

Look beyond the scars

Understanding and responding to self-injury
and self-harm

by Paul Bywaters and Alison Rolfe



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Introduction

This NCH report is written to raise awareness of self-injury and prompt debate about how best social care, health, education and other services can respond to young people who deliberately injure themselves.

NCH is a voluntary organisation which works with children and young people throughout the UK including those who have been in the care system, are homeless, in trouble with the police or who are disabled. NCH also provides services for parents and families as a whole to give children and young people a better chance in life.

Some projects work with children and young people who deliberately injure themselves. The staff were concerned both by the injuries themselves and the distress which they reflect. They wanted to know how best to help.

Two research studies

As a response, NCH commissioned two pieces of research from the centre for social justice at Coventry University. The results of both studies are woven together in the report which follows.

The first study, carried out in 1999, was designed to answer two questions. What was the extent of self-injury in NCH projects? How well did NCH staff feel equipped to work with people who were deliberately injuring themselves?

All the NCH projects in the UK – then over 300 – were sent a questionnaire and over a third responded. The questionnaire covered issues such as:

- how many children and young people each project was in contact with who were deliberately injuring themselves
- whether the staff felt adequately trained and supported in working with people who were injuring themselves
- whether there was a clear and helpful framework of policies to guide staff
- what other services there were locally which people who were self-harming found helpful.

The second study, carried out between October 2000 and April 2001, involved in-depth interviews with young people and adults who have been involved in a pattern of self-injury. NCH projects asked those who they knew had a pattern of self-injury whether they would be willing to talk about their experience in order to raise understanding of the issue. They were told that the interviews would cover:

- why people sometimes injure themselves deliberately
- how staff and other professionals have reacted to them when they have injured themselves
- what staff and other professionals could do which would be helpful to people when they injure themselves.

Twenty four people from widely different parts of the UK took part in this study, including five who were the friends or partners of people who had self-injured. Participants all had a connection with an NCH project. Many were current or former service users, or have children who were service users. A few were working for NCH projects or for connected projects (either as paid workers or as volunteers). The age range was from 16–49 years old. However, all but three were in their late teens or early 20s. The majority who had self-injured were female (almost 80%), and nearly all participants described themselves as white British.

This was not designed as a representative sample of people who self-injure. For example, around two thirds of those we spoke to had been in the care system. However, it would be all but impossible to ensure that interviews were representative for two main reasons. First, as we shall discuss below, there is no single agreed definition of self-injury. Second, self-injury often happens in private and injuries are kept secret so the full extent cannot be known.

The intention was, rather, to report on in-depth accounts of a significant number of mainly young people who have extensive direct experience of self-injury. They spoke at length: the shortest interview lasted 45 minutes and six were over two hours. With permission, most of the

interviews were tape recorded but, when participants asked, notes were taken instead. Copies of the tapes and notes were sent back to the participants to be checked and alterations were then made in two cases.

Many of the participants in the interviews said they felt that people who had not injured themselves could not really understand their experience. On the other hand, feeling understood, being listened to and not being judged were the benchmarks for identifying people who had been helpful to them. The participants, therefore, wanted to give their time and knowledge in order that other people – professionals and the wider public – would understand self-injury better. Their views are quoted extensively here but their names have been changed.

In this report, we have deliberately not written about the wider social policy context, such as the Mental Health National Service Framework (Department of Health 2001a) or the National Framework For the Prevention of Suicide and Deliberate Self-harm in Scotland (Scottish Executive 2001). Nor have we provided an extensive review of the research literature (Rolfe 2002). In this report, we want the experiences of people who have self-harmed and staff involved in providing social care to take centre stage, rather than the views of policy makers or researchers.

Self-injury: a complex issue

A key theme of the report is that self-injury is a complex issue. Far from claiming to provide simple answers we wish to represent the case for a sophisticated, many layered understanding. What forms a particular young person's self-injury takes, the reasons why they injure themselves and what they have found to be helpful to them will be unique, although there are some common patterns. The call from participants is for services, friends and families to respond to the distress which lies behind the self-injury, to see 'beyond the scars' to the person, as one of the participants put it.

For workers, this means having the quality of training and support which enables them to be concerned rather than afraid, to help them make sense of what is happening rather than feel it is alien. There also has to be a safe policy and organisational framework for practice.

For families and friends this means having information, explanations and sources of support, rather than just being left with the feeling that the injury is an act of rejection.

Self-injury: a distressing issue

What follows may at times be distressing to read. What people who self-injure do to themselves can seem frightening and hard to understand. The visible, physical evidence of someone's mental pain can be hard to bear. The fear that someone we know might threaten their own life can be deeply disturbing. But, like child abuse and sexual abuse, domestic violence, child prostitution and running away from home, the first step is to look it in the face. And what people who self-injure have to say is encouraging. Overwhelmingly, the message is that self-injury is a means of self-protection not self-destruction. It is a:
'Way of coping ... when things get really bad. People deal with things in different ways and, unfortunately or not, this is my way.'

Kirsty (early 20s)

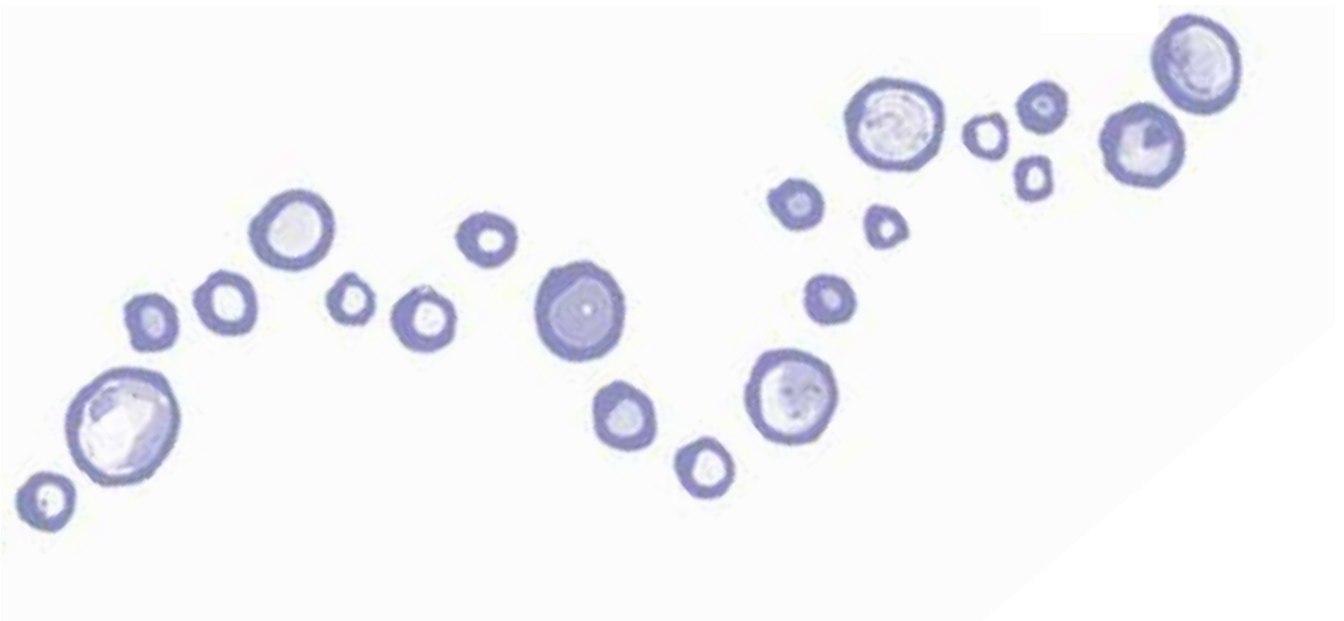
At the end of the report we give the names and addresses of some resources which readers could contact if they wish to discuss self-injury with someone experienced.

The structure of the report

The report which follows begins by describing and defining self-injury before discussing why people deliberately injure or harm themselves. Finally, it turns to what people who self-injure have found helpful and makes recommendations. Although self-injury may be a way of coping, it also points to profound personal distress. What people who self-injure have asked is that, individually and as a society, we respond to the distress as much as to the injuries. This means that professionals, service providers and policy makers have important lessons to learn.

References

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- Rolfe, A. (2002). *Self-injury and 'deliberate self-harm': a review of the literature*. Coventry: Centre for Social Justice.
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What is self-injury?

What do people do?

All of the interview participants had injured or harmed themselves using several different methods. All had cut themselves at some point, and all had also taken overdoses. Nearly all named cutting, usually with razors, knives or broken glass, as their main form of self-harm. The exceptions to this were one young woman who described her main form of self-harm as getting 'paralytic' through alcohol, and three men who took regular overdoses. However, as we shall discuss in more detail later, overdosing as self-injury was distinguished by participants from overdosing with the intention of committing suicide.

In addition to cutting and overdosing, a number of other types of deliberate self-damage were mentioned by several participants: burning, hitting walls, alcohol, drugs, jumping from a height and self-strangulation. A minority described blood letting, chopping off their hair, letting themselves be hurt by others and solvent abuse.

For example, Mel first started injuring herself when she was about twelve, and although she now thinks of this as self-harm, at the time she didn't. She describes using a variety of methods of self-injury: *'I used to hit walls, or cut myself. I never used to smoke, but my friends did, and I used to take the last drag and see if I could put the cigarette out with my fingers.'*

Mel (late teens)

Others also used a limited range of methods of self-injury. Sandra stated that she mainly cuts herself, although she occasionally burns herself using an aerosol. However, she prefers cutting, because it is easier and quicker. One young man who took overdoses about twice a month would sometimes use other forms of self-harm. He stated that:

'It didn't really matter what I did. A couple of times I've got a piece of glass and put it through my hand.'

Tom (early 20s)

Self-injury, self-harm and suicide

Some authors, particularly those with a medical or psychiatric perspective, treat 'self-injury' as part of a wider category of 'self-harm', which includes suicide and suicide attempts (para-suicide). For example, the NHS Centre for Reviews and Dissemination systematic literature review (1998) is entitled 'Deliberate Self-Harm' and defines it as 'intentional self-poisoning or injury, irrespective of the apparent purpose of the act'.

Others make a distinction in terms of whether the person intended suicide (Babiker and Arnold 1997). For them, 'self-injury' implies no suicidal intent while 'self-harm' means suicide and attempted suicide.

Our participants mainly saw self-injury as distinguished from attempted suicide in that it was a means of relieving emotional pain and distress. Indeed, their perspective was that self-injury can be seen as a means of preventing suicide. For example, when Rachel was young, she had thought that she wanted to kill herself. As time went on, she cut her arm instead:

'Because I didn't want to kill myself, I just wanted some of the hurt and all the pain just to go away.'

Rachel (late teens)

Similarly, Vicky had felt that:

'It's something that needs to be done to get me living.'

Vicky (over 25)

And Mel asserted:

'People always look at the negatives of self-harm, whereas they should actually look at the positives, and the positive is that person is still alive.'

Mel (late teens)

In this report, therefore, we focus on deliberately self-damaging behaviour which is not intended to be life threatening. This may involve actual injuries or other kinds of harmful behaviour such as overdosing, so we (and the participants) sometimes use the term self-injury and sometimes

self-harm. Usually, when we use the term ‘self-injury’, as in the title of the report, we do not mean to exclude other kinds of self-damaging behaviour, but simply to avoid always having to write ‘self-injury and self-harm’.

However, the relationship between self-injury and suicide is complex. Nearly all of the participants said that they had thought of suicide at some point. Many also talked about suffering from depression, sometimes severely. For example, Tracey said:

‘There’s been a few times when for no reason I’ve just felt really low, and I’ve just sat there, and you know when you feel like you’re going mad? You’re sat there and you... can’t stop crying, and you just don’t want to feel like that any more. You don’t know whether you want to be here or not. The best thing to do is to go to bed and see how you feel in the morning, but you can’t go to bed, because you need to cry it all out.’

Tracey (early 20s)

Anna described herself as severely depressed and found that cutting was a way of coping with this. Along with several other participants, she did not see the self-injury as a problem, but did see depression as a problem for her. She stated:

‘Sometimes you just get knocked down and you just can’t be bothered to get back up, because you just know that you’re going to get knocked down again. So you just stay at the bottom, where you know that at least it’s going to be the same. Being dead’s probably better than being alive, isn’t it?’

Anna (late teens)

All but two participants had attempted suicide at some point, almost all on more than one occasion. For the vast majority, suicide attempts took the form of overdosing. However, it is important to note that very few participants had tried to kill themselves through cutting. Most distinguished clearly between cutting as a coping mechanism, and attempted suicide by other means. As Kirsty explained:

‘When I self-harm I don’t want to die, because

basically, if when I self-harmed I wanted to die, I’d cut underneath, rather than on the top of my forearms. I’d cut where my veins were, obviously... If I wanted to die when I self-harmed, then I wouldn’t be here, because I’d have made sure.’

Kirsty (early 20s)

Similarly, Sharon commented:

‘The only time I overdose is when I want to die. The cutting up’s not about wanting to die, whereas the overdoses were because I wanted to die.’

Sharon (early 20s)

Thus, nearly all of the participants had been severely depressed to the point of feeling suicidal. Nearly all had attempted suicide at some point. Some had attempted suicide on several occasions. Cutting, however, was very rarely used to try to commit suicide. Bernadette, in her early 20s, also described how she cut the outside of her arms, ‘because obviously I wasn’t trying to kill myself anyway’. Overdoses were more likely to reflect suicide attempts. However, overdoses should not be assumed to necessarily imply suicidal intent, as there were several participants who took repeated overdoses in order to harm themselves, but not to kill themselves.

Self-injury and self-harm were much more commonly seen by the participants as ways of coping with depression and emotional distress and, thus, ways of preventing suicide. But some recognised that this distinction was not always that clear in their minds and/or that what they did could be life threatening even if they did not intend to take their lives. Only two participants did not talk about having attempted suicide. However, in both of these cases, the participants recognised that their self-harm was severe enough to kill them, even though this was not their intention. Phil commented:

‘They’ve told me that one of these days I’m going to do some very serious damage or end up killing myself, and they’re more expecting it than I am. But I have been told that one of these days I won’t be waking up to phone 999, or anything else.’

Phil (over 25)

Different methods: different meanings?

Distinctions between different methods of self-injury and other forms of self-destructive behaviours are sometimes used to give a particular 'diagnosis' or for analytical purposes. However, the participants often seemed not to perceive a clear distinction between different actions. Sonia, who generally used methods of self-injury such as cutting or inserting needles, said that it didn't really matter what type of harm it was, as *'they all made me feel better'* (Sonia, over 25).

Other participants stated that self-injury through cutting was preferable to other forms of self-injury or self-harm. Sandra, for example, sometimes burnt herself, but preferred cutting because it was easier and quicker. Anna has tried overdosing and taking drugs, but she found that overdosing: *'Doesn't work. I do take drugs, and that helps your mind forget about things for a while'* (Anna, late teens). Anna finds cutting more effective at relieving emotional pain.

For others, alternative methods of self-injury and self-harm were used when access to the means of their usual form of self-harm was blocked. Joanne, for example, usually cuts herself. If she has nothing to cut herself with, she will bang her arm against a wall, or occasionally burn herself or take overdoses. Phil is diabetic, and explained that when he is prevented from cutting himself, he will deliberately neglect his diabetes: *'When I was in a social services residence, if you cut yourself you were out, so I wouldn't take my medication, or I would drink a bottle of pop or something to boost the sugar levels up, so they couldn't really say you're actually doing something that's visible to somebody else...'*

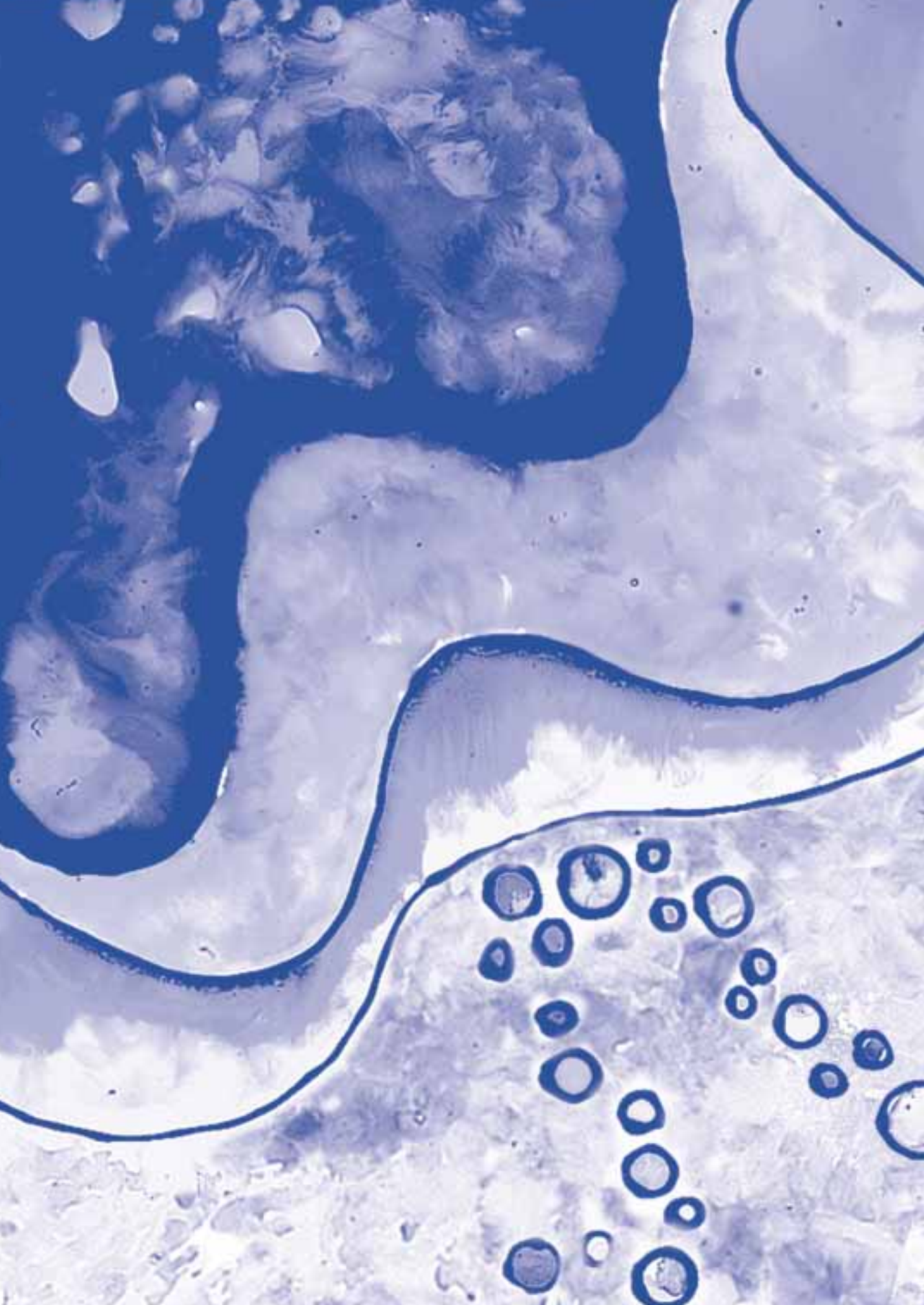
Phil (over 25)

Thus, whilst for some participants self-injury was felt to be more beneficial than other, less immediate forms of injury and harm, virtually all participants had used a range of self-harming actions at some point and some felt that all were beneficial. A third of the participants had (or had

had) eating disorders and a number of other behaviours were recognised as forms of self-harm.

'... And I don't think self-harm is just about cutting or hitting walls and things. I think it includes eating disorders, because they are self-harming. When I got a bit older I had some problems with alcohol and solvents, and a lot of self-harming behaviour through having multiple relationships. I think that's very self-harming. Because people think of self-harm as just cutting or something, but like, smoking and drinking are all self-harming.'

Mel (late teens)



How common is self-injury?

An unknown quantity

The one recent national survey in Great Britain (National Statistics 2001) found that, according to children, about 1 in 17 of 11–15 year olds had tried to harm, hurt or kill themselves. This study, too, highlighted the difficulty of knowing whether suicide was intended or not and so bracketed them together.

However, it is impossible to know for certain how many young people and adults injure themselves for two main reasons. The first is that, as we have just discussed, there is no clear, simple definition of self-injury or self-harm. Should we include all smokers or everyone who drinks heavily on a night out knowing that they will make themselves ill? Do we try to distinguish between suicide attempts and injury without suicidal intent?

The second reason is that self-injury and self-harm usually takes place in private and never comes to the attention of social, medical or other

services and will frequently be kept from parents or other carers. Indeed, as we report below, secrecy was a key feature of self-injury for some participants. Nearly all our participants harmed themselves in private, generally in their own room or own home. A typical remark was made by Sharon, who commented:

'I wouldn't do it if anyone else is there. I do it on my own.'

Sharon (early 20s)

Self-injury in NCH projects

Of the 38 per cent of NCH projects in England, Wales and Scotland who responded to the survey, 61 per cent reported at least one known incident of self-injury in the last three months. These involved 337 children and young people, three fifths were female and two fifths male. The types of injury involved are shown in Table 1.

Table 1

Numbers and types of injuries by gender in NCH projects during a 3 month period

Types of injury	Male		Female		Total	
	Number	Percentage	Number	Percentage	Number	Percentage
Cutting	34	16	98	32	132	25
Inflicting blows	45	21	31	10	76	15
Burning/scalding	7	3	10	3	17	3
Picking/scratching	41	19	64	21	105	20
Pulling out hair	15	7	26	8	41	8
Biting	27	13	24	8	51	10
Swallowing objects	17	8	19	6	36	7
Inserting objects	4	2	7	2	11	2
Other	24	11	27	9	51	10
Total	214	100	306	100	520	100

The definition of self-injury used in this survey may have led respondents to exclude overdoses and some other forms of self-destructive behaviours and can be expected to be an underestimate of the actual level of self-harm taking place amongst service users.

For all the reasons given above, caution should be exercised in drawing detailed conclusions from these figures other than that self-injury was not an uncommon occurrence for staff to deal with and that a range of forms of self-injury are involved.

How frequently do people injure themselves?

Our interview participants all had experience of repeated self-injury and/or self-harm, and had harmed themselves over a considerable period of time. This was anything between 1–30 years, with all but one self-injuring for over three years.

The average age at which those under 25 said they first started injuring themselves was 13. The earliest reported first incident was at age 7, the most common period for starting to self-injure was between 12 and 14. The frequency varied considerably between individuals, and also for each individual over time. At its peak, eight participants had harmed themselves on a daily basis. One participant was injuring herself over ten times a day at its peak, either by cutting or blood letting. Two participants self-harmed approximately every other day. Two estimated that they harmed themselves about once a week and two once a fortnight (Table 1).

However, many participants had also gone for periods of days or months without self-harming, before starting again. One young woman would sometimes self-harm for a few days, and then go for months without doing so. She used to time herself for how long she could go without doing it. For some, the pattern was erratic, and they did not know when they would feel the need to self-harm again. This made it very difficult for some participants to say if they had stopped.

In the NCH projects, 27 per cent of those who were known to self-injure were said to do so at least once a week, with a further 41 per cent injuring themselves at least once a month. Self-injury was most frequent in projects for disabled children and young people. Once again we would caution against using these figures as representative of all young people nationally, as our methods of study were not designed to and could not establish that.

References

Babiker, G. and Arnold, L. (1997) *The Language of Injury: Comprehending Self-Mutilation*. British Psychological Society.

NHS Centre for Reviews and Dissemination (1998) *Deliberate Self-Harm*. York: University of York.

National Statistics (2001) *Children And Adolescents Who Try To Harm, Hurt Or Kill Themselves*. London: National Statistics.

Why do people develop a pattern of self-injury?

Why do people start self-injuring?

Being asked to describe the first occasion on which they self-harmed involved most participants in thinking back over a number of years, usually into their childhoods. On this first occasion, the participants used a variety of forms of self-injury and self-harm. Six cut themselves. Five more used 'scratches' or surface cuts to the arms. Three burned themselves. One inflicted blows. Two took overdoses. While for some there were clearly identifiable triggers, for others there had been a gradual escalation of actions which, looking back, they now regarded as self-harm. For them, the reasons for self-harming were more diffuse.

Three of the participants did not know what had caused them to harm themselves for the first time, feeling that there was no particular trigger for this that they could recall. In two cases, the first injury was accidental, but these participants found they experienced relief from this, and continued to injure themselves in a more deliberate manner following this accident.

However, most participants linked the first time they harmed themselves to things that were happening in their lives around that time. Such factors included unwanted pregnancy, being bullied at school, not getting on with parents, the divorce of parents, physical abuse, bereavement and going into care. Several participants said they were having difficulty coping. For example, Kirsty felt that she cut herself the first time because of:

'Lots of pressures at the time, really: being bullied, I didn't get on with my step-mum, I lived with my dad, and I didn't really see my mum much – well, not at all really at that point... I was washing up one day, and I remember I had all this housework to do before my step-mum got home, and I thought "If I don't get it done she's going to lay into me again and everything". And I just remember it got to drying the pots, and for some reason, I don't know whether it was just the pressure of it then or what, I just ended up doing that.'

Kirsty (early 20s)

For three young people, the first time they harmed themselves was when they went into care: one into

foster care, and another two into residential units. All felt rejected or distressed by their circumstances at this time and stated that they did not want to be in care. Tracey described her circumstances as follows:

'My dad had just got sent to prison, and I was put in a foster family, and I really, really, really didn't want to be there. They just sort of dumped me there.'

Tracey (early 20s)

Tom gave his reason for injuring himself as:

'Just moving into care and thinking my family didn't like me.'

Tom (early 20s)

Jackie began self-harming:

'The day I went into the children's home. It done my head in, and I'd just left my friends and that, and I started smashing windows and getting glass, cutting my face, cutting my arms. I was just stressed and upset. Just lost my mind.'

Jackie (late teens)

Some participants felt their emotional state was the primary reason for self-harming, rather than life events. Two participants mentioned severe depression, and one mentioned boredom. Two felt that this first incident was an attempt to regain control of their lives. Mel strongly linked this first incident to self-punishment. When she first harmed herself by hitting the wall, she shouted, *'fat, ugly, stupid'* with each punch:

'So each punch had a word to it, and a reason. I also felt that everybody was taking control of my life.'

Mel (late teens)

Two participants stated they had got the idea after finding out that other people cut themselves. For example, at the age of 14 Tracey was placed on an adult psychiatric ward for patients with depression. At this point, she had never thought of harming herself by cutting, although she had taken an overdose as attempted suicide. On the ward, she met another woman who had scars on her arms. This woman explained to Tracey that she had cut herself, *'so a few days after that, I had a go.'*

Tracey (early 20s)

Another young woman cut herself at the age of 12 after her sister had already done so. This, however, was the experience of a minority, and does not explain why these participants continued to self-harm, after this first incident.

There were mixed experiences concerning this first incident of self-harm. At one extreme, Sharon (early 20s) was not actually aware that she was stubbing cigarettes out on her arm. She said, *'I didn't even know what I was doing... I got a cig, and I just put a cig out on my arms'*. Her friends pointed out to her what she was doing. They took her to the hospital, and took her cigarettes and lighter from her. Another very different reaction to the first incident was fear and shock. For Kirsty (early 20s), the first cutting incident made her feel *'panicky and shaky, at first'*.

However, all participants who could remember how they felt on this first occasion commented that they had experienced feeling a release of tension. For example, Vicky described how she felt after cutting herself semi-accidentally, the first time: *'A sense of release, calm, just a stillness. It was like as if I'd taken drugs, and I'd just collapsed back, and I was in a world of my own, and nothing could affect me, because it was like I was in this glass case and nothing could penetrate it. It was just a wonderful feeling... You didn't feel pain. It was just a sensation. A weird sensation.'*

Vicky (over 25)

Whilst it could be a frightening experience, for all there were certain benefits in self-injuring or self-harming, which led this to be repeated.

The progression to regular self-injury

For some participants, the first incident led straight on to regular self-harm. However, for one young woman, there was a gap of five months before she began to self-harm on a regular basis and for another the gap was four or five years. For most of those who went on to cut themselves regularly, there was a gradual increase in the depth of the cuts, with scratches becoming proper cuts and cutting becoming gradually deeper, until cuts required strips, stitches, or even surgery.

The reasons for the progression to regular self-injury and self-harm are varied, but all the participants linked this to the perceived benefits. Vicky described the progression from the first semi-accidental cut as follows. After the first incident, she would scratch herself with glass or anything sharp, erratically. She then went into a psychiatric unit for a break, and was very scared to find herself in an environment with people who she did not know, some of whom were men, and some of whom appeared to be behaving in unpredictable ways. She broke a picture frame and cut herself with the glass, and this relaxed her and helped her to sleep. The next morning when the cut was discovered:

'One of the staff nurses said "Oh, it's alright. I've seen worse than this. You can't be that bad". And so that's when the cutting became deeper, because I'm thinking, "I do feel bad. I need help", so that's when it became slices then, not erratic. It became controlled slices.' She found that this was even better, because it bled more. *'And then I got quite excited with my skin opening up, and seeing inside, and the fact that I didn't feel any pain when I opened my skin was amazing.'*

From the cutting, it progressed to bloodletting: *'Because I realised that fact that blood was going made you feel light. It made you feel drained and light and airy, and you could relax and sleep. So I then realised that I needed to get into veins, to let the blood come out, because it was that that I was trying to release.'*

Vicky (over 25)

However, a key reason for repeating self-injury, in particular, seems to be due to the relief of pent up emotions which is achieved. For example, Tammy described how she would want to repeatedly cut herself, because:

'It made the pain go away. The more I did it, the more I wanted to do it. I wouldn't have to cry, and I'd feel happy again.'

Tammy (early 20s)

Because of these perceived benefits of cutting, this participant, like many others, began to cut herself on a regular basis.

What are the reasons for self-injury?

Meaningful, not meaningless

Many participants felt it was difficult, if not impossible, for people without personal experience of self-harm to fully understand the issue. But they stressed the need to listen and to try to understand the meanings of self-harm for them, rather than making assumptions about them based on their self-harming behaviour. For this reason, and because self-injury can be seen as incomprehensible or meaningless, we give substantial space to this issue in this report.

The reasons given for self-injury and self-harm vary between individuals. Participants gave a range of reasons for their self-injury and self-harm, and the specific ways in which these factors combine are unique to each individual. There were also several interviews in which participants stated there were reasons for their self-harm which they did not wish to talk about. But the range of factors and the distress they reflect is illustrated in Box 1.

Unravelling these factors and how they combine together in each individual is complex and may result in an apparent clarity which is not felt at the time by those involved. However, there are patterns which may be helpful in understanding and we try to spell these out below.

Some factors relate to coping with events, either in the past or the present. Some relate to feelings and emotional responses, both those that lead to self-harm and those which are perceived to be achieved by self-harm. Other reasons were also given, notably self-injury becoming a habit and environmental and social factors. In the following section, each of these reasons for self-injury and self-harm are explored in detail.

Coping with events

(i) *The influence of past life events (trauma and abuse)*

Most participants mentioned traumatic events during childhood and early teenage years as factors in their self-harm. Some were very clear about the role of sexual, physical or emotional abuse in

Box 1

Self-hatred. It was different. Taking control. Bad things that happened in the past. Anger. Release. Calm. Turning mental pain into physical pain. A way of coping. Deserving it. Negative feelings about self. Childhood trauma. Severe stress. Purification. Going into care. At lowest ebb. No one caring. Suicidal intent. Difficulty coping. Getting feelings out to the surface. Taking anger out on self rather than others. Visual sign of feelings. Social exclusion. Discrimination. Being bullied. Trying to live up to others' expectations and conform. Being raped. Not being listened to. Self-punishment. PMT. Childhood sexual abuse. Physical abuse. To get high. It's fun. Testing people out. Only way of getting attention in care. Severe guilt. An addiction. Normal (in residential care). Rebellion. A way to keep living. People breathing down your neck. Seeing counsellor. Insomnia. Depression. Emotional hurt. Wanting help.

leading them to self-harm. Others spoke rather more vaguely of *'things in the past'* or stated that they knew why they did it, but that they did not want to talk about it. For example, Tammy commented: *'It leads from other problems. Other problems that you haven't been able to talk about with anyone.'*

Tammy (early 20s)

Those participants were not asked to expand on what these reasons were. But, in later interviews, participants were asked, *'Some people say that self-harm is a way of coping with feelings which relate to bad things that have happened in the past. What do you think about that? Do you think it is true?'* All of the participants replied, 'Yes'.

Amongst those who were clear about the role of abuse in their subsequent self-harm was Mel, who survived an attempted rape at the age of 11,

and was raped aged 16.

'Being raped, I didn't know how much it had affected me, but then I've realised, bloody hell, it has affected me, in a big, big way. It was only later that I realised that it wasn't my fault. I blamed myself for a long time.'

Mel (late teens)

Similarly, another young woman said:

'I've had a few traumatic experiences... When I was 11 I was sexually assaulted – sexually abused, from about October to January, and that person is the only person in the world who placed fear in my heart, who placed fear in my nightmares, and in my day.'

Rachel (late teens)

Tammy also strongly stressed the role of physical and emotional abuse as directly causing her to self-harm. Because of her physical impairment, she was: *'Made to feel guilty for being alive. I used to get angry, because I was being blamed for living basically... My brother used to beat me up and my mum used to beat me up as well... My mum, because I had a disability, thought that I wasn't normal, so she used to try to hide me away.'*

Tammy (early 20s)

In other interviews, the role of abuse was strongly hinted at, but not clearly stated as a factor in self-harm.

Other kinds of past life events were also pointed to as triggers. Kirsty had begun to cut herself regularly at a time when there were a large number of stressors in her life. She explained:

'Loads of stuff had happened in my life... I didn't get on with my dad and step-mum... my grandma died of cancer, which was hard, and I had to go and visit her every day, and nurse her through it, and things like that, and I had a miscarriage.'

Kirsty (early 20s)

(ii) Stress resulting from current life events

Some of the participants felt the stress caused by current life events was a factor in leading them to self-harm. This can be seen as in line with a

survivors' perspective on self-injury, as a coping strategy and suicide prevention strategy. For example, Sharon would harm herself:

'When I got stressed or anything, or if I got too wound up about things and if I couldn't cope with things.'

Sharon (early 20s)

Similarly, Kirsty stated that if there are a lot of things going on in her life that are hard to handle: *'I can almost guarantee that I'll self-harm.'* She added, *'It is my personal way of coping with things, when things get really bad.'*

One key reason why self-harming became habitual for some seems to relate to its role as a safety valve. As Sandra commented: *'I always knew that if things went wrong I could cut myself'* (Sandra, late teens). Vicky was told by social services that her children would be taken into care unless she stopped self-harming. At the time she could not understand this, as she felt that the self-harm was helping her to cope. She explained:

'I never wanted to hurt my children... I wanted to protect my children, and that were why I were doing it. To be able to cope as a mother. To function normal. I had to do this to function normal.'

Vicky (over 25)

So, for some, self-harm was a means of coping with current difficulties. However, the role of past trauma and that of current life circumstances are by no means mutually exclusive. In other words, participants did not feel that it was either past trauma or current circumstances that led them to self-harm, but the ways in which these combined. Sonia, who runs a self-help group for people who self-harm, felt that when things go wrong, self-harmers always blame themselves.

'It can build up for weeks. Each time you think "Oh, that's my fault" and it can build. Something else can happen and you say, "It's my fault", until you've got to let all this badness out, to release it, so that you feel alright again. And you do, you feel so much better afterwards. So you feel "Right, I've let all that out, that's me, I feel great".'

Sonia (over 25)

Thus, the accounts given in these interviews point to a complex interaction between past trauma and consequent emotional distress, which impact upon responses to current life stresses.

Coping with emotions

(iii) A release mechanism

Like Sonia, 7 of the 15 participants talked about using self-harm as a means of achieving a sense of release. This would be preceded by a period during which emotional distress would gradually build up to a point where it felt unmanageable:

'It's a build up of emotion, and adrenaline, and hurt and anger and pain, and anything you can possibly think of.'

Kirsty (early 20s)

The feelings that were released were often those of anger, or a sense of self-hatred and badness.

Sharon described this as follows:

'It was like trying to get out all the shit that I was feeling inside... getting all the anger and the hurt out, and the pain. For each cut, that's what it represented. But it helps with the anger, as well, because afterwards, I'm calm again, and then I can move on and do whatever, and then I'm alright. It's just like a release, basically.'

Sharon (early 20s)

This sense of release through cutting was also described by Kirsty, as follows:

'When you actually cut, there's about a minute, two minutes at the most of actual release, and relief, and my whole body goes kind of calm... It's kind of like everything bad, and all your hurt and pain pours out of you, for just that second or whatever. However long it lasts.'

Kirsty (early 20s).

The sense of release is short-lived, but may feel worth it, or necessary, for the release of anger, hurt and pain and for that short period of time when a feeling of calmness is experienced.

There are also further aspects to this sense of release experienced through self-harm. Some

participants talked about how they felt the need to cut deeply because of the feeling they had that the 'badness' was being carried around in the blood deep inside their bodies. So as well as functioning as a form of mental release of feelings of distress, cutting and blood letting can provide a sense of purification from feelings of badness. Vicky found herself gradually cutting deeper:

'I felt like as if I'd been taken over by bad things inside me. The deeper you went in, the more you could get them out. That was the release – getting it out.'

Vicky (over 25)

Similarly Sonia stated that when she self-harmed: *'I know it sounds really silly, but I felt really good, especially when I cut myself, because to me, it felt as if all the badness and everything that I had inside was all coming out, and it was releasing it all. So I felt so much better, which used to shock the paramedics.'*

Sonia (over 25)

This feeling that blood had to be removed to get the 'badness' out was particularly marked in the two cases where cutting had progressed to blood letting, using syringes to drain blood from veins into containers.

Thus, self-harm, particularly in the form of cutting and blood letting, can be a means of releasing difficult pent-up feelings; particularly anger, hurt and self-hatred, or feelings of 'badness'. In addition, some participants described using cutting as a means of converting unbearable emotional pain into a physical form:

'It's my way of turning emotion and pain, and things like that into something physical, which is a lot easier to handle at the time than it is in the long run. I'd rather deal with the physical pain, than I would feeling really hurt and upset. Things like that. It's like a release... The physical pain is nothing, compared to the pain inside.'

Kirsty (early 20s)

Similarly, Mel described the benefits of making the pain physical and visible to her:

'The mental pain that people have, and you know, all

the shit that goes round in your head, it makes it real. It doesn't seem real when it's in your head. When you reach this point everything seems like you're looking at yourself from deathly gothic eyes from somewhere else. You sort of watch yourself walk by, and you can't connect that that is actually you, so if you physically see it with scars on your arm, or another hospital visit or whatever, it is real. "There must be something wrong in her head, because it's there on your arm". You're there in a cast, or bandaged up.'

Mel (late teens)

iv) Relief: a brief escape

As well as describing the release achieved through self-harm, participants often spoke of using self-harm as a form of relief. This term seemed to be used in two ways. Firstly, some participants talked of feeling relieved in a similar sense to feeling a sense of release. In other words, they felt that the release led to a sense of relief: that they were relieved of the intense feelings which had preceded the self-harm, as if a weight was lifted off their shoulders through the act of self-harm.

However, the term relief was also used by a few participants to indicate a sense of escape. One young woman likened self-harming to other forms of escape:

'It's an escape, isn't it? And people that drink, drink because they want to escape from things. It's just that escape for a few hours. That few hours break. That's basically what it is.'

Sharon (early 20s)

Tammy used the same metaphor: *'It's an escape route, I'd say, from the real problem.'*

Tammy (early 20s)

Other participants emphasised the way in which self-harm could provide an escape from emotional pain by forcing them to concentrate on the physical and on practicalities. Again, the benefits of having to think about something physical rather than the mental are emphasised:

'All you think about is yourself, the buzz you get. That's all you have to think about. Is your razor blade

clean? Have you put your steroid stuff on?... And it's easy. You don't have to think about bills, you don't have to think about feeding kids, you don't have to think about anything that's normal life – getting washed, getting dressed. You don't have to think about anything like that, because that is all up in the sky. That doesn't matter.'

Vicky (over 25)

One young woman felt that this would be hard for people to understand, particularly if the sense of relief was so short-lived. She felt it was necessary to explain this in more detail:

'A lot of people don't see how it's worth it, considering it only lasts such a short time, but when you feel suffocated for so long, and even if you can only get one breath, then it's worth it. Say you're drowning and you're under water for so long, and you just pull up to get one breath. You're probably going to die anyway, but this one breath, it feels worth it, just for that one breath. Just for that one break from reality.'

Mel (late teens)

Viewing self-harm as positive – as a relief or a release – can be difficult to understand, as for most people, the idea of cutting oneself is so strongly associated with inflicting physical pain. However, the physical pain was often relatively minor. For example, Kirsty said: *'Sometimes it does hurt a bit. It's bound to hurt a bit'* (Kirsty, early 20s) However, many participants commented that cutting had hurt the first few times they had done it, but that after a while, they stopped feeling it. Some put this down to being used to it, or to nerve endings becoming dulled by repeated damage. For example, Rachel said that she did find cutting painful to start with, but:

'I lost feeling in both my arms, and I'm only just starting to get it back... I'm the girl who lost feeling. I'm the girl who stubbed a cigarette straight out on her arm and could not feel it.'

Rachel (late teens)

Some also described the feeling as *'a sensation'*, *'a weird sensation'*, *'a tingling sensation'*, or *'a warm sensation'*, rather than a pain. This lack of pain

when self-harming was contrasted with the acute pain they had experienced following accidental injury. Sonia commented:

'For all the cuts I've done, and the damage I've done, I've never felt. But if I go to open a tin, and I've cut my finger, I'm in agony, and I'm nearly in tears... And that's just a tiny wee cut, but you're doing all that damage and people are "why can't you feel it?" But there must be something up here, with everything that's happened, that blocks out all your pain and everything.'

Sonia (over 25)

Others felt that the extreme emotional pain that they were feeling at the time dulled the physical pain. Joanne stated, *'You're hurting too much in there to feel that pain'* (Joanne, late teens).

Similarly, Kirsty commented: *'The physical pain is nothing, compared to the pain inside.'* For Anna, cutting does hurt, but like Kirsty, Anna finds that: *'The hurt on your arms takes away the hurt that's inside your head. It releases the pain.'*

Anna (late teens)

(v) Self-punishment

Whilst self-harm can be a means of releasing feelings of badness and self-hatred, it can also be a form of self-punishment in itself, and some of the participants had felt that they were deserving of this level of punishment. For example, Rachel stated that:

'I get thoughts in my mind telling me that I'm not good enough... 90 per cent of the time I'm not trying to kill myself. It's just self-punishment because I've done wrong. It's this karma thing, I think. Because, like, OK, I've done wrong, so if I do wrong to me now it won't come back to me another way.'

Rachel (late teens)

Many of those who spoke of feeling that they *'deserved it'* related these feelings to past events. For example, a young woman whose father had been sent to prison for incest commented, *'I think I just felt really, really guilty, because I never wanted him to go to jail. It wasn't necessarily what he'd done, but that he wasn't there anymore.'* (Tracey, early 20s). Tracey thinks the self-harm

may have been a way of punishing herself for this feeling of guilt after her father went to prison.

Kirsty also felt a need for self-punishment:

'Because of things that have happened to me in my childhood, sometimes I can really hate myself. And the way that I've been brought up, I think that I deserve to hurt and have pain and that can be a reason why I do it, because I deserve it.'

Kirsty (early 20s)

(vi) Creating a visual sign/a form of communication

Some people find self-harm can be a means of converting unbearable emotional pain into physical pain, which is easier to manage. Some participants made a related, but slightly different point concerning cutting, particularly; stating that it could be a means of expressing feelings. Some participants linked this to being unable to express how bad they were feeling into words, or through other means. For some it seemed that the scars were markers of pain and trauma.

As Sharon explained:

'When you cut it's like... each cut is a bit of how I was feeling. But instead of telling someone, because I couldn't, I had to find another way of doing it, of expressing how I was feeling.'

Sharon (early 20s)

A similar point is made particularly powerfully by Sonia, who sees her scars as a visual reminder of overcoming adversity and pain. She said:

'I've seen more than a lot of people, and my scars now... when I look at them I think that just shows people how much pain I've been in all my life... I mean, when you cut, it's because you're so cut up inside... and you're showing other people how much you're hurting inside. But I look at mine and I see how much pain I've been in, and I've thought, "But I've come through it". We've fought it and we're coming through it.'

Sonia (over 25)

For some participants then, there seemed to be a relationship between communicating feelings and self-harm. This point is further exemplified

by the three young women who had written messages on their limbs in superficial cuts.

(vii) To be heard

A related, but slightly different motivation for self-injury, which was expressed by a minority of young people, was the need to be listened to. It should be stressed that for most of the participants self-harm was a very private act, and for some, the privacy of it and the fact that it was hidden was an important aspect of their self-harm. Furthermore, it cannot be stressed strongly enough that the vast majority of participants felt very strongly that the ‘attention-seeking’ label was insulting, and a complete misunderstanding of self-harm.

Having said this, about a third of participants did feel there was an element of their self-harm that was an attempt at communication. For these participants, self-harm was directed at getting others to listen, and to understand the degree of distress they were experiencing. Two young women (both of whom had been living in residential care at the time) felt this was an element in their self-harm. Joanne, for example, explained that she would harm herself: *‘When I get really angry – really angry, or I feel that nobody’s listening to me’* (Joanne, late teens).

Tracey expressed similar feelings: *‘You know when you just feel that muddled up, you can’t explain how bad you feel? Then if I cut myself it’s like “There. That’s how bad I feel. Now will you listen?”’*

Tracey (early 20s)

(viii) For the good feelings it brings

Many of the participants commented how much better they felt when they self-harmed, and this was one reason why it was difficult to stop. As Sandra said, after cutting herself, she always felt, *‘loads better’*, not for long, but for that night, at least (Sandra, late teens). Tammy commented that she *‘used to love the thought of harming myself’* when she was younger (Tammy, early 20s).

In addition to a general sense of *‘feeling much better’* during and after self-harming, a small minority of participants described more specific benefits for them, in terms of a rush, a *‘high’*, or a *‘fun’* aspect to self-harming. Rachel said:

‘I do it to get high. It does, it sends me high, because it’s all the adrenaline rush. It’s like wow! It’s just, it really is just good fun... When I actually do it, it’s better than sex. To put that razor blade in and watch the blood come out, it’s better than sex. It’s the best feeling ever.’

Rachel (late teens)

Others commented on how warm and soothing the blood felt against their skin. Vicky described cutting as: *‘Just a wonderful feeling... It was the blood I felt, not the cut itself. It was the blood I felt... nice, warm. It were just really, really nice.’*

Vicky (over 25)

These good feelings from self-harming could lead to more severe injury than intended. As Mel put it: *‘There’s such a rush from doing it, such a relaxation, such a relief, that you don’t actually feel yourself doing it. I think it’s probably like drinking Hooch or something, because it tastes like orange juice, so you can drink 500 bottles of it and you don’t realise how pissed you are until you try and get off your bar stool.’*

Mel (late teens)

(ix) Taking back control

Some of the participants saw self-harm as something over which they had control, unlike other aspects of their lives. For example, Vicky began self-harming at a time in her life when she had two very young children and became pregnant. She was unable to get a termination and was extremely distressed:

‘I just didn’t know what to do. I felt like people were controlling me, and telling me how to live my life’. At the peak of her bloodletting phase, ‘I felt in control of my own body. Nobody was controlling me. I was in control, because I was doing this.’

Vicky (over 25)

When she was being strictly supervised in a psychiatric unit, she felt good when she managed to harm herself without anyone

knowing. She explained, *'I was in control, not them. I decided when I wanted to stop, not them.'*

Mel also saw *'taking back control'* as a key reason for her self-harm. Like Vicky, she commented that: *'When I do it, it feels like one thing that I have control over. It's one thing that I can decide: how hard I hit that wall. It's one thing that I can decide: whether to pick up a knife or hit the wall. I decide how much pain I'm going to inflict, how deep it's going to be, how hard I'm going to hit, and so, at the time, it does feel like you have 100 per cent control over it... It's actually a very, very sane thing to do, because it's taking back control.'*

Mel (late teens)

Sandra also commented that, *'At least I'm doing it to myself and nobody's doing it to me. I'd rather kill myself than be hit by a car'* (Sandra, late teens). Sandra also commented she would rather cut herself than have someone hit her.

It is perhaps also worth making the point that others had a very different experience, of having no idea when they were going to be overtaken by the need to self-injure. Kirsty found this particularly frightening and distressing: *'If I feel really bad, then I can't control, it, and that's the frightening thing, to think that there's something that I can't control that's going to happen, where you don't know how bad you're going to cut.'*

Kirsty (early 20s)

Questions over the degree of real control over self-injury were also raised by those participants who describe their self-harming as an *'addiction'* or a *'habit'*, and by the difficulties they face in trying to stop self-harming.

(x) A habit or addiction

About half the participants felt the self-harm had started for specific reasons or for particular benefits, but that, over a period of time, these benefits had become muted. Instead, self-harming had become habitual. Because

of this, some participants likened it to an addiction. Tammy simply stated: *'It was deliberate before, and now it's a habit'*. Kerry (under 20) said:

'Would like to stop, because I've got enough scars, but it's just hard. When you've done it for so long, it's like an addiction, isn't it, it's just something you've got to keep doing. I would like to stop, and probably in time I will. It's just like second nature, so it's just time.'

Contextual Factors

(xi) A self-harming environment

For most participants, self-harm was a very individual act, and many had never spoken to another person who self-harmed. However, a small minority felt that the environment in which they found themselves was a significant factor, either in the initial self-harm or in the continuation of the self-harm. Such environments were residential children's homes, psychiatric units, and in one case, a group of self-harmers at college.

Some young people felt self-harm was treated as something normal and routine within residential units and that this could exacerbate self-harm. This was particularly strongly articulated by Tracey, who said:

'I think if I'd never gone in care and all that I'd never have dreamt of doing anything like that. When I went in there I didn't even know the names of any drugs, never mind what they did to you or anything. People try and blame things on what happened with my dad and that, but it's not. The main thing that's messed me up is being in the home. If I'd never have known about any of it, I'd never have done it. Because I thought people just slashed their wrists to kill themselves, and then when I went in the hospital, I said "Why have you cut the front of your arms?" "Oh, it wasn't to kill myself, just to cut myself." And I thought "Oh right, so you can do it without dying, then."

Tracey (early 20s)

For Rachel:

'Things started turning really bad when I went into college, because I met a group of self-harmers. This was helpful in a way that I didn't feel like an outsider, because I feel like an outsider. Helpful that people knew what I going through, certainly. But it wasn't that helpful, because when people took the overdose, it was good old reliable Rachel who would take them to hospital, and good old reliable Rachel would be patching them up, and it was absolutely screwing me up inside, watching my friends killing themselves. And I actually watched one of my friends die of an overdose.'

Rachel (late teens)

Rachel ultimately found the group of friends 'self-destructive' and moved to a different area.

(xii) Social factors

Neither study allowed for systematic examination of the role of social factors – social inequalities, social exclusion, discrimination – in initiating or perpetuating self-harm. For some participants, the negative reactions of others to aspects of their identity as disabled, of 'mixed' parentage or lesbian were clearly thought to have contributed to feelings of low self-esteem and guilt which were linked to their behaviour. And, as we have seen, there appear to be some gender differences in patterns of self-harm. These structural issues are under-represented in these accounts – what can feel to be a very individual and personal situation is inseparable from the social context and the reactions of others.



Cutting through the myths

Two misconceptions

One of the participants' main motivations in taking part in the interviews was to try to explain to others – professionals and the public – how they understood self-injury. This was the product of a common experience of being misunderstood. They were particularly keen to dispel what they saw as common misconceptions of self-injury. For example, as we have already seen, the majority of the participants distinguished between self-injury or self-harm and attempted suicide while some recognised the boundaries were sometimes blurred. Two other labels, that self-injury is 'attention seeking' and that people who self-injured are a danger to others, were powerfully rejected.

Attention seeking?

Most of the interviewees felt very strongly that it was insulting and simply wrong to label their self-harm as attention seeking. As Kirsty explained: *'I can honestly say I've never, ever done it for attention, because a lot of people don't actually know that that's what I do, and I wear long sleeves all the time, and people have accused me that I do it for attention. But the way I handle that is just by saying "Look, there's far easier ways of getting attention, than going through the pain of when you cut, and what you get after when you go to A & E, and the hassle you get there, and the humiliation. There's a lot easier ways".'*

Kirsty (early 20s)

Other participants described such 'other ways' as follows: *'I could go down the street stark naked and shouting obscenities. I'd get far more attention than cutting myself and going to the local hospital.'* (Phil, over 25). Mel commented: *'If I wanted attention I'd go out wearing my bright orange trousers and my tutu. That gets me attention. I'd do it in another way.'* (Mel, late teens).

Anna hates the attention seeking label:

'Because I'm not attention seeking. Just because I can't talk to other people about it. The reason why I don't talk to other people about it is because I have spoken to other people in the past and they let you down, so you just learn not to talk to anybody. So that drives me mad, how somebody who doesn't know what's going on inside my head can say, "She's attention seeking".'

Anna (late teens)

In fact, nearly all of the participants harmed themselves in private, generally in their own room or own home. A typical remark was made by Sharon, who commented, *'I won't do it if anybody else is there. I do it on my own'* (Sharon, early 20s). Many participants avoided telling others they had harmed themselves. For example, Joanne doesn't generally tell people when she has injured herself. She kept it secret for a year, but, *'Now people know. There have been times when I've hid it. But people can tell, by the way I'm acting.'* (Joanne, late teens).

There were very few cases of individuals harming themselves in front of others. In fact, for some, it was the very privacy of the act that they found beneficial, as self-harm felt like something over which they had control. Indeed, Sandra described her cutting as *'my little secret'* (Sandra, late teens). Vicky felt good about her self-harm being something that others did not know about. She would go to her GP for antibiotics to treat a cut on her arm. She commented:

'Even though he thought he was better than me, I knew that I was getting one over on him. Which made me feel good then, because even though he'd seen this one on my arm, he hadn't seen the one that I'd done on my stomach, which was much worse.'

Vicky (over 25)

The privacy of self-harming was an important feature for Vicky and apparently at odds with the 'attention seeking' label.

Some participants did describe themselves as 'attention seeking' on occasions. However, it is important to see their description of themselves in these terms in context. The label of 'attention seeking' seems to trivialise the reasons for self-harming. It is frequently prefaced by the word 'just', as in 'he/she is just attention seeking'. It is therefore illuminating to hear of the situations of those who felt that they had been seeking attention. Four had been in residential children's homes at the time.

Jackie, for example, stated that, 'I used to do it deliberately, to get attention, when I was pissed off, because I didn't think no one cared and that' (Jackie, late teens). Tracey commented, 'I have to admit, sometimes it was for attention, as well. The staff who were at the home see it every day, and there was no reaction, or "Oh, you're being stupid" or whatever'. Tracey would self-harm when there was a new member of staff who would react to her self-harm. If they didn't react it felt like they didn't care. 'It was never "why?" Mind you, I think if they say "why?" you'd say "I don't know".' (Tracey, early 20s). Tom felt that, 'I think I just did it for attention really, because with my family putting me in care at nine or ten I thought no one cared about me' (Tom, early 20s). Similarly, Sandra stated, 'I used to think people will only listen if you do something odd, or harm yourself' (Sandra, late teens).

However, an important argument was made by three of these young people, who pointed out that if someone was feeling the need to seek attention there was a reason for this, and it should not be simply dismissed. They had all felt that no one cared about them. Other interviewees argued strongly that even when self-harm does have an element of attention seeking to it, this is no reason not to take it seriously or not to explore why the individual feels that such drastic measures are needed in order for their distress to be heard.

Tammy commented:

'Most people see it as a cry for help, basically think in some cases it is a cry for help, but I wouldn't say people do it for attention. It leads from other problems. Other problems that you haven't been able to talk about with anyone. It's the problems that are up here [pointing at her head]. It's an escape route, I'd say, from the real problem.'

Tammy (early 20s)

Several other participants argued for the need to take it seriously, even where it is perceived to be attention seeking. As Tracey argued:

'Even if they are looking for attention, so what? There's a reason why they're looking for attention... If a baby wanted a drink of juice or something, and it crying and crying, you don't say "Oh, don't give him it" just because he's crying for it. But if it doesn't cry for it, you don't know that it wants it.'

Tracey (early 20s)

Mel also felt that the wish for attention should be treated seriously: 'If there's a positive way to get attention, you've already got attention.'

Mel (late teens)

A danger to others?

For nearly all of the participants in this research, the idea of harming others was anathema. Many of them felt upset by the idea that some people would think they could be violent towards others, as they had never, and would never harm another person.

They argued that to view people who injure themselves (particularly by cutting) as a danger to others was a complete misunderstanding of self-harm. The following three comments are all from people who used cutting. Sonia stated:

'I've had people say, "Watch your back, because if she can do that to herself she'll do it to you." And yet, believe it or not, most self-harmers care about other people more than they care about themselves. And they are more compassionate than people who don't self-harm... People think that if you can do that to yourself you can do it to other people. Which is totally wrong. Because I wouldn't hurt anybody else and I never have done.'

Sonia (over 25)

Joanne was excluded from school because of her self-harm: *'They thought I was a safety risk. They thought I'd hurt someone. I'd never, ever hurt someone else.'*

Joanne (late teens)

Mel also felt that the assumption that she might be a danger to others was completely wrong. As she explained:

'I would never hurt anybody, even my worst enemy... I'd always turn in on myself... that's probably the worst thing, if someone started picking on me, I'd blame myself for it by self-harming, whereas sometimes if I just punched them back it would have been a more effective way of dealing with it, rather than self-harming.'

Mel (late teens)

Four of the participants described harming themselves as a way of taking anger out on themselves rather than on other people.

'If I have feelings towards other people then it's a case of if I don't do it to myself, I'll probably end up doing it to somebody else, so it's more a necessity than anything. I don't want to go to prison or anything like that, so it is a necessity and I continue to do it.'

Phil (over 25)

Sharon also felt that:

'It's better than taking it out on somebody else, which I get that angry I'll want to do. I'll go out and I'll want to pick a fight with anybody, and I'm not a violent person, which is why the cutting up started, so I could take it out on myself, rather than taking it out on somebody else.'

Others felt that, although they had no desire to take their aggression out on others, self-harm was linked to aggression. For example, Tracey thinks that she used to harm herself sometimes when the anger built up, rather than fighting with someone else. She feels she was an *'evil child'*, because she would take out her aggression on other children. As a child, she had been physically abused herself, but was not allowed to express anger or to cry: *'It was just anger. I mean, we weren't allowed to cry or anything. We weren't allowed to get angry, and you'd just go out, and take it out on the first person you see.'*

Tracey (early 20s)

Thus, for some people who injure themselves, this is related to pent up anger. For a small minority of participants, self-injury was a means of preventing them from being violent towards others. These *'others'* were generally specific family members. However, the vast majority of participants were adamant they would never harm somebody else.



Whose problem?

Part of the solution?

As we have seen most of the participants perceived their self-harm, at least in part, as a useful coping mechanism. However, it does not necessarily follow that self-harm was not problematic to them. When asked directly, a range of responses was given. For example, Kerry commented that:

'It's something I've done for ages, so it's second nature, really, isn't it, so it's not a problem for me. I mean, probably when I get older it will be, with all the scars and that, but it's something I've got to deal with, isn't it.'

Kerry (late teens)

And Anna commented:

'What I can't understand is my self-harming doesn't hurt anybody, does it? It's something that helps me, and sometimes they can't understand that. They don't see that.'

Anna (late teens)

Those who did not see it as a particular problem for themselves were all still self-harming.

In contrast, Kirsty had always hated self-injuring. She commented:

'I still hate what I do. I don't like what I do, but I accept it, because I know that it is my personal way of coping with things, when things get really bad. People deal with things in different ways, and unfortunately or not, this is my way.'

Kirsty (early 20s)

Others saw self-harm as a problem if it became particularly severe. Joanne sees her self-injury as:

'More of a problem to other people than to myself. They can't see why we actually do it to our body. It's the risk – "Is she OK?" Sometimes, when I get to doing it three times a day, I do see it as a problem.'

Joanne (late teens)

Many of the participants had previously not seen self-injury as a problem for them, but did see it as a problem at the time of interview. Many of these were no longer self-harming or had significantly decreased their level of self-harm. Vicky described

how, at the height of her self-harm, she had believed that it was a very positive thing in her life, and could not understand why others wanted her to stop:

'I said, "Does it make you feel better when you've had a cig?", they say "Yes", Well, this makes me feel better. What's different? Just because less people do it, it's not acceptable. Nobody explained to you that it weren't helping you, it were only you realising after a while, and you seeing people being hurt by this – other people, then it became... And then I became upset, stressed, angry. I hated myself for doing it.'

Vicky (over 25)

Vicky saw that her five-year-old daughter was being affected by the self-injury:

'It's a big shock. You've come down from up in the clouds and being selfish. You've come down to reality, and realised that all these people who you loved and were trying to protect, you were hurting. But then you need it for a different reason then. You need to cut yourself to cope with this guilt, these bad feelings that you've got, so it just keeps going on.'

Vicky (over 25)

Rachel had also been through a process of gradually coming to see her self-harm as a problem for her. She described the reason for this change of belief as due to being: *'On the receiving end... and I know how much it hurts and destroys people.'* (Rachel, late teens). And, as described above, if self-harm has become a habit, finding a way to stop and alternative coping strategies could be a problem.

A problem for other people

One aspect which has been under-acknowledged in previous research is the effect of self-injury and self-harm on friends, family and peers of the person. However, Joanne, Vicky and Rachel were not alone in recognising that their behaviour did cause problems to others: to their friends and family and to professionals.

Sometimes this was made apparent by reactions which participants found unsympathetic. Sandra said her mother and sister did not understand, and would say things like, 'You divvy. What are you doing that for, you idiot?' Tammy's mother would tell her that she was 'abnormal' because of her self-harm. Kirsty's father and stepmother disowned her because of her self-harm at the age of 20. 'When they first found out about they panicked. Then they asked "why?" They got frustrated, and then they got angry.' They then said they were 'disowning' Kirsty, because to do something like self-harm, she 'must be on drugs or something'. Kirsty was shocked by this reaction, because she felt that it was 'a bit harsh'.

Some parents saw the self-injury as directed towards them or an attempt to hurt them. However, the participants felt strongly that this was not the case and that it was missing the point. As Mel stated, 'The most stupid thing that my mother ever said was "Do you do this to hurt me?" ... That is the worst thing to say, because that makes you feel so guilty.' (Mel, late teens). Although some participants had supportive

siblings, none of the participants had parents who had been particularly supportive over their self-harm and many had found the reactions of parents and step-parents particularly unhelpful. By contrast, some of the participants had partners and friends who had been a major source of support for them. Craig had lived with Kirsty for about three years. He was present during the interview and talked about how he coped with her self-harm. Craig explained: 'It's a shock. At first you don't know how to cope with it. I mean, I've been to A & E loads of times with her, and every time you see it you can't believe it. You don't know why it's happened.'

When I come home, whatever day it is, I could think "Great, we'll go out to the pictures tonight", or whatever. And then you come home and it's happened, you think, if you've had the idea of going out for a meal, or anything like that, you think "That's blown it". You can get angry, but you have to put those feelings aside. Not necessarily aside, but you have to understand. That's the main thing. You've got to try and understand. There's no point in shouting at all. It doesn't work. You go through hiding the knives. That doesn't work. You go through the shouting. You go through saying "Right. That's it. We're over". I've never done that, but other people could say that.'

Craig (early 20s)



Kirsty says Craig has felt at times like getting hold of her physically and trying to shake some sense into her, but hasn't. Kirsty finds it hurtful when someone gets angry, because she is not doing it to hurt somebody else. She understands why others may get angry but also feels that it is *'the last thing I need'*. Craig will sometimes walk into a different room, when he finds out. He says he's about 60 per cent better at dealing with it than he used to be. *'You can't get used to it. You can try and help, but you can't get used to it. It's the shock part of it, that actually gets you.'*

Sharon has no contact with her family of origin, but says the support of her friends has been invaluable:

'They've helped me through a lot. They've been there for me when I've needed them, and they've been there even though I've not needed them to be there, they've still been there.'

Sharon (early 20s)

Others had found the responses of friends less helpful. Tammy had found that other people: *'Have no understanding at all. It's just the old lectures. I've had so many lectures about it; it just goes in one ear and out the other now. It used to get me angry.'*

Tammy (early 20s)

For young people we spoke to who have friends or peers who injure themselves, seeing others self-harming can be a frightening experience especially because of the perception that it may

be life-threatening. Tony commented:

'Just seeing someone doing it to themselves though, it's just not very nice at all. It gets you deep inside. It scares you. Like, there's plenty of people who do it, and once you see someone doing it... I just grab the knife off them, or whatever they're using, because I'm not going to be around if they're going to do anything to themselves, not when I'm around, no way.'

Tony (late teens)

Particular groups of young people, especially care leavers and homeless young people, may be more likely to know other young people who injure themselves. Some of those we spoke to felt a fear of self-harm and found it difficult to understand. Peers sometimes felt that self-harming was *'stupid'* and that *'there ain't no problem in this world you can't talk out'* (Scott).

Other young people with friends who self-harm have a different perception. Andy's attitude has changed over time, as he has got to know two friends who self-harm and gained some understanding of why they do it. Andy explained his change in thinking about self-harm over the period since before he knew these two people, to the present day:

'So, first time I heard about it, I was like "God, that's a silly thing to do". Totally naïve. After that, I started talking to the person, getting to know about it, and I don't know, I was sort of feeling – pity would be an awful word to use... I've never done it myself, but I can see why if you were having

a really bad time you would actually do it. So, basically, I'm just trying to help as much as possible. It made me feel upset when they actually did it, because it made it feel could I have stopped them doing it? The only time I ever felt annoyed was when one of them did it in my flat... they knew what they were doing was wrong, and they didn't enjoy doing it, but they didn't know of any other release, which seemed quite sad... because there are plenty of other releases, but they couldn't see them, so it was really upsetting, in a way.'

Andy (early 20s)

However, Andy's story, and those of Tony and Craig above, also raise important questions about the need for support and information about self-harm for friends, peers, partners and relatives of people who self-harm. Being around self-harm was frightening for Tony. Craig was dealing with it as well as he could, and having tried a range of strategies, he had reached a position where he had some understanding of self-harm. Similarly, Andy's views on self-harm had evolved over time, due to his close friendships, but this was obviously not always easy for him and he sometimes feels out of his depth.

Kirsty and Craig highlighted the needs of friends and family. Craig felt that:

'There should definitely be more information for people who look after, or care, or are family, anything, in anyway related to someone who self-harms. There should be more information available.'

Craig (early 20s)

In addition to information, Kirsty also felt that there should be more support available to family and friends of people who self-harm. She commented:

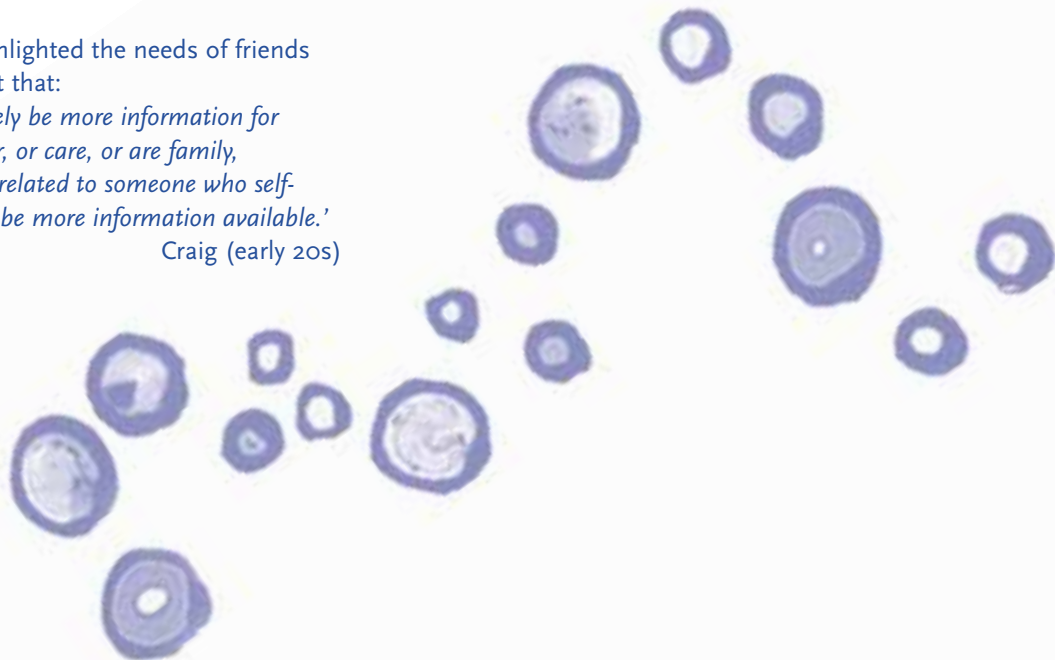
'He's had no support really. Just left on his own. Everyone's been rallying round, trying to sort me out, but what about Craig? In trying to make sure I'm okay, he completely doesn't look after himself, and obviously that has its own effects.'

Kirsty (early 20s)

If there was a local support group for the carers of self-harmers, or a helpline for carers, Craig said he would definitely use these services. He added:

'There should be something there for the other person really. A relative, friend, whatever. There should be something there. All the doctors say is "Are you going to be alright?" to the person who's self-harmed. They don't ask about the other person, but they should, whether it's a relative or whatever. They should ask, but they don't.'

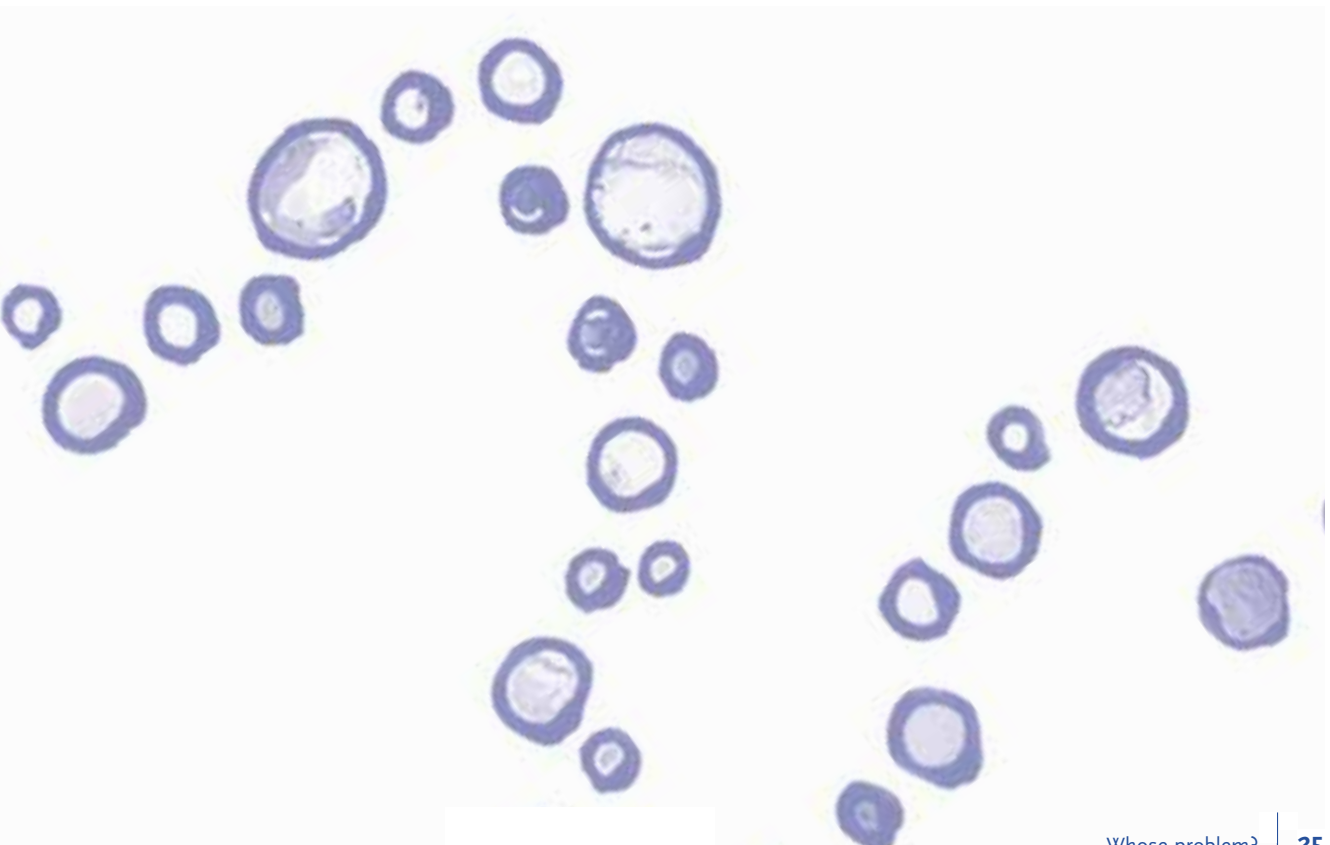
Craig (early 20s)

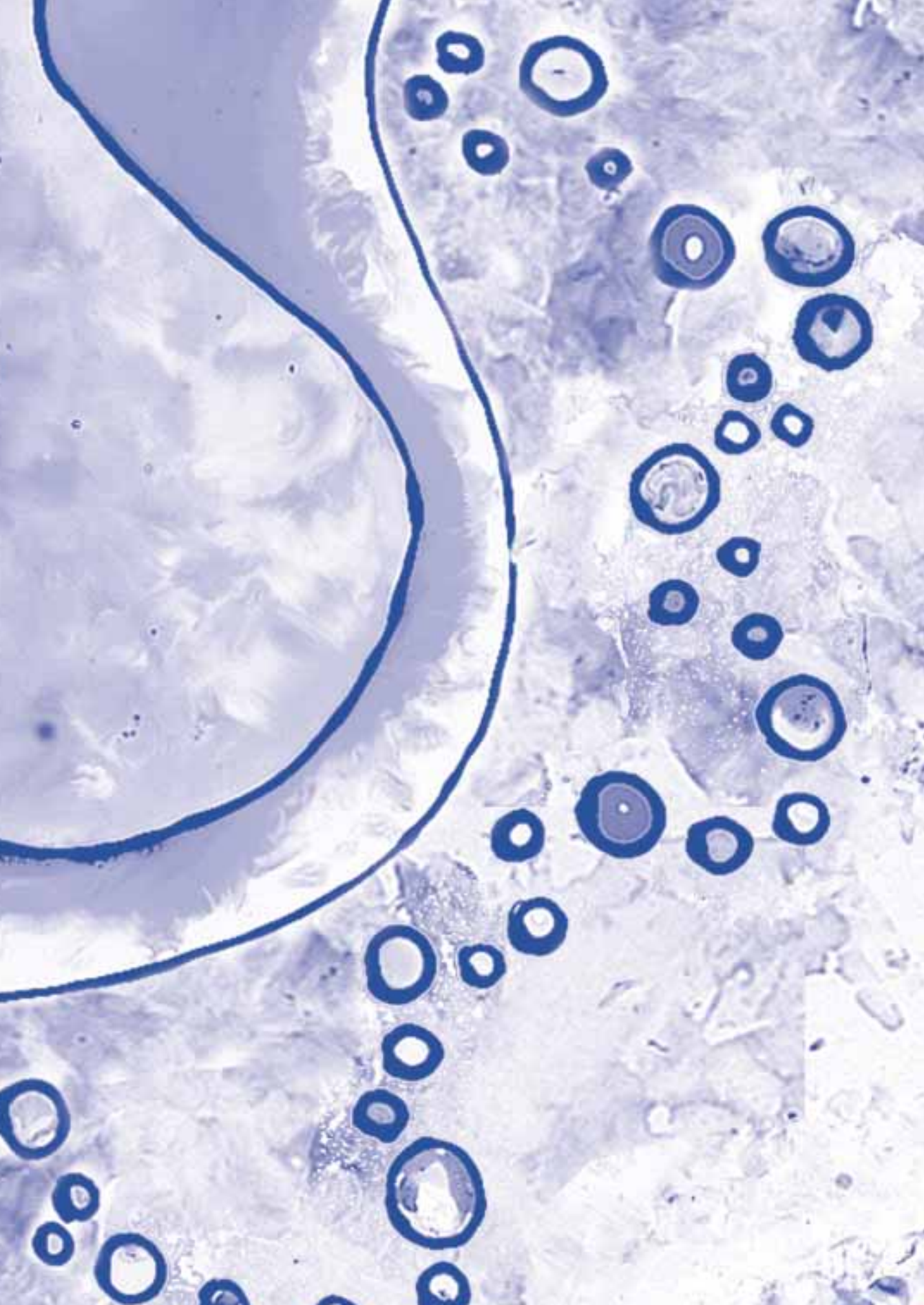


A problem for professionals

While NCH projects who responded to the survey were doing their best at the local level to respond to the needs of children and young people who were self-harming, there was a strong desire for more support and training. Most projects operate a system of individual plans in providing services for children and young people and these could include issues of self-injury. However, less than a quarter of the projects felt that they had staff who had particular expertise in dealing with self-harm and only around a fifth employed staff who had received specific related training. In projects working with disabled children and young people, the training had mainly been as part of a wider programme on 'challenging behaviour'. In other projects, training had focused either on understanding self-harm or on forms of therapeutic intervention. Around half the projects thought that more general training about self-harm would be valuable to them and a further quarter thought that shared learning between projects would be valuable.

In addition to the projects' own services – a small minority of which included specialist counselling, therapy or self-esteem work – around half the projects used external services for service users who self-injure. The majority of these were psychiatric or psychological services which, as we shall see below, are often not favoured by young people themselves. Some projects had very positive experiences of external services, but the large majority commented negatively, either about the quality of the services available, because services were over-subscribed, with inadequate funding and long waiting lists, or because of lack of awareness and stigmatising attitudes amongst professionals.





What does and doesn't help?

The participants in the interview study had accumulated considerable experience of professional responses to self-injury and other forms of self-harm. They spoke about primary and community care services, attendance at accident and emergency departments, being an in-patient in general and psychiatric hospitals, receiving counselling and psychological help, the role of fieldwork and residential social care staff and teachers. A majority of participants had attended accident and emergency departments for treatment of injuries and almost all had been referred for psychiatric assessment. Over two thirds had been in the care system and had experience of statutory social services as well as NCH provision.

Many of the experiences of these services were negative and what was reported to be helpful and unhelpful was consistent across settings and professions. But there were also consistent reports of staff and services which had been helpful, although these were usually seen in terms of the quality of individuals rather than something essential about a pattern of services.

Attitudes – positive

Central to participants' positive accounts of services and professionals which had been helpful to them were a set of attitudes based on tolerance, trying to understand, treating them like a person and with respect. These attitudes and this basic approach cut across all the services.

For example, Sharon felt that her GP treated her with respect:

'He actually spoke to me, rather than talking down to me. He spoke to me like a person, instead of just a silly little girl, who cuts up and all this. He was different. Because a lot of GPs' attitudes are "Oh, it's nothing. You'll get over it". But his wasn't. He was genuinely concerned, for a change, so it was nice.'

Her GP also understood that Sharon wasn't trying to kill herself: *'Because he talked to me about it, to try to find out why I did it, and to find out whether it was to kill myself. And because he was actually*

talking to me to find out about it, I actually found myself talking to him, and being honest and open with him, which before, I couldn't do that.'

Sharon (early 20s)

Kirsty and Phil, in contrast to most respondents, had positive experiences of A & E staff:

'There's a nice nurse at the A & E, and she's usually the triage nurse. And if I'm lucky enough to get her when I go, then she's understanding, and she says, "How are you? Obviously you're not so well" ... And she's seen me since I first did it, to now, and she says "Well, obviously you're doing a lot better. Stick with it, you're a lot better than what you was", but she's one of the only nice ones there.'

Kirsty(early 20s)

'Casualty have normally been very professional. One of the sisters has stood for an hour and a half stitching me up... they've never turned round once and said "You're a pain in the arse for keeping coming in. Why do you do it?"'

Phil (over 25)

Emma and Vicky had found psychiatrists very helpful:

'I was very lucky with my first psychiatrist. She was lovely... She was absolutely wonderful... She was so caring. She really did seem to give a shit, and she didn't label me. She just talked to me, and tried to help me through it.'

Emma (late teens)

'She's understanding. She listens to you. She'll ask your point of view. She'll not just shove you out of the room. I see her every time. I don't see her understudy ... because that's what I couldn't cope with. You go into the room and there's somebody different again, and you feel like they don't even know you.'

Vicky (over 25)

One participant described her social worker as the most helpful person over her self-harm:

'She understood, and she cared, and she knew that I wasn't just being silly, or whatever. She worried about me when I did do it... I mean, she genuinely

... cared. It wasn't, come in at 9 o'clock, go home at 5 o'clock and have a decent night sleep.' Tracey felt that she understood because 'We used to just talk for hours.... I mean, she was the only one who said "Please don't do this to yourself". And we talked about why. It wasn't just like "Oh, don't do this because we can't be dealing with it" ... To me, my social worker was like my mum.'

Tracey (early 20s)

Kerry passed 11 GCSEs whilst in residential care, and she feels she could not have done this without the support of certain teachers:

'When I overdosed the first time, one of my teachers pulled me up in the corridor and asked if she could speak to me and that, and just the stuff she said, like "I'm here for you", and stuff like that. It was just something that I'd never really heard before, and I was like "God"!'

Kerry (late teens)

Not surprisingly, perhaps, given how they were contacted, many participants spoke very positively about NCH staff:

'Absolutely fantastic. Just very supportive. I never felt ashamed of telling them that I was a self-harmer.'

Kirsty (early 20s)

'This place has saved my mental health like you wouldn't believe.'

Rachel (late teens)

'I'd sing NCH's praises from top of the roof, so that every one could hear me, because they've been my life line.'

Vicky (over 25)

'I think they're brilliant.'

Tammy (early 20s)

'They're lovely. They are just really nice.'

Kelly (late teens)

The participants felt that NCH staff were more likely than other professionals to have some understanding about self-harm, or, if they did not know or understand about self-harm, they were less likely to be judgmental. Sandra felt that NCH staff treated her with respect:

'They're quite good. They don't really judge you. A lot of them ask me to explain about self-harm, because they don't know really. It helps them to understand, as well.'

Sandra (late teens)

'They were very supportive. They didn't panic. They didn't flap. And it was like, "Well, how bad is it?" They've got, obviously, to ask certain questions like that.'

Kirsty (early 20s)



Attitudes – Negative

Equally, some staff in almost all services came in for criticism. Kirsty commented that her GP:

'Doesn't treat me like normal, as if I'm not normal because I self-harm, like there's something wrong with my intelligence or something. Like a retard, I suppose. Because I self-harm, then obviously I'm thick.'

Kirsty (early 20s)

A & E staff came in for particular criticism. Kirsty described how nurses:

'Don't even speak to you. Just come, have a look at you, do what they've got to do, don't say a word. They seem very cold about it, they don't smile, they don't even make eye contact with you. They just do their job, get on with it, and go.' She once had a nurse who looked at her arms, counted the scars on her arms, and then said "Well, what's the point in stitching you up?" Kirsty felt: *'Absolutely horrified. Humiliated and everything.'* She commented: *'They basically cleaned it in silence, and they don't say nothing to you. Once they asked "Can we use a student nurse on you? It's not like it matters".'*

Kirsty (early 20s)

'People that self-harm, as well, also get left at A & E departments for hours and hours. You could sit there for eight, nine, ten hours for you to see a doctor, because they don't want to waste their time, basically that's their attitude.'

Sharon (early 20s)

Participants believed that A & E staff's attitudes reflected a belief that they were wasting their time, a belief which extended to in-patient wards:

'I think they think it's a waste of time, because they should be treating people who don't hurt themselves rather than having to treat people who do.'

Anna (late teens)

'They were alright on accident and emergency. Then they took you down to the ward, and they were like, "There's real sick children who need these beds"... which is like, fair enough, but if they helped us out we wouldn't keep coming back.'

Tracey (early 20s)

Compulsion and control

Issues of compulsion and control had raised problems in self-harmers' relationships with two particular services: in-patient psychiatric services and local authority social services. A number of participants commented on the surveillance of patients in psychiatric wards and the use of sanctions to prevent self-injury. It was felt to be more helpful to give individuals responsibility for their own behaviour. Those who had had implements such as razors and knives removed from them, simply found other sharp objects with which to cut themselves. In addition, alternative ways of harming oneself could always be found. If they were prevented from cutting themselves or overdosing, for example, they could stop eating.

Some argued that compulsion was actually counter-productive. This would seem to be particularly the case for those for whom self-harm was a way of taking back control over their lives and their bodies. For example, one young woman who was an in-patient on a psychiatric unit was not allowed to go out on her own and found this very difficult. She explained:

'Sometimes, I just wanted to get away from, one, the hospital and, two, from what was going on in my head and they took that right away from me. They did it for my own good, but at the time you don't see it like that... And then the day they turned around to me and said, "If you do it, you clean it up yourself" then I was alright... I felt better because they were giving me the responsibility back... When I felt low and I felt like cutting I'd talk to them, because I knew that they'd given me the responsibility back for my own actions.'

Sharon (early 20s)

Similar experiences were reported in residential care situations. For example, Anna had had her knives and razors taken off her, but said that only made her angry and she simply bought replacements. Tracey was told that if she harmed herself she would have to go into a secure unit for 72 hours:

'It was stupid though, because it was like being sent to prison for cutting myself... I just don't think that was the way to go about it. It was like, "Instead of helping her, let's punish her so she'll stop doing it".'

Tracey (early 20s)

Many participants had known social workers because they had been in the care system and described social workers as a 'waste of time'. For those with children, contact with a social worker carried an additional threat. Sonia said:

'They just don't do what they're supposed to do. They've never helped me. I mean, their concern is, when I've been in hospital, "Do you want the kids put in care?" And I'm like, "Don't you dare!"'

Sonia (over 25)

Two mothers had had their children taken into care although three of the four children concerned were now living with them. Both had been told that their self-harm was a child protection issue, but neither could understand this at the time, as neither cut themselves in front of their children and both found that cutting helped them deal with the stresses of being a mother. In each case, getting their children back had been a major reason why they were no longer cutting themselves. In a third example, a mother reported that she could not receive sufficient help because her children were doing well. She felt that the focus of the social services and the health visitor was on the safety of her children and that she was not seen as a priority for assistance.

Talking about it

A number of the participants had found it helpful to talk with a professional about their self-injury and the reasons behind it. Kirsty has been seeing a psychologist for several years. She commented:

'It has been very, very useful, because there are lots of things that I never really talked about that happened in my past that I'd never been able to face before, and we're actually in the process of starting to work through those things, which I never thought I'd be able to do. So it's obviously doing something. If we'd have been having this interview a couple of years ago, I'd just have been sat here and really defensive, and the only way I felt emotion was through self-harming. I'd just have been thinking "What does she want?"'

Really like, attitude. Just so angry, and just so different than what I am now. Kirsty puts this down to: 'Sitting down and getting my psychologist, and getting somebody who I can rely on, somebody stable who I know more often that not is going to be there every week.'

Kirsty (early 20s)

Others felt that it had been useful, but had some doubts at the time. Sandra felt that psychodynamic counselling was: 'Useful. You don't think so at the time, but when you look back it has been.'

Sandra (late teens)

However, not all experiences of counselling had been so positive. Some of those who were not currently seeing a psychologist or counsellor were very reluctant about talking to these professionals, feeling that this would only intensify their distress. Others felt that counselling could bring up feelings and memories from the past which they wanted to forget. Rachel stated:

'They can come and see me for an hour, and then leave me for, like, a mess of nightmares, and constantly in my mind... eight years I've been living with this, and not one day has it been easy.'

Rachel (late teens)

Tracey commented:

'Sometimes the more you talk about it, the more of an issue it is. I suppose if it's an issue anyway... I spent ages going to see a counsellor, and I just felt awful all the time. I felt really down, and I couldn't get on with my life, because there were that many things going round in my head, and I stopped seeing her and I just got on with things. Because I was sat there every week talking about it. I mean, you can only talk so much. There's only so much to say.'

Tracey (early 20s)

Tammy felt counselling had been unhelpful to her:

'Because they want to know about my past, and the more I talk about it, the more the flashbacks come back, and the more I cut into my arms. It felt like the counselling was making the self-harm worse, because they want to know every niggly detail to get a full picture. I don't want to go through that again. I've been through it once. I don't need to go through it twice.'

Tammy (early 20s)

Some participants had had both bad and good experiences of counselling at different times. Three young women had seen counsellors who were unhelpful, in not respecting confidentiality, banning self-harm, or not speaking to them as a young adult. For example, Kirsty was told that she could not have counselling if she self-harmed.

'I just couldn't understand, how can someone say, if that's your problem, self-harm, and that's why you've gone to counselling, that you can't self-harm if you go into therapy, because that's just avoiding the issue. It's not actually looking through it... If anything it made it worse, because of the pressure I was put under... If anything it put me in more danger, because of the massive build up.'

Kirsty (early 20s)

Some participants were reluctant to seek the help of professionals because it could involve telling your story over and over again. Vicky, who had to do this with her CPN, health visitor, social worker, psychiatrist and psychologist, expressed this particularly clearly. She said it is daunting asking for help:

'Because of the fact that you've got to start all over again, explaining, because it's not like you're just explaining. You're going through everything again – just as much pain, just as much heartache, you're going through it all again, because you're having to drag everything back up. Unless you do (start from the beginning) they can't understand everything'. Each time Vicky tells her story: 'You feel like you're having to make them understand. Are they getting it quite right? Are they listening? ... So you're constantly thinking that when you're telling people. So you've got to try and understand what type of things they'd understand. What point of view they're looking at it from. Look at it from that angle... To me it's good. You've learnt something from it, but it's tiring.'

Vicky (over 25)

A number of those who had been referred to psychiatrists had not attended. They explained the reasons for this as not liking doctors, not being able to speak to male professionals or finding it too hard to talk about the reasons for their self-harm to a stranger. Two had only been once, but had resented being treated like a child. Kerry explained: *'She was asking me all these questions, and she was talking to you, treating me like a kid. The way they speak to you. It really gets into your head.'* (Kerry, late teens). Because of this, Kerry only went once to the psychiatrist, but left after about half an hour and never went back. Kelly similarly only went once. She was 15, and the psychiatrist: *'Made me sit there and play with Barbie dolls, so I was pulling their arms and legs off and chucked them at him, and told him to piss off. He just sat there. I said "I'm not dealing with you*

and walked out' (Kelly, late teens). Many young people found it difficult to talk to a stranger about the reasons for their self-harm, without getting to know them first. Anna had felt that there was some compulsion to her assessment, as it took place in a police cell. She said: *'I don't like going through those sorts of processes, because they try and make you talk about things and that.'* (Anna, late teens).

Most participants had also talked to other people who have self-harmed and most of them had found it useful. As might be expected, a support group was thought valuable by some – including one participant who runs such a group – but only about a third would want to take this up. Those who thought it would be valuable cited the importance of talking to someone else who knew 'what it's like'. Those who did not think it would be helpful either did not feel comfortable in groups or were concerned that talking about self-injury might either trigger further incidents or that the issues were too personal to discuss.

Information

Two thirds of the participants had received information about self-harm either in the form of leaflets or information from professionals. Two thirds had found the information themselves. Common sources were the internet and organisations such as the National Self-harm Network, the Bristol Women's Crisis Centre and 42nd Street.

Many participants did not feel that more information would be valuable for them. But a third felt that it would be valuable for other people who self-injure, one reason being that it would be useful for people who self-injure to realise that they are not alone. Three people suggested a need for more information about local services, two suggested a helpline and others thought that information targeted at particular groups of self-harmers (such as men or young people being looked after) would be useful.

In contrast, all the participants thought more information should be available for others including families, friends and carers, professionals, young people (through schools) and the public at large. This pattern is consistent with the messages given earlier by participants, that they faced a major problem in the widespread negative attitudes and lack of understanding they faced from those close to them, the public in general and service organisations. There can be a temptation to think this is the self-harmers' problem so they need more information, this was not the participants' view.



A range of services

Some of the services which participants experienced had been highly stressful. This was particularly the case for psychiatric wards and residential children's homes. A third of the participants had been an in-patient on a psychiatric unit. For some, this was for a short stay only. Two participants had spent long periods of time in psychiatric units. All of those admitted for short stays had found the experience frightening. Some of the women were particularly frightened to find themselves on a mixed ward. Young people tended to feel that it was also very frightening being on a ward with much older patients:

'I was 17. Everybody else there is much older and it's really frightening. A lot of people are in there for being violent. I think they should have separate units for self-harm. It's quite frightening. You get scared because you think they're going to attack you or something. There's nothing at all for people who self-harm. It's just pushed under the carpet. I think it's because people don't understand.'

Sandra (late teens)

'If you get sectioned, for example, they have a ward which goes up to 16, and then you're on an adults ward, and that is a problem. At 16, 17, 18, 19, 20, you're not an adult. You know, we like to think we are, but we're not. It's the most scary thing... There should be some sort of in-between ward, like for 17 to 20 year olds, because there is such a big difference between a 17-year-old, and a 40-year-old man, for example.'

Mel (late teens)

Others did feel there was a role for in-patient units. Phil felt he would really like a residential stay, but one that is therapeutic, rather than simply for monitoring. Vicky felt that it was very beneficial to talk to other patients:

'Talking to other patients, I think that's what helped you. Not the fact that you've got these doctors, you've got these nurses. The fact that you talk to other people and there were other people who felt exactly the same as you, no matter what state they

were in, no matter what part of life they came from, there were people that felt like you. It felt good to feel that you weren't on your own. You weren't this strange person that had been beamed down onto earth and nobody else was like it. There were other people like you, so you realised that it weren't you that had done something wrong. So that were a help, going into hospital and discovering those people.'

Vicky (over 25)

Some participants felt being in a residential unit was a factor in their self-injury and self-harm, as seen above. In these cases, self-injury and self-harm tended to be seen as the norm within the residential unit and, where this was so, some young people felt it was necessary to behave in fairly extreme ways in order to receive care and attention. Secondly, looked after young people frequently felt no one cared about them, so self-injury and self-harm would, on occasions, be a 'cry for help'. Thirdly, the fact that self-harm tended to be treated as routine events was felt to be generally unhelpful.

On the other hand, participants mentioned a number of positive dimensions of services provided by NCH projects in addition to those identified above. The core aspects were that staff were reliable, accessible and non-judgemental, but there were also many aspects of provision on offer: *'You get free food packages. This place, I'd praise it. This place is a godsend. There's a counsellor on the Thursday. You can have a laugh, you get to meet people. Oh, they just do so much. I couldn't even describe all the help they've given me. They've helped me with furniture. They've helped me with everything. I would have been lost without them. My main source of help is NCH... I've got free use of the phone as well... it's brilliant. I've never got one bad word to say about this place.'*

Rachel (early 20s)

‘What they did was get me involved in activities. Built my confidence up that way, and they aim to empower young people rather than run around and run their lives for them. And I’m obviously living proof that it works, because I’m a volunteer now, and I’m a lot more capable than when I walked in that door... They give you a lot of opportunities, which is good. And it’s at your pace as well. You don’t get pushed along.’

Kirsty (early 20s)

The multi-dimensional, non-stigmatising approach apparent in some of the NCH projects was also reflected in participants’ views about what would look like an ideal service. The suggestions included the following features:

- a non-clinical setting such as a drop-in centre
- staffed by people who were approachable and understanding including those with personal experience of self-injury
- a relaxed atmosphere where service users could have fun and participate in activities as well as receiving support
- nurses available to treat cuts and other injuries without the need to go to hospital.

Some felt it would be important for the service to be open 24 hours.

Why do people stop?

Stopping self-injuring

The majority of participants stated they had either not harmed themselves for a considerable time or had decreased the regularity of the self-harm. About a quarter had not self-injured for a year or more. Another quarter had not harmed themselves for a matter of months. Five more had decreased their level of self-injury. However, most were reluctant to state that they had stopped altogether. As Mel stated, *'You can never say you've stopped, but you can say "I haven't done it for a while". "Stopped" is such a final word.'* (Mel, late teens). In fact, only two respondents stated they had stopped.

Three were still harming themselves on a regular basis and were unsure about stopping. One described self-injury as a 'necessity' as it stopped him from harming others. The other felt, although she would like to stop because:

'It's fucking my arms up, and I'm running out of room on my arms... at the moment, it's the only thing that I've found that works. So I'm not going to stop it if it helps me, am I?'

Anna (late teens)

Bernadette (early 20s) said:

'I don't feel like I need help for the self-harm. I feel that that's something I'll probably do till the day I die. How often depends on how uptight I get, depends on how my life goes, depends on how much contact I have with my mum.'

Those who had decreased or ceased self-injury gave a variety of reasons. Improved self-esteem seemed to be a significant factor for a number of respondents. As Sonia put it, *'It's been hard. It's been really hard, but you know, I've got there. I've started to like myself'*. Others felt that it was due to working through feelings from the past, 'growing up', being able to communicate with people more effectively, moving out of care, wanting to keep their children, or generally having more to lose.

Tom had not harmed himself for two years. He would be tempted to take an overdose if he had access to tablets, but gave them to someone else to lock up. He stated:

'There's no point in harming yourself, is there? There's always someone to listen to you: professional body, family, friend. There's always someone there... I'd rather talk to somebody now than harm myself.'

Tom (early 20s).

For Sharon, too, having people to talk to:

'Makes a big difference. I've not cut up now for at least five months, because I've got people around that I know I can talk to. And I know that they aren't going to judge. If I turn around and say "I feel that pissed off, or I feel that down that I want to cut" they aren't going to judge me for it, which makes a hell of a difference.'

Sharon (early 20s)

Linked to this is learning to communicate more. Kelly (late teens) said, *'I'm more open about how I'm feeling. I tell them when I'm angry. I shout at them when I'm pissed off.'*

Tracey had also not cut herself for two years and found it difficult to imagine doing it now. One important factor was the experience of having her children taken into foster care because of her self-harm and having to fight hard to try to get them living back with her. Stopping cutting was part of, *'Trying to prove to everybody I am responsible now'*. She also felt that it was significant that she had left care and now mixed with different people. However, she also stressed the importance of having other things in her life now.

'I think I just thought I had something to live for – not to live for, but there were other things to focus on. For one thing, I didn't have time to make a bit of toast, never mind cut my arms!... I've come so far, why should I? You know, I've got aims and things, and if you start doing silly things, you just ruin everything.'

Tracey (early 20s)

For Vicky too, her children were providing a crucial motivation to reduce self-harming:

'You've got a brick wall. A big ball's just come and smashed it to smithereens. Not only have you got to put the bricks in place. You've got build the bricks first, and then that's just one brick. And then you build another brick. And then you've got to build mortar, which holds it in place. I've got mine. Mine's my kids, and that's holding mine in place, but I'm still building my bricks, and I'm still making my wall, and it's slow. And unless you accept that it's a slow process, you'll never get there.'

Vicky (over 25)

Stability and a supportive environment were also factors identified by the participants. For Kirsty this meant:

'Settling my home life down. When I moved in here, there were no carpets. There was no wallpaper. There was nothing. I just had the clothes that I was stood in, because I'd been homeless. To me, it was everything, but building that up was hard. And once I got to a point where I had the essentials and stuff like that, I could start settling down, and trying to work out where I wanted to go, instead of having all these things going round my head. Instead of "Where am I going to get food from? Or sleep tonight?". Before you can sort yourself out, you need to get yourself a safe environment and safe, reliable relationships really, and support around you, before you can even begin to contemplate tackling anything.'

Kirsty (early 20s)

Others used a variety of methods to stop themselves self-harming. A minority smashed things up, or used alcohol or drugs instead. The majority tried to distract themselves and to work through their thoughts and feelings by talking to people, listening to music, or reading, for example. A few tried other creative methods, including writing poems, drawing, martial arts moves, meditation and singing. Two young women used drawing and poetry as means of expressing how they were feeling, and found that this could sometimes allow them to visually represent their feelings without harming themselves.



Lessons for the future

Current policies and service provision for young people who self-injure or self-harm link self-harm with suicide, give priority to tackling suicide and see self-harm as a mental health issue. While this approach is understandable and suicide is a serious issue affecting young people, it should be borne in mind that our participants perceived self-injury very differently, rejecting the connection to suicide and often reporting negative experiences of mental health services. They did not see the traditional range of common psychiatric services (medication with in or out-patient treatment) as particularly relevant. In part, this is more evidence supporting the case made by government for radical changes in mental health services (Department of Health 2001b), including listening to service users' views.

Primary prevention of self-injury and self-harm will involve tackling the root causes of young people's distress resulting, primarily, from social and economic inequalities and disrupted and abusive relationships. Secondary prevention will involve targeting policies and services at particularly vulnerable groups, such as those in care. But for those young people who are injuring or harming themselves, we suggest the following approaches to policy and practice should be considered.

Policy makers, commissioners and service providers

i. Establish a national network of locally based, appropriate services for people who self-injure

In most parts of the country there are no specific services for people who self-harm and, at best, patchy and frequently stigmatising mental health services for young people, often with long waiting lists. The participants in this study had some clear ideas about the kind of service which would be valuable to them. And in some places, something like it already exists. Sharon described such a service:

'Where I am now, they've got a self-harm team. They cut the hospital out altogether and just go to the self-harm team and I think there needs to be a

lot more of them. A lot more. They come out and provide support for at least four weeks, and then they've got a crisis point where you can go for a week. It's like a hostel but for people with mental illness who self-harm. They can go for a week, get their head straight, and then go back home... Some of them need longer, but a minimum of a week. There needs to be more places like that for people that self-harm... even if it's just overnight and I think the self-harming rate will come right down, because they know that they can go there and be safe and there's going to be no-one there that judges them and they're going to have no attitude, off either the public or off hospital staff.'

Sharon (early 20s)

Local services might also provide a helpline.

ii. Provide a range of supportive and therapeutic opportunities to young people

It is also important to offer opportunities, services and environments which can both help relieve the stresses which young people face – particularly those who face multiple forms of disadvantage – in making the transition into adulthood and which offer them the chance to repair damaging experiences which may have caused them to start harming themselves. As described above, it can be the availability of a range of opportunities, services, activities, material support and accommodation which enables people to have the capacity to cope without the release or relief of self-injury.

iii. Re-examine the impact of institutional placements on children and young people

Participants in the study spoke clearly about the impact of being placed in residential care situations where self-injury was commonplace, in children's general wards as a teenager and in mixed adult psychiatric wards as a young person. Once again, this study points up the importance of the quality of care involving residence which is offered to children and young people, as well as the placement decisions which are made, often against a background of limited alternatives.

iv. Ensure services focus on friends, families and paid carers as well as people who self-injure

Our evidence suggests that both paid health and social care workers and the families and friends of people who self-harm can find their actions distressing and difficult to understand. At the same time, the informal support they sometimes provided was highly valued. Services for people who self-harm should also provide information, advice and support for family members, friends and partners and as well as for paid workers who lack information or advice.

v. Support self-help

For some people who self-harm, exchanging information, advice and support with others who have injured themselves is seen as particularly valuable because they are felt to know what it is like. Different participants had found different forms of self-help important to them including one-to-one conversations, groups and internet contacts.

vi. Establish clear policy frameworks.

In the absence of clear local policies, staff are liable to fall back on their own attitudes and common sense. This may be dangerous or damaging for the staff involved, service users and the employing agency. A policy framework with accompanying staff training, can give staff and service users some security within which to manage distressing and sometimes frightening incidents. Such a policy needs not to be over-defensive. The kind of policy which would require every incident to result in a visit to a medical setting would not be welcomed by service users and would undermine staff's potential for offering meaningful help.

vii. Ensure staff are provided with training and support

Both staff in the national survey and participants who had self-harmed were clear that professionals across all fields – but particularly health, social care and education – need better training. People who self-harm are faced repeatedly with a lack of understanding of self-harm and by negative, and sometimes punitive, attitudes. Certain groups of staff who are particularly likely to come across young people who are self-harming should be the first focus for training. These include those dealing with young people in the care system, suffering from poor mental health and who have been exposed to excessive stress such as abusive relationships, family breakdown, homelessness and discrimination due to racism, homophobia or other factors.

viii. Establish a public information campaign to raise awareness and understanding

Participants interviewed for the study gave graphic accounts of their feeling that their behaviour was misunderstood and that this gave rise to unhelpful responses from lay as well as professional contacts. This contributed to the likelihood that people would self-harm in secret with attendant dangers to their health and reduced chances of being helped to access useful service provision.

Staff in health, social care, education and other services

i. Understanding and sympathetic attitudes

Those on the receiving end of services provided by a range of professionals gave graphic accounts of the negative attitudes they had experienced and the impact it had on them. Disrespectful, dismissive, patronising and judgemental attitudes were widely experienced from trained and untrained professionals alike. This appeared particularly likely in certain settings where the context of the work (Accident and Emergency Departments and field social work), the perspective, age and gender of staff (psychiatry) or low levels of training, pay and support (residential care) seemed to result in patterns across the country. Staff who did not have prior knowledge but who asked and attempted to understand were experienced as helpful. Even staff without specific training in dealing with self-injury might be expected to exhibit such attitudes as part of their occupational duties but it was commonly not so.

ii. Practical care

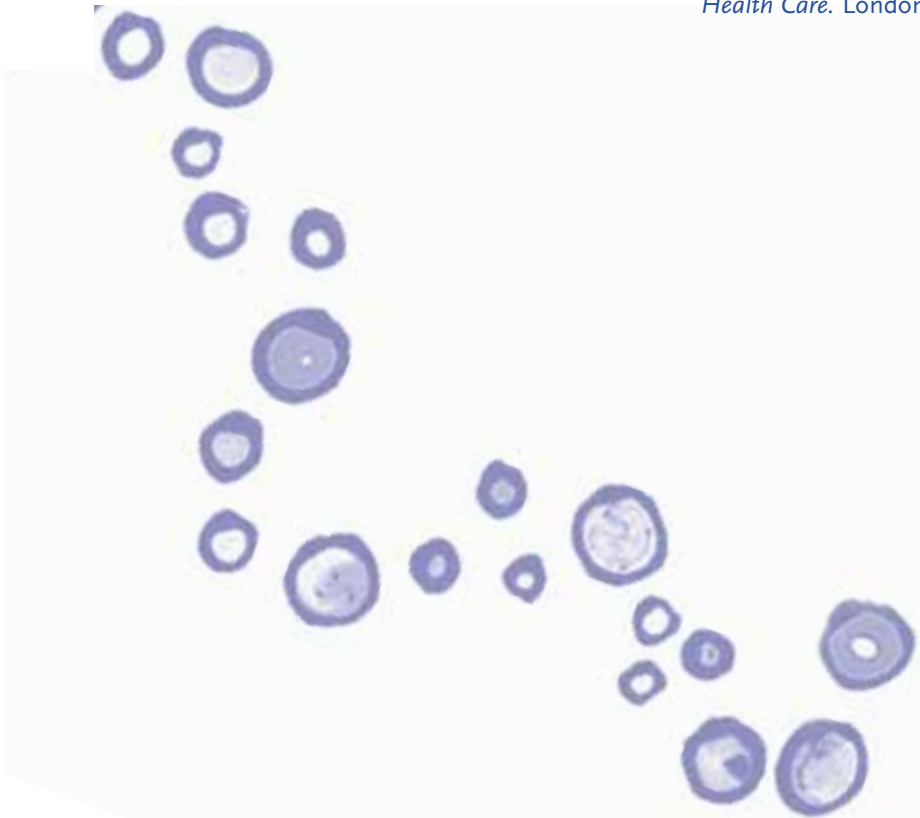
Those who self-injured recognised that sometimes they needed or wanted medical or nursing help, particularly with treating their injuries. Where possible they preferred this to be away from medical settings where there was less stigma and the atmosphere was less clinical. Services for young people need to include staff with the training and capacity to deal with injuries where possible.

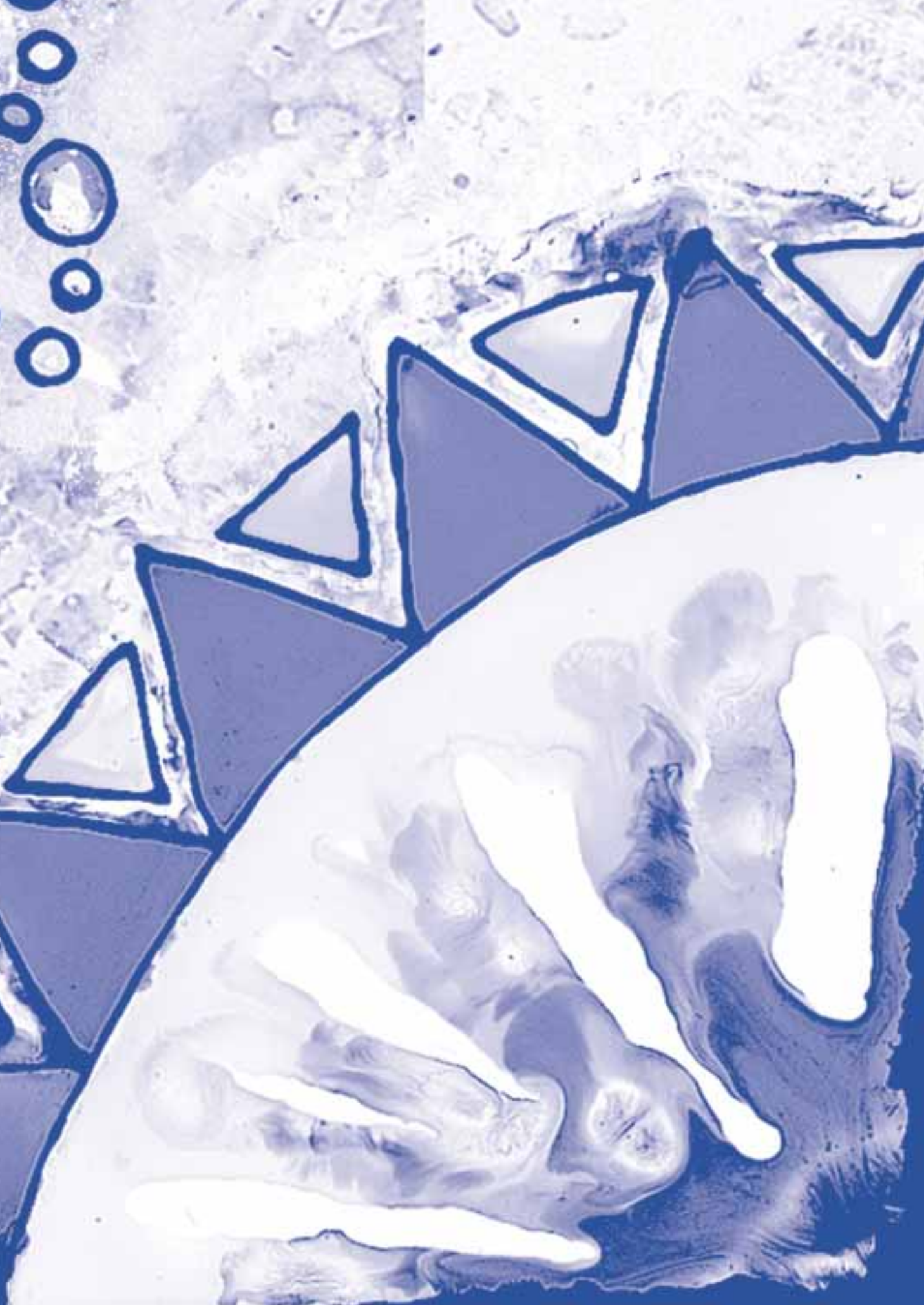
iii. Educational programmes

As some of our participants described, giving information about self-injury to those who had not considered it could lead to them starting, if their emotional needs were not being met in other ways. However, consideration should be given to including information about and discussion of self-harm in wider health education programmes for young people in schools and care settings.

References

Department of Health (2001b). *The Journey to Recovery – The Government's Vision for Mental Health Care*. London: Department of Health.





Last words

At the end of the interviews, participants were asked if they had key messages which they would like to pass on to service providers and professionals working with people who self-harm. Those mentioned most often concerned attitudes:

- treat us with more care, compassion, concern, support and interest
- listen to us
- don't judge us
- respect us as you would others. Treat us as human beings, not as children or as alien beings
- don't just see it as attention seeking.
- look at the individual. Different people may have different reason for self-injury and self-harm
- there's always a reason for self-injury and self-harm
- the issue needs to be out in the open much more
- be firm as well as caring, but don't try to compel someone to talk, or to stop.

'They just need to listen to the person and try to understand, and if they don't know something, put the person in touch with someone who does know. That's what's needed, instead of it being pushed underneath the carpet. If somebody doesn't know about it, they should refer us to somebody that does, so that the help can be given that is needed.'

Sharon (early 20s)

'Look at the individual, not the harm. Look at the person beyond the scars. Scars aren't important. It's the person that did them that's important.'

Mel (late teens)

'To be there, offer a hand to hold, even if it can't be a hug, or a shoulder to cry on. And to look for the reason behind the self-harm, not just the self-harm. To treat everyone who self-harms as an individual, because we don't all do it for the same reason.'

Joanne (late teens)

'They could probably try and listen better and take it all in, rather than going in one ear and out the other. They should show interest no matter how many times they've done it.'

Anthony (late teens)

'I always think when you're going to do something like this then there's always something behind it. It may be something from the past or it may be because they don't like themselves, but there's always a link to something behind the problem.'

Tammy (early 20s)

'I feel that not to judge and to understand that people can go back, and although they've gone back to self-harming, it's not a backward step. They've got to look at it as a forward step and try and stop them but let them think that they're stopping themselves. Let them be in control. If they choose to cut themselves, fair enough. If they want to go down that path, fair enough, but give them alleyways, other alleyways. because at the minute, they think they're in a tunnel. And that's all they can see. Give them some lights.'

Vicky (over 25)

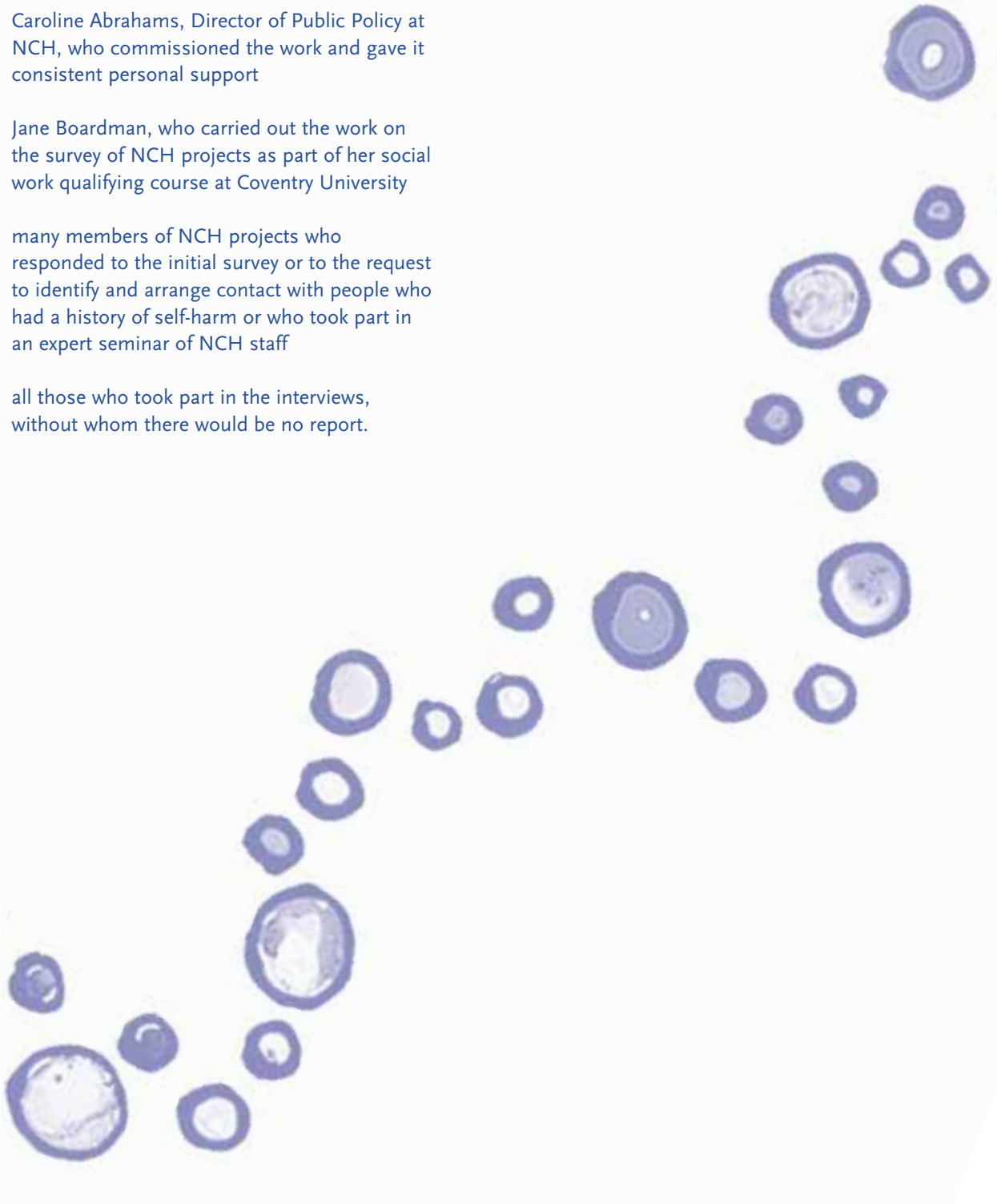
Paul Bywaters is professor of social work and director of the centre for social justice at Coventry University. He supervised both the research projects reported here.

Alison Rolfe is currently a part-time lecturer in the department of sociology at the University of Warwick, teaching a course on youth, and an associate lecturer teaching social psychology and qualitative research methods for the Open University. She undertook and analysed all the research interviews in the second project and undertook a literature review.

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Sources of help and further information

Help is available for people who self-harm and for their families and friends.

Children and young people can contact **ChildLine** by telephoning **0800 1111**. This free helpline provides confidential counselling for children and young people 24 hours a day.

Alternatively you can write to ChildLine at:
ChildLine (England) ChildLine (Scotland)
Freepost 1111 Freepost 1111
London N1 0BR Glasgow G1 1BR

ChildLine ChildLine
(Cymru/Wales) (Northern Ireland)
Freepost 1111 PO Box 1111
Swansea SA1 5ZZ Belfast BT1 2DD

YoungMinds, the children's mental health charity, offers a parents' information service on **0800 018 2138**.

YoungMinds also produce a helpful booklet called *Worried About Self-injury?* which can be downloaded free from their website at **www.youngminds.org.uk**

National Self-Harm Network

PO Box 16190
London NW1 3WW
Website: **www.helen.ukpet.com**
This service provides information and support to people who self-harm.

The Samaritans can be contacted

on **08457 909090** (24 hours)
E-mail: **jo@samaritans.org**
The Samaritans offer free emotional support to anyone going through any problem.
Website: **www.samaritans.org.uk**

Mind (England and Wales) infoline on **08457 660163** covers all aspects of mental health, including information on self-harm and how to help someone who is suicidal.
Website: **www.mind.org.uk**

Please note that there are many other internet web-sites which cover self-harm. The content and quality of these is very varied. Take care about what you see and read.

NCH is one of the UK's leading children's charities. Through more than 480 projects we work with over 98,000 vulnerable children, young people and their families to ensure they reach their full potential.

NCH

85 Highbury Park
London N5 1UD

Tel: 020 7704 7000

Fax: 020 7226 2537

Website: www.nch.org.uk/selfharm

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