.g.  
178 ‘Why do you keep on self-harming?’ ‘What do you think might help you to stop self-harm?’) and  
179 4) experience of supports and services (including clinical services and more informal sources).  
180 The interview schedule was developed in collaboration with an advisory group of young people  
181 who self-harm.

182 The interviews were audio-recorded and were transcribed verbatim. Their length ranged  
183 from 17 to 57 minutes ( $M = 27.25$ ).

### 184 **Analysis**

185 The interview transcripts were analyzed by the first author on a case-by-case basis  
186 (ideographically) in five discrete steps using published IPA guidelines (Smith et al., 2009): 1)  
187 familiarization with the material through re-reading transcript, noting first impressions of the  
188 account (including preconceptions/expectations); 2) initial exploratory notes on the data (largely  
189 descriptive, though moving to more interpretative comments); 3) develop emerging interpretative  
190 themes, map interrelationships and patterns between exploratory notes, create a set of themes  
191 ordered chronologically (reflecting participant’s words and analyst’s interpretations); 4) organize  
192 themes at a conceptual level (e.g. superordinate/subordinate themes, abstractions) and map how  
193 themes fit together, a table of structured themes captures the essential qualities of the account; 5)  
194 steps 1 to 4 are repeated for each participant, then themes are ‘reworked’ at the group level,  
195 organized theoretically into a meaningful hierarchy across the accounts (using clusters, super-  
196 and subordinate levels), prominent connections and ‘potent’ themes are identified (see Figure 1).  
197 A reflective record was used to document processes and decisions in the analytical process,  
198 which served to improve transparency when moving from the participants’ words to more  
199 interpretative meanings, particularly regarding the researcher’s preconceptions and expectations.

200 The analyst was a researcher with extensive experience in conducting and analysing interviews  
201 with young people (including IPA) but was new to the field of self-harm. Her background in  
202 psychological research focused on adolescent socioemotional functioning most likely shaped the  
203 focus of the analysis to some extent.

204

205

## Results

### 206 Self-harm History and Mental Health

207 The participants reported their first self-harm episode between the ages of 10 and 15  
208 years ( $M = 13$ ) and had repeated self-harm for between one and seven years. Most said that when  
209 their self-harm was at its most frequent, incidents occurred daily (57.1%) or weekly (21.4%).

210 The majority reported self-cutting as a method they had (ever) used (85.7%), and 57.1% reported  
211 overdosing. All but one participant reported using multiple methods of self-harm. Six  
212 participants self-reported mental health diagnoses, most commonly depression and/or anxiety  
213 (each reported by four participants).

### 214 Overview of Themes

215 The decision to focus on relational factors associated with self-harm and supports was  
216 reflected in the prominence of these issues across the participants' accounts and the rich  
217 descriptions of such factors provided by individuals. The iterative process of analysis allowed the  
218 data to be organised hierarchically into themes. The themes are presented in Figure 1, with  
219 interrelationships between themes and self-harm represented by arrows (solid arrows represent  
220 relationships overtly referred to by participants; dashed arrows represent additional assumed  
221 relationships). Also presented in Figure 1 are two organisational meta-themes - psychosocial

222 stressors and psychosocial supports. Two hypothesized meta-themes (‘Difficulties talking about  
223 distress/self-harm’; ‘Impact on help-seeking’). were identified as inter-related issues contributing  
224 to both interpersonal stressors and self-harm, and how interpersonal supports were experienced

225 <INSERT FIGURE 1 ABOUT HERE>

226 **Theme 1) Arguments and Worries about Family Breakdown**

227 Arguments with parents were a commonly reported stressor for self-harm. Many  
228 participants described either a specific argument prior to self-harm, “*My mum was being a*  
229 *complete raging bitch... she just went ‘right let’s go pack all your stuff then because you’re*  
230 *obviously moving out’” (ID22), or that they were generally not getting on with their parents at*  
231 *the time of self-harm “...not really communicating, just arguments” (ID11). ID15 described a*  
232 *combative relationship with her mother prior to self-harming for the first time:*

233 *“we’re quite similar which is why we clash, so we’ll have a lot of arguments and we’re*  
234 *both trying to get our point across but we can’t. I always feel so frustrated with her and I*  
235 *think I just felt really frustrated, and you know I was 13, so I was really annoyed at*  
236 *everyone anyway, so I just wanted to kind of get it out at first.” (ID15)*

237 For some, the backdrop for arguments with parents was characterised as a stressful home  
238 environment but not out of the ordinary: “*...quite a lot of arguments at home, which were quite*  
239 *normal” (ID31), “we were all stressed, everyone...the whole family situation as well so yeah,*  
240 *awkward- not good time” (ID07). However, other young people had tangible fears of imminent*  
241 *family breakdown when they first self-harmed. For example, ID26 described how attempts by*  
242 *her biological father to contact her led to a “really negative environment” at home and fears of*

243 “it breaking down the family” around the time of self-harm. ID22 talks about first self-harming  
244 when she knew her parents were going to split up:

245 *“I had to mature quite quickly and so I was very much aware of everything that was*  
246 *going on and I guess that added to my reasons to self-harm. I felt like there was a lot of*  
247 *responsibility...we knew that mum and dad were splitting up but he was still living with*  
248 *us for three months whilst he was trying to find another house, and it was just a bit like*  
249 *“just f\*\*k off, just get out the house”, so yeah, that contributed a lot” (ID22)*

250 Arguments with parents and a stressful home environment were reported by young  
251 people as precipitants of self-harm, and these ranged from the day-to-day quibbles within  
252 families through to major family breakdowns. Difficulties communicating with parents  
253 effectively were also apparent. The question of why family conflict should lead these young  
254 people to self-harm is an important one. We explored the accounts further to identify any  
255 commonalities in the participants’ emotional reaction to family arguments, reported prior to self-  
256 harm. Three participants said they were worried about the impact of family discord on another  
257 member of the family (ID22, ID26, ID30), and three reported feelings of anger directed at a  
258 parent before self-harming (ID07, ID12, ID15). It is interesting that these emotional reactions are  
259 interpersonal rather than self-directed (i.e. anger and anxiety regarding others rather than self).  
260 The data suggest that it is important to consider the emotional response of young people to  
261 family relationship stressors as a possible driver for self-harm, although this requires further  
262 examination.

263 **Theme 2) Unhelpful Parental Response when Self-Harm Discovered and Impact on**  
264 **Seeking Support**

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265           The reactions of parents when their child’s self-harm was disclosed or discovered were  
266 described, by some, as unhelpful – for example, if parents were very emotional “*they were really*  
267 *upset, I think my mum cried actually*” (ID14), “*it’s always my family that are more upset than*  
268 *me...they didn’t know what to do*” (ID16). ID15 described her mother’s angry response after  
269 finding out about her self-harm by reading her text messages:

270           *“My mum was like, ‘well why are you doing it?’ She got dead angry with me, she*  
271 *wouldn’t give me eye contact or talk to me. The next day... we had this huge argument*  
272 *and I was crying and she was shouting at me and she was like ‘is it something that you*  
273 *and your friends do?’ And I was like ‘no’. (ID15)”*

274       Other young people experienced their parent’s initial response to their self-harm as being  
275 somewhat trivialising: “*His [dad’s] reaction was to tell me to stop listening to the music I was*  
276 *listening to*” (ID18); “*She [mum] was like ‘I don’t get why you self-harm’ ... ‘is it you just*  
277 *attention-seeking or like is something actually going on’.*” (ID12); “*She’d [mum] be like ‘go out*  
278 *for a walk you need serotonin and blah’ and all this rubbish*” (ID22).

279           It is also pertinent that some young people reported that arguments with parents (as a  
280 stressor leading to self-harm) were about their self-harm and/or their mental health “*my mum*  
281 *was getting quite stressed at the fact that I was self-harming, so that was causing arguments*”  
282 (ID26). These parents were perceived to not understand or appreciate the emotional difficulties  
283 the young people were experiencing, or the help they needed. ID30 reported that when her  
284 mother told her off for an obsessive behaviour “*...that triggers me and it makes me feel*  
285 *abnormal, and like I’m stupid or whatever*” (ID30). For ID19, a disagreement over the support  
286 she felt she needed led to her most recent self-harm episode:

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287            *“I was angling for admission to the adolescent [inpatient] unit but my parents didn’t*  
288            *think that was a good idea, then it turned into this huge argument where I just screamed*  
289            *at them and then they sent me to bed, so there I just self-harmed.” (ID19)*

290            Reaching out and talking to parents was not something that everyone found easy to do,  
291 particularly for those young people who described their parent’s initial reactions as unhelpful:

292            *“Sometimes my mum tries to talk to me about it and I just say, no. We don’t have that*  
293            *sort of relationship at all, I don’t talk to her about stuff at all, so when she does try to, I*  
294            *just say I don’t want to talk about it.” (ID15)*

295            *“My mum will sometimes talk to me about it [self-harm], but we don’t really discuss it*  
296            *that much because it kinda makes me feel uncomfortable.” (ID18)*

297            *“I don’t speak to any of my family about it, so I just do it and that’s it. I think they’re*  
298            *more frustrated at the fact that I don’t go to them and talk to them first, and then I end up*  
299            *in hospital again. If my mum and that found out again then it’d just be a whole lot of*  
300            *drama again and I just, I think I’d rather not deal with the drama” (ID16)*

301            There was also evidence that young people wanted to protect their parents from the  
302 ‘upset’ caused by their self-harm, which would impact on willingness to seek support from  
303 parents. For example:

304            *“Even though I’ve always known I’m able to talk to them I tend not to...I always had a*  
305            *tendency to keep things to myself and think it’s better off that way ‘cos that way no one*  
306            *else can get upset about it.” (ID26)*

307           *“I didn’t want my mum to find out because she had a lot of stress going on as well”*  
308           *(ID12)*

309           The response of parents upon discovering self-harm was often described as unhelpful.  
310 This, coupled with some young people’s desire to protect the family from their self-harm, could  
311 inevitably affect help-seeking from parents. It is important to try and understand the reaction of  
312 parents upon discovering self-harm, especially in the context of an already stressful family  
313 environment. For example, sometimes the young person’s emotional health difficulties could be  
314 a focal point of these family arguments.

### 315 **Theme 3) Ongoing Parental Support**

316           Parents were, nonetheless, a key source of support with all but one of the participants  
317 describing instances where they had sought or received support from a parent in relation to self-  
318 harm and emotional distress, *“My mum’s really good for that [support]. I’ll go to her for hugs.*  
319 *She’ll usually help me; hugs are amazing for getting out those kind of feelings” (ID07).*

320 Supportive parental responses were described as more accepting and, in some cases, understated:  
321 *“dad was a bit more accepting” (ID22), “he [dad] treated me like normal afterwards” (ID15).*  
322 ID26 described a more emotional but thoughtful reaction from her mother, having kept self-harm  
323 secret for two years:

324           *“She just broke down into tears. She wasn’t angry or anything, she broke into tears and*  
325 *she just gave me a massive hug, and told me that we’d get it sorted and everything. And*  
326 *said she wouldn’t tell anyone, like, said my dad needed to know. But she’d tell him while*  
327 *I wasn’t there and stuff, so that I wouldn’t see his reaction. And that she wouldn’t tell*  
328 *anyone else. (ID26)”*

329 These accounts suggest a preference for understated acceptance (whilst not being dismissive),  
330 rather than an overt emotional reaction to self-harm. In understanding young people's  
331 perceptions of parents as a source of support it is useful to examine parents' initial reactions to  
332 self-harm when it was discovered, but also the role of parents as an ongoing source of support.  
333 There is some evidence that if young people perceive their parents' first reaction to self-harm to  
334 be unsupportive, they may develop a continued reluctance to talk to them about their distress, or  
335 seek support when needed. However, from a parental perspective an initial emotional reaction to  
336 self-harm can be understood as being driven by fear or guilt or shock, and may nonetheless lead  
337 to acceptance and support later on.

#### 338 **Theme 4) Long-Term Peer Victimization/Bullying as a Backdrop to Self-Harm**

339 When discussing salient and stressful factors experienced prior to an episode of self-  
340 harm, around half the participants said they were being bullied. Importantly, this bullying was  
341 experienced as long-term victimization, rather than isolated incidents: *"I was bullied throughout*  
342 *primary school and secondary school, because I used to be quite chubby"* (ID09), *"I've always*  
343 *got bullied at school, from year 2 to the day I left"* (ID26), *"when I went to my new primary*  
344 *school I was really quite badly bullied and when I first started secondary school...some of the*  
345 *girls still bullied me"* (ID14).

346 Bullying was characterised as an ongoing or background stressor leading to self-harm,  
347 when other temporary but critical stressors were present. For example, ID12 was experiencing  
348 physical abuse prior to her first self-harm, but cited victimization as an additional contributing  
349 factor, *"I got bullied as well, and that wasn't nice"* (ID12). ID09 reported self-harming recently  
350 as a result of sexual abuse, but at the same time experienced bullying because of this incident,

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351 *“again, the bullying was still going on, ‘cause people had found out things that had happened*  
352 *and then I was getting called a slag” (ID09).* ID31 described several stressful events leading to  
353 her first episode of self-harm (moving school, arguments with parents and friends), again with  
354 bullying as an additional and continuous stressor:

355 *“I’ve experienced bullying since the age of 6, so that’s been like a continuous thing and*  
356 *at this time it was quite bad, because a new girl had just moved and she hated me straight*  
357 *away and everyone in the school knew she hated me. So, it caused quite a lot of tension.*  
358 *So, that didn’t really help”.* (ID31).

359 Thus, bullying was described as an enduring background interpersonal stressor  
360 contributing (collectively with other stressors) to self-harm.

### 361 **Theme 5) Mutual Support and Reactive Support from Friends (and Instances of a Lack of** 362 **Support)**

363 The young people’s accounts of seeking support from friends were largely positive.  
364 Participants found that some friends were emotionally supportive when they knew about their  
365 self-harm and/or associated distress: *“My friends, like, are there. They’ll help you through it and*  
366 *everything” (ID12), “if I talk to my friends about it, then my friends can be quite supportive”*  
367 *(ID18).* In describing the characteristics of a supportive friend, ID15 highlights the balance  
368 between wanting to talk and be open with a friend, and other friends pestering or interrogating  
369 her about self-harm:

370 *“I don’t even have to go to her and say, “oh this happened” I’ll just go to her and talk to*  
371 *her and it’ll make me feel better. Sometimes she’ll be like ‘okay, you know, have you been*  
372 *alright recently?’ But she doesn’t go on about it. Sometimes people will be ‘have you cut*

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373            *yourself’ or ‘are you okay?’ whereas she just kind of subtly just asks how things are”*  
374            *(ID15)*

375            For some young people, friends were clearly an important source of support – someone to  
376 reach out to, who helped them to stop engaging in self-harm (reactive support):

377            *“I texted someone else and I was like ‘I’m really upset right now, I think I might relapse*  
378 *[self-harm], help’. And I think it’s good to be able to reach out to people that you’re*  
379 *close [to]”.* (ID07)

380            *“Talking to a friend [is helpful], because that’s the only thing that really takes my mind*  
381 *off it [self-harm], because you’re actually talking to someone. Whereas if it’s like reading*  
382 *a book or watching TV, you’re still thinking about it”.* (ID15)

383            It was not always clear whether the supportive interactions described were face-to-face or  
384 online. One participant explicitly sought help from friends online, in preference to school friends  
385 whom they regularly saw in person: *“Well, two of my friends... I messaged both of them two after*  
386 *[self-harm], because they know about it. And they won’t judge me for it. And like, they’ve been*  
387 *supportive.”* (ID31).

388            Some young people valued talking to friends who had experience of self-harm (mutual  
389 support), *“I told my friend about it and he said that he used to do it when he was a teenager so*  
390 *that was quite nice cause I had someone to talk to about it.”* (ID15) Indeed, two participants  
391 talked about making agreements with friends to try and stop self-harming together: *“I made a*  
392 *friend... he was going through the same stuff and he was a self-harmer, we tried to quit*  
393 *together”* (ID06)

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394           *“The only thing that really has ever helped me stop [self-harm] in the past was when I*  
395           *had other friends who were hurting themselves and so we would agree to stop together,*  
396           *and try and avoid it and talk to each other if we felt like we were going to.” (ID18)*

397           However, young people also recounted instances where friends had not been supportive  
398 when they had learned of their self-harm. These reactions varied from being *“shocked” (ID19)*  
399 and nonplussed *“they just didn’t know what to do with it” (ID16)*, through to being dismissive  
400 *“She was there like, you’ll be fine, just don’t think about cutting or being suicidal and*  
401 *everything” (ID12)*. Some responses from friends were particularly hurtful, such as friends  
402 gossiping *“everybody was kind of saying stuff about behind your face, [rather]than to your*  
403 *face” (ID14)*, or making cruel comments:

404           *“I told one of my friends once. He was one of my best friends at the time; I don’t talk to*  
405           *him anymore because, basically, he just turned around and told me to cut deeper. And I*  
406           *know, it wasn’t very nice. So, it was a bit like, that scared me off telling people.” (ID06)*

407           Such experiences did lead individuals to be more cautious about who they talked to about self-  
408 harm. ID15 had previously disclosed her self-harm to friends who dismissed it as attention-  
409 seeking, and now *“if I meet new people, I’ll hide it from them...I just wanted people to talk to,*  
410 *and then people would think I was being like attention-seeking, and I was like, no, I just want*  
411 *someone to talk to” (ID15)*.

412           Overall, friends were an important source of support, in terms of having someone to talk  
413 to and being able to reach out when trying not to self-harm, and also in the form of mutual  
414 support from others who self-harm. However, experiences reported with friends were not always

415 positive (some did not know what to say or do), and responses could be dismissive, unhelpful or  
416 unkind. This could influence willingness to seek support from peers.

417 **Theme 6) Emotions Shaped by Others (*Shame, Regret and Feeling ‘Stupid to Self-Harm’*)**

418 When asked about thoughts and feelings experienced after they had self-harmed, most  
419 young people spoke about shame, regret and guilt: “*I always regret it*” (ID07), “*I [feel] regret*  
420 *mostly*” (ID19), “*I was just ashamed of myself*” (ID30), “*I was ashamed of myself*” (ID12), “*I*  
421 *just felt really guilty...like I’d done something really bad*” (ID18). These emotions clearly had a  
422 strong interpersonal, even moral component:

423 “*I just think that I felt horrible in myself for doing it because, well, I promised people, my*  
424 *boyfriend, that I wouldn’t do it [self-harm] anymore and then I did it. It was kind of the*  
425 *‘breaking the promise thing’ as well.*” (ID06).

426 “*You just feel bad because you’re put in this ward with these children who are trying to*  
427 *make their lives better and fighting for life and you just tried to take yours away, just feel*  
428 *kind of guilty*”. (ID30)

429 In reflecting back on previous episodes of self-harm, several young people concluded that  
430 they were “*stupid*” (ID16) to self-harm: “*I was an idiot*” (ID09), “*every time I do cut I feel*  
431 *stupid and I feel like I’ve let everyone down*” (ID12), “*looking back now, I’d think that I was*  
432 *stupid and that if I could [go] back, I would never do that again*”. (ID06).

433 “*I just felt really stupid I was like why have I done that? I just felt really silly, I was like*  
434 *what, I’ve just done something that you know is just gonna be there for ages and it didn’t*  
435 *make me feel any better about myself at all but then I kept doing it.*” (ID15)

436 It is important to note here that the young people also reported feeling better, comforted  
437 or a 'release' after self-harming (consistent with extant research), the exceptions being ID12 and  
438 ID15, who did not report feeling better but nonetheless stated that they wanted to self-harm  
439 again. It seems these temporary personal 'gains' from self-harm are often attenuated by  
440 interpersonal considerations (such as the impact on and perceptions/expectations of others),  
441 leading to feelings of guilt, regret and shame.

### 442 **Theme 7) 'Empty Promises': Feeling Personally Let Down by Clinical Services**

443 Young people's experiences of clinical services were varied, with both positive and  
444 negative reports regarding different interventions (e.g. psychotherapy, dialectical behaviour  
445 therapy) and clinical approaches (e.g. group sessions versus one-on-one). As such, no coherent  
446 theme regarding what may, or may not, be helpful clinical input could be identified. Although  
447 most participants had been in contact with clinical services (currently, or in the past), three  
448 reported having no input from clinical services (IDs 06, 12 and 31).

449 Of those young people who had received support through CAMHS and reported their  
450 experiences in the interview ( $n = 12$ ), there was a sense of being let down by clinical services as  
451 a whole, at an organisational level. Familiar complaints included waiting lists ("*I think it was*  
452 *about eight months that I waited just for the initial meeting and then you have to wait again*"  
453 *ID09*; "*well, I've been on a waiting list for psychotherapy for a very long time*" *ID07*) and  
454 receiving an inadequate number of sessions ("*then it [therapy] just sort of started and ended*  
455 *before you even realise*" *ID09*; "*I already knew that six sessions wasn't gonna be enough for me*  
456 *to be completely honest with someone*" *ID26*). Two young people felt they were just repeatedly  
457 being offered the same therapeutic strategies, regardless of their efficacy:



480           This analysis of accounts of self-harm in UK adolescents emphasizes the importance of  
481 interpersonal/psychosocial issues as contributing factors for self-harm. It also explores the role of  
482 other people in providing support for self-harm, and in the emotional response to self-harm and  
483 clinical services. The findings from this study are congruent with the small number of qualitative  
484 studies that highlight the intersubjective nature of self-harm. In reference to affect regulation  
485 models of self-harm, we found that family arguments did elicit distress in young people prior to  
486 self-harm, that difficulties discussing these emotions were evident and that most young people  
487 reported relief or release following self-harm (Chapman et al., 2006; Klonsky, 2009; Nock  
488 2009). This potentially shaped the inter-relational experience of self-harm and support seeking  
489 efforts. The themes also reflect some of the complexity regarding psychosocial influences on  
490 self-harm and support seeking (e.g. feelings of guilt following self-harm). Most qualitative  
491 research has not included young people who self-harm – instead focusing on their caregivers or  
492 professionals. This study adds to a small corpus of studies that increase our understanding of  
493 self-harm. We consider specific implications for UK teens who self-harm with the potential to  
494 inform the design of effective interventions, since these are significantly lacking for young  
495 people who self-harm (Hawton et al., 2015).

496           Family conflicts and experience of bullying are established precipitants of self-harm, but  
497 the specific nature of these relationships is less clear (Brunner et al., 2014; Michelson & Bhugra,  
498 2012). Our findings suggest that family difficulties reported to lead to self-harm can vary from  
499 mundane daily arguments to life-changing family break-downs. Furthermore, it is chronic and  
500 long-term peer victimization that was found to be a prevalent background stressor for self-harm.  
501 This experience of bullying may not be described by young people as a specific identifiable  
502 trigger for self-harm, but may have a cumulative effect with other more acute stressors (Madge et

503 al., 2011). These findings emphasize the importance of the clinical assessment of psychosocial  
504 factors in self-harm (and training in psychosocial assessment for frontline staff), which should  
505 assess both short and longer-term influences, i.e. immediate triggers and underlying issues. For  
506 example, 1) the potential impact of everyday arguments with parents should not be  
507 underestimated (though may be perceived by adults as trivial) and 2) continuing peer  
508 victimization may not be highlighted as a key stressor leading to self-harm, but the possible  
509 cumulative effect in the context of other life stressors should be considered. Bullying within the  
510 school environment emerged as a salient factor contributing to self-harm in a recent systematic  
511 review of qualitative research (Evans & Hurrell, 2016). Interventions for self-harm can focus on  
512 helping bullied adolescents to cope with their distress and build their self-esteem, but the  
513 potential impact of additional life stressors and family environment should also be targeted (e.g.  
514 Fisher et al., 2012).

515         Parents are a significant and ongoing source of support for young people who self-harm.  
516 However, it is important to acknowledge the potential impact of parents' initial reaction upon  
517 learning about self-harm, particularly on a young person's willingness to talk with parents in the  
518 future (Arbuthnot & Lewis, 2015; Rowe et al., 2016). Characteristics of helpful parental  
519 responses to self-harm suggests a delicate balance of acceptance and emotional validation is  
520 needed, whilst being careful not to over-react or dismiss emotional pain. Previous research  
521 suggests that young people are more willing to seek help from parents when they feel that they  
522 genuinely care and are able to discuss self-harm with them (Arbuthnot & Lewis, 2015).  
523 Encouraging improved and non-judgemental parent-child relationships has been highlighted by  
524 adolescents as pivotal in helping those who self-harm (Berger, Hasking & Martin, 2013;  
525 McAndrew & Warne, 2014). However qualitative studies of parents with children who self-harm

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526 indicate they can struggle to understand and cope with self-harm and express a need for external  
527 support (Byrne et al., 2008; Oldershaw et al., 2008). It is also apparent from the current study  
528 that young people (and some parents) found it difficult to talk about distress and self-harm.  
529 Clinical services should not underestimate the worry and stress that parent's experience, and it  
530 may be helpful to find youth-friendly ways to scaffold discussions about self-harm and difficult  
531 emotions (e.g. card sorting tasks; Townsend et al., 2016). Offering clinical interventions tailored  
532 to the young person individually, together with family-focused interventions or parent support  
533 groups, may be helpful (Morgan et al., 2013; Wright-Hughes et al., 2015). Psychoeducation  
534 about self-harm as an expression of distress and the young person's struggles to talk about it  
535 could be part of care-plans to enable parents to maximise their understanding and support.

536         This study found that friends can also be a vital source of support for young people who  
537 self-harm, with some indication that reaching out to peers can help a young person delay or  
538 avoid self-harming. There was also some evidence of receiving mutual support from friends who  
539 also self-harmed, directly or online, but this requires further exploration. The nature of friends'  
540 responses to self-harm can influence help-seeking behaviours in the young person and even deter  
541 presentation to clinical services (Wu et al., 2012). Advice and support for both parents and peers  
542 is readily available online but is not clear whether people choose to access these sources or,  
543 indeed, trust them. Broader whole-school psychoeducational interventions (related to coping  
544 with emotional distress and supporting others) may offer a useful approach (Silverstone et al.,  
545 2017; Wasserman et al., 2015).

546         Young people's accounts of clinical services speak to feelings of being personally failed  
547 or let down by the system (long waiting lists, too few sessions, miscommunications, being  
548 dropped or dismissed from services). These experiences of systemic failures and limitations may,

549 unfortunately, leave a young person feeling that they are not worth helping, or are beyond help.  
550 Such experiences may also undermine attempts of individual clinicians to develop personal  
551 therapeutic connections with their clients. A qualitative study found that young people accessing  
552 therapy for self-harm reported problems with continuity of services, which led to disengagement  
553 from services (Storey et al, 2005). In adults who self-harm, the cycle of referral to the same or  
554 similar services and a lack of personalised follow-up care contributed to feelings of hopelessness  
555 (Hunter et al., 2013). Commissioners, policy makers and service managers as well as clinicians  
556 need to be aware of these risks when making decisions about funding and placing limitations on  
557 service provision. Short-term funding decisions can actually lead to long-term increased costs  
558 due to ‘revolving door’ referral of these young persons, who may continue to self-harm  
559 chronically and with serious presentations. Effective involvement of young people and parents in  
560 the development and delivery of services also has a role to play here, by suggesting system-level  
561 changes that could help young people feel better cared for and valued.

562           Finally, most young people felt guilt and regret following their self-harm acts. It is  
563 important to highlight these feelings of guilt considering the reported functionality of self-harm  
564 (in terms of affect regulation; Chapman et al., 2006; Klonsky, 2009; Nock., 2009). Though  
565 young people may feel better after self-harm, this is likely short-lived or tempered by guilt.  
566 These guilty feelings are clearly driven by interpersonal considerations (that were generally  
567 prominent in the data), such as the desire not to let significant others down. Previous qualitative  
568 work has found that for some young people, the feelings of shame subsequently associated with  
569 self-harm, in addition to their original stressors, led to suicidal ideation (McAndrew & Warne,  
570 2014). Furthermore, negative experiences with clinical services served to perpetuate a negative  
571 cycle of shame, avoidance of services and further self-harm in young people attending hospital

572 (Owens et al., 2016). Thus, parents, peers and clinical services all play an intricate role in the  
573 contributing factors for self-harm, accompanying emotions and the perceived receipt (or lack) of  
574 support.

### 575 **Limitations**

576 The theoretical generalisability of the study is limited to the majority white female  
577 sample that was recruited. Qualitative research targeting males and ethnic minority groups is  
578 needed (National Institute for Clinical Excellence, 2004) to explore the psychosocial experience  
579 of self-harm and effective supports for these groups (e.g. different supportive social resources  
580 may be salient and experiences of clinical services may vary). Whilst friends and peers emerged  
581 as a crucial source of support for young people, it is not clear to what extent these supportive  
582 interactions were in person versus online. Upon reflection, it is likely that the interview schedule  
583 did not allow for these issues to be adequately explored with the participants. The internet is an  
584 important source of support and coping strategies for young people who self-harm and should be  
585 considered in future research examining informal or interpersonal sources of self-harm support,  
586 and barriers to support.

### 587 **Conclusions**

588 We explored young women's experience of self-harm in the context of interpersonal  
589 stressors and supports (interpersonal relationships were foregrounded in the data). This study  
590 adds to the very limited body of qualitative work focused on UK teenagers who self-harm.  
591 Parental and family conflict, and the young person's emotional reaction to this conflict, was an  
592 important stressor driving self-harm (consistent with current research evidence and models). At  
593 the same time, support from parents was important, but our findings suggest this could be

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594 undermined if initial parental reactions were perceived as minimizing or over-emotional. As with  
595 previous research, bullying emerged as an important stressor. Our study adds to this literature by  
596 highlighting that *persistent* victimization by peers was described as a *cumulative* or background  
597 stressor, also contributing to self-harm. However, most young people reported friends to be a  
598 valuable source of different types of support. Reports of support from clinical services were  
599 more heterogeneous, with systemic limitations (e.g. waiting times, inadequate intervention,  
600 miscommunications, case closure) sometimes experienced as being personally let down – a  
601 finding that has potentially important implications for service development. Finally, most young  
602 people reported feelings of guilt and regret following self-harm, often driven by interpersonal  
603 considerations (e.g. not wanting to let significant people down). Thus, the relationship between  
604 self-harm, interpersonal difficulties, psychosocial supports and emotions is complex. It was  
605 apparent that young people experienced difficulties talking about their self-harm and emotional  
606 distress, which also feeds into this complexity.

607         The findings emphasize the importance of preventative strategies and psychoeducational  
608 initiatives to be undertaken at the universal service levels in collaboration with targeted and  
609 specialist mental health services. This should include education and training to parents, students,  
610 teachers and other allied professionals around understanding the nature, underlying emotions and  
611 appropriate response to self-harm. Our results suggest school-based interventions that focus on  
612 supporting young people who may be helping a friend who is self-harming, and developing  
613 strategies to deal with persistent victimization. The findings also suggest the need for changes in  
614 the existing pattern of service provision in the specialist services to ensure a quicker and more  
615 flexible response, young person-led intervention that leads to effective engagement, and  
616 collaborative decisions about discharge.

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754 Table 1. Participant details

<b>ID</b>	<b>Age range</b>	<b>Ethnicity</b>	<b>Current education/ Employment</b>	<b>Under CAMHS</b>
06	16-18	British	Further education	No
07	16-18	Asian/Asian British Indian	Further education	Yes
09	16-18	White British	Further education	Yes
11	13-15	White British	School	Yes
12	13-15	White British	School	No
14	13-15	White British	School	Yes
15	16-18	White British	Further education	Yes
16	13-15	White British	School	Yes
18	16-18	White British	Further education	Yes
19	16-18	Asian/Asian British Indian	Further education	Yes
22	16-18	White British	Employed	No
26	16-18	White British	Further education	No
30	13-15	White British	School	Yes

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31	16-18	Asian and White British	Further education	No
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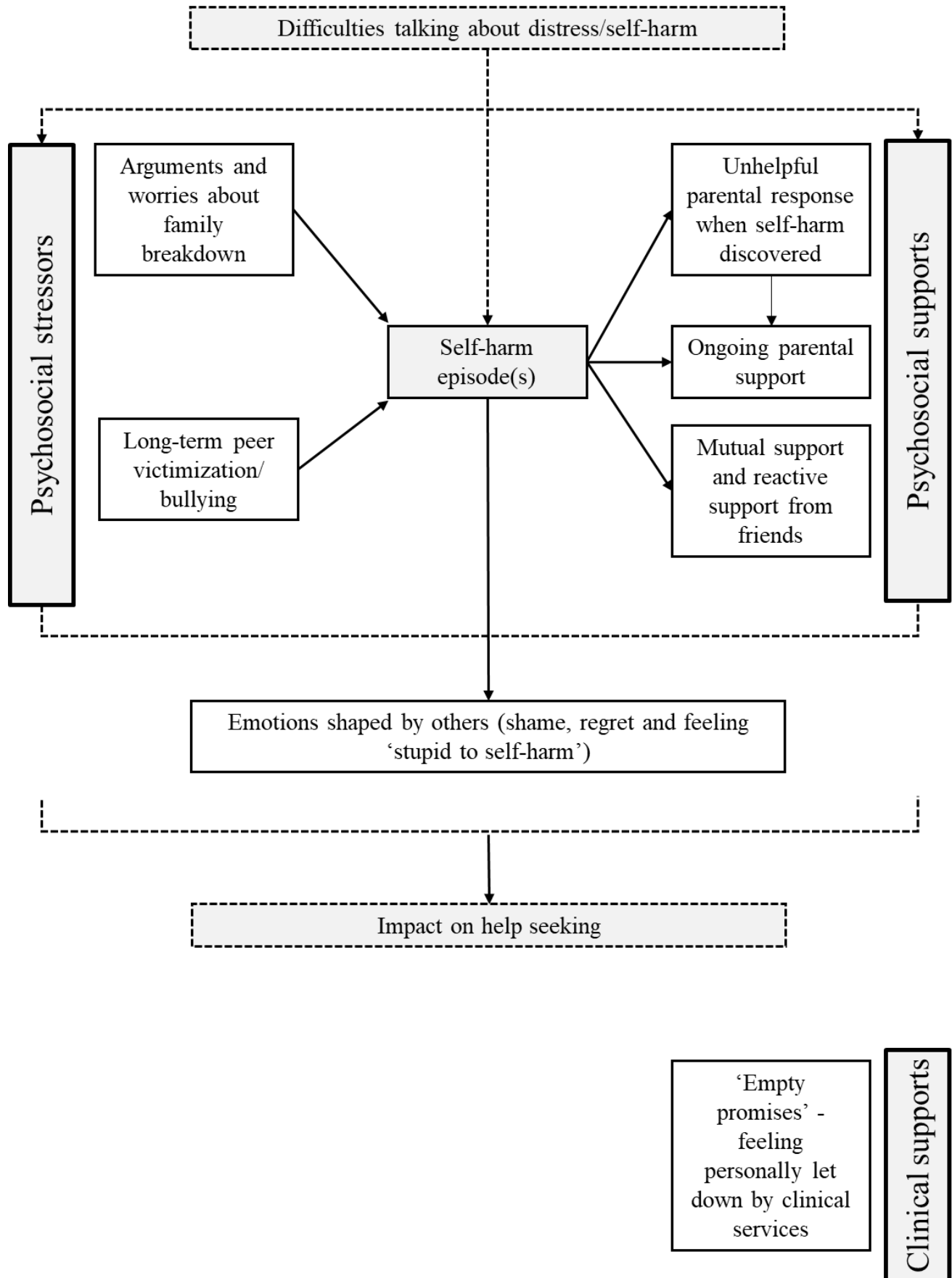
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777 Figure 1. Thematic map

778 Solid arrows represent relationships between themes/factors explicitly referred to by participants.

779 Dashed arrows represent inter-relationships between themes inferred in the process of analysis.

780 White boxes present themes. Shaded boxes denote meta-themes (higher level of abstraction than

781 the original emergent themes) that either serve an organisational role (psychosocial stressors,

782 psychosocial supports) or a hypothesized explanatory role (difficulties talking, help seeking).