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An interpretative phenomenological analysis of young people's self-harm in the context of 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.

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

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

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

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

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

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

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

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

teenage girls (Morgan et al., 2017). The Department of Health (2015) has highlighted a self-harm 'treatment gap' in the UK, with insufficient service provision to meet the needs of young people. Clinical guidelines state that psychosocial factors (that might explain an act of self-harm) should be routinely assessed and inform a management plan, but not every patient receives such an assessment (Kapur et al., 2008). There is also a substantial evidence gap relating to effective interventions for young people who self-harm (Townsend, 2014).

In this context, qualitative investigations can provide fresh insights into the interpersonal difficulties faced by adolescents who self-harm, and how both clinical and informal (family/friends) supports can be tailored to better meet the needs of this group. We focus on a group of adolescent females with a history of repeated and recent self-harm, with varying levels of contact with clinical services. The use of IPA affords a focus on the intersubjective and relational nature of self-harm, exploring the complexities of both the individual and shared experiences.

Method

Participants

Young people (11 to 21 years) who had self-harmed within the last six months were eligible to be recruited as part of a larger UK-based study of self-harm in young people with and without experience of living in foster care or residential care homes. Participants were recruited across various clinical settings, in the community and via social media.

This study reports interview data for fourteen females aged 18 years and under who had never lived in care (none of the recruited participants were aged 11 or 12 years). It was desirable to focus on a homogenous sub-sample for in-depth qualitative analysis (Smith, Flowers and

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

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

<INSERT TABLE 1 ABOUT HERE>

Data Collection

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

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

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

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

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

Analysis

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

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

Results

Self-harm History and Mental Health

The participants reported their first self-harm episode between the ages of 10 and 15 years (M = 13) and had repeated self-harm for between one and seven years. Most said that when their self-harm was at its most frequent, incidents occurred daily (57.1%) or weekly (21.4%). The majority reported self-cutting as a method they had (ever) used (85.7%), and 57.1% reported overdosing. All but one participant reported using multiple methods of self-harm. Six participants self-reported mental health diagnoses, most commonly depression and/or anxiety (each reported by four participants).

Overview of Themes

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

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

<INSERT FIGURE 1 ABOUT HERE>

Theme 1) Arguments and Worries about Family Breakdown

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

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

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

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

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

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

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

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

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

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

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

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)"*

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

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

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

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

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

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

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

Theme 5) Mutual Support and Reactive Support from Friends (and Instances of a Lack of Support)

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

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

yourself' or 'are you okay?' whereas she just kind of subtly just asks how things are" (ID15)

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

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

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

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

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

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

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

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

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

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

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

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

> *"I just felt really stupid I was like why have I done that? I just felt really silly, I was like what, I've just done something that you know is just gonna be there for ages and it didn't 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:

458 *"[CAMHS] just giving me the same solutions over and over again, it didn't feel like*
459 *there was anything new. It was just 'have you tried this, have you tried that' and I'd just*
460 *be like 'no it doesn't work', and she'd just be like 'well try it again'." (ID14)*

461 More worryingly, some young people's overriding experience of CAMHS was of being
462 dismissed, let down, or even turned away. There was an overarching sense of being personally
463 let down 'by the system'. One young person summed up her experience with CAMHS as *"just*
464 *empty promises really" (ID09),* because she felt she never had the opportunity to talk about her
465 underlying emotional distress following a family bereavement, which she desperately wanted to
466 do. Two young people specifically spoke about being 'dropped' by CAMHS:

467 *"I had CAMHS, they then after my first meeting said that they didn't know what sort of*
468 *support I'd need, so dropped my case…I was referred to CAMHS again, CAMHS then*
469 *dropped me two weeks early, didn't carry out my full six sessions." (ID26).*

470 "*I didn't turn up to a meeting that I didn't know I had, so a miscommunication - I didn't*
471 *know I had it. They [CAMHS] turned around and sent a letter a couple of weeks after*
472 *saying 'considering that you haven't turned up, it seems as if you're doing alright so*
473 *we're just gonna discharge you', and they didn't hear anything obviously, so they*
474 *discharged me. Then a couple of weeks after that I ended up in hospital again." (ID16)*

475 These negative experiences with clinical services relate to systemic and organisational factors,
476 that may be difficult for young people to comprehend or accept. As such, it is not surprising that
477 systemic limitations in service provision can be experienced as personal rejection by young
478 people who self-harm.

479 **Discussion**

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

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

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

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

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

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

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

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

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

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

Limitations

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

Conclusions

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

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

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

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754 Table 1. Participant details

ID	**Age range**	**Ethnicity**	**Current education/ Employment**	**Under CAMHS**
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

31	16-18	Asian and White British	Further education	No

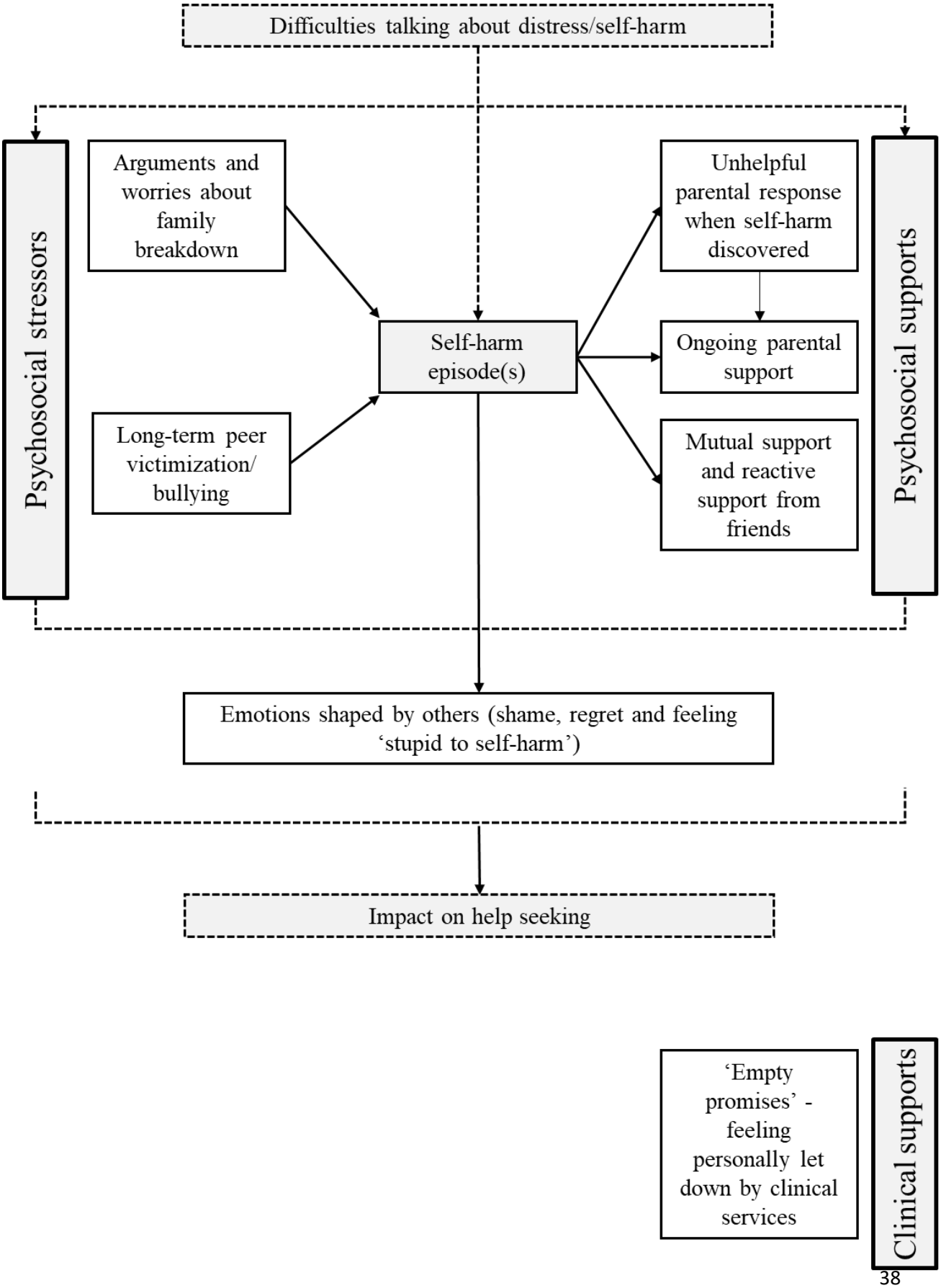
Difficulties talking about distress/self-harm
Psychosocial stressors
Arguments and worries about family breakdown
Long-term peer victimization/ bullying
Self-harm episode(s)
Unhelpful parental response when self-harm discovered
Ongoing parental support
Mutual support and reactive support from friends
Psychosocial supports
Emotions shaped by others (shame, regret and feeling 'stupid to self-harm')
Impact on help seeking
'Empty promises' - feeling personally let down by clinical services
Clinical supports

Figure 1. Thematic map

Solid arrows represent relationships between themes/factors explicitly referred to by participants. Dashed arrows represent inter-relationships between themes inferred in the process of analysis. White boxes present themes. Shaded boxes denote meta-themes (higher level of abstraction than the original emergent themes) that either serve an organisational role (psychosocial stressors, psychosocial supports) or a hypothesized explanatory role (difficulties talking, help seeking).