How Individuals Who Self-Harm Manage Their Own Risk— 'I Cope Because I Self-Harm, and I Can Cope with my Self-Harm'

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Abstract

Self-harm is a complex and idiosyncratic behaviour. This article focuses on how those who self-harm manage their own risk. Utilising opportunity sampling, ten members of a self-harm support group were interviewed about how they risk manage their self-harm and the data analysed using interpretative phenomenological analysis. The analysis showed that all participants were actively involved in risk management of their self-harm. Through a process of managing consequences, exercising control in the process, and an awareness of the social context. It is posited that people who self-harm should be viewed as actively engaging with the risks of self-harm whilst it is

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a coping mechanism, as opposed to passive or ignoring. This understanding can be integrated into current risk management plans within services and invites a more dynamic conversation of self-harm between services users and services. Effective risk management involves good relationships between individuals who self-harm and clinicians, services which promote positive risk taking as opposed to defensive practice, and true collaboration between services and service users.

Keywords
Self-harm, self-hurting, risk management, service user, qualitative

Introduction

The assessment and management of risk has become a core expected process within mental health services where clinicians are frequently expected to make decisions regarding a service user's risk to themselves or others (National Patient Safety Agency, 2004). The first UK guidelines stipulating that clinicians should perform risk assessment and management plans were published in 1994 and related to discharge from hospital (Department of Health, 1994).

Theoretical understanding of risk

Graham and Weiner (1995) defined risk as "the probability of an adverse outcome". Rosa (2003, p. 56) defined risk as "a situation or an event where something of human value (including humans themselves) is at stake and where the outcome is uncertain" highlighting the necessary inclusion of uncertainty in our understanding of risk and comprising both positive and negative consequences. However Hansson (2005, p. 7) identified that it was the 'first myth of risk' that it has 'a single, well-defined meaning'.

These definitions highlight the two prominent paradigms of understanding risk within society. One is from an ontological realism perceptive which specifies risk as objective and independent of our experiences and perceptions. More recent conceptualisations of risk include the observer as integral to the classification of risk. A relational theory of risk, first proposed by Hilgartner (1992) and developed by Boholm and Corvellec (2011), understands risk as a product of a relationship between a risk object and an object at risk. Therefore risk definitions are socially bound, although this theory does acknowledge some objective risks.

Risk in mental health services

In current practice, risk assessments usually involve a clinical interview between a professional and a service user, with a created plan to prevent or minimise

harm. Increasingly they include the use of a checklist of risk factors, however these are employed inconsistently across services and there is no evidence that they result in improved outcomes (National Institute for Health and Care Excellence, 2011).

There have been many criticisms of the current risk management approach in services (Beck, 1999). Crowe and Carlyle (2003) state that risk management in mental health services is a form of 'non-knowledge' (p. 25) and argue that the current system promotes services which are fearful and watchful, as opposed to engaging and therapeutic, where the primary aim is to justify the clinician's decision making. This potentially results in service users being positioned as victims of risk factors where their agency and autonomy are negated.

Moving towards living without the need to self-harm is a value for some who currently self-harm and the people in their lives who care about them. Indeed this is the overt goal of some psychotherapeutic practices such as Dialectical Behavioural Therapy (Linehan, 1993) and Structured Clinical Management (Bateman & Krawitz, 2013). This current research considers whether, whilst working towards building alternative responses and ways of coping, it is meaningful and relevant to simultaneously consider the intricacies associated with the risks of self-harm and this be a part of the recovery journey.

The characteristics of self-harm

For the purposes of this study, the term self-harm is used to refer to what may also be known as self-mutilation or self-injury; that is the intentional injury of one's own body tissue without suicidal intent by means of behaviours such as cutting, burning, scratching, and interfering with wound healing (Klonsky, 2007a). 'Self-hurting' has recently been proposed as an alternative term, as a way of capturing one of the central features of the phenomenon, specifically the use of physical pain as a means of coping with emotional distress (Barton-Breck & Heyman, 2012). However, we have chosen to use the term self-harm, as this is widely used within services, and also within 'lay' discourses, including by the participants of this research.

Self-harm is one of the top five causes of acute medical admission in the UK (Gunnell et al., 1996). Estimates of the prevalence of self-harm are approximately 2.7% in the general population (Nock et al., 2008), rising to 22% in primary care samples (Kerr et al., 2010), and a significant minority of people who self-harm do so repeatedly (Kapur et al., 2005). Given that not all those who self-harm will present to services, and the potential impact of the stigma associated with self-harm, these figures will be a severe underestimate of the general prevalence.

Self-harm is linked to a variety of harmful outcomes including repeated and elevated self-harm severity (Favazza, 1999), mental health difficulties (Skegg et al., 2004) and increased risk of suicide (Owens et al., 2002; Zahl

& Hawton, 2004), which remains elevated even if the self-harm has stopped (Whitlock & Knox, 2007). Given the prevalence of self-harm and the associated outcomes, it is vital that risk management practices for self-harm are the most effective possible.

Theoretical understanding of self-harm

There are many differing theoretical perspectives on self-harm. One of the more dominant can be referred to as the medical/diagnostic perspective where self-harm is viewed as a symptom and can often involve a 'pathologizing discourse' (Franzén & Gottzén, 2011). This model can become associated with the view that self-harm is a problem behaviour and must be stopped (Stevenson & Fletcher, 2002). Neurobiological research suggests that abuse and neglect, particularly early in life, can lead to heightened emotional sensitivity and reactivity to stress suggested through changes to the threshold of limbic reactivity or changes in perceptual and cognitive appraisals related to threat (see Dvir et al., 2014, for a full summary). This view positions self-harm as a response to emotion dysregulation (Linehan, 1993). Psychological theories include psychodynamic perspectives, such as Van der Kolk et al.'s (1996) theory based upon object relations where babies and children develop their sense of self and safety from interactions with others, therefore connecting self-harm with the experience of trauma, attachment, and emergent self identity. Furthermore self-harm can be viewed within a sociocultural perspective categorised as 'pathological self-mutilation' as opposed to culturally sanctioned self-mutilation such as piercings and tattoos (Favazza, 1996). Favazza states that self-harm, particularly in western cultures, tends to be explained with reference to the individual psychopathology rather than cultural contexts such as healing oneself, restoring power and control, and the body as a way of conveying internal pain. Participants within Straiton et al.'s (2013) study understood their self-harm in relation to social explanations. Each theoretical perspective generates different reactions and intervention options.

The literature directly investigating people's views of self-harm and its functions is vast and varied. Individuals who self-harm have described it as a coping mechanism or a way to distract themselves from difficult feelings (Chapman et al., 2006; Skegg, 2005) and have reported feeling calmer and less angry following self-harm (Klonsky, 2007b). Some participants state that an act of self-harm does not equate to an intent to die and see self-harm as an act of self-preservation (Hjelmeland et al., 2002). One particular intention or motive might predominate or there may be several concurrently, and repeated self-harm is unlikely to be limited to the same motive or method each time (Horrocks et al., 2003).

Therefore the act and functions of self-harm can be complex and idiosyncratic, whilst being associated with both short and long-term risks; warranting further understanding and more effective interventions.

Involving the service user in risk management

Recent guidelines state, 'Risk management is everyone's business – including the service user's,' (Department of Health, 2007a, p. 25), where best practice includes collaborating with service users to create risk management plans (Department of Health, 2007b).

Despite this emphasis on service user involvement, there is little research into how risk is managed or understood by service users (Mitchell & Glendinning, 2007). There is a relatively large evidence base regarding the functions of self-harm, but little research has attempted to understand the individual's experience of self-harm; specifically their perception of the associated risks and the ways in which they manage those risks.

Instead, most research is focused on the risk posed to others (Langan, 2008), despite the fact that people with mental health diagnoses are more likely to be at risk from self-harm or suicide than pose a risk to other people (Langan, 1999). Although, the idea of risk managing self-harm has been discussed within the lay-literature for some time (National Self-Harm Network, 2000; Pembroke, 2007) it has only recently begun to be explored within the academic literature.

A theme from recent qualitative research by Barton-Breck and Heyman (2012) showed that participants were mitigating the downsides of self-harm which the authors termed 'accentuate the positive, eliminate the negative' (p. 445). Participants described attempting to reduce the risk in self-harm by making smaller cuts or using different instruments for different effects. It appeared that participants were able to continue to fulfil the functions of self-harm while minimising the risks. This current research aims to build upon this knowledge and explore this experience in more detail.

The current research

The main aim of this research was to understand whether and how individuals who self-harm engage in risk management, specifically addressing how they conceptualise, understand, and manage the risks associated with their self-harm. From this we identify applications of this understanding.

Method

Participants

Participants attended one of three self-harm support groups run by individuals who self-harm in the Northwest of England. Ten people volunteered to take part in the research, comprising three males and seven females. Ages ranged from 19–45 with a mean of 27.4 years and all were currently engaging in self-harm at the time of interview.

Ethical considerations

To conduct the research, approval was gained from an NHS Research Ethics Committee and the local Research and Development department. Informed, written consent was received from each participant.

Given the sensitive nature of the research topic, there was a likelihood that participants would wish to discuss emotive experiences or risky situations within the interview. The risk management plan was heavily discussed with both field supervisors, one of whom was a service user at the time of the research, focusing on the benefits and costs of the chosen approach. Additionally, one of the field supervisors, a Clinical Psychologist, offered participants the opportunity to meet and discuss any issues arising from participating in the research. The risk management process for the interviews was clearly defined at the start of the interview prior to asking for consent, consistent with informed consent practices, and any action taken involved discussion with the participant. The authors believe that this form of risk management is in accordance with the ethos of this research.

The quotations selected are assigned pseudonyms and chosen because they are free from idiosyncratic styles so that participants are unlikely to be identified.

Data collection and analysis

The study was conducted using Interpretative Phenomenological Analysis (IPA), an approach designed to develop an understanding of how participants make sense of their experiences (Smith et al., 2009). As well as having an interpretative dimension, IPA has a strongly idiographic dimension, keeping the sense-making of each participant in the foreground throughout the analytical process. The first author conducted semi-structured interviews lasting approximately one hour with each participant. Interviews were audio recorded and subsequently transcribed.

Each transcript was analysed individually and these individual analyses then were merged across the whole set. First, each transcript was read and reread, then coded line by line. This included noting descriptive comments of the content, linguistic comments on the use of language, and conceptual comments. The next stage involved using these comments to explore the relationships and links between comments within the transcript. To do this, the first author wrote each comment on a separate piece of paper and rearranged the papers until comments were sorted into groups of similar meaning. These groups were termed emergent themes and given working titles. This process was repeated for each transcript. Comparing across all transcripts, the emergent themes were amalgamated or discarded until the themes were deemed a full and fair description of all the transcripts. Finally each theme was titled.

Results

The analysis described above resulted in four themes, namely why the risk is worth taking, practical risk management, the social dimension of risk management, and the riskier side of self-harm. As a set, these themes encapsulate the way in which participants understood and engaged with the risk associated with their self-harm.

Theme one: Why the risk is worth taking – 'I don't like self-harm, but it works'

All the participants said they would prefer not to self-harm, yet all were able to describe the reasons why they self-harm and how it helps them. These reasons echoed those cited in previous research such as inducing positive feelings and reducing negative feelings (Klonsky, 2007b) and so will not be explored in depth here. Feelings of relief or release were common and some reported positive or euphoric feelings following self-harm, as Chloe said, 'It's the best feeling in the world afterwards'. Self-harm was described as quick, accessible, and effective and therefore became dependable and reinforcing: 'It's the quickest, easiest way out and I know that's what people say that there's nothing second. Nothing is going to be more effective than self-harm really, and it isn't. Unfortunately' (Chloe).

All participants reported struggling to cope with difficult emotions and stated self-harm helped them to feel better or more able to cope, making the risks associated with self-harm seem worth taking. Participants were able to clearly identify associated risks including pain, injury, infection, long-term damage, possible negative reactions from others, and potential unwanted inpatient admissions.

Self-harm was described as a 'last resort' (Anna) where participants tried to utilise other coping strategies first, as explained here: 'I've worked my way through the coping skills list, I think I've literally tried everything' (Anna).

Despite the stigma, the efficacy of self-harm and the associated increased ability to cope was described as making self-harm seem to be a risk worth taking.

Theme two: Practical risk management – 'get the job done'

This theme encapsulates how participants manage their self-harm. It comprises three subthemes namely damage limitation, managing the consequences, and downplaying the risk.

The overarching theme comprises the way in which participants view self-harm as a task or a job that requires completion. Anna likened this to a 'pressure cooker' and for David his 'chest goes tight'. In recognition of this build-up cycle, some participants made self-harm accessible by keeping instruments

around the house: 'I store them [blades]' (Jamie); 'There's always one [blade] in my purse' (Anna). Then participants would plan to self-harm as shown here: 'I know I'm going to do it, I plan to do it and because I plan to do it, I get everything ready and then I do it, clean myself up' (Beth); 'I know I'm going to do it so I get everything out ready' (Emma). In their linguistic choices they likened self-harm to a task. David said he 'went to work on the top of [his] leg' and said it was 'a job well done', and Anna described 'working with' her hands under the table.

Participants differed in the extent to which they planned to self-harm. For example, Fay planned the day, time, and severity of her self-harm, and Heather and David planned how many cuts they would make. David was distressed at the extent to which he planned it: 'That's what worries me most, how calculated I can be about it, how I can plan it, how I can think about it'. For others, such as Gemma and Anna, they would feel the need to self-harm building and in this way self-harm felt less specifically planned but included some planned elements. Chloe described this dichotomy:

> You just don't think. You are not rational at that time. So I would say it's impulsive because I'm not thinking rationally but I have obviously got an element of control over it because I'm not kind of doing it really, really deep or doing it in certain areas.

Damage limitation. Participants described engaging with the risks to gain the most benefit from minimal damage. Anna described it as self-harm 'just enough to keep me going', as echoed by Heather who said, 'It's just to get enough out, it's just enough to cope, it's just enough to get a bit of a release, just enough to get to the next stage of being ok'.

Participants reported learning to become more skilled at damage limitation and more aware of the risks over time: 'I used to do it with anything. Absolutely anything. I've used sharp sticks, broken glass that I've broke myself . . . and it never used to bother me what I used but now as I've got older, I'm more aware' (Emma); 'When I was younger, it was basically anything that I could find erm, now I'd never, never put myself at risk with it. I would always make sure I was safe' (Beth).

The instrument selected impacted the extent of the damage. Several participants reported trying different instruments:

> I found I had less control using the razor blades because the cuts would hurt less and you could cut deeper. Whereas I found when I used the blade in the pencil sharpener it wasn't as sharp but it was sharp enough where you could gauge your length and your depth more. (David)

'I was too scared for the knife, I couldn't do it properly and at the end, I needed to do it properly. And then the scissors just wasn't, they weren't sharp enough' (Gemma). Both David and Gemma described finding an instrument that allowed them sufficient control of the injuries but the ideal instrument was different for each of them.

It was imperative to many participants that they could manage their self-harm on their own and therefore they selected methods which enabled them to retain control over their injuries and cause minimal damage.

Managing the consequences. After self-harm, the participants managed the consequences by reducing the risk of scarring and infection as explained by Beth:

> I make sure I've always got clean blades. Erm, after I have cut myself I will always wipe off all the blood, make sure I put some form of antiseptic cream on. Erm, if it's, if it's quite bad, I'll cover it with erm, a dressing to make sure that no dirt or anything can get in it, just until it's healed over.

Many participants reported having a first aid kit which was accessible. Rachel said, 'I have dressings and that in the bathroom cabinet . . . I don't want to get infections, I even stitch myself as well'. Heather described how this could also act as a form of self-care: 'I've always almost first aided myself. Like I've usually always kept steri-strips . . . It also helps in a way afterwards with the guilt in a way do you know to kind of try to make it better'. The primary motivation of this behaviour was to help to minimise the risk of infection. The secondary gains were that the wounds could be managed by the person, thus avoiding the need for outside help and scarring was kept to a minimum, reducing the risk of other people finding out; altogether maintaining a position of control where they could manage both the injury and the consequences.

Gemma said, 'I don't do it as deep as I'd like to sometimes because I think, no, because that's going to go in your medical record . . . if you are going to do it, do it sensibly'.

Downplaying the risk. At various points in the interviews, participants appeared to downplay the risks of self-harm. Anna said, 'I can't imagine ever cutting deep enough to need stitches or anything 'cause they're just I don't know I don't like my muscles I don't want to see them (laughs) no I don't know how people cope when they do that – I'd freak out' (Anna). 'You know how some break razors and do it proper deep? It was more just with the razor. So again it wasn't deep, very deep at that time' (Chloe). In all comments of this type, the participant identified their self-harm as less risky compared to others.

Several participants described their self-harm as superficial. Jamie said, 'It's not that deep, it's just cuts' and he used 'just blades'. Similarly Fay said, 'I did it

on my arm, it wasn't that bad, well it was bad enough that it scarred for a few years'. It is clear to see the paradox between how participants describe the risks and the actual risks present, along with some acknowledgement of these risks.

This suggests an element of cognitive dissonance where participants have a belief that self-harm enables them to cope yet also a belief that self-harm is dangerous. In an attempt to reduce this dissonance participants may attempt to alter their belief that self-harm is dangerous by altering their perceptions or beliefs of the risks. This may be an iterative process as participants may have to constantly alter their belief during and when talking about self-harm, leading to some paradoxical or contradictory statements.

In discussing these results with the support groups, members of the group described how they would downplay the risks of self-harm to protect both themselves and other people. They would attempt to disguise the true risks associated with their self-harm as a way of allaying their fears about the damage they may cause. Additionally they downplayed the risks to others because they were aware of the potential impact of their self-harm on other people as discussed in more detail in Theme Three.

Theme three: the social dimension of risk management – 'it's my self-harm'

This theme shows that participants were aware of the social context of self-harm and how the risks associated with self-harm can be altered by the reactions of others. Participants perceived that self-harm negatively impacted others: 'I would see the effect it was having on my family and it was awful and it got to the stage one time, my family they were ill with worry about me, they couldn't sleep' (Heather). Fay linked the guilt she felt with the increased risk of self-harm:

> I'd never seen my dad cry until that day so that's when I thought oh my God I've really let him down, I've really hurt him, he's really hurting, this is my fault. I don't know if they ever thought for one second that the worse I was feeling, the stupider things I'm going to do.

As a result, many participants described their self-harm as personal and private and went to great lengths to uphold the privacy of their self-harm, such as harming themselves on parts of their body that were less likely to be seen or waiting until their family members went to bed. Heather described hiding injuries on her feet: "I'd then just wear socks, or just- if I was coming out of the bath, angle my feet a different way and stuff. You do get really good at hiding things and it's a bit of an art form".

When others were aware of self-harm, their response was primarily one of worry and concern and often involved restricting the freedom of participants in an attempt to keep them safe.

> My nan tells me off about it but that makes it worse for me and I still do it. Interviewer: Why does telling you off make you feel worse? Jamie: 'Cause it's not good telling me off 'cause if you tell me off I'll just like do stuff more and more. (Jamie)

This was echoed by Ian:

> I'd lifted the razor up, she snatched the blade off, out of my hands, knocked my hands so I dropped the blade. Then obviously she goes ape shit and then she makes me feel worse and then I will sneak off and try to do it again. (Ian)

Participants stated this often increased the urge to self-harm, or led to further secrecy which potentially increased the risk of wounds not being treated or not accessing the appropriate services. While participants could understand and shared their loved ones' concerns, their loved ones' attempts at risk management could paradoxically increase risk of infection and isolation.

Theme four: the riskier side of self-harm – 'I could have easily killed myself'

Participants described a qualitatively distinct form of self-harm which is perceived as more impulsive and therefore associated with greater risk and severity of injury. This theme appeared across five of the ten participants and for these individuals this form of self-harm was very important and formed a significant portion of their approach to risk management, hence its inclusion as a separate theme. 'Sometimes it is just spontaneous and I just can't control it and then, you know, there's not much– to me it's totally different, there's not much planning to it' (Heather); 'There are other times where it's just spontaneous, it's like oh fuck, I just feel like shit and bumph' (Ian).

This type of self-harm was often triggered by an event such as an argument, as opposed to a build-up of emotion. Participants associated this harm with greater risk and greater damage to themselves as described by Rachel:

> I was having an argument with my husband at the time erm I locked myself in the kitchen, smashed the glass that I was drinking out of and cut myself with the glass. Interviewer: Ok what made that time particularly risky for you? Rachel: Well it could have been anything couldn't it? I could have ended up with shards of glass in me.

With this type of self-harm, the risks were not managed as effectively because it was not as planned and the methods available were different to those normally used as described here: 'Because it wasn't controlled, because I was in that heat of the moment and I didn't really realise how bad I was doing it, that's when I looked back afterwards and thought, that's not good' (Beth).

> This day I just hadn't planned it and I really needed to do it so I went and got it and I did it and I went at the top of my arm sort of in a diagonal thing so it was completely different to how I'd ever done it. (Fay)

Jamie described it as, 'It's more like really, really not thinking straight at all'.

This type of self-harm is described as distinct from the controlled and risk managed form of self-harm where participants do not control the risks as effectively as they would like to and are sometimes worried by the extent of their injuries.

Discussion

In summary, the results of the research indicate that participants were actively involved in risk managing their self-harm. They did this by aiming to cause the least amount of damage possible, managing the consequences of self-harm through first aid, and downplaying the risks. Participants went to great lengths to maintain the privacy of the self-harm for example by selecting the times and places to self-harm. Additionally a small but significant number of participants described a more impulsive form of self-harm which was not similarly risk managed.

Participants clearly described the reasons they self-harm and how it helps them to cope. This is in line with understanding self-harm as a form of emotion regulation (Klonsky, 2007b; Linehan, 1993; Straiton et al., 2013). As Franzén and Gottzén (2011) state, within a normalising discourse, self-harm is viewed as understandable in reaction to psychological distress, whereas a pathologizing discourse regards the self-harm as problematic and unacceptable in itself. Conceptualising self-harm as a form of self soothe may generate more compassionate responses from individuals and systems.

Furthermore, it is not merely a weighing up of the positives and negatives of a situation as might be predicted by rational choice theory (Scott, 2000), but is an engagement with the risks in a way that produces the required effects while mitigating the consequences.

The concept of control ran throughout the themes and through participants' stories. Participants exercised control in the self-harm itself by selecting particular instruments they felt gave them the required amount of control over their injuries. Participants positioned themselves as in control of their self-harm and invested heavily in managing their self-harm without input from others. It is

important to note that agency in this sense is within the realm of self-harm and is not seen as equivalent to free will or free choice as all participants stated they would not self-harm if they felt this was an option. That is, participants have agency in the way they self-harm and choose to exercise this agency by managing the harm and attempting to mitigate the consequences. Therefore it can be argued that people who self-harm should not be viewed as passive victims of self-harm, but as actively engaging with it in order to cope. As described by Adler and Adler (2007), 'To be seen as ill is to be derogated, to be seen as self-healing is normal' (p. 560).

Building on previous research

Recent research is turning towards service user's views of their own risk. Peterson et al. (2011) found that service users accurately predicted risk of self-harm at eight and 15 weeks post-discharge from hospital, and results were comparable to predictions made using the Beck Hopelessness Scale. This and previous research highlights the potential value in including service user perspectives within risk management.

In risk management practices, it is often considered helpful to remove access to means of self-harm, however in some circumstances this could lead to increased urges to self-harm or self-harm using alternative materials which could increase the risk. Indeed more restrictive measures in hospitals is associated with greater risk of self-harm (Drew, 2001).

Participants in this research felt they became more skilled and private about their self-harm over time. This is in contrast to previous research where participants state they found it harder to conceal and manage their self-harm over time (West et al., 2013). Participants were keenly aware of the potential social reaction to their self-harm and all held beliefs that self-harm impacted others. This could be an indication of shame and experience of stigma in relation to self-harm. Similarly the subtheme 'downplaying the risk' could be a form of shame management through distancing or minimising the event (Silfver, 2007). More research is needed to explore the process of ownership and mastery and how this can change over time.

These findings align with a strengths model of mental health. People who self-harm have referred to themselves as survivors living in distress and difficult situations. Those posting on an internet community group related to self-harm wrote about themselves as, 'Strong and resilient individuals facing psychological difficulties' (Franzén & Gottzén, 2011, p. 285). A strengths based model assumes that people have strengths, skills, and abilities (Rapp & Goscha, 2006). Use within mental health services involves conversations which highlight the details of the person's problem solving abilities and reveals all the ways in which the person is managing/coping with their distress. It positions the person themselves as the expert where others can learn from and

understand, and support collaboratively. It occurs in a manner which is open, curious, not knowing, and non-prescriptive.

Limitations

Participants in this research were part of a self-harm support group and these specifics of the sample could impact the data. It necessitates that the participants have sought support and are in a position of wanting to talk about their experiences in this research. Potentially these individuals may have a different relationship with or view of self-harm compared to those who do not seek support. Additionally, risk management strategies are sometimes discussed within the group. Further research is needed using different sampling strategies to assess the extent of proactive risk management across different populations and within individuals across time.

This research is positioned more from an individualist cultural perspective and included all western individuals. The nature of the questioning leaned towards individual accounts thus leading to intrapersonal descriptions. Whilst the results acknowledge a cultural response to self-harm, still the focus of discussions is how the participants manage this individually. Further research could explore different cultural responses to self-harm and therefore whether these results are replicable multiculturally as highlighted by Hjelmeland et al. (2008).

Implications for clinical risk management

Effective risk management strategies may involve approaches similar to a harm-minimisation approach as advocated by Louise Pembroke (2007) where self-harm is viewed as a valid coping strategy until other, less harmful, coping strategies are able to be employed. The harm-minimisation approach involves giving people permission to self-harm while providing education about anatomy, first aid, and wound care to enable them to self-harm in a safer way. Participants' accounts highlight that outsider attempts at risk management which either involved telling people to stop self-harm or removing instruments, may have managed the immediate risks but increased feelings of shame and guilt, and motivation to hide self-harm; merely increasing the perceived need to self-harm and the risk of infection and isolation.

Effective risk management would include consideration of the sociocultural facets of self-harm. Professionals can move away from pathologizing discourses which would in turn reduce stigma, reduce barriers to help, posit the individual as resilient with strengths and coping, and ultimately move towards more effective support as well as risk management.

Some participants described a more impulsive form of self-harm which increased risk and injury severity. The appearance of two distinct forms of

self-harm within one person, challenges the assumption of self-harm as a single construct and provides a more complex picture. The more impulsive form of self-harm was often triggered by an event or argument as opposed to a build-up of emotion so may be more difficult to predict or protect against. Effective risk management may necessitate different or concordant risk management plans.

Predominantly this relies on good relationships between the service user and their clinicians where service users feel they can discuss their self-harm and that any subsequent risk management plans are appropriate and meaningful. Creating an environment where both individuals and staff teams can discuss and hold complex and multiple understandings of self-harm will lead to more individualised and effective responses.

Interestingly, of those who had accessed services, participants commented that they had never been asked about their self-harm or risk in detail while in services. Thus merely starting this dialogue may positively impact the relationship and subsequent interventions. In the same way that participants are able to actively engage with the risks of self-harm, it may be beneficial for services to actively engage in these risks.

Service user involvement or influence?

The overall recommendation is to treat service users who self-harm as autonomous individuals rather than victims of self-harm, and explore the option of engaging in risk management. As Spandler (2009) suggests, being inclusive is not about people slotting into existing frameworks, but to be truly inclusive would be people involved in services in the way they want to and for services to enable this flexibility. Additionally, the assumption is that service users want to be involved in their care planning which may not always be the case.

Langan and Lindow (2004) make a distinction between involvement and influence. Involving service users may be assumed to be merely helping them to complete current standardised risk assessment tools, however enabling them to have influence in their care would require an understanding of the way they currently risk manage their own self-harm and to build upon that knowledge and understanding to create individual plans. While this does not exclude the use of standardised tools which may have their own utility, it must be done in collaboration where the service user is treated as an equal and an expert on their own self-harm.

Some professionals have expressed concern that at certain times service users may lack the capacity to be involved in their care plans (Langan & Lindow, 2004). Where this is the case, the use of advanced directives and independent advocacy services become paramount.

Defensible not defensive practice

Collaborative risk management involves positive experiences for the service user, greater engagement, and increased likelihood that minimum risk management strategies are adopted and effective (Department of Health, 2007b). Engaging with the risk management of self-harm as outlined here, along with the harm-minimisation approach requires a level of positive risk taking, and it is easy to see how positive risk taking may be undermined within services. Morgan (2000) states that positive risk taking 'is perhaps one of the most difficult concepts to put into practice within a context of a "blame culture"' (p. 49). Conversely, Linsley and Mannion (2009) argue that a 'no blame culture' is unfeasible because blame is a product of society. Instead, they recommend movement towards a culture which is most appropriate for risk management, and this involves services which value equality and empathy. The approach to risk management as recommended here promotes treating the service user as an equal and necessitates good working relationships which are dependent on empathy.

Conclusion

Individuals who self-harm are often actively involved in risk management of their self-harm by minimising the risks of damage, scarring, and impact on others. Potential applications of these findings within services involves enabling service users to be truly included in risk assessment and risk management. This is dependent on creating good relationships with service users and a reduction in defensive practice. Services and clinicians can learn from individuals' current risk management strategies and integrate these strategies into risk management plans that ultimately will have increased accuracy and relevance, and therefore be more effective.

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