The quest for genuine care: A qualitative study of the experiences of young people who self-harm in residential care

Charlene Rouski[1], Susan Frances Knowles[1] ⓘD, William Sellwood[2] ⓘD and Suzanne Hodge[2] ⓘD

[1]Changing Minds, Warrington, UK
[2]Lancaster University, Lancaster, UK

Abstract

Levels of self-harm for young people in care are high, and even higher for those in residential care. Recent research highlights the importance of understanding self-harm relationally. Such an approach may be of particular value for understanding the self-harm of young people in care. The aim of this research was to understand the experiences of young people who self-harm whilst living in residential care, with a particular focus on the effect of the care setting on their self-harm. Five young people participated in semi-structured interviews which were analysed using Interpretive Phenomenological Analysis. Four themes emerged: 'The black hole of self-harm', 'Seeking genuine care and containment', 'The cry to be understood' and 'Loss of control to the system.' Young people recognised their need for support with their self-harm, but organisationally driven approaches to managing risk contributed to a perception that the care offered was not genuine, which led to an unwillingness to accept care. The findings highlight the need for a more compassionate, relational response to young people who self-harm in residential care.

Keywords

Introduction

Children in care ('looked after children') are a particularly vulnerable population (Pinto & Woolgar, 2015) with 63% of those in England having experienced abuse or neglect (Department for Education, 2019). Early exposure to trauma has been linked to a range of psychological difficulties and risk-related behaviours including the development of self-harm (Yates, 2009), defined here as an act of self-injury or self-poisoning regardless of motivation or intent (NICE, 2013). Evidence

Corresponding author:
Suzanne Hodge, Division of Health Research, Lancaster University, Health Innovation One, Sir John Fisher Drive, Lancaster LA1 4AT, UK.
Email: s.hodge@lancaster.ac.uk

suggests that it is the relational aspect of trauma associated with maltreatment, rather than the maltreatment itself, that may put young people most at risk for self-harm (Martin et al., 2016).

Children in care are significantly more likely to self-harm than others. For example, Harkess-Murphy et al. (2013) found that 24.5% of their sample had engaged in self-harm. This compares with 15.5% in a similarly aged sample from the general population (Morey et al., 2016). Furthermore, young people in residential care display more self-harm than those in foster placements (Hamilton et al., 2015), with prevalence in residential settings reported to be up to 60% (Laye-Gindhu & Schonert-Reichl, 2005).

Looked after children are usually placed in residential homes after multiple unsuccessful foster placements, and thus multiple disrupted relationships, and often have significant emotional and behavioural difficulties (Berridge et al., 2012). Residential homes aim to support the development of nurturing bonds, meet the child's needs and provide a safe environment (Department for Education, 2015). However, providing therapeutic support to children in residential care can be challenging. Qualitative research with staff highlights the challenges of the "corporate parent" role; fulfilling organisational demands, for example, around risk management, whilst providing nurturing care (McLean, 2015).

Evans (2018) explored the interpretative repertoires employed by foster carers and residential care staff in speaking about young people's self-harm. In the repertoire of "security", young people were seen as using self-harm to test the authenticity of care offered. In the "survival" repertoire, self-harm was seen as providing young people with a sense of agency in circumstances over which they had little control. Finally, self-harm was perceived as a way of young people "signalling" their need for care. Underpinning all three repertoires was an assumption that self-harm is relational; a response to experiences prior to entering the care system, and a means of communicating the need for genuine care. Even when participants classed young people's self-harm as "attention-seeking", they still saw it as understandable, mirroring research with young people (Chandler, 2016, 2018). These findings reflect an implicit understanding of self-harm as communicative, expressing a need for recognition (Steggals et al., 2020), with a view of help-seeking as complex and social (Chandler, 2016).

Thus engaging therapeutically with looked after young people who self-harm requires an empathic response which recognises its relational dimension (Morrissey et al., 2018). This is not without challenges because carers' natural empathic responses may be hindered by feelings of being overwhelmed and unprepared, highlighting the need for better support and training (Brown et al., 2019). However, in line with Evans' (2018) findings, this support itself needs to be informed by carers' expertise, particularly their relational understanding of self-harm.

Given the emerging importance of this relational approach to self-harm, there is a need for research with young people themselves. Wadman et al. (2018) explored looked after young people's experiences of self-harm and of mental health professionals' interventions. Their findings mirror those of Evans (2018), with participants seeing self-harm as a means of exercising some control in relation to changes in placement and describing a lack of trust in professionals as a barrier to talking about their self-harm. The authors report young people's experiences of mental health services as a "relational mixed bag" (Wadman et al., 2018, p. 372), identifying both negative and positive experiences as centring on the quality of their relationship with the professional. The need for professionals to better understand the relational context of young people's self-harm was highlighted, along with the importance of development of trusting, compassionate relationships.

The present study explores further the experiences of young people who self-harm in residential care settings with a particular focus on understanding how the relational context of the setting, including staff responses, affects their experience.

Method

Design

Interpretative phenomenological analysis (IPA) was chosen as a research design because it focuses on individual meaning-making, using an explicit double hermeneutic in which the researcher makes sense of the way participants make sense of their experiences (Smith et al., 2009). Thus it allowed us to focus on the ways in which each young person talked about their experiences. Because of its emphasis on developing fine-grained understanding through detailed idiographic accounts, rather than emphasising the identification of broader patterns, IPA is well-suited to studies with small samples in specific settings. The disadvantage of this approach over, say, a thematic analysis with a larger sample drawn from a wider range of settings, is that it limits the degree of theoretical generalisability possible.

Ethics

Ethical approval was obtained from Lancaster University Research Ethics Committee (Reference: FHMREC15116). Because of the vulnerable nature of the population and the sensitive nature of the topic, particular care was taken to minimise risk to young people from taking part. This included recruiting via care home managers, ensuring that a staff member was aware when an interview was taking place, and debriefing the young person after their interview to check how they were feeling and remind them of support available.

Recruitment

We aimed to recruit looked after young people aged 13 to 18, who were either currently self-harming or had previously done so whilst living in residential care. Participants were recruited from four therapeutic residential care homes run by two residential care providers in the UK.

Young people were excluded if their care home manager deemed that they would not be suitable because they: were at risk of undue distress; did not have the cognitive ability to participate; presented with high levels of risk.

Home staff identified and approached eligible participants. Where the young person was 16 or older, written consent was obtained directly before the interview. Where the young person was under 16, an assent form was completed prior to interview and consent was obtained from the individual with *Parental Responsibility*.

Data collection

One-to-one semi-structured interviews were conducted by the first author, a trainee clinical psychologist, between December 2016 and March 2017. Five young people took part; two males and three females. Each interview was conducted in a private room in the residential home in which the participant lived. No-one else was present in the room during the interview, but a member of staff was on site and aware that the interview was taking place. Interviews lasted approximately 45 minutes and were audio-recorded and transcribed by the first author. Names were replaced with pseudonyms and identifying information was removed. See Table 1 for participant characteristics.

Data analysis

Analysis was conducted by the first author using IPA (Smith et al., 2009). This involved reading and annotating each transcript with descriptive statements, notes of linguistic features and tentative

Table 1. Participant characteristics.

Participants (pseudonyms)	Gender	Age	Self-harm behaviour	Approximated length of time in residential care
Iris	Female	14 years	Cutting, scratching, ligatures	1 year 6 months
Lilli	Female	16 years	Head banging, cutting, self-induced vomiting	4 years 6 months
Finn	Male	16 years	Cutting	3 years
Bob	Male	16 years	Cutting	4 months
Chantelle	Female	18 years	Cutting and burning	3 years

interpretations. From these annotations, emergent themes were developed. These themes were then collated and sorted into superordinate themes. This process was repeated for each transcript and the superordinate themes for each participant were then collated and sorted to develop a final set of themes across all participants.

Results

Four themes were developed: 'The black hole of self-harm', 'Seeking genuine care and containment, 'The cry to be understood' and 'Loss of control to the system.'

The black hole of self-harm

This theme captures the consuming relationship that all participants had with their self-harm: "Once you start self-harming, depending on not whether you like it or not, you carry on" (Bob). For Iris, self-harm was like a black hole, reflecting a loss of control: "this black thing in my head. It's like a round thing and it's like a hole. . .that hole in my head tells me go and do that." The unattainable goal of "good enough" self-harm maintained Lilli's behaviour: "You never overdose enough, you never cut enough." Chantelle regretted starting self-harming, not anticipating either its addictiveness or the lasting impact of her scars: "I didn't know it was going to be something that happened all the time and would stay with me in some way forever". Participants appeared stuck in a repeating pattern of self-harm over which they had no control.

Participants expressed ambivalence about stopping: "I want to stop but I don't" (Iris). Lilli felt unable to stop: "I'd love to stop. But I can't". Chantelle's desire to stop was hindered by the presence of her scars so instead she focused on harm reduction: "the damage is already done so if I want to do it, I'll just do it. I try to do it so I don't have to go to hospital".

Participants acknowledged the functionality of self-harm. Finn described self-harming in an attempt to communicate the need to see his mother: "I knew that if I put myself in hospital then mum would come" (Finn). Self-harm was also a way of reducing intense emotion: "It's like opening the bottle and all the pain just releases" (Bob).

Seeking genuine care and containment

This theme captures participants' perceptions of their self-harm as manifesting their underlying desire for genuine care and their struggles to obtain this from staff: "look at my arms, I'm bleeding and I want attention" (Bob). The "attention" they sought was essentially relational care, motivated not by organisational requirements, "I think it's more like, to make it look like they're doing what they should be doing, if you know what I mean" (Chantelle), but by genuine concern that could

contain their distress. To illustrate the difference Chantelle described an occasion when she attended Accident and Emergency (A&E) with another staff member after self-harming:

> . . .the woman on shift took me to A&E but she weren't like, she didn't act like staff. She was just like, acting like she was there just to support me really (. . .). She stayed all night and you can usually tell when staff are not happy because they have to do erm a waking night in A&E but she wasn't like that, she genuinely cared. And that's what made the difference.

Where staff were experienced as offering genuine care, this provided participants with a sense of safety and trust in a parental figure who could notice and contain their distress: "she knows when something is bothering us without a doubt" (Bob); "They check on you all the time. . .so if you say I'm not feeling so good they can stop and have that chat. And it don't feel forced because it's just relaxed" (Finn).

However, at times care could also be experienced as intrusive, particularly in situations where levels of emotion were heightened, as described by Iris:

> . . .they were knocking on the door saying my name, are you ok? Iris, Iris, Iris, Iris. What! And then I get more mad because they are banging on my door calling my name. If they leave me I'll calm down and I'll come out in my own time. But when I don't answer they give me like five seconds to answer and if I don't answer then they come in and then they're like what are you doing. (. . .) It makes me mad. It makes me want to self-harm more because they won't listen to me and they won't get out of my personal space.

Whatever the motivation for this response, it not only had the effect of exacerbating rather than containing Iris's distress, it also increased her desire to self-harm.

Participants described needing emotional containment particularly at the time of their self-harm: "unless you're going to bring me down I've got no reason to take it [ligature] off" (Lilli); "It's already been and gone now. What good is talking about it with you?" (Chantelle). Bob felt that although his physical health needs were addressed when he self-harmed his emotional needs were not: "It's not helping me emotionally, but it's helping me physically". Several participants described occasions when they believed that the staff supporting them were unable to manage their distress, for example: "They didn't quite have the training and they didn't quite know how to deal with me" (Finn). Consistency of response was crucial to feeling contained: "Like you've not got the whole what will they do if I do this or what will they do if I do that?" (Lilli).

Self-harm could evoke observable emotional distress in staff, leaving the young people feeling uncontained: "They get scared and they panic" (Iris); "they're all supposed to be like the ones looking after me" (Chantelle). For Finn, it was particularly unhelpful when staff with whom he had established a relationship became upset: "I think what were bad was that staff-wise, obviously if it's one that I have known for two years, get quite upset". However, Bob found the expression of emotion by staff helpful as it demonstrated genuine care: "at least they're showing emotion and they are actually worried about people in their job and they're not just here because they have to."

Despite ambivalence about the responses they received, there was clearly a desire for help. Iris was reliant on support from staff to enable her to make meaningful change to her self-harm: "That's what I want help with, people finding me solutions" (Iris). Having a trusting relationship was crucial, which for Chantelle meant not being judged: "It's more about having someone there that - when it has happened - who won't judge you or make you feel like an idiot". Similarly for Chantelle, having trusting relationships meant she felt able to seek support after self-harming, but not before:

> Well once I got to know the staff a bit and built relationships with them, I felt like I could tell them. I still wouldn't tell them before I do it, but if I done it and it was quite bad then I could tell them. . . (Chantelle).

In summary, even though participants described rejecting care at times, there was a strong desire for support and emotional containment. The development of trusting, secure relationships with staff was crucial to this.

The cry to be understood

The importance of genuine, secure relationships with staff described in the previous theme also underpins the current theme which is about young people's need for staff to understand them, and particularly for their self-harm to be understood in the context of their lives: "the way I act is because of how I have been brought up. I haven't had the best life (. . .) listen to my point and like, understand why I am the way I am" (Iris). Where the previous theme highlights the role of staff in helping participants to manage their self-harm and cope with the underlying distress, this theme reflects their need for staff to understand their self-harm in order to help them make sense of it themselves.

There was a general perception that staff saw self-harm crudely as "attention seeking" behaviour designed to elicit care: "They just think, oh she just wants the attention, but I genuinely don't, I didn't ask them to check on me" (Iris). Lilli described feeling judged by staff who lacked an understanding of the context of her self-harm: "I was like you know what, go and fuck yourself. Cos at that point they knew nothing about my history - and yet, they decided that they can make that quick judgement". As highlighted in the previous theme, to the extent that their self-harm could be construed as "attention-seeking", the "attention" participants sought was essentially genuine, relational care in which they were listened to and understood.

Participants wanted staff to understand their life story and to be able to talk about the reasons behind their self-harm. However, staff rarely initiated conversations that allowed them to do this. Chantelle felt that this was because it was an uncomfortable topic: "I found that people avoided it, like they didn't want to talk about it because it made them uncomfortable." Most participants wanted staff to understand their behaviour in order to get the support they needed. However, they felt that whilst many staff had a basic knowledge of self-harm, they did not really understand the complexity of the behaviour: "They think - all different ways but it's not really to the point of why" (Bob); "You can't just give a couple of reasons and expect it to fit every single box" (Lilli).

There was a sense that staff could never connect with self-harm as they lacked lived experience of it: "I think unless you have gone through it yourself you don't understand it" (Lilli). Finn suggested that training for staff should include personal testimonies from young people: "let young people who have self-harmed in the past do a couple of training sessions, then they get the emotional bit".

Loss of control to the system

This theme captures the loss of control that young people experienced whilst living in residential care as they were subject to systems and rules that were enmeshed in policy to manage risk. These provided the framework within which their relationships with staff were lived out.

Chantelle perceived policy for managing self-harm to be "punishing" and risk assessments to be depersonalised: "sticking to the script". Participants described risk management plans, which included room searches, limiting access to specific items and restricting independent access in the community. Such boundaries served as reminders that they were not 'at home': "It just made me a bit sad that I wasn't at home really. Just reminded me that it weren't my home" (Chantelle).

Some participants reflected that boundaries did not prevent self-harm: "They're not stopping me, they're just saying don't do it. And then what are they going to do like. They can't do anything

about it" (Iris). If the desire was intense, they would find a way to self-harm, regardless of risk management plans: "you're gonna find something to do it with. I could hurt myself with a padded cell" (Lilli). Iris reflected that boundaries could in fact increase the urge to self-harm, as distraction techniques may be restricted: "you're making me more dangerous to myself because you won't let me do what I want to do" (Iris).

Room searches, which included removal of personal belongings perceived as posing a potential risk, were experienced as invasive: "they don't find everything but they find the most important things to you" (Lilli); "If they did it in front of me then fair enough but they do it behind my back and to me that's theft" (Iris).

Increased observations were used to manage risk: "They start doing like every 15 minute checks to make sure you're still alive" (Bob). Being observed through the night was particularly challenging: "How would you like somebody to watch you sleep. It's not good, very unnerving" (Lilli).

There were also confrontations between staff and young people regarding the extent to which self-harm injuries required medical attention: "They just take me to hospital and I'm like I don't need to go to hospital over a scratch" (Iris). Chantelle hypothesised that staff sought medical guidance to cover themselves, rather than out of genuine care: ". . .just probably don't want it to be worse than it is and they get in trouble for it I suppose".

Discussion

The four themes reported here together capture the different relational dimensions of young people's experiences of self-harm in the residential care system.

The first theme, *the black hole of self-harm* represents their relationship with self-harm itself. Whilst representing an internal psychological, rather than social, relationship, this relationship is nonetheless important in the power it exerts. Their relationship with self-harm led participants to feel stuck and alone, dependent on self-harm as a way of coping with emotional distress (Laye-Gindhu & Schonert-Reichl, 2005), and regulating intense emotions (Klonsky, 2007; Nock & Kessler, 2006). Their descriptions of being stuck in a cycle of self-harm over which they had no control, unable to stop despite recognising its risks, reinforce the view of self-harm as an addiction (Brown & Kimball, 2013; Nixon et al., 2002).

The participants' struggles with their self-harm were mirrored in the second theme, *seeking genuine care and containment*, which captures their struggle to obtain genuine, relational care that could contain their distress and help them manage their self-harm. The young people needed to feel listened to (Ward et al., 2005) and wanted to establish genuine, trusting relationships with staff. However, staff responses to them when they self-harmed rarely appeared to be experienced in this way. Instead, they were often experienced either as intrusive and uncontaining (even increasing their need to self-harm) or as insincere, motivated by organisational requirements rather than genuine care. This theme could be seen as mirroring the interpretative repertoire of security identified by Evans (2018), where carers viewed young people's self-harm as a way of testing the authenticity and safety of their relationship with staff.

Although the young people in our study did not report self-harming as a way of intentionally testing staff's caring responses, their perceptions of staff responses could be seen as reflecting their challenges in building trusting relationships. Exposure to early trauma can make it difficult to establish trust (Cook et al., 2017). Disrupted early attachments are common in looked after children (Bovenschen et al., 2016) and may predispose young people to either reject care or become preoccupied with wanting to be close to others (Mikulincer et al., 2003) or alternate between these two patterns (Golding, 2008). Young people can also be fearful of establishing reciprocal, responsive relationships (Golding, 2017).

The third theme, *the cry to be understood*, conveys the young people's need for staff to understand their self-harm relationally. They wanted staff to help them make sense of their self-harm, to initiate conversations and to have a much greater awareness of how their life stories might have influenced their self-harm, rather than seeing it simplistically as attention-seeking behaviour. If staff appeared not to have this understanding, young people felt invalidated. Invalidating responses lead to increased levels of emotions and arousal (Shenk & Fruzzetti, 2011). Thus, when staff respond in a manner perceived as invalidating, young people's distress may increase, which may lead to self-harm as a method of emotional regulation (Klonsky, 2007).

It is important that staff understand the influence of adverse childhood experiences and developmental trauma and the links to self-harm and regulating emotions (Kisiel et al., 2014; Lawson & Quinn, 2013). Evans (2018) showed that despite using the trope of self-harm as attention-seeking, staff also held more compassionate and nuanced understandings of young people's self-harm, linking it to their traumatic histories. It is possible that if we had interviewed staff working with the young people in our study we would have found similarly nuanced understandings, albeit this is not reflected in young people's perceptions of staff responses to them.

The final theme, *loss of control to the system*, represents the systemic constraints experienced by young people as standing in the way of genuine, relational care. This can be understood as reflecting the colonisation of the lifeworlds of both staff and young people by the care system, whereby individuals and relationships are governed by instrumentally rational processes and rules which have to be followed for their own sake (Habermas, 1984). Living in the care system created an environment in which relationships with staff were experienced as being driven by organisational requirements to manage risk rather than by genuine care. This presents a challenge to the therapeutic alliance, something which is crucial in supporting people who self-harm to develop alternative methods of coping (Nafisi & Stanley, 2007). Bordin (1979) identified the three elements of the therapeutic alliance as being the development of therapeutic bond, and agreement about tasks and goals. These elements mediate each other; the quality of the bond influencing the extent to which therapist/staff member and client/young person are able to negotiate agreement about tasks and goals; and the ability to negotiate agreement about tasks and goals influencing the quality of the bond (Newhill et al., 2003). In residential care settings, the space for shared goals to be developed can be constrained, particularly where the need for consistency in approach to managing the behaviour of all young people is prioritised over the needs of the individual (McLean, 2015). This affects the quality of the bond between staff member and young person, resulting in the tensions experienced by staff (McLean, 2015) and, as our study shows, by young people themselves.

Clinical implications

The findings highlight the importance of understanding self-harm relationally, and of the need for secure relationships between young people in care and the staff who care for them. However, this desire for connection appeared to be obstructed by the responses of both young people and staff and by systemic constraints. It is essential that professionals are enabled to establish ways of letting young people know that it is safe to form relationships with them in order for the therapeutic bond to develop. The other elements of therapeutic alliance – shared tasks and goals – could be facilitated by involving young people in their own risk management plans instead of using depersonalised plans based on standardised risk assessments. Not only would this ensure that they are tailored to the young person's needs, but they could also open up conversations about the reasons behind their self-harm. This could go some way to developing a new culture within residential care settings, in which staff are empowered to engage more confidently and openly in discussions with young people about their self-harm and about the distress underpinning it.

Training which includes young people's perspectives may help staff to develop a more compassionate understanding of self-harm, both in terms of its origins and how best to respond to the young people in their care. On an individual basis, the use of psychological formulation would give staff the space to understand an individual's self-harm in the context of their 'story' and establish optimal ways of responding.

Finally, working with young people who self-harm can be emotionally challenging for staff, especially working in a dual role of providing therapeutic care and managing risk. The use of clinical supervision for staff is important in enabling staff to consider the complexity of their roles, their own emotional responses to self-harm and how this may influence their ability to care for young people.

Strengths and limitations

The findings provide valuable insights into how the relational context of residential care may influence young people's self-harm, complementing research undertaken from a staff perspective, and adding important knowledge to a still limited evidence base.

The participant group of five was small but sufficient for an IPA study where homogeneity is prioritised over range of experience, allowing the detailed, idiographic exploration achieved here. A target sample of 10 was aimed for, but challenges in the recruitment process prevented this from being reached. These challenges were mainly due to the concerns of home managers, who were 'gatekeepers' to recruitment, regarding the perceived vulnerability of young people in their care and whether discussing self-harm might exacerbate distress and risk. Several discussions occurred with service providers to overcome these obstacles, but recruitment remained low. This may also have had the effect of excluding the experience of those perceived to be 'most vulnerable' or higher risk from the study.

Future research

Following on from this work, and from that of Evans (2018) further research could be undertaken with a combined sample of young people and staff recruited from the same residential settings to develop a more fully relational understanding of self-harm. By adopting a dual perspective, it would be possible to explore the tensions between care and behaviour management highlighted in both studies and to uncover hidden connections between the experiences of staff and young people.

Conclusion

This research aimed to capture young people's experiences of self-harm whilst living in a residential setting. The findings reinforce the view of self-harm as having a strong relational dimension. Although recognising their need for care and support from staff, the willingness of young people to accept care was blocked by the perception that the care offered was not genuine. Organisationally driven approaches to managing behaviour and risk contributed to this perception and potentially increased risk. The study highlights the need for staff in residential care settings to be supported to develop a greater awareness of the relational dimension of self-harm and how this impacts on their work with young people, particularly in negotiating their complex dual role of providing therapeutic care and managing risk, but also in understanding how their own emotional responses to self-harm may influence their ability to provide containing, therapeutic care.

ORCID iDs

Susan Frances Knowles (iD) https://orcid.org/0000-0002-7042-5413

William Sellwood (iD) https://orcid.org/0000-0001-8260-9503

Suzanne Hodge (iD) https://orcid.org/0000-0003-0416-8188

References

Berridge, D., Biehal, N., & Henry, L. (2012). *Living in children's residential homes. Research Report DFE-RR201*. https://www.gov.uk/government/publications/living-in-childrens-residential-homes

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice*, *16*(3), 252.

Bovenschen, I., Lang, K., Zimmermann, J., Förthner, J., Nowacki, K., Roland, I., & Spangler, G. (2016). Foster children's attachment behavior and representation: Influence of children's pre-placement experiences and foster caregiver's sensitivity. *Child Abuse & Neglect*, *51*, 323–335.

Brown, A., Chadwick, R., Caygill, L., & Powell, J. (2019). One moment you're covered in blood and next it's what's for tea? An interpretative phenomenological analysis of residential care staff's experiences of managing selfharm with looked after children. *Scottish Journal of Residential Child Care*, *18*(3), 68–91.

Brown, T., & Kimball, T. (2013). Cutting to live: A phenomenology of self-harm. *Journal of Marital and Family Therapy*, *39*(2), 195–208. https://doi.org/10.1111/j.1752-0606.2011.00270.x

Chandler, A. (2016). *Self-injury, medicine and society: Authentic bodies*. Springer.

Chandler, A. (2018). Seeking secrecy: A qualitative study of younger adolescents' accounts of self-harm. *Young*, *26*(4), 313–331. https://doi.org/10.1177/1103308817717367

Cook, A., Spinazzola, J., Ford, J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Habbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E., & van der Kolk, B. (2017). Complex trauma in children and adolescents. *Psychiatric Annals*, *35*(5), 390–398.

Department for Education. (2015). *Guide to the children's homes regulations including quality standards*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/463220/Guide_to_Children_s_Home_Standards_inc_quality_standards_Version__1.17_FINAL.pdf

Department for Education. (2019). *Children looked after in England (including adoption), year ending 31 March 2019*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/850306/Children_looked_after_in_England_2019_Text.pdf

Evans, R. E. (2018). Survival, signaling, and security: Foster carers' and residential carers' accounts of self-harming practices among children and young people in care. *Qualitative Health Research*, *28*(6), 939–949. https://doi.org/10.1177/1049732318759935

Golding, K. (2008). *Nurturing attachments: Supporting children who are fostered or adopted*. Jessica Kingsley Publishers.

Golding, K. (2017). *Foundations for attachment training resource: The six-session programme for parents of traumatized children*. Jessica Kingsley Publishers.

Habermas, J. (1984). *The theory of communicative action – Vol. 1: Reason and the rationalisation of society* (T. McCarthy, Trans.). Polity Press.

Hamilton, D. J., Taylor, B. J., Killick, C., & Bickerstaff, D. (2015). Suicidal ideation and behaviour among young people leaving care: Case-file survey. *Child Care in Practice*, *21*(2), 160–176. https://doi.org/10.1080/13575279.2014.994475

Harkess-Murphy, E., MacDonald, J., & Ramsay, J. (2013). Self-harm and psychosocial characteristics of looked after and looked after and accommodated young people. *Psychology, Health & Medicine*, *18*(3), 289–299. https://doi.org/10.1080/13548506.2012.712706

Kisiel, C. L., Fehrenbach, T., Torgersen, E., Stolbach, B., McClelland, G., Griffin, G., & Burkman, K. (2014). Constellations of interpersonal trauma and symptoms in child welfare: Implications for a developmental trauma framework. *Journal of Family Violence*, *29*(1), 1–14.

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, *27*(2), 226–239. https://doi.org/10.1016/j.cpr.2006.08.002

Lawson, D. M., & Quinn, J. (2013). Complex trauma in children and adolescents: Evidence-based practice in clinical settings. *Journal of Clinical Psychology*, *69*(5), 497–509.

Laye-Gindhu, A., & Schonert-Reichl, K. A. (2005). Nonsuicidal self-harm among community adolescents: Understanding the "whats" and "whys" of self-harm. *Journal of Youth and Adolescence*, *34*(5), 447–457. https://doi.org/10.1007/s10964-005-7262-z

Martin, J., Bureau, J.-F., Yurkowski, K., Fournier, T. R., Lafontaine, M.-F., & Cloutier, P. (2016). Family-based risk factors for non-suicidal self-injury: Considering influences of maltreatment, adverse family-life experiences, and parent–child relational risk. *Journal of Adolescence*, *49*, 170–180. https://doi.org/10.1016/j.adolescence.2016.03.015

McLean, S. (2015). Managing behaviour in child residential group care: Unique tensions. *Child & Family Social Work*, *20*(3), 344–353. https://doi.org/10.1111/cfs.12083

Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion*, *27*(2), 77–102. http://doi.org/10.1023/A:1024515519160

Morey, Y., Mellon, D., Dailami, N., Verne, J., & Tapp, A. (2016). Adolescent self-harm in the community: An update on prevalence using a self-report survey of adolescents aged 13–18 in England. *Journal of Public Health*, *39*(1), 58–64. https://doi.org/10.1093/pubmed/fdw010

Morrissey, J., Doyle, L., & Higgins, A. (2018). Self-harm: From risk management to relational and recovery-oriented care. *The Journal of Mental Health Training, Education and Practice*, *13*(1), 34–43. https://doi.org/10.1108/JMHTEP-03-2017-0017

Nafisi, N., & Stanley, B. (2007). Developing and maintaining the therapeutic alliance with self-injuring patients. *Journal of Clinical Psychology*, *63*(11), 1069–1079.

Newhill, C. E., Safran, J. D., & Muran, J. C. (2003). *Negotiating the therapeutic alliance: A relational treatment guide*. Guilford Press.

NICE. (2013). *Self-harm: NICE quality standard [QS34]*. Manchester. http://www.nice.org.uk/guidance/qs34/resources/selfharm-2098606243525.

Nixon, M. K., Cloutier, P. F., & Aggarwal, S. (2002). Affect regulation and addictive aspects of repetitive self-injury in hospitalized adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *41*(11), 1333–1341.

Nock, M. K., & Kessler, R. C. (2006). Prevalence of and risk factors for suicide attempts versus suicide gestures: Analysis of the national comorbidity survey. *Journal of Abnormal Psychology*, *115*(3), 616–623. https://doi.org/10.1037/0021-843X.115.3.616

Pinto, C., & Woolgar, M. (2015). Editorial: Looked-after children – A perspective into a more resilient future. *Child and Adolescent Mental Health*, *20*(4), 181–181. https://doi.org/10.1111/camh.12127

Shenk, C. E., & Fruzzetti, A. E. (2011). The impact of validating and invalidating responses on emotional reactivity. *Journal of Social and Clinical Psychology*, *30*(2), 163–183.

Smith, J., Flower, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage

Steggals, P., Lawler, S., & Graham, R. (2020). The social life of self-injury: Exploring the communicative dimension of a very personal practice. *Sociology of Health & Illness*, *42*(1), 157–170. https://doi.org/10.1111/1467-9566.12994

Wadman, R., Armstrong, M., Clarke, D., Harroe, C., Majumder, P., Sayal, K., Vostanis, P., & Townsend, E. (2018). Experience of self-harm and its treatment in looked-after young people: An interpretative phenomenological analysis. *Archives of Suicide Research*, *22*(3), 365–379. https://doi.org10.1080/13811118.2017.1355286

Ward, H., Skuse, T., & Munro, E. R. (2005). 'The best of times, the worst of times': Young people's views of care and accommodation. *Adoption & Fostering*, *29*(1), 8–17.

Yates, T. M. (2009). Developmental pathways from child maltreatment to nonsuicidal self-injury. In M. K. Nock (Ed.), *Understanding nonsuicidal self-injury: Origins, assessment, and treatment*. (pp. 117–137). American Psychological Association.

Author biographies

Charlene Rouski is a Senior Clinical Psychologist at Changing Minds UK. She works with young people, families and systems. Her special interests include attachment, developmental trauma and self-harm.

Susan Frances Knowles is a Consultant Clinical Psychologist at Changing Minds UK. She works with young people and those who care for them, and specialises in anxiety, self-harm, complex trauma and attachment.

William Sellwood is a Professor of Clinical Psychology at Lancaster University. For the last seventeen years he has had senior roles in the training of clinical psychologists. His research focusses mainly on the psychopathology of psychosis and the role of families in recovery. Prior to his university career he worked for fourteen years in the UK National Health Service as a clinical psychologist specialising in adult mental health and family based interventions for long-term mental health problems.

Suzanne Hodge is a Lecturer in Health Research at Lancaster University where she teaches on the Doctorate in Clinical Psychology. Her research interests are in psychosocial and relational approaches to mental health policy and practice. Twitter: @suzannemhodge