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Understanding adolescents' experiences of self-harm: secondary analysis of Family Therapy sessions from the SHIFT trial

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Abstract

Objectives: To explore, using first-hand accounts, adolescents' understandings of why they self-harmed, what their responses to self-harm were, and how they resisted or ceased self-harm.

Method: Secondary analysis of video-recorded Family Therapy sessions from the Self-harm intervention: Family Therapy. Recordings of 22 participants, approximately 170 hours of footage, formed the dataset.

Results: Five core themes were developed; (1) Distress can be difficult to convey (2) Self-harm and suicidal ideation; a complex relationship (3) Self-harm as a form of communication (4) Self-harm to manage emotions and (5) Moving forward.

Conclusion: Self-harm was a means of communicating distress as well as managing emotions. Accounts highlighted the complex interplay between self-harm and suicidal intent. Encouragingly, many participants described being able to resist self-harm.

Introduction

Self-harm is prevalent amongst adolescents (Morey, Mellon, Dailami, Verne & Tapp, 2017), with research highlighting an increase in incidence, particularly among females aged 13-16 (Morgan et al 2017). Rates of self-harm are consistently higher in adolescence compared to adulthood (Swannell, Martin, Page, Hasking & St John, 2014), peaking during adolescence (Mumme, Mildred & Knight, 2016). Understanding why adolescents engage in self-harming behaviour is important for a number of reasons. Self-harm is positively correlated with low mood and anxiety (Brunner et al, 2014), as well as being linked to mental health difficulties in adulthood (Morgan et al, 2017). Most importantly, adolescents who self-harm are at higher risk of a repeated episode (Klonsky, May & Glenn, 2013) and non-fatal self-harm is the strongest risk factor for subsequent suicide (Morgan et al, 2017), though this relationship is complex (Kapur et al, 2013; Brown & Kimball, 2013). Given the risk factors associated with self-harm, further exploring how adolescents are able to resist, or even cease, harming themselves, may contribute to future interventions aimed at managing or reducing self-harm.

There have been a number of theoretical and primary research studies that have explored why individuals harm themselves (Klonsky 2007; Nock, 2010, Edmondson, House & Brennan, 2016). Both in research with adults, and adolescents, affect regulation has been cited as the most common reason (Nock & Prinstein, 2004; Lloyd-Richardson, Perrine, Dierker and Kelley, 2007; Edmondson, House & Brennan, 2016). Primary research examining adolescents' personal accounts of self-harm is limited. Hill and Dallos (2011) used narrative methodology to explore the way in which six adolescents (5 females, 1 male, aged between 13 and 18 years), who had engaged in self-harm, made sense of their self-harm and its relationship to events that had occurred in their lives. This study highlighted the importance of allowing adolescents to gain a better understanding of their self-harming behaviour through reflective conversations. Klineberg, Kelly, Stansfield and Bhui (2013) interviewed an ethnically diverse sample of thirty adolescents in East London. This study investigated self-harm first-hand from the perspectives of the adolescents, however the sample consisted of a majority of female participants (24/30).

Questionnaires have often been used in research, arm, predominantly to assess prevalence and identify reasons given for self-harm (Nock & Prinstein, 2004; Lloyd-Richardson, Perrine, Dierker and Kelley, 2007; Palmer, Welsh & Tiffin, 2016). One difficulty with the use of questionnaires to understand the reasons why people self-harm is that the very use of the measure limits the choices for the respondent. If the questionnaires are informed by reasons suggested in existing literature then this only reinforces the current reasons identified. It may be that this method of capturing data related to a person's motivation for self-harm doesn't fully capture that individual's experience of self-harm.

Therefore, the current study aimed to explore, using first had accounts, adolescents' understandings of why they self-harmed, what their responses were and how they resisted or ceased self-harm.

Method

As the research was exploratory, qualitative methods were used to gain insight into how adolescents understood their experiences of self-harm. Data was gathered via a secondary analysis of video-recorded Family Therapy sessions collected as part of the Self-Harm intervention: Family Therapy (SHIFT, Wright-Hughes et al, 2015). The SHIFT trial was a multi-centre, individually randomised, controlled trial comparing Family Therapy (FT) with Treatment as usual (TAU) for adolescents aged 11-17 who had engaged in at least two episodes of self-harm. Self-harm was defined as "any form of non-fatal self-poisoning or self-injury

regardless of motivation or the degree of intention to die" (Wright-Hughes et al, 2015). This definition was also used in the current study in line with current UK clinical practice (Wright-Hughes et al, 2015). . While 415 participants were randomly allocated to the FT arm of the SHIFT trial, 269 of these participants consented to the use of their session recordings to be used for future research (L Graham, personal communication, August 13, 2015). This constituted the potential data set in the current study.

All participants had engaged in at least one previous episode of self-harm and had self-harmed prior to assessment by the Child and Adolescent Mental Health service (CAMHS) with self-harm being the key feature of presentation of that assessment (Wright-Hughes et al, 2015).

Participants

Participants in the current study were sampled purposively from the available data set to ensure variation on key attributes of age, gender and ethnicity. Only participants who had a minimum of three Family Therapy sessions were included in the sample to ensure that participants had engaged with the therapy and discussions of their self-harm would be included in the data.

Data collection

Sessions were viewed by the first author to begin the process of familiarisation with the data. Every session recording for each participant – where the adolescent was present – was viewed. Sessions were only discounted if the adolescent was not present, for example parent only.

After first viewing, sessions were reviewed and excerpts of data were selected for transcription if they contained discussions of self-harm from the perspective of the adolescent or discussions of contextual factors identified as important on initial or subsequent viewings of the sessions. Transcribed data and subsequent analysis were managed using NVivo 11. Each participant had a single transcript covering all of their recorded sessions. Approximately 170 hours of footage formed the dataset.

Analysis

Data was analysed using inductive Thematic Analysis, a method for identifying, analysing and reporting patterns (themes) within data which can potentially provide a rich and detailed account of the data (Braun & Clarke, 2006).

Each participant transcript was read, re-read and initial codes generated. Coding was undertaken by the first author, with the developing themes reviewed and discussed on a number of occasions with the co-authors.. After all of the transcripts had been fully coded, the generated codes were grouped into potential themes, and further developed through discussions with all authors. This process was refined over several iterations of the analysis.

Ethics

The SHIFT management approved the use of the data for secondary analysis and ethical approval was sought and granted from the National Health Service integrated research application system. The project did not require local NHS research governance review.

Results

Session recordings for 22 participants were viewed, a total of 113 sessions (mean of 5.1 sessions per participant) and approximately 170 hours of footage.

Of the 22 participants, 14 were female (63%) and 8 were male (37%). Twelve participants were aged between 11 and 14 (55%) and ten were aged between 15 and 17 (45%). Participants were mostly white (77%), with the remaining sample Asian (9%), Mixed Race (9%) and Black (5%).

Multiple methods of self-harm were described including cutting, scratching, biting, punching, poisoning and overdosing. Table 1 displays the participant demographic information.

Participant	Sex	Age Group	Ethnicity	Method	No of sessions (adolescent present)
1	Female	15-17	White	Not known	2
2	Female	11-14	White	Cutting	11
3	Female	11-14	White	Cutting	1
4	Female	11-14	White	Multiple	8
5	Female	15-17	Black	Multiple	6
6	Male	11-14	Asian	Not known	3
7	Female	15-17	White	Overdose	4
8	Female	15-17	White	Cutting	7
9	Female	11-14	White	Overdose	5
10	Female	11-14	White	Cutting	7
11	Male	11-14	Mixed	Scratching	1
12	Female	15-17	White	Multiple	6
13	Male	15-17	White	Cutting	4
14	Male	15-17	White	Cutting	11
15	Male	11-14	White	Punching	1
16	Female	11-14	White	Multiple	6
17	Female	11-14	Mixed	Multiple	5
18	Male	15-17	White	Punching	4
19	Female	11-14	White	Multiple	6
20	Female	11-14	White	Overdose	3
21	Male	15-17	White	Multiple	3
22	Male	15-17	Asian	Multiple	9

Table 1: Participant demographic information

The topic of self-harm was introduced in the first session in 18 of the 22 (81%) cases, and in most instances this was by the therapist (77%). In a minority of sessions the adolescent or parent discussed the issue first. The SHIFT protocol states that for each session the therapist

should obtain a description of the most risky periods between sessions, and present situation (Boston, Eisler & Cottrell, 2018).

Five core themes were derived from the data: Difficulty of communicating distress; Self-harm as a way to communicate difficult emotions; Self-harm as a way of managing emotions; Self-harm and suicidal ideation; a complex relationship; and Moving forward.

The following key refers to individuals included in the illustrative quotes:

T = Therapist

P = Participant

FM = Family member

Theme 1: Difficulty of communicating distress

Given the therapeutic modality, content often focussed on how the family communicated, both inside and outside of the sessions. However, conversations also specifically explored how the adolescents communicated. A number of participants found it very difficult to explore their distress, or even broach the subject of self-harm. For example, when posed a question, some adolescents managed only limited verbal responses, replying with "don't know" or "can't remember". It's likely with these replies there were elements of the content of the questions being difficult to address in the therapy setting, but also genuinely not knowing the answer. Individuals may not have had the words to explain, were not able to remember, or perhaps did not want to remember.

While some adolescents found it difficult to put words to their distress, others chose not to share their feelings. Often they were trying to manage alone, by 'bottling' their feelings up. For example, in this extract, the participants reflects that they decided not to share their thoughts with anyone and eventually this resulted in an eruption of their emotions:

> *"I just let it bottle up…bottle up then just exploding basically"*
>
> P12, session 2

Similarly, the impact, or feared impact, of sharing their thoughts and worries prevented some adolescents from opening up and talking to those around them. Not wanting to burden other people with their worries, or wishing to protect loved ones from harm, caused individuals to keep quiet. In the quote below, a participant describes feeling pressured into talking and this not being helpful. They describe a complex mix of self-blame – for not talking in the first place – coupled with feelings of regret for revealing things that had then caused upset:

> *"Well yeah because I would probably say more than I wanted because I've been pushed to say it and stand up and be like well are you happy now well nobody is happy now and I'd be feeling even worse because I didn't say it i*n the first place because I *didn't want to upset them and I'd feel it's my fault not what I've said but because I've said it and now they're upset and its then caused a problem and it feels like either way I don't win"*
>
> P5, session 6

The fear of being of judged was also a barrier to communication. For example, a participant described not feeling able to talk to their parent or grandparent when they were feeling very low, and suicidal, as they were scared that their grand-parent would tell other people. In the example below, another participant explains how being asked to discuss self-harm made them feel judged and this was incredibly distressing, to the extent that they left the therapy session to avoid the distress:

> *"Makes me feel like I'm being judged and I don't like that so I'm gonna go before I cry even more and before I have a breakdown"*
>
> P1, session 2

Some adolescents recalled facing negative reactions from family and friends, having talked about self-harm. In the example below, a participant explains how they were viewed as "mad". Despite not wanting to tell their family about self-harm, they found out and reacted with a stereotypical response which the adolescent found extremely upsetting:

> *T: "What was it like telling your family?"*
>
> P*: "Horrible, but I didn't really tell them, they found out and I had to deal with them calling me a nutcase and it wasn't very nice at all"*
>
> P8, session 1

Theme 2: Self-harm as a way to communicate difficult emotions

As highlighted in theme one, distress was difficult for some individuals to discuss. While some participants may not have had the words to voice their distress, or not wanted to share their thoughts, the act of self-harm offered others a means of communication.

When asked to reflect on self-harming behaviour, family members – of more than one adolescent – described adolescents doing so "for attention" or as a "cry for help". This is the idea that an individual would choose to self-harm so that others will take notice and/or offer assistance. Data in the current study suggests that self-harm is more nuanced than simply a means of drawing attention. For example, an individual may harm themselves so others would notice, but not necessarily want them to help. In the extract below, a participant reflects back to a parent that they understood why they had formed the view that self-harm was a "cry for help", but pointed out that they had not displayed their self-harm for others to see:

> *"I wouldn't say it was a cry for help although I can see why you've come to that conclusion…I mean I wasn't really parading around showing everyone"*
>
> P8, session 1

In contrast to this, there were examples of self-harm being utilised so that others would attend to them. However, the function was not simply to draw attention to themselves, but to communicate to others the severe level of distress they were experiencing. Not being heard was stated as being important and linked to self-harm. In the example below, a participant recalled a family disagreement from childhood, commenting that they had harmed themselves as a way of expressing how distressing they found this conflict and wanted it to stop, hoping self-harm would make their family members "shut up":

> T: *"Did you say you were ten or eleven when you first self-harmed?"*

FM: *"Eleven"*

A: *"I don't remember what it was about but I just remember an* argument between members of the family and I just wanted them *to shut up basically"*

P14, session 8

Not being heard was stated as being important and linked to self-harm. In one example a parent suggested that the adolescent was at more risk of harming themselves when the two of them had argued. The adolescent's response suggested that while that could have been the case, their self-harm was also related to people not acknowledging them, or listening to them. In the extract below, another adolescent, who was experiencing a tough time at school, explains that cutting allowed them an opportunity to express to their family, and staff at the school, how distressing they found attending school. They hoped that self-harm would make the school staff notice and take action:

*T: "Can you thi*nk what made you decide to cut *yourself?"*

A: "I knew that if I did that school would actually listen"

P4, session 3

Theme 3: Self-harm as a way of managing emotions

This theme reflects the role self-harm played in managing emotions. For some self-harm was pre-meditated. These instances were often described as a process of internal dialogue, with adolescents mentally cycling through their options and ending up at self-harm. In contrast, some instances were depicted as impulsive acts. In the excerpt below the adolescent describes how when they were angry they did not think that they had another option available other than to self-harm:

"Sometimes I'm angry and I don't know what else to do"

P10, session 3

Self-harm to manage emotions took a number of forms. For example, self-harm was often used to seek relief from distress, with the hope that the act would release feelings such as anger and frustration. For example, in the extract below, this adolescent describes self-harming to reduce their level of arousal. They explained how they self-harmed to draw blood and this was important for them as the sight and taste of blood had a calming effect:

*"I think that's maybe why I was self-*harming before because I got blood and when I get blood something happens in my mind and I *calm down"*

P2, session 11

In contrast to those who described experiencing relief from self-harm, some individuals wanted to get rid of or stop feelings. Several participants recalled when feeling angry they harmed themselves to try and stop feeling this way. For example, a participant, recalling the aftermath of a disagreement with a parent, wanted some way of managing an overwhelming feeling of rage which engulfed them. They used self-harm to try and rid themselves of their rage, rather than just seeking a reprieve:

"My body just felt like my blood was boiling and I just needed something to get rid of it and I suppose that was it really"

P12, session 6

Self-harm was used to avoid distress. For example in the extract below, a participant describes thinking about a particular person who had caused them harm throughout their life and the things that had been done to them. They desperately wanted to avoid these experiences and describe self-harming regardless of the physical pain they would experience. They also portray the ultimate act of avoidance as an attempt to take their own life:

> *"I'd be sitting in my room thinking about what he's done and it'd be like a hurricane in my head and I would think I'm just going to do it and don't think about whether it hurts or not and when I'm in those bad feelings…and it sounds disgusting and sick but it's the way I feel…I'd happily jump* off a bridge and do something *and not think about it"*
>
> P7, session 1

As another means of avoiding distress, self-harm was used to replace one type of pain (emotional) with another, more manageable type of pain (physical). For example, a participant described how they hoped that feeling the physical pain would allow them to forget about their sadness. However, they reflected that this strategy did not work – either in the short term or long-term:

> *A: "To feel pain instead of the sadness"*
> *T: "So you thought* that if you hurt yourself the sadness would go *away?"*
> *A: "That I would feel the pain and think about that instead of the sadness"*
> *T: "And did that work at all?"*
> *A: "No"*
> P11, session 1

In contrast to self-harm being used to avoid distress, there were examples of self-harm being utilised to stimulate feelings. For example, a participant described how experiencing a lack of feelings was intolerable, and they used self-harm to feel something. This same individual explained how as well as feeling numb, they did not feel in control of their emotions, and self-harm offered them a way to feel more in control of their emotional world:

> *"It was like when I got really low I felt numb and doing it was a way to feel I guess…I never felt in control of the way I was feel*ing *and it was a way to be in control"*
>
> P8, session 1

Self-harming and feelings of excitement were captured in the response of a participant. They explained how each time they have self-harmed they experienced an adrenaline rush and the act became compulsive:

> *"Yeah I think so because erm it's like each time I've self-*harmed *I've got an adrenaline rush and it feels like something you need to get done"*
>
> P5, session 1

Theme 4: Self-harm & suicidal ideation: a complex relationship

This theme reflects the complex relationship between self-harm and suicidal ideation. There were times when adolescents expressed clear suicidal intent, times when intent was not so clear and times when suicidal intent fluctuated. For some, self-harm was not at all related to thoughts of suicide and in a few instances self-harm was related to actively resisting an attempt to complete suicide. A number of participants reported attempts to complete suicide and for some there had been multiple attempts. Methods of attempted suicide varied across and within episodes.

A sense of rejection and abandonment, along with self-blame, were factors that contributed to participants experiencing suicidal thoughts or attempting to complete suicide. However even with intent to die, it was still complex. Thoughts were not always acted on and one participant explained how they had experienced mixed emotions following an attempt to complete suicide. They described experiencing both relief and disappointment relief as they thought they could not have not done much harm to themselves, and disappointment as they would still have to face their problems that had contributed to them taking the overdose:

> *P: "I went to the bathroom and was sick"*
>
> *T: "And were you disappointed with that?"*
>
> *P: "Erm, a bit of both, I was happy because I thought that if you'd been sick that you couldn't do that much damage and disappointed because I still have to go back to school"*
>
> P4, session 2

Suicidal ideation and self-harm co-existed within, and across, episodes. Some participants described episodes of self-harm without wanting to die, yet reflected on other episodes of self-harm with intent to complete suicide. There were also examples when intent was less clear. This was often expressed by adolescents as wanting problems to disappear, or themselves to disappear. The idea that they should disappear was perhaps recognition that it was not possible for all of their problems to vanish so the alternative was that they no longer exist, and therefore not have to face the difficulties in their lives.

> *"But I don't also think about self-*harm sometimes I want to *overdose or if I don't want to hurt myself I'll just want to run away and sometimes it's dead hard"*
>
> P10, session 2

In contrast to those individuals who expressed a clear intent to die, there were also statements that indicated for some, self-harm was not about wanting to die. For example, in this excerpt, a participant explains how their self-harm became more severe although this was an attempt to manage their distress and not an attempt to end their life:

> *"Well yeah it's like I do it further down and a bit deeper and stuff but I don't want to die or anything I just want don't want to keep on getting upset"*
>
> P4, session 1

Theme 5: Moving forward

This theme reflects how some participants were able to move forward and resist, or ultimately abstain from, self-harm. For many, the shift from self-harm to ambivalence or resisting the urge to self-harm occurred over the course of therapy. There were a minority of individuals who were able to abstain entirely from self-harm but for the majority the process was characterised as a struggle; on some occasions being successful in resisting but on other occasions not being successful.

A number of strategies to support temporary resistance from self-harm were reported by participants. Some identified distraction techniques as useful, including listening to music, watching television, painting, cleaning and talking to people. These tactics were not effective on every occasion and described by one participant as occasionally contributing to low mood:

> *"I try* to go to sleep or make myself a cup of tea and sometimes it *doesn't work and I'll wake up in a foul mood or feel even worse"*
>
> P8, session 1

Rather than attempting to distract themselves, other participants substituted self-harm with alternative behaviours. For example, one individual reported scraping their knuckles down a wall when upset. They thought of this as progress, having previously cut and experienced thoughts of wanting to end their life. While it was not always the case that substitute behaviours were less harmful, for instance one adolescent used smoking as a replacement for cutting, in some instances the alternative behaviours were actually productive. One individual used music as a creative outlet for releasing their anger, as opposed to punching objects which they had done previously:

> *"It's like with my rap music I use that to get my anger out"*
>
> P18, session 1

In addition, improved emotional regulation enabled some adolescents to resist the urge to harm themselves. Talking was identified as a healthier way to manage emotions; feeling listened to and understood played a role in resisting self-harm for some participants. In the quote below, a participant, at the end of one of their later therapy sessions, reflects that they had been able to talk about a very difficult subject, linked to their self-harm, without becoming distressed. They identified this as helpful and recognised this was an on-going process which would take time:

> *"I suppose the more I talk about and the more I talk about it without tears and get it out the more I can brush it aside…it's still* hard though and I *think it's going to take years…literally years"*
>
> P7, session 2

As well as being heard, it was important for some adolescents that they had people around them who shared similar experiences and could relate to their own difficulties. In the following extract, the parent suggests they could offer comforting words to their child in the same way a friend did. The adolescent's reply indicates that it was not only comforting words that their friend offered that was important; it was also that they had experienced similar difficult life experiences, and could empathise with their situation:

> *"It's not the same though* she has been through abuse as a child *and she can relate to it but you can't as you didn't go through* that as a kid *she can relate to pretty much anything"*
>
> P2, session 6

Accounts highlighted how some participants were able to step back and reflect on the impact of self-harm. Whilst the act of self-harm offered some individuals relief, several commented on the futility of self-harm, liking it to a vicious cycle; the act of harming themselves provided benefit in the short-term as it offered a release from their distress but this reprieve was only short-lived. Their distress soon returned and they were then again in a position of wanting to seek relief. These discussions contributed to a shift in perspective which resulted in some adolescents being able to resist, or cease, self-harm. For example, this adolescent, who had not self-harmed for a number of weeks, was asked to reflect on their self-harm:

> *"I don't know I just felt better afterwards but then I felt even* worse a few hours later and it just made me do it more and *more"*
>
> P4, session 1

Recognising the impact, or potential impact, of friends' self-harm enabled some adolescents to think differently about their own self-harm. For example, in the quote below, a participant explains how they were motivated to avoid self-harm following a serious incident of a friend harming themselves. They described being shocked and upset, as they had witnessed the fallout and the emotional reaction of the friend's family, as well as realising they had been close to losing a trusted confidant:

> *"I was so upset after it happened and I've seen what it does to other people and I don't want to do that and it's shocked me nearly losing one of my best friends who I tell my problems to"*
>
> P10, session 5

Discussion

This is the first study to use recorded family therapy sessions to explore adolescents' understanding of their experiences of self-harm. The approach allowed first-hand accounts to be explored, developing an understanding of the experience of self-harm from the perspective of the adolescents.

There have been a number of attempts, both theoretical as well as primary studies, aiming to understand why individuals self-harm. Many of the reasons found in the current study replicated previous research. Within the literature affect regulation is widely cited as a prominent reason for self-harm. In this study self-harm was used to manage emotions, although how it was used varied. There were examples of adolescents using self-harm for more than one purpose in relation to managing feelings, for example using self-harm on occasions as a release, whilst at other times using self-harm to avoid distress. The current research adds to the understanding of self-harm to manage emotions, demonstrating that this is nuanced and complex.

Adolescents in the current study described difficulties communicating their thoughts and feelings in general, and specifically their thoughts and feelings related to self-harm. It seems that for some, not sharing their internal experiences eventually resulted in them harming themselves as an outlet. Some adolescents described being met with unhelpful responses when

they did share their thoughts and feelings. For example, that their self-harm was for "attention". These myths surrounding self-harm only serve to perpetuate stigma and lead individuals to discuss self-harm less, thus contributing to the secretive nature of self-harm which maintains the problem and ultimately continues to perpetuate the cycle of silence, distress and self-harm.

Present in the accounts of adolescents was evidence of self-harm explicitly related to suicidal intent, in keeping with previous research (Rodham, Hawton & Evans, 2004; Klonsky, May & Glenn, 2013). Self-blame, hopelessness, desperation, worthlessness and suicidal ideation were all linked to attempts to complete suicide (Rutter & Behrendt, 2004; Klonsky, May & Glenn, 2013). However, suicidal ideation fluctuated and was not always acted on. Even with intent to end life there was still complexity. For instance, some participants reflected that on occasions they had harmed themselves with an intention to complete suicide, yet differentiated episodes of self-harm where there was no intent to die, as found in previous research (Brown & Kimball, 2013). Evident in the accounts of participants were times when self-harm was not about wanting to die, or actively trying to stay alive. These findings demonstrate the complex relationship between self-harm and suicidal ideation; with self-harm not always being related to suicidal intent. This is an important consideration for individuals working with adolescents to bear in mind as over half of GPs, teachers and parents think that young people who self-harm are likely to try and commit suicide (Cello & Young Minds, 2012). While suicidal intent should be explored and the risk assessed, it should not be assumed. Equally, it is vital to revisit intent throughout an intervention as adolescents' motivations can change over time and across episodes of self-harm.

How adolescents were able to resist or cease self-harm often mirrored why some adolescents harmed themselves in the first place. For example, those individuals who had moved forward, and were able to resist self-harm, often described managing their emotions more effectively. These findings support previous research, which has found that individuals who had stopped harming themselves had higher levels of emotional regulation and were able to tolerate stronger emotions (Tatnell, Kelada, Hasking & Martin, 2014). While it may have been the case in the research by Tatnell et al (2014) that emotional regulation increased once self-harm had stopped, accounts from the current study suggest that developing greater emotional regulation coincided with reduced self-harm. Central to improved emotional regulation was stronger connections with those around them and enhanced communication. Vital were better-quality relations with family and friends and being able to share their thoughts and feelings without judgement, or conflict. This increased sense of connection mirrors previous findings that has found family support to be a salient factor in cessation of self-harm (Tatnell et al, 2014; Mumme, Mildred & Knight, 2016).

In the current study, the use of secondary analysis ensured there was no additional burden on the individuals of having to discuss their difficult experiences in more depth. The approach also presented the opportunity of adding a richer understanding to the topic of self-harm. For example, rather than selecting reasons from a checklist participants were able to provide detailed accounts.

Participants in the SHIFT trial were selected on the basis that their self-harming behaviour resulted in an admission to Hospital/Accident and Emergency, or they were already under the care of primary services. Therefore, adolescents that were self-harming but did not seek help, or did not receive treatment as a result of their self-harm, would not have been captured by the SHIFT trial. It is plausible to consider that those adolescents seeking help were more open to conversations relating to self-harm. For example, those adolescents in the family therapy treatment arm did, albeit possibly reluctantly, attend the therapy session and communicated in some way, shape or form. It may be that if data were collected from a sample of adolescents

who were harming themselves, but not seeking help, they would have offered alternative accounts which would not have reflected the themes generated in this study. Likewise, we only had access to those participants who had consented to take part in the SHIFT trial and agreed to have their sessions recorded and be available for use in future research. It may be those individuals were contemplating their self-harming behaviour already and more willing to change.

It should also be acknowledged that during the family therapy sessions the adolescents were often, although not always, reflecting on episodes of self-harm that had occurred sometime previously. It is possible to consider that the adolescents, when reflecting on their experiences of self-harm with a therapist and/or their family in a therapy session, may have made sense of their experience of self-harm in a different way if they had been interviewed without the presence of others. For example, they will have only talked about things they were willing to allow their parents and family to know. Therefore the presence of family members may have influenced the data collection and subsequent analysis.

During the analysis phase, the first author was in training to be a Clinical Psychologist. This may have influenced the data selected and transcribed for later analysis. For example, when in the role of researcher it may be that the data was approached from a certain perspective, though it is likely that clinical experiences influenced how the data was approached, and vice versa.

Investigating personal accounts of self-harm can educate health professionals about the sensitivities and complexities they will encounter when gathering information during clinical assessments and therapies (Klineberg, Kelly, Stansfield & Bhui, 2013). Information then obtained during assessment and therapy would inform the formulation, which underpins treatment. For example, if the function of self-harm is to avoid distressing emotions then treatment would be focussed on helping the adolescent to tolerate difficult emotions without harming themselves. As the present study has highlighted the nuanced complexity of self-harming to manage emotions, exploring the function of self-harm for that individual – from their perspective – would be crucial in the success of the treatment. On a wider level, exploring personal accounts may contribute to further understanding of self-harm in adolescents.

Future research could focus on increasing diversity within the sample and explore first-hand accounts from adolescents who may be approaching self-harm from a different perspective, such as those self-harming but not seeking help, or in the care of the local authority. This would allow alternative accounts to be generated and further the understanding of adolescent self-harm.

Summary

Common themes were identified from the data relating to how adolescents understood their experiences of self-harm. Although several found self-harm a very difficult subject to discuss, many were able to articulate their thoughts and describe why they had harmed themselves. While self-harm was used to manage emotions, this was expressed in a range of ways and a number of reasons for self-harm were evident in the accounts of adolescents. The interplay between self-harm and suicidal ideation was described as complex and difficult to disentangle. On a positive note, adolescents were able to discuss factors important in moving forward and reducing, or ceasing, self-harm.

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