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Investigating the understanding and management of self-harm in a children's residential therapeutic community

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Abstract

The definition of self-harm has been widely debated and has expanded from the traditional idea of habitual cutting to more abstract versions, such as self-harm by inadequate self-care (Hunter, 2011). There is sparse research on self-harm involving young children, with the focus predominantly upon adolescents. This small-scale, work-based study explores the understanding and management of self-harm within a therapeutic residential community caring for children aged 5-12. A mixed-methods design was used, combining quantitative analysis of secondary data of self-harm with qualitative data derived from professional discussions with community directors and semi-structured interviews with care staff. Results reflected the variance in defining self-harm and how semantics such as 'intent', 'level' or 'risk' are based on subjective interpretation and may vary between children and contexts. Such fluidity in terms can make self-harm a challenging subject to understand, compounded by the idea that self-harm is often seen as a taboo subject. The study concludes that identifying self-harming behaviour relies on the therapeutic relationship, and responses to this should be tailored to the child's individual needs. The value of staff communication, training and support were highlighted as recommendations for future practice.

Keywords

Self-harm, therapeutic, residential care, children, England

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Introduction

The definition of self-harm has been debated for decades, having expanded from self-cutting to include extreme physical activity, swallowing objects and eating disorders (Koutek et al., 2016, p. 788). Encompassing children in their definition, the National Institute for Health and Care Excellence (NICE) guidelines use the term self-harm to describe 'any act of self-poisoning or self-injury carried out by an individual irrespective of motivation' (2011, Clinical Guideline 133, n.p.). These guidelines refer to children aged 8-17 and there is little mention of younger children self-harming within the wider literature.

Research indicates the high prevalence of self-harm within residential settings. Meltzer et al. (2004) reported 39% of children in residential care had tried to harm themselves, in comparison to 14% in foster care (as cited by Johnson et al., 2017, p. 444). Storey et al. (2005) reported individuals in care were significantly more likely to have a history of self-harming behaviour dating back to childhood which increased in intensity as they grew older. It is necessary to note here the limitations of this literature in relation to the current study, as it was written several years ago and based upon an older age range of children. Again, this highlights the sparse representation of self-harm within the younger age group in the current literature.

This study explored the understanding and management of self-harm in children within a residential therapeutic community (pseudonym Fairview) caring for children aged 5 to 12 years. Fairview is one of four therapeutic communities within an organisation caring for children who have experienced early life trauma and present with emotional and behavioural difficulties, including self-harm and sexual or physically aggressive behaviour. Fairview offers a methodology of treatment named Integrated Systemic Therapy (iST) where 'robust theory and organisational structures together provide the setting within which the art of healing can take place' (Blunden, 2007, p. 6). This is specialised work, not restricted to the child's conscious contributions, but wherein their unconscious communication is also attended to. Blunden (2007, p. 11) states this is 'a particularly significant mode of communication for those who have troubled

emotions, or who have not had the development opportunities to learn to make feelings and thoughts conscious and to verbalise them'.

Some children at Fairview present with self-harming behaviour, for example head banging or self-biting. Although this may be viewed by some as low level in severity, it might be argued that addressing such behaviours at this early age could influence future behaviour. Murray (2003, p. 41) stated that 'escalation occurs when self-harm behaviour is not being heard or understood in the context of why it is happening'. Work with children at Fairview is continuously viewed within the iST model which emphasises the importance of relationships. Those relationships within the residential therapeutic community setting can offer children an alternative experience of relationships to those they have had in their early lives, providing a robust, nurturing, and safe base within which each detail of the children's lives can be carefully thought about and understood. Sellers et al. (2020, p. 136) highlighted that 'for children in residential care, safety and supportive relationships, particularly with direct care staff, are critical to recovery, growth, and development'. These relationships and attention to detail provide an opportunity within the work of the therapeutic community to reach an enhanced understanding of self-harm, which could help clarify the potential meaning of this behaviour, influencing how it might be responded to. This has implications for informing future placements and preparation for adolescence.

Self-harm has been described as a means of seeking attention (Klineberg et al., 2013), expressing traumatic experiences (Inckle, 2010), and a self-punishing or self-soothing method (Murray, 2003). The various approaches in the literature led to the question of whether such inconsistencies in understanding self-harm would be reflected at Fairview, exploring whether there was a consistently shared definition of the term used to identify self-harm, as well as how children were supported with this behaviour.

Method

This study employed a sequential exploratory design using mixed methods (Robson & McCartan, 2016), initially collecting quantitative data which then

informed the collection of the qualitative data. This met both university and organisational ethical requirements. To gain an initial understanding of reported self-harming behaviour, quantitative data was collected and analysed from recorded incidents of self-harm between October 2019 and March 2020. This included any acts or attempted behaviours which caused or had the potential to cause physical harm, as well as suspected self-harm where the behaviour was not directly witnessed.

This recorded data is exclusively informed by the serious incident and physical intervention reports, where the children's actions are categorised into 'hard measures actions', such as self-harm or physical aggression. Staff record these by ticking relevant hard measures boxes when completing these reports. The frequency of recorded incidents involving self-harm, type of self-harm, antecedents to self-harm and staff response were collected. Evidence of self-harming behaviour being noted but not recorded within the hard measures data was collected for the same time period, for example in children's daily records or within the text of serious incident reports where the hard measure action was not ticked.

This study was focused on Fairview, but professional discussions with all four directors of each community within the organisation were conducted to gain context and an overview of practice.

Qualitative data was then collected through semi-structured interviews with members of the therapeutic care team at Fairview. This was designed to explore staff experiences of witnessing, recording, and managing self-harm. Sixteen therapeutic care staff were invited to participate in these semi-structured interviews. Initially, three staff members volunteered; one therapeutic care worker, one deputy team leader, and one team leader. Senior management were included to provide a purposive stratified sample of four participants spanning the hierarchy of staff. The four interviews were audio recorded and lasted for 30-40 minutes. Interviews were transcribed and a thematic analysis was conducted, guided by the phased method described by Braun and Clarke (2006), where the data was coded, patterns identified, and themes generated and named.

Results and analysis

Quantitative data: Incidents of self-harm

Hard measure actions recorded within serious incident and physical intervention reports between October 2019 and March 2020 were collected to ascertain the prevalence of recorded self-harming behaviour (see Figure 1). Self-harm had a lower rate of being recorded than physical aggression. It may be that physical aggression was more prevalent or that the definition of physical aggression was more consistently understood than that of self-harm.

	Hard Measure Actions					
Month	**Physical Aggression**	**Serious Damage to Property**	**Self-Harm**	**Sexual Behaviour**	**Offsite without permission**	**Other**
Oct-19	1	0	0	0	1	1
Nov-19	8	2	1	1	2	1
Dec-19	1	1	0	0	0	0
Jan-20	19	7	6	0	0	2
Feb-20	6	1	1	0	0	0
Mar-20	11	2	10	0	1	0
Total	46	13	18	1	4	4

(Note: 'Other' – involved verbally abusive/disruptive behaviour

Figure 1: Recorded hard measure actions between October 19-March 20

There were 18 incidents reported as having involved self-harming behaviour, most commonly featuring head banging/hitting (28%), biting (19%) and hair pulling (16%).

Evidence of self-harming behaviour being noted but not recorded within hard measures data was also explored. A further 23 incidents involving self-harming behaviour were found. It was noted that further exploration as to why these were not recorded would be included within the interviews with staff. Head banging/hitting (31%), biting (16%) and pulling hair (10%) again featured most prominently, with the addition of suspected/attempted self-harm (13%) where self-harming behaviour was noted but not directly witnessed.

With incidents where self-harm was officially recorded, 94% were recorded by staff who had been working within Fairview for over six months, and 6% by newer staff who had been employed for less than six months. Within the documents where self-harm was not officially recorded, 57% were recorded by staff who had been working at Fairview for over six months, and 43% by newer staff who had been employed for less than six months. This raised the question of whether newer staff have less clarity around where and when self-harming behaviour should be recorded.

Context from professional discussions

Professional discussions with directors of each of the four residential communities within the organisation provided context and an overview of practice regarding which behaviours were classed as self-harm in training or recording systems. All four communities had children/young people self-harming to the extent that hospital treatment was required. The method of training varied between communities. At Fairview, external training was utilised, with this last occurring several years previously. There is no mandatory requirement for this training, which is employed as a precautionary measure to improve practice.

A common method across all communities was to record self-harm within serious incident or physical intervention reports, within the child/young person's daily records and in the accident book. Fairview exclusively utilised body map books, where the location of the self-harm was monitored.

Qualitative data: Semi-structured interviews

Data trends

Semi-structured interviews were designed to explore staff experiences of witnessing, recording and managing self-harm. Participants were asked the same set of questions featuring scenarios to allow comparison of opinion. All participants agreed brief self-biting, putting a cloth bag over their head and running into a road were examples of self-harm. Running into the road and

putting a cloth bag over their head were not included in the hard measures data within the quantitative analysis.

Many of the physical actions of self-harm raised by participants were consistent with those identified within the quantitative data. Participants also highlighted the broader spectrum of behaviour extending to suspected, indirect or attempted self-harm.

Thematic analysis

Following the phased method of thematic analysis described by Braun and Clarke (2006), six main themes were identified (see Figure 2 for thematic map of analysis).

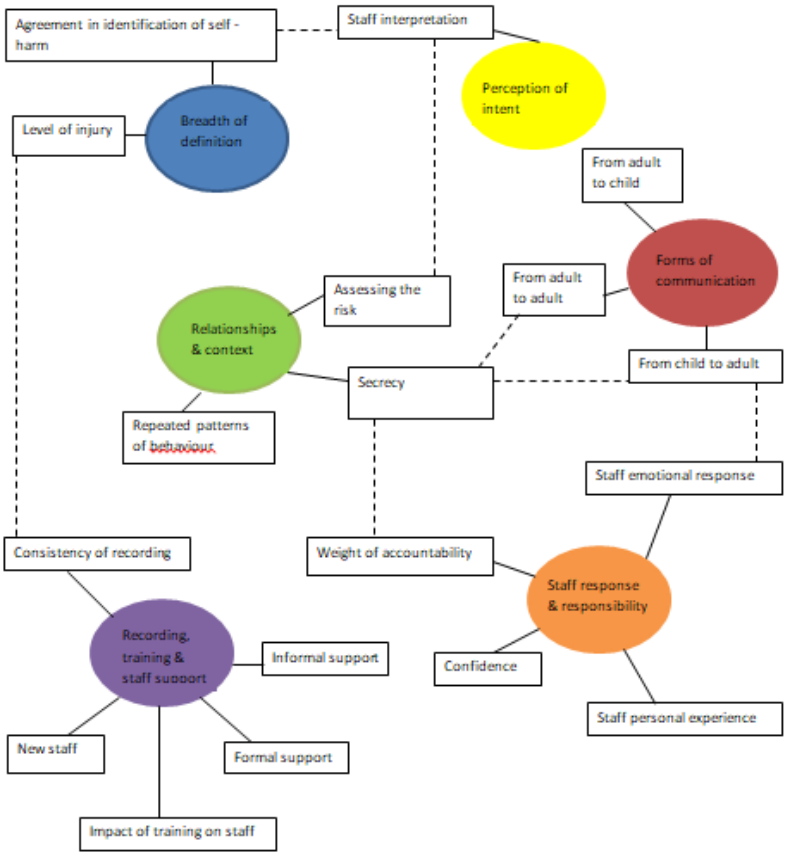

Figure 2: Thematic Map

I. Breadth of definition

All participants talked in terms of the scale of injury caused when identifying a behaviour as self-harm, describing this as *'low'* or '*moderate'* level, indicating a subjective breadth of definition. Many of the physical behaviours evident within the quantitative analysis, such as hair pulling, were reported by interviewees. By looking at this quantitative analysis alone, these behaviours may appear 'low' level. However, when behaviours were described by staff a more violent image of attack is often evident. For example '*I've seen children who have used sharp objects to scratch massive gouges out of themselves'* or '*pulling their own hair, clumps out as well, I mean really wrapping their fingers around it, pulling it out as much as they can'.*

Communicating the intensity of self-harming behaviours appeared important to participants, with evidence of staff attempting to categorise the scale of these behaviours: '*there are possibly things that do get missed slightly. Especially, if it's not something that you would class as major self-harm'*. Here the definition of self-harm appeared to be based upon subjective staff interpretation. Attempts have been made by clinicians to construct scales of self-harm based upon severity of injury. This may help when medically treating an individual, however within a therapeutic environment it might be suggested that all forms of self-harm should be viewed with equal caution irrespective of the physical damage caused, due to the potential significance of this communication in itself. In accordance with this, one participant commented, '*it's not about the injury is it, it's about what's going on inside of them and in their minds'*. Participants agreed that brief behaviours should be regarded as self-harm. One participant commented, '*even if it's for a few seconds, one word takes a few seconds and one word can communicate a thousand things as well'.* If this perspective is not shared by staff, it could lead to inconsistencies in defining and identifying self-harm.

The word 'risk' was used by three participants, and there was shared opinion that the behaviour did not need to have caused physical injury to be defined as self-harm, with the potential for harm being an indicating factor. This was concurrent with the quantitative data, where attempting to jump from a height

was reported as self-harm. Participants agreed that running into the road should be classed as self-harm, however, this was at odds with the quantitative data where this was not recorded.

One participant spoke about '*just not looking after yourself',* specifically the omission of a behaviour, such as not using eczema creams resulting in sore skin. This idea of defining self-harm by omission featured within the literature (Hunter, 2011) but was absent from the quantitative data.

Suspected self-harm was referred to by all participants. Knowing the individual child was seen to be important, as by having an understanding of the child's history or their patterns of behaviour it felt possible to attribute behaviour not witnessed or seemingly benign behaviours to self-harm. For example, a child purposefully falling off their bike or a child going into their bedroom and then appearing with bruises. This behaviour was absent from the recorded incidents of self-harm in the quantitative analysis. Long et al. (2013, p. 106) state that 'types of self-harm may present in various ways and hold multiple meaning for each individual who enacts the behaviour', highlighting how much of a challenge staff face in consistently identifying and defining self-harm.

II. Staff perception of intent

Three participants described how children had been verbally explicit about their intent alongside their behaviour. This might allow for these behaviours to be defined and identified as self-harm by staff. For example, '*biting herself and kind of trying to cut herself with bits of broken DVDs and she's always saying that she hates her life and she doesn't deserve to live*', or '*that child will tell you that they want to die before doing it*' (running into the road). These details of what children say whilst they are harming themselves cannot be derived from the quantitative data alone, but when this information is viewed alongside it, we are able to gain some insight into staff interpretation of the child's intent. Many of the deliberate physical behaviours within recorded incidents of self-harm featured biting or scratching, which is consistent with the above description from the participant. However, running into the road was not recorded as self-harm in the quantitative data, which implies a discrepancy in staff interpretations of a

child's intent to harm themselves in this situation. This again highlights the complexity of identifying self-harm.

James and Stewart (2018) discussed the ambiguity in interpreting intent, reporting that some practitioners would determine an individual's suicidal intent based on what they told them. Others felt that those who did not disclose their feelings were more likely to be suicidal. In our interview one participant stated '*it's almost like if they do tell you, they are actually asking you for help. It's when they don't tell you, it's more of a worry*'. James and Stewart (2018) concluded that intent can be unclear and may change during a single incident.

One participant referred to the behaviour as being '*a real impulsive feeling within them that they have no idea how to communicate*', which might suggest that the intent of the child might not necessarily be to harm themselves in that moment. This participant highlighted how these responses might be triggered by something unconscious related to past trauma, like sound or smell. Another participant spoke about how children are often unable to put words to this: '*I don't think they can actually name exactly why they do it. Or what even release they get from it after they've done it or how they feel afterwards'*. This can often be the case if the trauma occurred at a preverbal stage. Schore (2002) described how early trauma can directly impact an infant's brain development and ability to process emotions. One participant articulated this link as follows: '*the child's traumatic upbringing has an impact on their functioning'* and they *'resort to self-harm as a way of communicating'.* Another participant linked bruising to the child's internal state of mind, '*it was all to do with the fragile state of mind and if everything was great the bruises went and if there was a lot going on they got more'*. This highlights the depth of thinking within the therapeutic work around the child and how this can provide valuable insights. Interestingly, self-bruising was absent from recorded incidents of self-harm, which might further indicate a challenge in maintaining a consistent collective definition.

III. Relationships and context

All participants stated their relationship with the child was important when identifying self-harm and noticing repeated behaviours. One participant stated that '*CHILD last year, scheduled his own death date and then he this year around the same time he attempted to jump off the bannister to hurt himself*'. This highlights the quality of staff paying attention to and remembering details, as well as the importance of handing these over to newer staff who have not yet had the opportunity to forge such relationships.

Three participants spoke about the importance of holding the child's history in mind. One participant stated that someone '*might just think it's because they're clumsy or something like that, as opposed to knowing their history and knowing that it is self-harm'*. Long et al. (2013, p. 108) support this viewpoint, claiming 'if self-harm is to be understood in all its complexity it must be considered holistically in the context of a person's life'.

Secrecy was raised by two participants, wherein '*sometimes it can be happening right under your nose and you not even know it'.* Some children were suspected of self-harming, as staff did not directly witness the behaviour but noticed bruises: '*we don't quite know where the bruises come from but that when she went to bed she didn't have them*'. Within the relationships children build with the staff at Fairview there is an opportunity for these details to be noticed and carefully thought about. Similarly staff spoke about needing to pay close attention to environmental factors, for example '*her bed was broken and it was in such a place that unless you moved the mattress you wouldn't have seen it'* (referring to a child bruising herself against furniture). Storey et al. (2005, p. 72) revealed how young people reported incidences of intentionally harming themselves during childhood that they had 'successfully disguised as accidents', thereby highlighting the need for close attention from an early age.

All participants commented on using their relationship with the child to assess the context of their behaviour and the potential risk. One participant stated, '*if it's repeated behaviour you know the risks a little bit more and how far they are going to push it*'. Participants also considered the risk to the child if they

intervened. For example, one senior participant said, '*it's their release and if it's a safe release then it's better that they do it that way'.* Different contexts were associated with different risks, highlighting how many variables are components to assessing self-harm. Cahill and Rakow (2012, p. 407) reported that how people predict self-harm risk in terms of 'low', 'moderate' and 'high' varies both between contexts and within the same context. This implies there could be great potential for ambiguity if discussions around these variables as a staff team do not occur.

IV. Forms of communication

Within all interviews it was clear that self-harming behaviour initiated significant communication from both children and adults.

i) Child to adult

All participants agreed that self-harm represented a significant communication from the child. Gardner (2001, p. 149) commented that 'attacking the body is both a symptom and a symbolic action, and like both symptoms and symbols needs to be 'read''. However, there was some variance regarding how this communication was perceived.

One participant spoke about '*self-harm as a way of communicating their stress and trauma*'. Two participants spoke about self-harm being a '*release*' or '*relief*'. There was some discrepancy around this, as the behaviour was also referred to as communicating an element of manipulation, '*a threat and that they can do it if they want to*' or 'i*t is effectively to get your attention*'. Rasmussen et al. (2016, p. 178) found evidence of motives from adolescents wanting attention, but the motive of wanting 'relief from a terrible state of mind' was most commonly reported. They found that multiple motives are often present simultaneously. This implies that multiple communications may be attributed to an act of self-harm, depending upon which resonate most with staff.

The way children communicate via self-harm was not always in an openly aggressive manner. One participant extended this to the use of 'physical ailments', stating that '*it says more about their state of mind and their need for*

care'. This might also be applicable to the act of a child putting objects in their ears, present within both interviews and the quantitative data. It may be debatable whether the child was aware of the potential damage they might cause to their ears, possibly focusing more on a goal of experiencing medical care in hospital. Hunter (2001) commented that there is often a discrepancy between intent to harm and the degree of actual harm caused in individuals with limited medical knowledge.

As an underlying principle of the work at Fairview, it was expected that participants would refer to being attuned with the unconscious. One senior participant referred to '*projections*' from children and stated '*you just get filled with such panic'.* There was also some less direct evidence of this, with two other participants describing feeling '*rubbish*' and '*useless*'. Nathan (2004) shared his experience in psychoanalytic terms, as containing intolerable feelings projected by self-harming patients.

Two participants made reference to children self-harming as a result of not being able to communicate their feelings or not feeling heard. One participant commented '*when I picture a child self-harming I almost picture a big cross of tape across their mouth, that it's like they just cannot get out whatever is inside'*. This idea is shared by Gardner (2001, p. 20): 'it is as if the attack on the body becomes the only way to communicate deep distress, which both at the time it was experienced and at the time it re-emerges, cannot be put into words'. McAndrew and Warne (2005) described women's experience of not feeling heard and resorting to self-harm to communicate their frustration. The feeling of not being heard appears to be reflected within the wider literature, where the majority of research focuses on adolescents rather than on younger children such as those at Fairview.

ii) Adult to child

One participant commented that '*there are different ways of intervening'* which was apparent within both interviews and the quantitative data. This is important to pay attention to as Johnson et al. (2017) highlighted that the response from caregivers can be pivotal in either easing or perpetuating a cycle of self-harm.

All participants spoke about the value of talking with the child and acknowledging their behaviour. Piggot et al. (2004, p. 47) reported how young people in residential care described the most helpful support as when staff 'took time to talk and find out about the young person who self-harmed'. Gardner (2001) posits that this may begin to role model the value in using words to replace wounds.

Within the quantitative data and the interviews, it is clear that on occasion it is necessary for staff to physically intervene to ensure the safety of the child. Staff have MAPA (Management of Actual or Potential Aggression) training in safe and age-appropriate physical intervention. This training was directly referenced by one senior participant, while another described an alternative way of physically intervening: '*do you need a cuddle? That's really important, especially with some of the younger children that we've got at the moment, that tends to be the thing that they're actually craving after self-harming'.*

Participants spoke about the possibility of ignoring behaviour or using distraction techniques to avoid escalation. This was not a shared opinion amongst all participants however: '*I wouldn't ignore the behaviour, I would acknowledge it, I think that's really important'*. This highlights how staff response is tailored to the individual child, and no response can be prescribed for all contexts. Inckle (2010, p. 161) supports this, stating 'responses to self-injury need to be equally multifaceted and developed in collaboration with the individual'.

iii) Adult to adult

All participants raised how self-harm initiated communication between adults. One participant shared how they worked with a colleague to helpfully approach the child. One senior participant also described role-modelling a response to a colleague: '*reassure them that you feel that it's safe to take a step back and just observe and not intervene'.* There was also evidence of staff discussions about self-harm within their smaller teams. There was agreement regarding the accessibility of reflective groups, with senior staff being '*very available',* and the value of supervision. These details were not obvious from the quantitative data, but there is consistent emphasis within the literature on the value of colleague

support. Wilstrand et al. (2007) described nurses working with self-harming individuals as reporting value in feeling supported by co-workers. However, there was also a consistent opinion within the current study that '*it's not spoken about enough'.*

V. Staff response and responsibility

There was some variance in staff members' emotional responses to self-harm. Three participants described how it felt '*really disturbing', 'distressing',* and *'heart-breaking'.* One senior participant described witnessing the response of other staff members: '*you can see their anxieties rising',* sharing how they felt '*a bit desensitized'* and could '*rationally detach from it'*. It might be that this is a reflection of staff experience. Gardner (2001, p. 8) suggests 'such feelings do not necessarily go away with familiarity, but over time they can become blunted and so easier to handle'.

Two participants expressed the responsibility associated with caring for children who self-harm. One commented '*there's always a bit of disappointment in yourself in that moment that you've not managed to catch something before they feel like they have to get to that point'.* Another participant spoke of feeling unable to '*switch off*', stating that '*you've got to live with it if the worst happened and you couldn't prevent it'.* Both these participants shared that they had personal experiences with self-harm and '*what it can put you in touch with*', highlighting the sensitivity of the topic and how personal experience can influence staff response to self-harming behaviours.

Furthermore, Smith (2002, p. 599) reported that care-workers felt anxious about patients self-injuring, which 'resulted in staff and patients feeling that they were unable to talk about the subject'. All participants in the current project voiced how they felt self-harm was not spoken about enough: '*it's a bit taboo and so it's just something that you don't really concentrate on',* and '*because it's such a hard subject to think about, how easy it is to forget about it'.*

VI. Recording, training and staff support

All participants reported feeling clear about where self-harm was recorded, but with the suggestion of needing a '*more solid system in place*' to improve consistency. This might go towards explaining some of the variance between the quantitative data and interviews. For example, all participants agreed that a child running into the road should be recorded as self-harm, but this was absent from recorded incidents in the quantitative data. Several recording systems were described as useful: incident reports, accident books and daily records. Body map books were regarded by all participants as valuable in documenting suspected self-harm and identifying patterns of behaviour. However, not all children have a body map book, with these being generated when the need arises. Consistent with the aforementioned potential fluidity in intent, Wadman et al. (2017, p. 401) stressed 'young people in care should undergo regular monitoring and assessment of each self-harm episode'.

All participants agreed that the incident example where a child bit herself and pulled her hair should be recorded as self-harm. This was consistent with the quantitative analysis of recorded incidents as these particular behaviours were two of the most commonly recorded. In response to the question of why the hard measure action self-harm was not ticked for this example, one participant wondered whether it had been recorded elsewhere. Three participants linked this to individual staff interpretation, such as '*different people's definition of what self-harm is*'. Two participants spoke about the pressures of working on shift meaning '*things do get missed, but not intentionally*'. One of these participants spoke about reliving the traumatising experience of the incident and being '*shut off to where it's happened*' which can impact report writing. These examples highlight the need for a consistent method of recording that is understood by staff, alongside acknowledging the strain felt with respect to completing paperwork following incidents.

With regards to staff support, all participants were clear about formal support systems, mentioning supervision and group forums. There was shared agreement that '*there's enough support around'*. Smith (2002, p. 599) echoes this sentiment, reporting that when working with self-injury 'supervision was

thought to be essential, as was peer group support and working as a team'. Despite these structures being in place, three participants recognised that self-harm was not often a topic of discussion. One participant commented '*we know that we've got these forums where we can talk, but acknowledging these feelings, I guess this is the hardest part'.* Two participants commented positively on the availability of colleagues for more informal support. Perhaps due to the highly sensitive nature of this topic, these conversations on a one-to-one basis felt more comfortable.

Although all participants commented they had not received self-harm training for some time, they agreed it was useful and expressed a desire for further training. Research has shown that supporting staff to work through their discomfort and explore self-harming behaviour ignites a willingness to learn. Samuelsson and Asberg (2002, p. 120) described how training in suicide prevention for nursing personnel 'stimulated a growth in awareness that makes it reasonable for them to seek further information', which is encouraging. Although training appeared to be highly regarded within Fairview, one participant commented '*I guess even if you were trained up to your eyeballs in that moment, do you follow that? Or do you just go with your gut?*' This highlights how it is not possible to be prescriptive when training staff around self-harm, with the complexity of each situation depending on multiple variables, meaning staff are required to further draw upon their experience and relationship with the child involved.

The benefit of training was reiterated by another participant, suggesting '*having a refresher maybe every year and that would kind of help us with our practice and maybe passing on our practice to the new members of staff*'. All participants spoke about the potential difficulties for newer staff in identifying self-harm: '*where we've got new staff and that if people don't know about it, they don't notice it*', as well as recording it: '*there's a situation where we don't pass on the knowledge of this being recorded and the need of this being recorded'.* This top-down influence of senior staff was supported by Brown and Kimball (2013, p. 205): 'if supervisors understand self-harm and assessment and treatment protocols, then supervisees may be more attentive to those issues as they arise'.

Conclusion

Through pulling the quantitative and qualitative data together throughout this study, and alongside the informing literature, the wide variance in defining self-harm is clear. This, combined with the variance in semantics used in the taxonomy of self-harm, makes understanding it more challenging. The terms 'risk', 'intent' and 'level' can have different meanings to different individuals and may vary between children and contexts, or even within the same context. Such fluidity in definition and terms can make self-harm a challenging subject to understand. This is compounded by the idea that self-harm is often seen as a taboo subject, uncomfortable to look at or discuss.

It was an intention of this study to compose a definition of self-harm in relation to what this means within the therapeutic residential setting of Fairview. As with the nature of the management of this behaviour, it can be concluded that there is no quick fix in answering this, with the answer ultimately being found within the therapeutic relationship with the child. Self-harming behaviour within Fairview is well held by a network of people working together to support the children, so it is hoped that as a community by opening up a conversation about self-harm, we may be able to reach consistency and enhanced understanding. As such, the success of this study would be best measured not through the achievement of reaching a specific definition, but rather through the successful implementation of discussion groups across all roles.

Clinicians have attempted to categorise self-harm, and although this may have value in a medical setting when treating injuries, it arguably has limited use in a therapeutic environment, where there is value in thinking about the communication behind each behaviour. Furthermore, it would not be helpful for children to become categorised as 'self-harmers' as this would risk this behaviour being perceived by the child as an intrinsic part of them that is difficult to separate from. Instead, in line with the fluid nature of the definition, a fluid approach to self-harm is advised, based on the relationship with the child, an awareness of its possible existence, and staff being prepared and informed with regards to how to notice and respond.

The child's repeated experience of a care-giver's response to their self-harm can shape their future behaviour (Johnson et al., 2017). It could be argued that this also applies to the therapeutic care staff looking after them. Through repeated exposure to formal training, it is hoped that staff would have increased confidence in voicing their feelings around self-harm. This would complement the individual supervision and support from colleagues that was rated so highly within interviews.

Limitations and future work

This study was limited to a small scale where four participants were interviewed, and thereby cannot be viewed as representative of the entire staff population. Attempts were made to gain a broader perspective by interviewing a stratified sample of participants with varying experience. This was combined with professional discussions with directors from each therapeutic community and an analysis of quantitative data. This mixed methods approach provided rich data which can be built upon in future work.

This project set inclusion criteria for participants having been employed for over six months, inviting staff with experience working with children who self-harmed. The importance of the relationship with the child and understanding their history has been given great weight within this study, so future work could explore with newer staff how they could be supported with this.

Further work might also adopt the approach employed by McAndrew and Warne (2014), seeking views of adolescents around their self-harm and the usefulness of support. This approach for the younger age group at Fairview would need to be sensitively managed, but Curtis et al. (2004) have illustrated how children as young as four were able to respond meaningfully regarding their experiences of a health provision. This might also explore how it feels to be a child witnessing a peer self-harm, as well as providing children with the opportunity to have a voice, where they often feel unheard. Latif et al. (2017, p. 192) advocated for this 'bottom up' approach, allowing children to inform us about useful strategies.

Implications

This study has instigated discussions within Fairview regarding self-harm being integrated within MAPA training, added to the internal iST training course, as well as the need for a clear recording system.

Recommendations for future practice include self-harm becoming an agenda item within post-incident reviews to promote discussion and identify human error in recording hard measures data. A focus group was held as part of the dissemination process of this study within which the value of including self-harm in the new staff induction and the new staff Foundation Course was discussed. This would provide new staff with an introduction to the prevalence of self-harm and an explanation of how this is recorded, as well as offering details of emotional support available. It is hoped that in the longer-term further consideration of this topic may contribute to discussions around the broader implications of how self-harm is defined within other therapeutic communities, both within and outside of this organisation, as well as other residential care provisions or fostering services.

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