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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. These results have implications for improving support from both informal and clinical sources.

1. Introduction

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 and 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 misunderstood (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-

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harm and decreased negative affect and relief are experienced after self-harm. Further, alleviating negative affect was reported as a main function served by self-harm (Klonsky, 2007). Importantly, these changes in emotional experience predict a 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 and Hawton, 2008; Townsend et al., 2016a). In adolescents who self-harm, frequent interpersonal problems are reported with family, friends, peers (including bullying) and romantic partners (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 and Bhugra, 2012; Townsend et al., 2016a,b). Qualitative research is well-placed for this purpose.

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 and 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 and 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 and 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, a sense of 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 and Wright, 2013; Rissanen et al., 2013).

The present study extends this emerging body of qualitative research, which (except for McAndrew and 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.

2. Method

2.1. Participants

Young people (11–21 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 et al., 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.

2.1.1. 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

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