Section One:

Literature Review

A Review of the Experiences of Young People (Aged 11-25) who engage in Self-harm

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Rachael Ellis

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

All correspondence should be sent to:
Rachael Ellis
Doctorate in Clinical Psychology
Furness College
Lancaster University
Lancaster
LA1 4YT
R.ellis2@lancaster.ac.uk

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[1] Please see Appendix 1a for 'Notes to Contributors'

Abstract

Background: Self-harm in young people represents a significant public health issue. Qualitative research may contribute to current understanding via the provision of rich, individual data. However, this research has yet to be synthesised.

Method: Systematic searches of five databases were conducted. Following the application of exclusion criteria, 12 studies investigating young people's (11-25 year olds) experiences of self-harm were identified and synthesised in accordance with guidance provided by Noblit and Hare (1988).

Results: The findings of this review are expressed in three themes: 'Self-harm as the best response to adversity', 'Self-harm as an attempt to cope with unbearable emotions and thoughts' and 'Feeling isolated vs. Feeling accepted'

Conclusions: These findings contribute to current understanding and demonstrate the need for additional research in this area.

Key Words: adolescent; qualitative research; self-harm; self-injurious behavior

Key Practitioner Message

- Practitioners should attend to young people's perceptions of their ability to cope and the coping mechanisms they have available to them.
- Young people perceive their emotions as being uncontrollable and overwhelming. Self-harm is commonly experienced as a way of expressing and controlling distress.
- Practitioners should be aware of the social and interpersonal factors which may contribute to, and maintain, self-harm in young people.

A Review of the Experiences of Young People (Aged 11-25) who engage in Self-harm

Defining Self-harm

The term 'self-harm' encompasses a range of behaviour from culturally sanctioned body modification (Barstow, 1995) to socially unacceptable acts such as cutting, burning and poisoning (Zila & Kiselica, 2001). A variety of terminology has been used when referring to this behaviour including; parasuicidal behaviour, non-suicidal self-injury (NSSI) and self-mutilation. In the United Kingdom (UK), the National Institute of Health and Clinical Excellence (NICE) has defined self-harm as "Any act of self-poisoning or self-injury … irrespective of motivation" (NICE, 2011, p.4). However, the categorisation of self-harm and suicidal behaviours has been the topic of some debate.

Self-harm and Suicide

There is an accepted association between self-harm and suicide (Department of Health, 2012) as reflected in the breadth of the definition utilised by guiding bodies such as NICE. However, empirical evidence has suggested that the functions and correlates of suicide attempts and self-harm differ. For example, findings from Muehlenkamp and Guiterrez's (2004) community-based research with a sample of 390 adolescents, indicates that while suicidal ideation and depressive symptoms cannot reliably distinguish between self-harm and suicide attempts, attitudes to life and death do vary between these groups. As a result, Muehlenkamp and Guiterrez (2004) suggest that self-harm and suicidal behaviour are "phenomenologically distinct" (p.20) as self-harm can be understood as an attempt to avert suicide and, therefore, preserve life. Furthermore, it is suggested that, in order to enhance the utility and sensitivity of risk assessments, attempts should be made to distinguish between self-harm associated with, and without, suicidal intent (Brausch & Gutierrez, 2010). Therefore, self-harm and suicide will be understood to be separate constructs.

Measuring Self-harm

Quantitative investigations have indicated that self-harm is most commonly seen in young people, specifically 15-19 year old females and 20-24 year old males (Hawton et al., 2007). In an attempt to establish the prevalence of self-harm in a community sample, Madge et al. (2008) conducted a rigorous, European survey of 14-17 year olds which indicated a lifetime prevalence of 17.8%. While this investigation utilised a broad definition of self-harm which included suicidal behaviour, these findings are similar to those resulting from Muehlenkamp et al.'s (2012) international, systematic review which specifically focussed on NSSI in 11-18 year olds. It is suggested that, given that a significant proportion of young people experience self-harm, it is important that researchers focus on the extension of current understanding (Evans, Hawton & Rodham, 2005).

Understanding Self-harm

Several attempts have been made to develop explanatory models which aim to illuminate the motivations and mechanisms underpinning self-harm. It is relevant to note that these models have been inaccurately and inconsistently referred to as hypotheses or theories, contributing to confusion regarding the state and status of enquiry in this area. In relation to this review, a model is understood to be a representation of a set of hypotheses which illustrates the application of theory in an attempt to explain particular observations. However, while these representations are a useful way of understanding a particular set of processes, they are usually intended to provide a simple way of understanding something complex rather than to provide a literal description of the 'truth'. Therefore, the models of self-harm explored below are considered to represent a set of conceptualisations or ideas which are based on a range of broader, psychological theories.

For example, the 'cry of pain' model (Williams & Pollock, 2000), which initially focussed on explaining suicidal behaviour, was developed with reference to animal behaviour

literature and the evolutionary theory of arrested flight (Gilbert & Allan, 1998). According to this perspective, self-harm can be understood to represent internal anguish as opposed to an attempt to communicate distress (Rasmussen et al., 2010).

Williams and Pollock (2000) suggest that it is possible to identify key factors which increase individuals' risk of harming themselves, namely; exposure to stressors, the presence of defeat, the perception of entrapment and the absence of rescue factors. This model, which integrates elements of cognitive theory, is supported by empirical evidence which suggests that information processing biases and dysfunctional memory schema adversely impact upon the appraisal of stressors and recall of effective coping mechanisms leading to feelings of defeat and, subsequently, self-harm (Johnson, Tarrier & Gooding, 2008). Empirical research findings have provided support for key aspects of the model by demonstrating that perceptions of defeat, entrapment and the presence of rescue factors differ significantly between those who self-harm and hospital controls (Rasmussen et al., 2010). Furthermore, this approach usefully integrates both cognitive and social rescue factors which are thought to reduce the risk of self-harm.

However, it has been suggested that the 'cry of pain' model (Williams & Pollock, 2000) fails to fully represent the range of motivations underpinning self-harm. For example, Scoliers et al.'s (2009) school-based European survey found that while the most commonly endorsed motives for self-harm were internally focused "cry of pain" motives (p.601), participants also endorsed communicative "cry for help" motives (p.601). These findings provide evidence which demonstrate the complexity of self-harm and highlight the limitations of approaches, such as the 'cry of pain' model (Williams & Pollock, 2000) which attend exclusively to particular motives. Furthermore, difficulties arise when attempts are made to operationalise particular aspects of the model, for example researchers have been unable to reach a consensus in relation to the situations which result in feelings of defeat

(Gilbert et al., 2002; Rohde, 2001). This approach also fails to account for the role of emotional dysregulation, a concept which is central to current, evidence-based interventions for self-harm such as Dialectical Behavioural Therapy (DBT; Linehan, 1993). This draws into question how applicable this model is to clinical practice.

The 'experiential avoidance' model (Chapman et al., 2006) provides an alternative conceptualisation of self-harm rooted within behavioural theory. This model, which situates self-harm within a broader class of avoidant behaviours such as thought suppression and drug use, is based on the proposition that self-harm is a negatively reinforced attempt to reduce emotional arousal via the avoidance of, or escape from, unpleasant internal experiences. In contrast with the aforementioned 'cry of pain' model (Williams & Pollock, 2000), the 'experiential avoidance' model (Chapman et al., 2006) provides a thorough account of the role of emotion in self-harm. This approach acknowledges the role of deficits in emotional regulation and poor distress tolerance while providing a clear indication of how self-harm may be maintained over time. This perspective has been supported within empirical literature which illuminates the mechanisms by which self-harm reduces emotional arousal and additional factors which may contribute to emotionally avoidant behaviour (see Chapman et al. 2006 for a review).

Additionally, this perspective was specifically developed to explain self-harm in the absence of suicidal intent. It has been argued that this specificity and focus represents an area of strength for the 'experiential avoidance' model (Chapman et al., 2006). However, this model attends to the role of emotion at the detriment of the consideration of the cognitive processes which Williams and Pollock (2000) claim underpin this behaviour. Furthermore, the 'experiential avoidance' model (Chapman et al., 2006) could be considered to be particularly deficit focussed as there is no acknowledgement of protective factors and their impact upon self-harm.

The ‘integrated-volitional model’ (O’Connor, 2011), provides a biopsychosocial account of self-harm and suicidal behaviour via the integration of the ‘cry of pain’ model (Williams & Pollock, 2000), the diathesis-stress hypothesis (Schotte & Clum, 1987) and accounts of health behaviour (Ajzen, 1991). Researchers have utilised this approach in an effort to explain how thoughts of self-harm translate into action. This model, which comprises pre-motivational, motivational and volitional phases, is based on the premise that each phase is mediated by a range of internal and external factors which result in the negative appraisal of events being translated into thoughts, and subsequently, acts of self-harm (O’Connor, Rasmussen & Hawton, 2012).

Support for the ‘integrated-volitional’ model (O’Connor, 2011) has been provided by O’Connor et al.’s (2012) survey of 5,604 school pupils which indicates that participants who self-harm differed on a range of pre-motivational and volitional variables when compared to a control group. The findings of this investigation implicate the specific role of volitional factors (i.e. exposure to others self-harm and experience of stressful life events).

A strength of the ‘integrated volitional’ model (O’Connor, 2011) relates to its utility in distinguishing between individuals who have thoughts of self-harm and those who are likely to act on these thoughts (O’Connor et al., 2012). This aspect of the model has a clear relationship to clinical practice. However, it could be argued that its clinical utility may be limited by a lack of specificity as the range of potential moderating factors is extremely broad. Furthermore, this model does not attend explicitly to the emotional experiences associated with self-harm, further contributing to the segregation of cognitive and emotional perspectives.

In conclusion, there are a number of models which aim to explain self-harm. However, these models differ in relation to the theoretical focus adopted and the importance placed on different factors. In addition, none of these models provides a useful explanation

of how cognitive and emotional factors relate to each other. Therefore, it is argued that current understandings are limited in their clinical utility as professionals need to adopt a holistic, integrated approach which allows them to consider adolescents experiences in their entirety.

Focus of the Current Review

While the aforementioned models contribute to understandings of self-harm, the varying theoretical emphases and the breadth of the influential factors implicated may create confusion and limit utility in clinical practice. Furthermore, the complex and individual nature of self-harm may present a challenge to those who attempt to succinctly summarise this behaviour.

In an attempt to better represent this complexity, researchers have used qualitative methods in order to capture individual experiences. For the purposes of this review, the term 'experience' is thought to relate to young peoples' perceptions, views, understanding, meaning-making and representations of their own self-harm. It is suggested that this qualitative enquiry may enrich and contextualise models via the provision of individual examples of experience. Furthermore, qualitative data may also provide further supportive or contradictory evidence which contributes to model development. While the value of qualitative enquiry and its relevance to service development and delivery has been recognised (e.g. Crouch & Wright, 2004), this research has yet to be synthesised. Therefore, this review aims to synthesise qualitative research exploring young people's experiences of self-harm.

Method

This review was conducted using a meta-ethnographic approach (Noblit & Hare, 1988). It is recognised that Noblit and Hare's (1988) methodology has been criticised for being laborious (Lee et al., 2014), for failing to provide explicit guidance regarding analysis (Campbell et al., 2011), the formulation of questions, the identification of literature or on the

best approach to quality appraisal (Dixon-Woods et al., 2005). However, meta-ethnography was selected as it is the most commonly utilised and well-developed method of synthesising qualitative data (Bondas & Hall, 2007; Britten & Pope, 2012). Furthermore, as meta-ethnography adopts an interpretative focus this approach allows for the development of novel conceptualisations while protecting the integrity of the original analysis (Britten et al., 2002; Pope, Mays & Popay, 2007). This was appropriate as the aim of the research was to contribute to current understanding via the integration of qualitative research into a useful whole. Furthermore, meta-ethnography is a flexible approach which allowed for the synthesis of literature drawn from different methodological approaches. As the number of studies exploring this specific area is limited, it was essential that I adopted an approach which did not require that I place further restrictions on the inclusion of studies. Additionally, meta-ethnography was selected as this methodology was in broad alignment with my epistemological stance (which is discussed in further detail below and in Section Three: Critical Appraisal).

Nobilt and Hare (1988) suggest that meta-ethnography commences with the identification of an area of interest and the development of search terms and exclusion criteria. Systematic searches of academic databases are then carried out resulting in the identification of studies. In this instance, a quality appraisal tool was then utilised. These initial processes are detailed below (See Figure 1 for a visual representation of the process of synthesis, adapted from Moolchaem et al., 2015).

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Search Terms and Strategies

Search terms were generated using the Context How Issues Population (CHIP) tool (Shaw, 2010), combined using Boolean operators and entered into Academic Search Complete, Child Development and Adolescent Studies, Cumulative Index to Nursing and Allied Health (CINAHL), Medline and PsycINFO databases in August 2015. Search terms and strategies were adjusted to accommodate for database specific indexing systems and, where appropriate, age limiters were used (Shaw, 2012). Both subject mapping and free text search variants were utilised. This process was informed by consultation with a specialist librarian. (For information regarding search terms and strategies see Table 1).

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A total of 1,615 articles were screened for eligibility. Figure Two (adapted from Moher et al., 2009) depicts the procedure used to identify studies for inclusion.

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Inclusion and Exclusion Criteria

Several inclusion and exclusion criteria (details of which are provided in Table 2) were applied to determine the suitability of studies.

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Date restrictions. Studies published between 2000 and 2015 were included in this review. These date restrictions, in conjunction with the age limitations detailed below, were

imposed in an attempt to gather the experiences of a specific group which has been referred to as the "Dot.com Generation" (Stein & Craig, 2000). This generation has been exposed to vast social and technological change, including the increasingly ubiquitous use of the internet (Internet World Stats: Usage and population statistics, 2015). While it is recognised that this criteria is arbitrary, given the impact of these social, generation-specific influences the imposition of these date restrictions was considered appropriate.

Age range. Studies were restricted to those exploring the experiences of 11 – 25 year olds. For the purposes of this review, individuals within this age group are referred to as young people. Various definitions relating to this age group have been employed within NICE guidelines (National Collaborating Centre for Mental Health, 2004), United Nations Educational, Scientific and Cultural Organization (UNESCO) statistics (UNESCO, 2015) and academic research (e.g Cleaver, Meerabeau & Maras, 2014; Olfson et al., 2005).

Applying an upper age limit of 25 reflected recent systematic reviews focusing on self-harm in young people (Daine et al., 2013), while acknowledging evidence that social development and brain maturation continue into early adulthood (Steinberg et al., 2009; Townsend, 2014). Due to difficulties establishing a chronological age which marks the beginning of young adulthood, and in order to ensure that all relevant papers were included, a lower age limit of 11 was applied in order to reflect the average age for the onset of puberty[2](National Health Service [NHS], 2014).

Exclusion of studies specifically exploring suicide. For the purposes of this review, self-harm and suicidal behaviour were considered to be separate constructs. Therefore, studies exclusively and specifically exploring the experiences of young people who attempted

[2] It is recognised that the average age of the onset of puberty in males is 12 years old but the lower age limit was selected in order to ensure that all relevant papers were included.

suicide were excluded. Furthermore, a recent synthesis of qualitative research regarding suicidal behavior in young people already exists (Lachal et al., 2015).

However, it is recognised that researchers do not necessarily distinguish between attempted suicide and self-harm and the expressed intent of behaviour is not always considered. Therefore, in order to impose this exclusion criteria, articles were read in order to examine the terminology and definitions used, details regarding the sample and references to suicidal intent. Judgements regarding the inclusion of studies were made on the basis of this information.

Exclusion of papers focussing exclusively on the experiences of people with a learning disability. Studies exploring the specific experience of individuals with a learning disability were excluded as a consequence of the differing conceptualisations of self-harm within this population (e.g. Lovell, 2008).

Exclusion of papers focusing exclusively on young people's experiences of services and therapy, ceasing self-harm or others' self-harm. In order to focus on the lived experience of self-harm, studies which did not focus on young people's experiences of their own self-harm were excluded.

Quality Assessment

It is recognised that debate exists regarding the use of quality assessment tools to determine the inclusion and exclusion of studies (Sandelowski, Docherty & Emden, 1997) (For a further exploration of this debate, please refer to Section Three: Critical Appraisal). In this instance, the Critical Appraisal Skills Programme (CASP, 2013) tool was selected as it is a systematic, accessible and brief checklist which has been used successfully in recent, published research (Murray & Forshaw, 2013; Priddis, Dahlen & Schmied, 2013; Taylor, das Nair & Braham, 2013). To ensure extra rigor, a selection of studies were independently rated by an external rater (See Table 3 for results of the CASP).

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Rather than assigning quantitative scores to determine inclusion, the CASP was used to prompt consideration of each study's strengths and weaknesses. Studies which appeared to have multiple weaknesses were further examined. In accordance with guidance provided by Sandelowski et al. (1997), attempts have been made to contextualise decisions regarding the exclusion of studies.

Papers by Smith (2002) and Storey et al. (2005) were excluded from the final sample as they lacked sufficient information regarding methodological decisions, data collection and analysis to enable an assessment of quality. Furthermore, the researchers did not address their position in relation to the research or potential bias within the study and findings were not articulated clearly.

The CASP highlighted areas of weakness within Bheamadu, Fritz and Pillay's (2012) study which warranted additional exploration; namely, research design, reflexivity, sampling and value of the research. Furthermore, the brevity of the methods and discussion sections made it difficult to accurately judge the quality of the research. However, these concerns were balanced by the clear articulation of useful findings which were contextualised by demographic information and supported by quotations and reference to existing theory. On the merit of these strengths, Bheamadu et al. (2012) was included in the review.

Additionally, there were concerns regarding the analysis undertaken in Abrams and Gordon's (2003) study due to the categorical nature of the themes reported. However, further examination of the paper indicated areas of strength in relation to research design and reflexivity which allowed for a judgement to be made regarding the quality and contribution of the study and resulted in the inclusion of the paper. These concerns were considered

throughout the synthesis to ensure that the results were not unduly influenced by papers which appeared to have areas of weakness.

Epistemology

As a researcher, my position is most closely aligned with a critical realist epistemological stance. Therefore, I am of the belief that qualitative data represents possible explanations which could be considered to be the 'truth' for those participants. However, I do not believe that there is a way of establishing the 'truth' of this data. Furthermore, my understanding of participants' experiences, and the ways they have subsequently been interpreted by the original authors, will be influenced by my experiences and beliefs. Therefore, while it is acknowledged that this review represents my own interpretation of the research, it offers a useful and important summary of the existing literature base in this area where none previously exists. (For a further discussion of my epistemological stance please see Section Three: Critical Appraisal).

Analysis

Guided by the stages of meta-ethnography outlined by Noblit and Hare (1988), each paper was read repeatedly and contextual information was recorded (See Table 4 for contextual details relating to each paper).

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The results and discussion sections of each paper were reviewed and authors' interpretations, participant quotes and notes regarding key metaphors, phrases and ideas were recorded in a data extraction table (See Table 5 for an example).

This iterative process, which involved drawing comparisons between the themes and metaphors within each study, resulted in the formation of initial ideas regarding the

relationship between studies. Noblit and Hare (1988) propose three ways of conceptualising the relationship between studies, a reciprocal translation was adopted for this synthesis as the studies identified explored similar issues and the findings were complimentary (Barnett-Page & Thomas, 2009).

Finally, overarching themes comprising information drawn from the original studies were developed via the amalgamation of the information abstracted during the preceding phases (See Table 5 for an example of the development of a final theme). This method of reducing and reorganising the data led to the development of "third order" constructs (Britten et al., 2002, p.209). In relation to this review, first order constructs are the participants' reports relating to their experiences of self-harm, second order constructs comprise the original researchers' interpretations and third order constructs represent the synthesis of this information into the novel themes detailed below.

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Results

The findings of this review are expressed as three themes the contents of which are explored in detail below (See Table 6 for details regarding the contribution of each study to the final review themes).

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Theme One – Self-harm as the Best Response to Adversity

All the studies included in this metasynthesis referred to participants' exposure to challenging, traumatic or threatening experiences which were understood to be directly

associated with the initiation and maintenance of self-harm (Abrams & Gordon, 2003; McAndrew & Warne, 2014). The experiences reported were diverse, ranging from physical and sexual abuse (Abrams & Gordon, 2003), to parental separation (Moyer & Nelson, 2007) and increased pressure at school (Yip, Ngan & Lam, 2004). This diversity is interpreted by McAndrew and Warne (2014) as evidencing the complex and multifaceted nature of self-harm. However, it is clear that many young people who experience such stressors do not harm themselves.

Further consideration of author interpretations revealed that self-harm was commonly perceived by young people as the only available response to their difficulties e.g. “It’s the only way that I can mentally cope with anything … there’s nothing else I can do” (Hill & Dallos, 2012). These sentiments were echoed by participants in the Bheamadu et al. (2012) study, “It was the only thing that made me feel better”, the Craigen and Milliken (2010) study , “(I) didn’t know how else to cope” and the Moyer and Nelson (2007) study, "I didn't know any other way". While there were examples of self-harm being considered as part of a wider repertoire behaviours (Bheamadu et al., 2012; Craigen & Milliken, 2010), these coping mechanisms were equally destructive and maladaptive. Therefore, it is suggested that self-harm was related to a general absence of adaptive coping.

The studies included in this review indicated that young people commonly encountered difficulties within their family relationships. Participants negotiated challenges such as their parents’ marital disharmony, drug and alcohol use or physical illness, e.g. “When my parents quarrelled and shouted at each other in the evenings, I cried and cut my arms.” (Rissanen, Kylmä & Laukkanen, 2008). Lesinak (2010) suggests that these interpersonal challenges contributed to feelings of abandonment. This interpretation relates to Abrams and Gordon’s (2003) study in which participants reflected on the impact of the loss of a parent or caregiver, e.g. “after he passed, everything was just, just gone … I mean, a

lot of the things we went through at home are untellable, unspeakable". These interpersonal challenges, which were potentially exacerbated by the absence or unavailability of a caring adult, were interpreted as being directly related to young people's inability to cope (Bheamadu et al., 2012; Lesinak, 2010).

Theme Two – Self-harm as an Attempt to Control and Express Unbearable Emotions and Thoughts

Many of the studies included participant reports relating to their experience of overwhelming, uncontrollable emotional states which they felt unable to manage, e.g. "It's not even empty (…) It's worse than empty. It's like an unidentifiable pain that I have." (Craigen & Milliken, 2010). Similarly, Moyer and Nelson (2007) reported that participants experienced cognitive processes akin to rumination which were also perceived to be uncontrollable, "It goes over – it's like, I guess, a tape recorder going over in my head, just over and over and over". Self-harm was described as an effective method of providing relief from these internal experiences via the release of emotions (Abrams & Gordon, 2003; Crouch & Wright, 2004; Kokaliari & Berzoff, 2008; Lesinak, 2010). Kokaliari and Berzoff (2008) interpreted this process as a "quick fix" (p.265) which enabled participants to manage their emotions and continue to meet the demands and expectations of society.

In many of the studies, participants reported that self-harm allowed for their emotional states to be manifested physically. This process was often described using powerful imagery, "When I cut myself, it's like, all the bad escapes in the blood (…) you can physically watch everything just wash away" (Abrams & Gordon, 2003). In this way, self-harm was understood as a way of externalising emotional distress in order to render emotional pain visible to others. Furthermore, reference was made to participants' inability or unwillingness to communicate their distress within the confines of a research interview and in their everyday lives (Klineberg et al., 2013; Moyer & Nelson, 2007). Lesinak (2010)

refers to participants' "silently screaming" (p.145), so powerful was the message that they should avoid communicating their emotions to others. These communication difficulties were interpreted by Hill and Dallos (2012) and Kokaliari and Berzoff (2008) as representing the pressure placed upon young people to conceal their emotions. Furthermore, participants' reports indicated that they relied upon self-harm as a form of expression which served to elicit a response, get attention or convey their anger "I was furious and wanted to take immediate revenge. Suddenly, I saw the cutter on the table and I started self-cutting" (Yip et al., 2004). In this way, self-harm can be understood as a method of communication which allowed participants to elicit care or alert others to their distress.

Study authors commonly referred to participants' exposure to challenges in which they lacked control, "I didn't have any control in my life and (self-injury) was the only way to exercise some kind of command" (Craigen & Milliken, 2010). It is posited that self-harm created an enhanced sense of autonomy as young people took control of their bodies, emotional experiences and environments. Self-harm was understood to be within young people's control and therefore, less overwhelming (Bheamadu et al., 2012). According to Kokaliari and Berzoff (2008), self-harm is an individual representation of societal control which demands that young women conceal their emotions in order that they continue to contribute to capitalist culture. This interpretation provides a wider, systemic perspective which may contribute to conceptualisations of self-harm as a method of avoiding or supressing unpleasant emotion (e.g. Chapman et al., 2006).

Theme Three - Feeling Isolated vs. Feeling Accepted

This theme juxtaposes social isolation with acceptance and explores the relationship between these experiences and self-harm. The prominence of social factors in participants' narratives was interpreted as evidence that self-harm is best understood as a "systems issue" (Craigen & Milliken, 2010, p.123). Seemingly, participants related their experiences of

social isolation to the stigmatisation of self-harm (Klineberg et al., 2013). Experiences of exclusion were understood to pre-date the onset of self-harm (Bheamadu et al., 2012) and emerge as a direct consequence of this behaviour (Hill & Dallos, 2012). Kokaliari and Berzoff (2008) suggest that a societal focus on independence further isolates young people, forcing them to harm themselves in solitude.

Authors of the original studies suggested that others misinterpretations regarding the intent or function of self-harm contributed to enhanced feelings of isolation, resulting in young people becoming increasingly reliant on self-harm to manage their distress. Reference was also made to the impact of people failing to respond to, or seemingly ignoring self-harm, "My mother saw my cuts and scars and she just looked at me but said nothing" (Rissanen et al., 2008). These misunderstandings appeared to result in others taking inappropriate actions which seemingly arose from the misinterpretation of self-harm as suicidal behaviour (e.g. Craigen & Milliken, 2010; Crouch & Wright, 2004).

Young people referred to the importance of secrecy as self-harm was commonly viewed as a private act. For some, this included adapting behaviour in order to evade detection, "My mother realised that I had cut my arms. I stopped it because she wanted to check my arms. I began to cut my stomach" (Rissanen et al., 2008). This desire to conceal was interpreted as being related to participants' fears of becoming a burden, being disapproved of or feeling ashamed, e.g. "I wanted to have fun, and I didn't want to be a burden on them" (Craigen & Milliken, 2010). Attempts to avoid exposing their self-harm also appeared to be related to participants' reliance on this coping mechanism and the awareness that others would be motivated to prevent them from engaging in it in the future, "Everyone in the room teaches you. If you have a plan (to hurt yourself), you can't … you don't say anything" (Craigen & Milliken, 2010).

Seemingly, participants' experiences of being misunderstood and isolated influenced their desire to seek help. The dominant narrative emerging from this review is that young people who self-harm wish to be understood and treated in a non-judgemental fashion, "Just listen with an open mind; that's all people need" (Moyer & Nelson, 2007). They desired interactions which were qualitatively different from their past experiences. This is particularly important for those who experience shame or guilt as a result of their self-harm as these emotions appear to inhibit them from seeking appropriate support (McAndrew & Warne, 2014).

Reports of feeling rejected and misunderstood were juxtaposed by experiences of belonging to social groups in which self-harm was accepted as a legitimate coping mechanism, "I guess it seemed normal (…) I thought it must be kind of normal for smart girls to cut themselves" (Craigen & Milliken, 2010). Sharing experiences of self-harm with others appears to create a bond which contributes to a sense of being understood (Bheamadu et al., 2012) and the development of an identity which is intractable from their experience of self-harm, "I don't think anyone understands except self-harmers themselves" (Crouch & Wright, 2004). Crouch and Wright (2004) further explore the meaning of group membership and make reference behaviours which perceived to demarcate a "genuine self-harmer" (p.193) such as inflicting a particular level of damage and seeking to preserve secrecy. According to Crouch and Wright (2004), individuals whose behaviour falls outside of these group norms are considered to be self-harming in order to elicit attention and are rejected by their peers. These group processes are interpreted as evidence of young people's desire to seek acceptance via membership to a group which affirms identity while balancing their need for attention and help (Crouch &Wright, 2004).

The extent to which participants shared their experience of self-harm with their peers varied. For example, participants in Bheamadu et al. (2012) report harming others or

harming in the presence of others while those who participated in Crouch and Wright's study (2004) talked about the value of privacy. It is possible that public displays of self-harm are more prominent within specific subcultures, such as the satanic cults mentioned in Bheamadu et al. (2012) and Rissanen et al. (2008) as opposed to being representative of the behaviour of the wider population. Furthermore, Crouch and Wright (2004) indicated that the imitation of self-harming behaviour occurs within particular settings, such as inpatient units. However, there are examples (e.g. Craigen & Milliken, 2010) of participants describing membership of social groups which facilitated their introduction to self-harm which would be considered to be more normative within the general population.

Furthermore, it is recognised that there was some variation within the findings as some participants reported good levels of social support and helpful responses from friends and family (Craigen & Milliken, 2010). Such positive social experiences have been considered to serve as a buffer against stress (Bheamadu et al., 2012), further demonstrating the influence of social factors on self-harm.

Discussion

Three themes were developed from the synthesis of 12 studies. These findings will be considered, clinical implications discussed, limitations addressed and recommendations for future research suggested.

The findings articulated in Theme One suggest that self-harm may be best conceptualised as a coping mechanism via which young people respond to stressors within their environment. These findings can be understood with reference to the 'cry of pain' model (Williams & Pollock, 2000), which suggests that self-harm can be triggered when an individual feels defeated or trapped by external stressors. However, the findings outlined in Theme One provide additional insight as they emphasise the importance, and impact of, interpersonal stressors, specifically, difficulties within parent-child relationships and feelings

of abandonment. These findings can be understood with reference to psychodynamic literature which has drawn upon object relations theory in an attempt to explain self-harm. In summary, this perspective suggests that sense of self develops in relation to objects within the environment, including people, things and fantasies (McAllister, 2003). Ideally, as a result of receiving consistent and responsive care from their parents, children learn that others are trustworthy and reliable. However, it is suggested that when these optimum conditions are not met the developing sense of self is adversely affected (McAllister, 2003). Suyemoto and MacDonald (1995) suggest that, from this perspective, if young people are re-exposed to loss or the threat of loss later in life they may re-experience the emotional distress associated with their earlier experiences which can lead to self-harm (for a further exploration of this perspective see Suyemoto & MacDonald, 1995). This interpretation of self-harm appears to be supported by research which demonstrates the association between self-harm and exposure to childhood abuse or abandonment (Vivekananda, 2000).

The findings discussed within Theme Two can be understood with reference to the 'experiential-avoidance' model which purports that self-harm is best seen as an attempt to relieve or avoid emotional distress (Chapman et al., 2006). The findings of this review expand upon current understanding as they provide contextual information which indicates the mechanisms via which self-harm results in the dissipation of distress, namely; emotional control and expression.

The findings relating to emotional expression can be linked to work carried out by Strong (1998) who suggests that self-harm can be likened to crying as both of these behaviors serve a communicative and expressive function. In this way, self-harm can be understood as a way to "symbolically cry" (McAllister, 2003, p.180). These findings relate to evidence which indicates that young people who harm themselves may struggle to talk to their family about their difficulties (Evans et al., 2005). Therefore, self-harm may act as a method of

communicating distress when verbal means of communication are inaccessible (Hill & Dallos, 2012). However, evidence provided by Scoliers et al. (2009) suggests that self-harm can serve multiple functions and, as a result, may be best understood as a behavior which facilitates both communication and expression of despair.

According to Suyemoto (1998), self-harm may be used to "achieve a sense of control over emotion that threatens to generally overwhelm the individual, her sense of self, and her connectedness to the world" (p.542). The findings encompassed within Theme Two clearly relate to, and support, this understanding of the functions of self-harm within young people. According to Suyemoto (1998), evidence suggesting that self-harm functions in this way is best understood with reference to affect regulation models which are based on the premise that self-harm can be understood as an attempt to manage unpleasant internal experiences. The 'experiential avoidance' model is one such approach (Chapman et al., 2006).

Furthermore, the findings expressed within Themes One and Two could be understood in relation the work of Linehan (1993) who developed DBT. This therapeutic approach is grounded in cognitive and behavioural theory which is based on the hypothesis that young people who harm themselves experience intolerable, intense emotions as a result of an interaction between a biological predisposition and exposure to emotionally invalidating environments. This suggestion has obvious links with the content of Theme One which encompass young peoples' experiences of adversity, including exposure to emotionally invalidating environments. Furthermore, it is suggested that individuals who are exposed to emotionally invalidating environments are afforded little opportunity to develop adaptive ways of managing their distress and are, therefore, more likely to experience heightened emotional responses such as those described in Theme Two (Lynch et al., 2001; Sim et al., 2009).

Self-harm remains a controversial and misunderstood phenomenon within wider society, influenced by the presence of stigma (Long, Manktelow & Tracey, 2013). This was reflected in the findings articulated within Theme Three which encompasses young peoples' reports of social isolation and exclusion. According to Long et al. (2013), the stigmatisation of self-harm is perpetuated by the perception that this behaviour is attention–seeking in the derogatory sense. The results of this review imply that these myths and misunderstandings are commonly present in young people's interactions with their peers, family members and professionals and that they serve to dissuade them from disclosing difficulties or attempting to access support.

According to the 'integrated-volitional' model, whether or not an individual engages in self-harm is determined by a number factors including low levels of social support, perceptions of burdensomeness, exposure to others who harm themselves and the feeling that they don't belong (O'Connor et al., 2012). It is posited that the results of this review demonstrate the specific value young people assign to social acceptance, particularly in the context of experiences of stigma and isolation and, therefore, highlight the particular relevance of these volitional factors for this population. This information could be usefully extrapolated into clinical practice as consideration of these factors may assist in the identification of young people who are at an increased risk of acting on thoughts of self-harm.

It is interesting to note that qualitative and quantitative research focussing specifically on the experiences of lesbian, gay, bisexual and transgender individuals has implicated the specific relationship between homophobia, stigma and societal expectations regarding normative gender behaviour and self-harm (Alexander & Clare, 2004; Rivers, 2001; Scourfield, Roen & McDermott, 2008). While none of these studies met the inclusion criteria for this review, as they all included participants without direct experiences of self-harm, their findings appear to be similar to those explored in Theme Three. This central aspect of young

peoples' experiences is not effectively addressed by the current, dominant models of self-harm. Therefore, it is suggested that the findings of this review help to identify weaknesses within these models and, consequently, highlighted areas for future consideration.

In conclusion, via the integration of qualitative findings, the results of this review are able to contribute to current understanding of self-harm by highlighting salient points relating to young people's individual experiences. Primarily, the findings of this review demonstrate the complexities which can be associated with understanding young people's experiences of self-harm. It is suggested these findings clearly demonstrate the need for the development of a holistic, integrated model of self-harm which attempts to encompass elements of the pre-existing understandings in a clinically relevant way (Messer & Fremouw, 2008). This review illustrates that any novel conceptualisation should reflect both qualitative and quantitative data which indicates that self-harm is best understood as a response to adversity, and specifically to interpersonal stressors. Furthermore, while there are many potential functions of self-harm, the concepts of emotional control and emotional expression are central to young people's experiences. Finally, these findings highlight the importance of attending to systemic, social factors which may determine both the initiation and maintenance of self-harming behaviour in young people.

Implications

This review suggests that many young people who harm themselves find it difficult to access alternative coping mechanisms when they encounter difficult experiences or emotional discomfort. DBT (Linehan, 1993) is a therapeutic intervention which aims to address this lack of effective coping mechanisms by fostering the development of skills such as 'distress tolerance', 'emotion regulation' and 'interpersonal effectiveness' (Chapman et al., 2006). According to Slee et al.'s (2007) review, DBT is an effective therapeutic intervention which results in a reduction in the frequency and severity of episodes of self-harm.

The findings of this investigation indicate that young people feel misunderstood as a result of inaccurate conceptualisations of their behaviour and more specifically, their intent. These misunderstandings and negative perceptions appear to contribute to difficulties within young people's relationships, enhancing stigma and social isolation. These findings can be related to Saunders et al.'s (2012) systematic review which established that professionals commonly express a negative attitude towards individuals who harm themselves and demonstrates the importance of professionals being provided with training in order to improve understanding, reduce stigma and enable consideration of the complexities of the relationship between self-harm and suicidal intent. It is suggested that educating and supporting professionals to develop their perceptions of self-harm, and reconceptualise this behaviour as an attempt to self-soothe, may facilitate a change in the attitudes of health-care professionals (McAllister, 2003). Clinical psychologists may be well placed to provide training and consultation in order to support professionals to develop a framework within which they can better understand the distress experienced by young people (Onyett, 2007). This training could be usefully delivered in order to support both professionals who work therapeutically with young people who self-harm or, more widely, to those working within education, social care or community agencies systems in order develop understanding.

Furthermore, these findings indicate that there may be some utility in pursuing avenues of intervention which aim to improve public understanding of self-harm. Hill and Dallos (2012) hypothesise that if our understanding of self-harm shifts from one which focuses on abnormality and pathology to one which conceptualises this behaviour as an understandable attempt to mitigate the effects of living with overwhelming emotion, there is potential for stigma to be reduced and lines of communication to be opened. A systemic intervention such as this may involve developing connections with youth community groups and projects, resulting in enhanced community and individual resilience (Henley, 2010).

Limitations

It is recognised that controversy surrounds the synthesis of qualitative research with researchers questioning whether it is epistemologically and ethically appropriate to summarise findings from studies which explore human experience (Sandelowski et al., 1997). However it has also been argued that, if the synthesis of qualitative research is avoided, researchers risk contributing to "non-reconcilable islands of knowledge" (Walsh & Downe, 2005, p.205) which are unable to influence strategy or practice (Silverman, 1997). This review has synthesised the current state of knowledge in order to contribute to the development of clinical practice, and therefore improve the experiences of young people.

This review included studies which employed a range of qualitative methodologies, an approach which has been criticised (Zimmer, 2006). However, there are several published papers which have successfully synthesised research across a range of methodological approaches (e.g. Sandelowski & Barroso, 2003). To address this limitation, I remained mindful of the methodological differences within the sample during analysis (Zimmer, 2006) and ensured that contextual information was provided in order that the reader is able to make an informed judgement regarding potential influences upon the analysis.

Qualitative research is concerned with understanding the experiences of individuals. Therefore, attempts are made to ensure that the experiences and perspectives of participants are privileged and protected to ensure that qualitative findings accurately represent the nuances within individual narratives. However, research findings are likely to be influenced by the perspective of the original author as they interpret participants' reports (Britten et al., 2002). Similarly, it is recognised that the outcome of qualitative reviews are likely to be influenced by the position of the review author (Atkins et al., 2008). Therefore, it could be argued that qualitative reviews fail to accurately represent participants' experiences, as the researcher is removed from, and has no direct access to, original data.

This review utilised a number of exclusion criteria which limited the number of studies retrieved and, consequentially, those included in the final review. It is recognised that these methodological decisions may be challenged. For example, Britten et al. (2002) suggest that a failure to include information from books or dissertations is likely to result in informative data being disregarded. Furthermore, it is recognised that the decision to exclude papers published prior to 2000 may not necessarily exclude data collected before this time point. These methodological decisions may, therefore, have implications for the robustness of this review and the resulting conclusions should be considered in the light of these issues.

Finally, as previously mentioned, researchers have debated the use of quality assessment tools such as the CASP (2013). Therefore, this review could be criticised for using this tool to guide decision making regarding the quality of the studies selected for inclusion. However, the use of the CASP is justified as, while the findings of the CASP may be influenced by subjectivity of the researcher, the provision of information regarding the factors which have influenced judgements of quality allow the reader to contextualise the decisions made. This transparency surrounding decision making provides information which facilitates evaluation of the credibility of the resulting synthesis (See Section Three: Critical Appraisal for further discussion regarding the use of the CASP).

Future Research

It is recommended that future researchers focus on the maintenance of self-harm in the context of wider systems. This research could employ qualitative interviews to explore the perspectives of young people, their families, professionals and peers. This approach will allow for a full exploration of perceptions of emotions and self-harm and may contribute to current models. Researchers may also wish to consider the perception of self-harm within particular groups. A quantitative approach could be used, allowing for a comparison between

individuals who experience social isolation and those whose self-harm is accepted by their peers.

The findings of this review indicate that young people who harm themselves may struggle to communicate their experiences, partly as a result of others negative responses. Therefore, it may be helpful to employ creative research techniques which enable young people to become actively involved in the process (Bangoli & Clark, 2010). Alternative avenues of expression, such as art or creative writing, could be used to replace or supplement traditional approaches.

Conclusion

Young people who harm themselves experience their emotions as being overwhelming and uncontrollable, partly as a result of experiencing adverse events which may have led to feelings of abandonment or difficulties within relationships. It is suggested that the perception that emotions, and self-harm, should be concealed in order to avoid stigma may perpetuate this behaviour by contributing to social isolation and encouraging young people to seek kinship with others who harm themselves. This contributes to the perception that self-harm is a legitimate way to cope. These findings demonstrate the influence of intrapersonal and interpersonal factors relating to young people's experiences of self-harm, and highlight the importance of developing sensitive services which are able to respond to individuals who feel unable to communicate their distress.

References

Abrams, L.S., & Gordon, A.L. (2003). Self-harm narratives of urban and suburban young women. *Affilia, 18*(4), 429–444. doi: 10.1177/0886109903257668

Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes, 50*(2), 179-211. doi: 10.1016/0749-5978(91)90020-T

Alexander, N., & Clare, L. (2004). You still feel different: the experience and meaning of women's self-injury in the context of a lesbian or bisexual identity. *Journal of Community and Applied Social Psychology, 14*(2), 70–84. doi: 10.1002/casp.764

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: lessons learnt. *BMC medical research methodology, 8(*1), 21. doi: 10.1186/1471-2288-8-21

Bangoli, A., & Clark, A. (2010). Focus groups with young people: a participatory approach to research planning. *Journal of Youth Studies, 13*(1), 101 – 199. doi: 10.1080/13676260903173504

Barnett-Page, E., & Thomas, J. (2009). Methods for the synthesis of qualitative research: a critical review. *BMC Medical Research Methodology, 9*(1), 59. doi: 10.1186/1471-2288-9-59

Barstow, D. G. (1995). Self-injury and self-mutilation: Nursing approaches. *Journal of Psychosocial Nursing, 33*(2), 19 – 22.

Bheamadu, C., Fritz, E., & Pillay, J. (2012). The experiences of self-injury amongst adolescents and young adults within a South African context. *Journal of Psychology in Africa, 22*(2), 263-268. doi: 10.1080/14330237.2012.10820528

Bondas, T., & Hall, E. O. (2007). Challenges in approaching metasynthesis research. *Qualitative Health Research, 17*(1), 113-121. doi: 10.1177/1049732306295879

Brausch, A. M., & Gutierrez, P. M. (2010). Differences in non-suicidal self-injury and suicide attempts in adolescents. *Journal of Youth and Adolescence, 39*(3), 233-242. doi: 10.1007/s10964-009-9482-0

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research and Policy, 7*(4), 209-15. doi: 10.1258/135581902320432732

Britten, N., & Pope, C. (2012). Medicine Taking for Asthma: A worked example of meta-ethnography In K. Hannes and C. Lockwood (Eds.), *Synthesizing qualitative research: Choosing the right approach* (pp. 41-57). Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/9781119959847.ch3/summary

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment, 15*(43), 1–164. doi: 10.3310/hta15430

Chapman, A.L., Gratz, K.L., & Brown, M.Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy, 44*(3), 371-394. doi: 10.1016/j.brat.2005.03.005

Cleaver, K., Meerabeau, L., & Maras, P. (2014). Attitudes towards young people who self-harm: Age, an influencing factor. *Journal of Advanced Nursing, 70*(12), 2884-2896. doi: 10.1111/jan.12451

Craigen, L. M., & Milliken, T. F. (2010). The self-injury experiences of young adult women: Implications for counseling. *The Journal of Humanistic Counseling, Education and Development, 49*(1), 112-126. doi: 10.1002/j.2161-1939.2010.tb00091.x

Critical Appraisal Skills Programme (CASP). (2013). *Qualitative research checklist: 10 questions to help you make sense of qualitative research*. Retrieved from: http://media.wix.com/ugd/dded87_29c5b002d99342f788c6ac670e49f274.pdf

Crouch, W., & Wright, J. (2004). Deliberate self-harm at an adolescent unit: A qualitative investigation. *Clinical Child Psychology and Psychiatry*, *9*(2), 185 – 204, doi: 10.1177/13591045004041918

Daine, K., Hawton, K., Singaravelu, V., Stewart, A., Simkin, S., & Montgomery, P. (2013). The power of the web: a systematic review of studies of the influence of the internet on self-harm and suicide in young people. *PloS one*, *8*(10), pp.e77555. doi: 10.1371/journal.pone.0077555

Department of Health. (2012). *Preventing suicide in England: A cross government outcomes strategy to save lives.* London: Department of Health. Retrieved from https://www.gov.uk/government/publications/suicide-prevention-strategy-launched

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: A review of possible methods. *Journal of Health Services Research & Policy*, *10*(1), 45-53. Retrieved from http://hsr.sagepub.com.ezproxy.lancs.ac.uk/content/10/1/45

Evans, E., Hawton, K., & Rodham, K. (2005). In what ways are adolescents who engage in self-harm or experience thoughts of self-harm different in terms of help-seeking, communication and coping strategies? *Journal of Adolescence, 28*(4), 573-587. doi:10.1016/j.adolescence.2004.11.001

Gilbert, P., Allan, S., Brough, S., Melley, S., & Miles, J.N.V. (2002). Relationship of anhedonia and anxiety to social rank, defeat and entrapment. *Journal of Affective Disorders, 71*(1), 141-15. doi: 10.1016/S0165-0327(01)00392-5

Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: An exploration of an evolutionary view. *Psychological Medicine, 28*(3), 585–598. doi: http://dx.doi.org.ezproxy.lancs.ac.uk/

Hawton, K., Bergen, H., Casey, D., Simkin, S., Palmer, B., Cooper, J., ... & Owens, D. (2007). Self-harm in England: a tale of three cities. *Social Psychiatry and Psychiatric Epidemiology, 42*(7), 513-521. doi: 10.1007/s00127-007-0199-7

Henley, R. (2010). Resilience enhancing psychosocial programmes for youth in different cultural contexts: Evaluation and research. *Progress in Development Studies, 10*(4), 295–307. doi:10.1177/146499340901000403

Hill, K., & Dallos, R. (2012). Young people's stories of self–harm: A narrative study. *Clinical Child Psychology and Psychiatry. 17*(3), 459-475. doi:10.1177/1359104511423364

Internet World Stats: Usage and population statistics [Webpage]. (2015). Retrieved from http://www.internetworldstats.com/stats.htm.

Johnson, J., Tarrier, N., & Gooding, P. (2008). An investigation of aspects of the cry of pain model of suicide risk: The role of defeat in impairing memory. *Behaviour Research and Therapy, 46*(8), 968-975. doi: 10.1016/j.brat.2008.04.007

Klineberg, E., Kelly, M.J., Stansfeld, S.A., & Bhui, K.S. (2013). How do adolescents talk about self-harm: a qualitative study of disclosure in an ethnically diverse urban population in England. *BMC Public Health, 13*(1), 572-582. doi: 10.1186/1471-2458-13-572

Kokaliari, E., & Berzoff, J. (2008). Non-suicidal self-injury among non-clinical college women: Lessons from Foucault. *Affilia, 23*(3), 259-269. doi: 10.1177/0886109908319120

Lachal, J., Orri, M., Sibeoni, J., Moro, M.R., Revah-Levy, A. (2015). Metasynthesis of youth suicidal behaviours: Perspectives of youth, parents, and health care professionals. *PloS one, 10*(5), pp.e0127359. doi: 10.1371/journal.pone.0127359

Lee, R. P., Hart, R. I., Watson, R. M., & Rapley, T. (2014). Qualitative synthesis in practice: some pragmatics of meta-ethnography. *Qualitative Research, 15*(3), 334-350. doi: 10.1177/1468794114524221

Lesinak, R. G. (2010). The lived experience of adolescent females who self-injure by cutting. *Advanced Emergency Nursing Journal, 32*(2), 137-147. doi:10.1097/TME.0b013e3181da3f2f

Linehan, M.M. (1993). *Cognitive behavioural treatment of borderline personality disorder*. New York: Guilford Press.

Long, M., Manktelow, R., & Tracey, A. (2013). We are all in this together: working towards a holistic understanding of self-harm. *Journal of Psychiatric and Mental Health Nursing, 20*(2), 105-113. doi: 10.1111/j.1365-2850.2012.01893.x

Lovell, A. (2008). Learning disability against itself: the self-injury/self-harm conundrum. *British Journal of Learning Disabilities, 36*(2), 109-121. doi: 10.1111/j.1468-3156.2007.00477.x

Lynch, T.R., Robins, C.J., Morse, J.Q., & Krause, E.D. (2001). A mediational model relating affect intensity, emotional inhibition, and psychological distress. *Behaviour Therapy, 32*(3), 519-536. doi:10.1016/S0005-7894(01)80034-4

Madge, N., Hewitt, A., Hawton. K., Jan de Wilde, E., Corcoran, P., Fekete, S., … Ystgaard, M. (2008). Deliberate self-harm within an international community sample of young people: Comparative findings from the child and adolescent self-harm in Europe (CASE) Study. *The Journal of Child Psychology and Psychiatry, 49*(6), 667–77. doi:10.1111/j.1469-7610.2008.01879.x

McAllister, M. (2003). Multiple meanings of self-harm: A critical review. *International Journal of Mental Health Nursing, 12*(3), 177-185. doi: 10.1046/j.1440-0979.2003.00287.x

McAndrew, S., & Warne, T. (2014). Hearing the voices of young people who self-harm: Implications for service providers. *International Journal of Mental Health Nursing, 23*(6), 570-579. doi**:**10.1111/inm.12093

Messer, J. M., & Fremouw, W. J. (2008). A critical review of explanatory models for self-mutilating behaviors in adolescents. *Clinical Psychology Review, 28*(1), 162-178. doi: 10.1016/j.cpr.2007.04.006

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D.G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA Statement. *Annals of Internal Medicine, 151*(4), 26 –296. doi:10.7326/0003-4819-151-4-200908180-00135

Moolchaem, P., Liamputtong, P., O'Halloran, P., & Rosediani, M. (2015). The lived experiences of transgender persons: A meta-synthesis. *Journal of Gay & Lesbian Social Services, 27*(2), 143-171, doi: 10.1080/10538720.2015.1021983

Moyer, M., & Nelson, K. (2007). Investigating and understanding self-mutilation: The student voice. *Professional School Counselling, 11*(1), 42 – 48. Retrieved from http://web.b.ebscohost.com.ezproxy.lancs.ac.uk/ehost/detail/detail?sid=386e43a2-1220-408b-a070- be82bfef72a3%40sessionmgr110JnNpdGU9ZWhvc3Qtb Gl2 ZQ% 3d%3d#AN=27264342&db=a9h

Muehlenkamp, J. J., Claes, L., Havertape, L., & Plener, P. L. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(10), 1-9. doi: 10.1186/1753-2000-6-10

Muehlenkamp, J. J., & Gutierrez, P. M. (2004). An investigation of differences between self-injurious behavior and suicide attempts in a sample of adolescents. *Suicide and Life-Threatening Behavior, 34*(1), 12-23. doi: 10.1521/suli.34.1.12.27769

Murray, C. D., & Forshaw, M. J. (2013). The experience of amputation and prosthesis use for adults: a metasynthesis. *Disability and Rehabilitation*, *35*(14), 1133-1142. doi: 10.3109/09638288.2012.723790

National Collaborating Centre for Mental Health (UK). (2004). *Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care*. British Psychological Society. Retrieved from www.ncbi.nlm.nih.gov/pubmed/21834185

National Health Service (NHS). (2014). *Puberty* [Webpage]. Retrieved from http://www.nhs.uk/Conditions/Puberty/Pages/Introduction.aspx

National Institute of Health and Clinical Excellence. (2011). *Self-harm Longer-term Management.* London*:* NICE. Retrieved from https://www.nice.org.uk/guidance/cg133

Noblit, G., & Hare, R. (1988). *Meta-ethnography: Synthesising qualitative studies*. Newbury Park, CA: Sage.

O'Connor, R.C. (2011). Towards an integrated motivational-volitional model of suicide behavior. In R.C. O'Connor, S. Platt & J. Gordon (Eds.), *International Handbook of Suicide Prevention: Research, Policy & Practice* (pp. 181 – 98). London: John Wiley & Sons.

O'Connor, R. C., Rasmussen, S., & Hawton, K. (2012). Distinguishing adolescents who think about self-harm from those who engage in self-harm. *The British Journal of Psychiatry, 200*(4), 330-335. doi: 10.1192/bjp.bp.111.097808

Olfson, M., Gameroff, M. J., Marcus, S. C., Greenberg, T., & Shaffer, D. (2005). Emergency treatment of young people following deliberate self-harm. *Archives of General Psychiatry, 62*(10), 1122-1128. doi: 10.1001/archpsyc.62.10.1122

Onyett, S. (2007). *New Ways of Working for Applied Psychologists in Health and Social Care - Working Psychologically in Teams.* Leicester: British Psychological Society.

Pope, C., Mays, N., & Popay, J. (2007). *Synthesising qualitative and quantitative health evidence: A guide to methods*. Berkshire, England: Open University Press.

Priddis, H., Dahlen, H., & Schmied, V. (2013). Women's experiences following severe perineal trauma: A meta-ethnographic synthesis. *Journal of Advanced Nursing, 69*(4), 748-759. doi: 10.1111/jan.12005

Rasmussen, S. A., Fraser, L., Gotz, M., MacHale, S., Mackie, R., Masterton, G., ... & O'Connor, R. C. (2010). Elaborating the cry of pain model of suicidality: testing a psychological model in a sample of first-time and repeat self-harm patients. *British Journal of Clinical Psychology, 49*(1), 15-30. doi: 10.1348/014466509X415735

Rohde, P. (2001). The relevance of hierarchies, territories, defeat for depression in humans: Hypotheses and clinical predictions. *Journal of Affective Disorders, 65*(3), 221–230. doi: 10.1016/S0165-0327(00)00219-6

Rissanen, M. L., Kylmä, J., & Laukkanen, E. (2008). Descriptions of self-mutilation among Finnish adolescents: A qualitative descriptive inquiry. *Issues in Mental Health Nursing, 29*(2), 145-163. doi:10.1080/01612840701792597

Rivers I. (2001). The bullying of sexual minorities at school: its nature and long-term correlates. *Educational and Child Psychology, 18*(1), 32–46. Retrieved from https://scholar.google.co.uk/scholar?cluster=8416505346920032880&hl=en&as_sdt=0,5

Sandelowski, M., & Barroso, J. (2003). Focus on research methods: toward a metasynthesis of qualitative findings on motherhood in HIV-positive women. *Research in Nursing & Health, 26*(2), 153 – 170. doi: 10.1002/nur.10072

Sandelowski, M., Docherty, S., & Emden, C. (1997). Focus on qualitative methods qualitative metasynthesis: issues and techniques. *Research in Nursing and Health, 20*(4), 365-372. doi: 10.1002/(SICI)1098-240X(199708)20:4<365::AID-NUR9>3.0.CO;2-E

Saunders, K. E., Hawton, K., Fortune, S., & Farrell, S. (2012). Attitudes and knowledge of clinical staff regarding people who self-harm: a systematic review. *Journal of Affective Disorders, 139*(3), 205-216. doi:10.1016/j.jad.2011.08.024

Schotte, D. E., & Clum, G. A. (1987). Problem-solving skills in suicidal psychiatric patients. *Journal of Consulting and Clinical Psychology, 55*(1), 49-54. doi: 10.1037/0022-006X.55.1.49

Scoliers, G., Portzky, G., Madge, N., Hewitt, A., Hawton, K., Jan de Wilde, E., … van Heeringen, K. (2009). Reasons for adolescent deliberate self-harm: a cry of pain and/or a cry for help? Findings from the child and adolescent self-harm in Europe (CASE) study. *Social Psychiatry and Psychiatric Epidemiology*, *44*(8), 601 -607. doi:10.1007/s00127-008-0469-z

Scourfield, J., Roen, K., & McDermott, L. (2008). Lesbian, gay, bisexual and transgender young people's experiences of distress: Resilience, ambivalence and self-destructive behaviour. *Health & Social Care in the Community, 16*(3), 329-336. doi: 10.1111/j.1365-2524.2008.00769.x

Shaw, R. L. (2010). Conducting literature reviews. In M. Forrester (Ed.), *Doing qualitative research in psychology: A practical guide* (pp. 39-52). London: Sage

Shaw, R.L. (2012). Identifying and Synthesizing Qualitative Literature. In D. Harper & A. R. Thompson (Eds.), *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*. (pp.9-22). London: John Wiley & Sons, Ltd. doi: 10.1002/9781119973249.ch2

Sim, L., Adrian, M., Zeman, J., Cassano, M., & Friedrich, W.N. (2009). Adolescent deliberate self-harm: Linkages to emotion regulation and family emotional climate. *Journal of Research on Adolescence, 19*(1), 75-91. doi:10.1111/j.1532-7795.2009.00582.x

Silverman, D. (1997). Towards an aesthetics of research. In D. Silverman (Ed.), *Qualitative Research: Theory, Method and Practice* (pp. 239 – 253). Sage: London

Slee, N., Arensman, E., Garnefski, N., & Spinhoven, P. (2007). Cognitive-behavioural therapy for deliberate self-harm. *Crisis, 28*(4), 175-182. doi:10.1027/0227-5910.28.4.175

Smith, M. (2002). Half in love with easeful death? Social work with adolescents who harm themselves. *Journal of Social Work Practice: Psychotherapeutic Approaches in Health, Welfare and the Community, 16*(1), 55-65. doi: 10.1080/02650530220134764

Stein, A., & Craig, A. (2000). The dot.com generation: IT practice and skills of transition students. *Proceedings of the Australasian Conference on Computing Education, 8,* 220-227. doi: 10.1145/359369.359403

Steinberg, L., Cauffman, E., Woolard, J., Graham, S., & Banich, M. (2009). Are adolescents less mature than adults?: Minors' access to abortion, the juvenile death penalty, and the alleged APA" flip-flop". *American Psychologist, 64*(7), 583. doi: 10.1037/a0014763

Storey, P., Hurry, J., Jowitt, S., Owens, D., & House, A. (2005). Supporting young people who repeatedly self-harm. *The journal of the Royal Society for the Promotion of Health, 125*(2), 71-75. doi: 10.1177/146642400512500210

Strong, M. (1998). *A bright red scream*. New York: Viking.

Suyemoto, K. L. (1998). The functions of self-mutilation. *Clinical Psychology Review, 18*(5), 531-554. doi: 10.1016/S0272-7358(97)00105-0

Suyemoto, K.L., & MacDonald, M.L. (1995). Self-cutting in female adolescents, *Psychotherapy, 32*(1), 162 - 171. doi: 10.1037/0033-3204.32.1.162

Taylor, N., das Nair, R., & Braham, L. (2013). Perpetrator and victim perceptions of perpetrator's masculinity as a risk factor for violence: A meta-ethnography synthesis. *Aggression and Violent Behavior, 18*(6), 774-783. doi: 10.1016/j.avb.2013.09.002

Townsend, E. (2014). Self-harm in young people. *Evidence Based Mental Health, 17*(4), 97 -99. doi:10.1136/eb-2014-101840

United Nations Educational, Scientific and Cultural Organisation (UNESCO). (2015). *What do we mean by youth?* [Webpage]. Retrieved from http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth definition/

Vivekananda, K. (2000). Integrating models for understanding self-injury. *Psychotherapy in Australia, 7*(1), 18–25. Retrieved from http://search.informit.com.au/documentSummary;dn=550871830081580;res=IELHEA

Walsh, D., & Downe, S. (2005). Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing*, *50*(2), 204-211. doi: 10.1111/j.13652648.2005.03380.x

Williams, J. M. G., & Pollock, L. R. (2000). The psychology of suicidal behaviour. In K.

Hawton & K. van Heeringen (Eds.), *The international handbook of suicide and attempted suicide* (pp. 79-93). Chichester: John Wiley & Sons.

Yip, K-S., Ngan, M-Y., & Lam, I. (2004). Adolescent self-cutters in Hong Kong. *Asia Pacific Journal of Social Work and Development, 14*(2), 33-51. doi: 10.1080/21650993.2004.9755953

Zila, L.M., & Kiselica, M.S. (2001). Understanding and counselling self-mutilation in female adolescents and young adults. *Journal of Counseling and Development, 79*(1), 46–53. doi: 10.1002/j.1556-6676.2001.tb01942.x

Zimmer, L. (2006). Qualitative metasynthesis: a question of dialoguing with texts. *Journal of Advanced Nursing, 53*(3), 311–318. doi:10.1111/j.1365-2648.2006.03721.x

Figure 1. Figure Showing Stages of Meta-synthesis in Accordance to Guidance Provided by Noblit and Hare (1988).

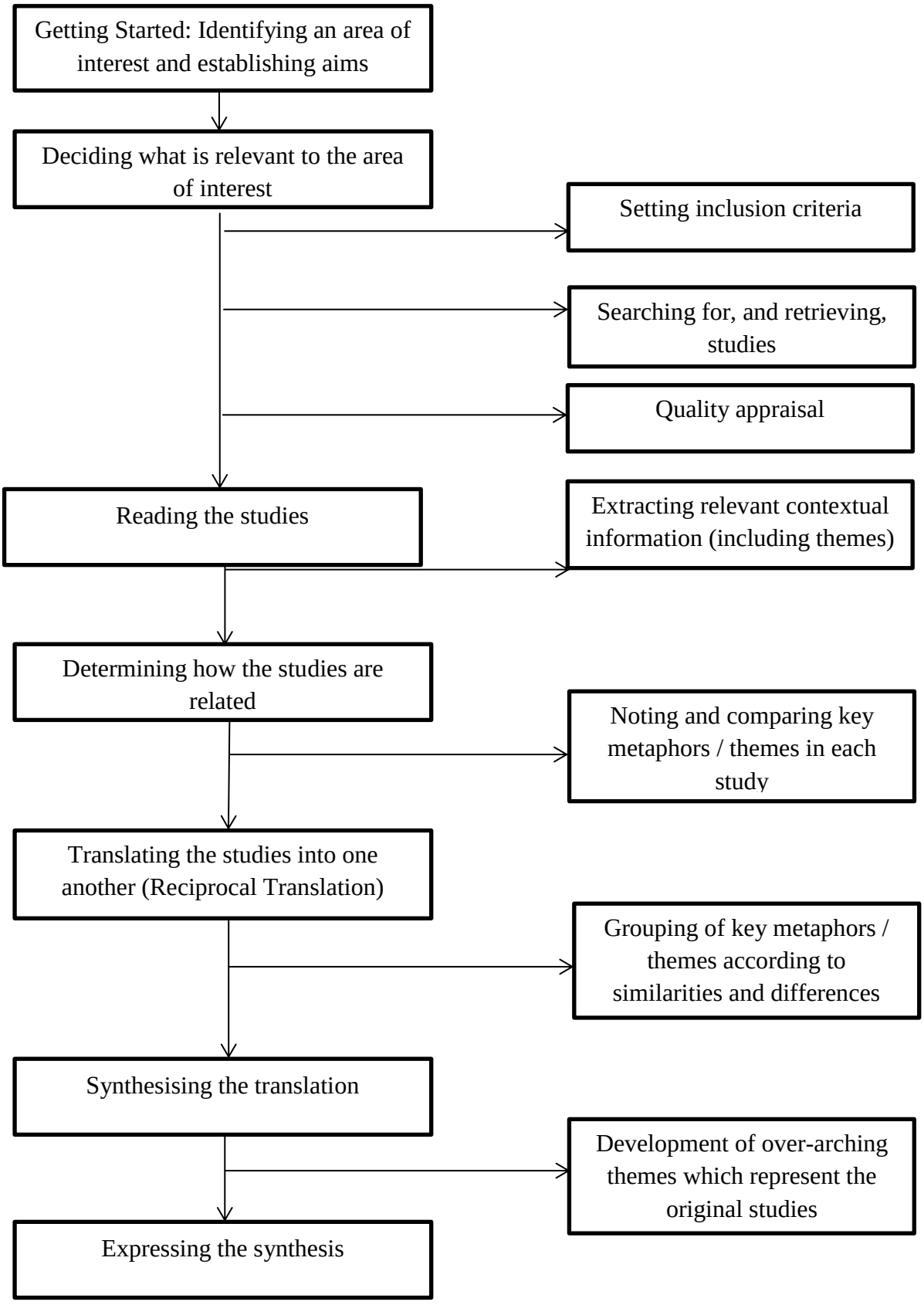

Table 1: Details of searches relating to database specific indexing systems

Database	Free Text - Self-harm (S1)	Free Text – Methodology (S2)	Subject Mapping – Self-harm (S3)	Free Text - Age (S5)	Limiters
Academic Search Complete	"body marking" OR "self-injurious behaviour*" OR "self-mutilati*" OR cutting OR "self-poisoning" OR "self-harm*" OR "self-injur*" OR "non suicidal self-injury" OR "NSSI" OR "deliberate self-harm" OR "DSH"	qualitative OR "qualitative analys*" OR "qualitative research" OR "qualitative approach" OR "qualitative data" OR interview* OR "focus group*" OR "qualitative method*" OR thematic OR "thematic analys*" OR "grounded theory" OR "interpretative" OR "IPA" OR "interpretative phenomenological analy*" OR phenomenolog* OR narrative	DE "SELF-mutilation in adolescence" OR DE "SELF-mutilation" OR DE "CUTTING (Self-mutilation)" OR DE "HESITATION wounds" OR DE "SELF-torture" OR DE "SELF-injurious behavior" OR DE "PARASUICIDE"	adolescen* OR teenage* OR "young adult*" OR youth OR "young m*" OR "young wom*"	Publication Date 01.1999 – 01.2015 Scholarly (Peer Reviewed) Journals Language: English
Child Development and Adolescent Studies	As above	As above	-	-	Publication Date 01.1999 – 01.2015 Scholarly (Peer Reviewed) Journals
CINAHL	As above	As above	(MH "Injuries, Self-Inflicted") OR (MH "Self-Injurious Behavior")	-	Publication Date 01.1999 – 01.2015 Peer Reviewed Journals Language: English Exclude

					MEDLINE records Child (6-12) Adolescent (13-18) Adult (19-44)
Medline	As above	As above	(MH "Self-Injurious Behavior")	-	Publication Date 01.1999 – 01.2015 Language: English Child (6-12) Adolescent (13-18), Young Adult (19-24), Adult (19-44)
PsycINFO	As above	As above	DE "Self Inflicted Wounds" OR DE "Self Injurious Behavior" OR DE "Head Banging" OR DE "Self Inflicted Wounds" OR DE "Self Mutilation"	-	Publication Date 01.1999 – 01.2015 Peer Reviewed English Exclude Dissertations School Age (6-12) Adolescence (13-17) Young adulthood (18-29)

Figure 2. Figure showing process used to determine relevance of studies

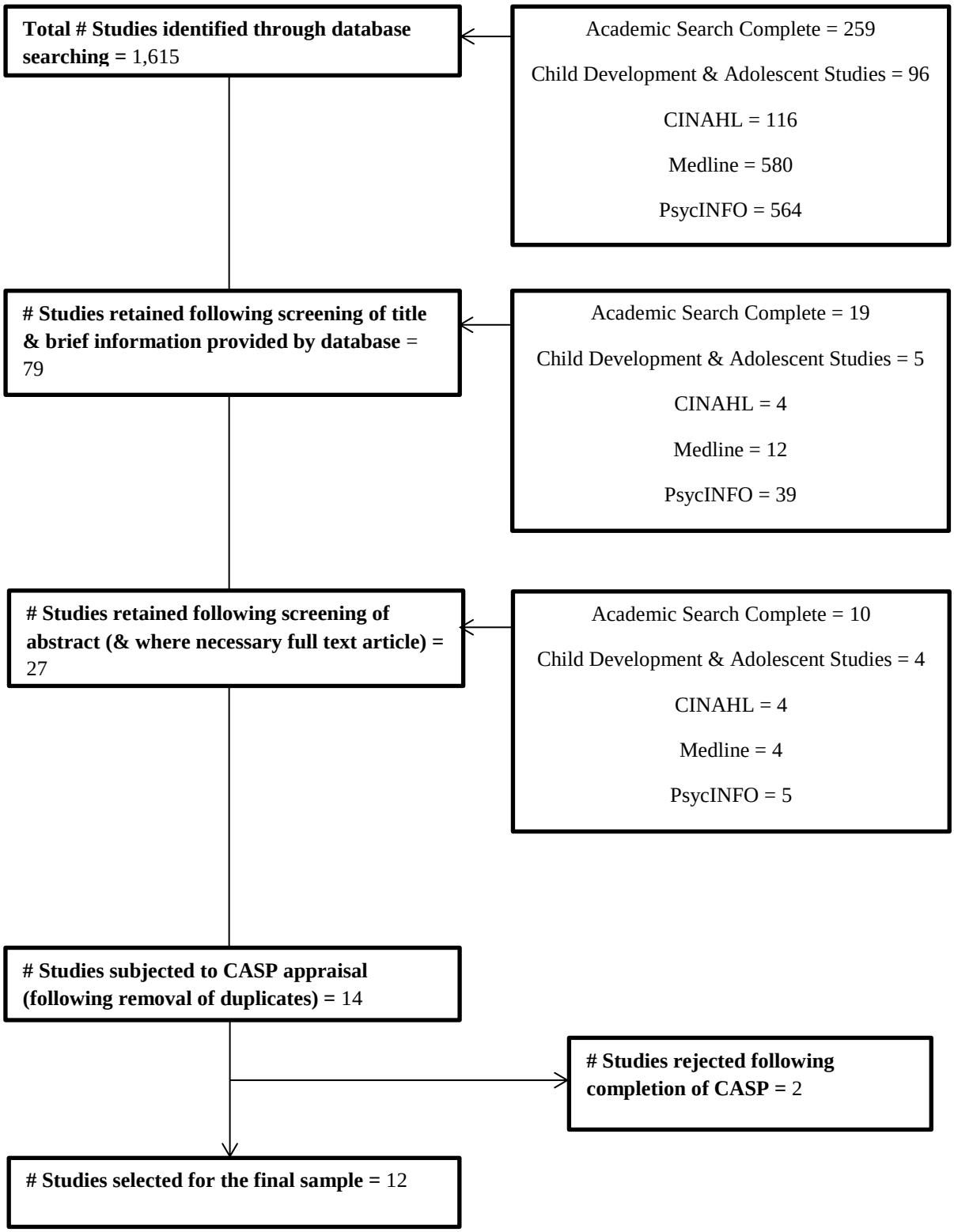

Table 2: Details of criteria used to determine inclusion in the final sample

Exclusion Criteria	Inclusion Criteria
Studies exploring the experiences of individuals who harm themselves with expressed suicidal intent	Studies using qualitative methods to explore young people's (aged 11 – 25 years) personal experiences of self-harm
Studies focusing exclusively on the experiences of individuals with a learning disability	Studies published in English language, peer reviewed journals between January 2000 – January 2015
Studies focussing exclusively on young people's experiences of services, therapeutic modalities or ceasing self-harm	
Studies which recruit young people who do not harm themselves and do not provide clear information which distinguishes the experiences of those with direct experiences of self-harm and those without.	

Table 3. Critical appraisal of study quality using the CASP qualitative appraisal tool

Study	Research Design	Sampling	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Findings	Value of Research
Abrams & Gordon (2003)	3	3	3	3	1	1	2	3
Bheamadu et al. (2012)	1	1	3	1	2	2	3	1
Craigen & Milliken (2010)	2	1	2	3	1	3	3	3
Crouch & Wright (2004)	3	3	3	1	2	3	3	3
Hill & Dallos (2012)	3	2	3	2	1	3	3	3
Klineberg et al. (2013)	3	2	3	1	2	3	2	3
Kokaliari & Berzoff (2008)	3	3	3	1	2	1	2	2
Lesinak (2010)	3	2	3	2	2	1	1	2
McAndrew & Warne (2014)	3	1	3	1	3	2	3	3
Moyer & Nelson (2007)	3	2	3	3	1	3	3	1
Rissanen et al. (2008)	2	2	2	1	2	2	3	3
Smith (2002)	2	1	1	1	1	1	1	1
Storey et al. (2005)	1	1	1	1	2	1	1	1

Yip et al. (2004)	2	1	2	1	2	2	3	2

Table 4. Methodological characteristics of included studies and demographic information relating to participants.

Author	Year	Location	Research Aim	Data Collection & Analysis	Sample
Abrams & Gordon	(2003)	America	To explore the motivations, meanings, functions and consequences of self-harm for young women in urban and suburban contexts	Self-administered survey and interviews Thematic analysis	6 females Aged 16-17
Bheamadu et al.	(2012)	South Africa	To explore the experiences of self-injury among adolescents and young adults	Interviews, collages, journal entries and personal written work Thematic analysis	12 (11 females: 1 male) Aged 18-22
Craigen & Milliken	(2010)	America	To examine young adult women's overall experiences with self-injury	Interviews Phenomenological approach	10 females Aged 18-23
Crouch & Wright	(2004)	United Kingdom	To identify some of the personal and interpersonal processes involved in deliberate self-harm at a residential treatment setting for adolescents with mental health problems	Interviews Interpretative phenomenological analysis	6 (4 females: 2 males) Aged 12-16
Hill & Dallos	(2012)	United Kingdom	To look at the stories of adolescents who have engaged in self-harm in order to examine their attempts to make meaning of their self-harm and life experiences	Interviews Narrative analysis	6 (5 females: 1 male) Aged 13 – 18
Klineberg et al.	(2013)	United Kingdom	To investigate how adolescents spoke about self-harm and their experiences of disclosure and help-seeking	Interviews Content and thematic analysis.	30[3] (24 females: 6 males) Aged 15-16

[3] 10 young people in the study had never self-harmed. Their data was clearly distinguishable and has not been included in this synthesis.

Kokaliari & Berzoff	(2008)	America	What psychosocial functions does self-injury serve in a nonclinical population of college women?	Interviews Grounded theory	10 females Aged 18-23 years
Lesinak	(2010)	America	To explore the experience of adolescent females who self-injure by cutting	Interviews Phenomenological approach	6 females Aged 15-19 years
McAndrew & Warne	(2014)	United Kingdom	To elicit the narratives of young people who engage in self-harm and suicidal behaviour	Interviews Interpretative phenomenological analysis	7 females Aged 13-17
Moyer & Nelson	(2007)	America	To explore the meanings that self-mutilating behaviours have to adolescents	Interviews Phenomenological approach	5 (4 females: 1 male) Aged 12-18
Rissanen et al.	(2008)	Finland	To describe self-mutilation from the perspectives of self-mutilating adolescents	Written passages Inductive content analysis	70 (69 females: 1 male) Aged 12-21 years
Yip et al.	(2004)	Hong Kong	To establish the ways in which secondary school students cut their bodies, the causes of self-cutting and the consequences of self-cutting.	Interviews Inductive analysis	9[4] (2 females: 1 male) Aged 14-16 years[5]

[4] (3 young people; 3 friends; 3 family members)

[5] The age of one of the participants in the Yip et al., (2004) study was not disclosed. However, the sample was derived from secondary school students

Table 5. Table demonstrating how metaphors, phrases and themes from each study contribute to Theme Two: Self-harm as an attempt to cope with unbearable emotions and thoughts

Study	Authors Original Interpretations and Representative Participant Quotes, Metaphors and / or Interesting Phrases	Authors Original Theme Title	My Initial Comments and Interpretations
Abrams & Gordon (2003)	• Self-harm became representative of overall despondency and associated with unpleasant emotional experiences • The language used by the young women may be related to the environments they live in (urban / suburban) • Self-harm is a cathartic way to relieve emotion and communicate with others as well a psychological strategy to deal with stressors • Self-harm can be related to a lack of "language of pain" and so, becomes the only way to cope with and express anger or frustration • There may be cultural influences which affect the ways in which young people communicate their distress • "But the blood, coming out of my body, was the pain releasing. That's what made sense to me … and after a while, it was like 'OK, I'm OK now'. (Jenna)	*"Meanings: What Does the Behaviour Represent?"* *"Functions: What Do I Gain From Hurting Myself?"*	Unpleasant emotional experiences which the young people have no way of dealing with or responding to. Implies that it's essential that emotional discomfort is someway communicated to others – 'the language of pain' Indicates that, if young people lack 'language', self-harm becomes a method of communication
Bheamadu et al. (2012)	• Physical pain is experienced as controllable whereas emotional pain is global and abstract • There is a difference between the anticipated pain inflicted by the self and unanticipated pain inflicted by others • Cutting can be psychologically addictive • Negative feelings precede self-harm and positive ones result from it • Self-harm interpreted as a method of gaining autonomy and control	*"Biological Experiences"* *"Psychological Experiences"*	The central importance of control for young people – emotions cannot be tolerated they must be controlled and supressed. How does this relate to wider societal expectations of young people and their emotion?

	• "At first cutting was almost like some sort of outlet and then it became addictive … it was the only thing that made me feel better" (Nandi). • "Creating order out of the ensuing chaos" • "The scars and bruises are outward manifestations of their inward distress which provide concrete evidence that they can endure hardship"		
Craigen & Milliken (2010)	• Understanding and connecting to young people's experiences can enhance empathy in professionals • A distinction is made between self-harm and suicide attempts • Self-harm is associated with the relief of pain via externalization and physical manifestation of feelings • Emotional experiences (including anger, depression, disappointment) lead to self-harm • A humanistic approach to therapy is recommended in response to participants desire to tell their stories and be heard • The variety of feelings associated with self-harm are interpreted as evidence for the importance of professionals attending to the individual • "The pain inside was so much and I didn't want to talk about it, so it was just easier to cut and feel some sort of physical manifestation of the emotional pain" (Amy). • "Cutting was a physical representation of the emotional pain"	*"Theme 2 – Interwoven Elements of Self-Injury – Subtheme 2a – describing cutting"*	'physical manifestation' – the body becomes a way of representing emotional discomfort Relates to communication, a lack of ways to communicate or externalise distress Distress is trapped inside – self-harm lets it out, physically represents it Self-harm as a response to a wide variety of emotions – commonality between these experiences? All emotions experiences as intense or unbearable?
Crouch & Wright (2004)	• Self-harm is understood in a basic cause and effect model – strong emotional states result in self-harm which creates a release • It was accepted that self-harm was an effective way of	*"Precipitants of DSH"* "*Effects on the individual*"	Self-harm is conceptualised as an accepted way of managing emotions – it is essential that these emotions are attended to, that they are released

	managing and avoiding emotional states • "Yeah it's a way of trying to get emotions out: to calm [pause] some people do it to calm down" (Natalie) • "Avoidance of difficult feelings was perceived to require a literal evacuation of unwanted emotions"		in some way – controlling the way that they are expressed
Hill & Dallos (2012)	• Young people's narratives are interpreted as representing their lack of control over their circumstances • Young people stressed how self-harm helped them to cope • Young people appear to have difficulties communicating about their experiences which may stem from family environments in which emotional expression is not welcome • Self-harm as expression of emotion or act of self-punishment • Young people may have had difficulties telling their stories because they resisted engaging with difficult memories • Young people's experiences of being misunderstood by others drove them to emphasise their use of self-harm as a way to cope • This emphasis on coping may be superficial as young people conceal more complex stories • Society may influence young people to direct their emotions inwards • Young people have no access to opportunities to process their emotions because they don't talk about them • "I don't want to talk about it, that's why I cut because I don't want to talk about it" (Rose) • "Brooke's story is one of little choice or control over the decisions being made about her life" • "All of these stories ask us to consider the way in which self-harm has been a necessary means for survival"	"*People just don't understand, self-harm is my way of coping; it doesn't mean that I'm weird or crazy*" *"Talking is difficult, so I keep it all inside"* "*Putting the anger inwards*" "Structure and coherence" "Defended aspects of the stories"	There is no other way to gain control? Self-harm understood as being a legitimate coping mechanism Self-harm is a way of coping when opportunities or skills relating to emotional expression or communication are lacking – it's the only viable alternative?

	• "Alison describes self-harm as "the short way round"" • "This way of telling their story allowed them to remain emotionally distant" • "The treatment that she received rather than validating her distress and teaching her to express her emotions verbally, caused her to internalise and to believe that she is a bad person for feeling and expressing her emotions in this way" • "Self-harm may be the only visible alternative for adolescents faced with unmanageable emotions and memories that are painful to confront"		
Klineberg et al. (2013)	• Self-harm associated with relief from emotional distress • Relief from emotions was interpreted as a reinforcing factor • Self-harm is something that is turned to in a moment of extreme distress • Participants difficulties talking about experiences were interpreted as being related to a general difficulty expressing feelings • Young people's intense feelings may make it difficult for them to recall their intentions for engaging in self-harm • "It's like a way of getting your emotions out, it's focussing on something else, other than what's making you angry" (Female, 15, Black, repeated self-harm). • "a private, inwardly focused expression of distress"	*"Talking about self-harm: Adolescents who had self-harmed"*	Self-harm is understood to be the only option when young people can't express themselves in other ways The feelings that precede self-harm are 'intense'
Kokaliari & Berzoff (2008)	• Participants perceive emotions (and expression of emotion) to be related to weakness • Emotions are perceived as something to be suppressed in order to allow the participants to meet expectations of society • Self-harm perceived as something which allows for the localization of pain	*"Autonomy, self-reliance and the denial of feelings"* *"Self-injury as a Western form of*	Societal expectations are that emotions are not expressed. Therefore, these emotions build up and become unbearable? Because they need to be 'let out' or expressed?

	• Self-harm provides immediate relief • Self-harm understood as functioning as forms of self-surveillance • From a psychological perspective, self-harm helps the body to organize unbearable affects • Self-harm understood as a form of social control which has become an internalized punishment system that quickly alleviates psychological pain • Women have been forced to achieve at any cost, including the denial of feelings • "I think to some degree it is a quick fix… I think it can help you relieve that stress immediately" (Penelope). • "All of the participants talked about their discomfort with dependence and emotions" • "Alter their emotional states to comply with the need to be productive as college students" • "These women were harming their bodies, in private, to be able to function productively in the world" • "In this way she was condensing the consumer society's need for quick fixes and for gratification in the service of greater productivity" • "Self-injury may help the body regain its capacity to produce and be a useful subjugated body"	*personal and social control"* *"Self-injury as a quick fix"*	Self-harm as a quick way / 'quick fix' – it effectively reduces emotional discomfort
Lesinak (2010)	• Participants had difficulties expressing emotions • These emotional experiences accumulated until they were unbearable • Wounds became physical representations of their distress • Young people felt trapped • Cutting provided a relief from escalating emotion • Cutting allows for the externalization of internal pain	"*Silently Screaming*" "*Releasing the Pressure*" "*Feeling Alive*"	'Unbearable' – emotions which are not expressed become unbearable / intolerable Idea of emotions 'building up' – there is no other way to release or manage them effectively

	• Themes represent angst and desperation and a recovery process following the cutting • "Expression inside yourself which builds up and finally when I get to a point where I'm at that peak and someone just sets me off the edge and I want to scream" (Annie) • "Cutting became her friend, making her feel better when nothing else did" • "Danielle visualised her blood as the repository of all her pain" • "Cutting was there for her and did not abandon her" • "The wound became a tangible and visible external representation of the pain she felt internally" • "Struggling for wellbeing and hoping for more by using their skin as a canvas"		
McAndrew & Warne (2014)	• Self-harm is complex • Self-harm is understood as an attempt at self-preservation • Self-harming maintained because of the power to bring relief • Self-harm has the power to being immediate relief resulting in the reduction of internal distress • "It would be a relief from basically, like, everything that was going on; the stress. It was kind of a relief for me because each cut that happened was a relief from a problem" (Fiona).	"*Theme 1: Cutting out the stress"*	Self-harm as the only way to relieve distress – it's a last resort in order to maintain 'self-preservation'?
Moyer & Nelson (2007)	• Cutting used as a coping mechanism to prevent the expression of emotion and to allow for control • Young people repeatedly replayed difficult situations in their mind • Thoughts build up and result in self-harm which functions to stop emotions that would otherwise seem unstoppable	"*A tape recorder in the head*" *"A way to handle life situations and cope with emotions"*	The 'build up' of emotions – indicates that emotions need to be 'let out' or released by some method. The metaphors and imagery used by young people powerfully demonstrate

	• Cutting as a temporary relief • Consequences of self-harm include shame and regret • Young people pushed down emotions because they didn't feel they could talk to anyone – this should influence professionals approach • "When I see the blood, it's like, I don't know, I just zone out into it, and imagine just being like in my own little world with it, just like puddles, jumping in puddles of blood" (Ian) • "Cutting was described as a way to allow feelings out" • "There was no escape, with the expectation of self-mutilation" • "cleansing his mind"	*"Feelings of guilt, shame and regret"*	the intensity of the experience
Rissanen et al. (2008)	• Negative emotions (anger, rage, low mood) are an internal factor which may lead to self-harm • Personal sequels of self-harm included meanings and experiences related to blood and pain • Young people experienced positive, negative and neutral emotions following self-harm • Self-harm is an intentional act which is engaged in in order to reduce unwanted emotion which is difficult to verbalise • "Self-mutilation is a way to master myself and have some kind of control of things"	"*Descriptions of the self-mutilation act: Intentions of the self-mutilation act*" "*Descriptions of the sequels of self-mutilation*"	The importance of control and how this relates to self-harm. Implies that emotions are, otherwise, uncontrollable. Self-harm as a method of expression, demonstrating internal distress and discomfort.
Yip et al. (2004)	• Young people had prolonged problems in emotional regulation • Self-cutting used to release tension and gain control • Accumulation of emptiness, depersonalization and anger is unbearable • Self-cutting used to demonstrate anger • Self-harm could result in both positive and negative emotional consequences (relief or guilt)	"*Process*" "*Aftermath*"	There is a deficit in emotional literacy, expression and regulation. The more emotionally 'uncomfortable' young people felt the more they relied upon self-harm to relieve these feelings.

	• A holistic approach to treatment would bolster young people's alternative coping by encouraging appropriate emotional expression • Young people's experiences of frustration, anxiety and emptiness should be addressed • "After I cut myself, I felt released and comfortable … The more unhappy I was, the more frequently I cut myself" (A)	Emotional discomfort seemingly directly linked to self-harm.

Table 6. Contribution of each study to the meta-synthesis themes

		Study											
	Metasynthesis Theme	Abrams & Gordon (2003)	Bheamadu et al. (2012)	Craigen & Milliken (2010)	Crouch & Wright (2004)	Hill & Dallos (2012)	Klineberg et al. (2013)	Kokaliari & Berzoff (2008)	Lesinak (2010)	Moyer & Nelson (2007)	McAndrew & Warne (2014)	Rissanen et al. (2008)	Yip et al. (2004)
1	Self-harm as the Best Response to Adversity	X		X		X	X		X	X	X	X	X
2	Self-harm as an attempt to cope with unbearable emotions and thoughts	X	X	X	X	X	X	X	X	X	X	X	X
3	Feeling Isolated vs. Feeling Accepted		X	X	X	X	X	X	X	X	X	X	X

Appendix 1:A. Author Guidelines

Child and Adolescent Mental Health

Edited By: Crispin Day, Jane Barlow, Kapil Sayal, Leslie Leve and Andre Sourander

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Author Guidelines

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1. Contributions from any discipline that further clinical knowledge of the mental life and behaviour of children are welcomed. Papers need to clearly draw out the clinical implications for mental health practitioners. Papers are published in English. As an international journal, submissions are welcomed from any country. Contributions should be of a standard that merits presentation before an international readership. Papers may assume any of the following forms: Original Articles; Review Articles; Measurement Issues; Innovations in Practice.

Original Articles: These papers should consist of original research findings.

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Disclosure of interest form
All authors will be asked to download and sign a full Disclosure of Interests form and acknowledge this and sources of funding in the manuscript.

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Authors are reminded that the *Journal* adheres to the ethics of scientific publication as detailed in the *Ethical principles of psychologists and code of conduct* (American Psychological Association, 2010). These principles also imply that the piecemeal, or fragmented publication of small amounts of data from the same study is not acceptable. The Journal also generally conforms to the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors (ICJME) and is also a member and subscribes to the principles of the Committee on Publication Ethics (COPE).

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