Title:

Discovering one's own way: Adolescent girls' different pathways *into* and *out* of self-harm

Keywords:

adolescence, mental health/ psychopathology, identity issues, peers/friends, qualitative methods, suicide.

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Discovering one's own way: Adolescent girls' different pathways *into* and *out* of self-harm

Abstract

Self-harm is associated with mental illness and suicide risk. The present study aims to increase knowledge of adolescent girls' pathways into and out of self-harm. 19 girls, 13-18 years of age. Participants were strategically selected from an outpatient care unit. A naturalistic multiple case-study with personal interviews. The interviews were analyzed using Interpretative Phenomenological Analysis, and capacity for "mentalization" – representation of behavior in terms of mental states – was measured with the Reflective Functioning Scale. Analysis of the topic "beginning self-harm" resulted in two meta-themes: (a) beginning self-harm as a way to handle difficult feelings and relational problems, and (b) becoming influenced by peers to experiment with self-harm. Analysis of the topic "quitting self-harm" resulted in three meta-themes: (a) ambivalence towards help, treatment, and ending self-harm; (b) finding one's own way of quitting self-harm; and (c) exploring self-harm together with the therapist. Three case-stories illustrate variations in trajectories of change and capacity for mentalization. Findings suggest that self-harm may be a way of handling developmental challenges in autonomy and identity formation during adolescence. Adolescents need an opportunity to discover their own way of quitting self-harm. Variations in mentalization may provide for different pathways.

Keywords: adolescence, mental health/psychopathology, identity issues, peers/friends, qualitative methods, suicide.

Discovering one's own way: Adolescents' different pathways *into* and *out* of self-harm

Self-harm has received increased attention in many countries. "Self-harm" refers to "intentional self-poisoning or self-injury, irrespective of type of motive or extent of suicidal intent" (Hawton, Saunders, & O'Connor, 2012, p. 2374). There is an ongoing discussion of the definition of self-harm – including or excluding suicidal intent. Despite this disagreement on definition, studies show that self-harm usually starts in adolescence (approximately 12-13 years of age; Whitlock & Selekman, 2014). Cutting is the most common method used by both genders but hitting and scratching are also prevalent.

The estimated prevalence of self-harm depends on the definition used, but ranges from 13-17% in nonclinical adolescent populations to 40-60% among inpatient adolescent samples (Swannell, Martin, Page, Hasking, & St. John, 2014). Self-harm is more common among girls than boys during early adolescence (12-15 years of age; Swannell et al., 2014). Morgan and colleagues (2017) reported that the annual incidence of self-harm was higher in girls (37.4 per 10,000) compared to boys (12.3 per 10,000), and between 2011 and 2014 self-harm increased 68% among girls aged 13-16 (from 45.9 to 77 per 10,000). Given these statistics, we need more knowledge on how self-harm becomes part of a young person's life, particularly among girls, during the *transitional phase* of adolescence. A qualitative research method offers an option to explore adolescents' inner world, how the idea of self-harm is related to life challenges, and differences among youths, which may complement context-independent data from quantitative studies.

The function of self-harm

An urgent question is: How can we understand self-harming behavior? Different theoretical models have been proposed to understand the function of self-harm (see Soyemoto, 1998). In a review of empirical research on self-harm among adults and adolescents, Klonsky (2007) found converging support for self-harm as "an affect-regulation

function.” He described self-harm as a way of managing overwhelming negative emotions and, at the same time, getting relief and control. Because most reviews on self-harm focus on adults and often exclude qualitative studies of subjective experience, Stänicke, Haavind, & Gullestad (2018) conducted a meta-synthesis on qualitative studies of adolescents’ (12-18 years of age) firsthand experience of self-harm in clinical and non-clinical populations. This analysis resulted in four meta-themes: Adolescents experience self-harm as a way 1) to obtain release, 2) to control difficult feelings, 3) to represent unaccepted feelings, and 4) to connect with others. The meta-themes support self-harm as a function of affect-regulation but emphasize how self-harm may contain important emotional and relational “messages”. Stänicke and colleagues (2018) discuss the findings in regard to developmental challenges during adolescence, which is a transitional life-period, including cognitive, biological, psychological, and social changes. We argue that self-harm may be a destructive solution to a developmental conflict between a need to express affective experiences *and* a relational need for care that makes it important not to bother caregivers.

Risk factors and the beginning of self-harm

Studies have identified numerous risk factors (socio-demographic factors, negative life events, psychosocial stressors and psychological factors) for self-harm (Larkin, Blasi, & Arensman, 2014). Self-harm is associated with several mental disorders and, in the worst case, risk of death (Hawton et al., 2012). Sinclair and Green (2005) found in a qualitative study that adult persons with a history of self-harm retrospectively associated beginning to self-harm with unpredictability, lack of control, and chaos in their family. Ending self-harm was related to less family-conflict. In personal interviews, young people also underline how emotional problems, such as psychological pain and anger (Abrahms & Gordon, 2003), and trauma or conflict involving their family and friends can influence, elicit, and sustain self-harming during adolescence (McAndrew & Warne, 2014; Evans & Hurrell, 2016). These

findings were supported by a study by Wadman and colleagues (2018) who underline how adolescents experience family, friends and clinical services *both* as possible stressors to begin self-harm and as important support to end self-harm. We propose that knowledge of ways *into* and *out* of self-harm should be analyzed in relation to developmental psychological challenges in the transformation from childhood to adulthood, such as identity formation (Erikson, 1980; Siegel, 2015) and autonomy (Gullestad, 1993).

Treatment methods and the diversity among adolescents who self-harm

Different treatment methods – like cognitive behavior therapy, dialectic behavior treatment, and mentalization behavior treatment – have been shown to reduce self-harm, depression, and suicidal ideation among adults and adolescents. However, more research for effective interventions for adolescent and children is needed (Saunders & Smith, 2016; Hawton et al., 2015) because although some of the treatment methods are adjusted for adolescents, they are primarily developed for adult patients – often with borderline personality disorder. Further, no single treatment method is able to help every self-harming adolescent, who often struggles with motivation for treatment or drops out of treatment. Furthermore, self-harm is carried out once by some, but repeatedly and extensively by others. Therefore, we need more knowledge to understand the relationship between adolescent self-harm and (a) the meaning invested in this behavior, (b) the mental health challenges related to self-harm, and (c) what is perceived as helpful for the patient in coping with these difficulties (Hawton et al., 2012). Even though some studies on adolescents' experience of self-harm exist, a multiple case-study offers a systematic way to explore girls' different ways *into* and *out* of self-harm.

Concerning treatment and the question of what helps, young adults who self-harm emphasize the importance of being understood (Brown & Kimball, 2012). Adult patients underline poor communication and a lack of knowledge of self-harm in clinical treatment

services (Taylor, Hawton, Fortune, & Kapur, 2009). When adolescents engage in self-harming behavior, it can be difficult for parents, peers, therapists, and hospital staff to understand, and either overwhelming feelings or lack of empathy is not uncommon (Johnsen, Ferguson, & Copley, 2017). To better enable adolescents to feel understood, and presumably increase motivation for treatment, knowledge from their perspective is important.

In several treatment models, self-harm is regarded as a consequence of biological vulnerability and a lack of emotional validation in early relationships (Saunders & Smith, 2016). Consequently, the child may be overwhelmed by emotional difficulties without sufficient problem-solving strategies and “act out” intolerable affect and psychic content by harming. In the theory of mentalization, the quality of the caregivers’ way of *talking* and *being with* the child when experiencing difficult emotions is essential for the development of a capacity for affect-regulation *and* for mentalization – to represent behavior in terms of mental states (Rossouw & Fonagy, 2012). To regulate affect and to represent behavior in terms of mental states is critical for developing an integrated and coherent self-experience and self-organization. To increase our knowledge on the trajectories of self-harm, we need to study differences in emotional problems, interpersonal stressors, and inspirations to begin self-harm. In this regard, youths’ ways into and out of self-harm warrant investigation in relation to their capacity for mentalization.

The aim of the study

We present results from a naturalistic qualitative study of self-harm among adolescents (13-18 years of age) in an outpatient unit. The aim of this study was to explore girls’ experiences of beginning and quitting self-harm, and more specifically, of how self-harm became part of their life and development. The research questions were: (a) How do young girls experience the beginning of self-harm and how was it related to challenges in their life? (b) How do young girls describe finding a way out of self-harm? Do they

experience treatment helpful for quitting self-harm (independent of treatment method)? By highlighting three young girls' narratives about the ways into an out of self-harm, we present the diversity in adolescents experience *and* explore differences in terms of level of coherence, integration and capacity of mentalization.

Method

Study Setting and Participants

The study was conducted at an outpatient clinic for children and youth in Norway, offering treatment (free of charge) for mental health challenges to children 0-18 years of age. Patients were asked to participate if their therapist documented self-harm (impulsive or repetitive, with or without suicide intention) during the initial clinical assessment or in the six months after starting treatment. Exclusion criteria were comprehensive psychosis or high suicidal risk. A total of 33 patients were invited within nine months, and 21 consented to participate.

Although we invited both girls and boys to participate, only two boys accepted; four were invited. To increase sample homogeneity, we chose to focus only on girls in the data analysis. The final sample consisted of 19 girls (13-18 years of age, mean = 15.9 years; see Appendix A for description of participants). The principal reasons for being referred to the clinic were suspicion of depression (some with suicidal thoughts or an attempt), self-harm, and eating disorder. All 19 participants self-harmed through cutting, although 15 participants also used other methods, such as scratching or burning. On average, the participants started to harm themselves at 13.1 years of age with a frequency of approximately 1-3 times per week. All participants confirmed thoughts of suicide, and eight had an earlier suicide attempt, three of whom had an attempt during treatment. The participants' primary diagnoses were mood disorders (n=13), anxiety (n=3), eating disorders (n=2), and schizophrenia (n=1). Most (n=14) had more than one diagnosis. Thirteen participants met criteria for one or more

personality disorders, mostly avoidant, borderline, and depressive type. During the project, three participants withdrew because they moved. They confirmed that the data from the interviews still could be used in the project.

Therapists and therapy. The therapists were five clinical psychologists (three women, two men) and one psychiatrist (woman). All but one had more than ten years of experience in clinical practice with adolescents. They had from one to six participants in the study, and represented different theoretical and methodological orientations, such as cognitive, integrative, and psychodynamic therapy. On average, the participants had 35.4 individual treatment sessions, 4.0 family sessions, and 3.7 sessions with their parent(s) during a treatment period of 20.2 months. On three occasions, the principal investigator informed a participant's therapist about suicidal thoughts in order to ensure sufficient intervention. Apart from that reporting, the principal investigator had no role in the treatment process.

Interviews and Measures

Personal interviews. The adolescents participated in a qualitative in-depth interview, called the *Life-mode Interview* (Haavind, 2019), in which the interviewer invites the informant to describe events from the day before the interview, what they did and who was present. Participants told about their self-harm practices and experiences while describing other activities related to be a young girl who attended school and had family and friends. The girls were invited to explore and reflect upon their self-harming in their every-day life context together with a reflexive listener, and this focus was useful to obtain adolescents' cooperation and to evoke their personal experiences. The interviewer asked specifically about concrete experiences of self-harm (e.g. when self-harm occurred, when it started, and if there were patterns of change). The interviewer asked about feelings and thoughts as well as prospects for the future.

Semi-structured interviews. We included some semi-structured interviews to describe our sample – young girls referred to a clinic for mental health challenges – such as the frequency and methods of self-harm in the last year (*Linehan Parasuicide History*, LPH; Linehan & Comtois, 1996), symptom disorders (*International Neuropsychiatric Interview*, MINI; Sheehan et al., 1998), personality disorder (*Structured Interview for DSM-IV Personality*, SIDP-IV; Pfohl, Blum, & Zimmerman, 1997), and attachment (*Transition to Adulthood Attachment Interview*, TAAI; Crittenden, 2005; a modified version of the *Adult Attachment Interview*; George, Kaplan, & Main, 1985). In the TAAI, the adolescent is asked to describe and reflect upon important relationships, every-day routines, separation, trauma, rejection and loss. The *Reflective Functioning (RF) Scale* (Fonagy, Steele, Steele, & Target, 1998) is an operationalization of mentalizing capacity based on the autobiographical memories. The TAAI was used to rate RF as a measure of an ability to understand mental states on a scale from -1 (negative RF; a systematic resistance to a reflective stance) to 9 (exceptional RF; complex reflections). In a non-clinical population, an RF score of 5 is the common rating (Fonagy et al., 1998). We did not score attachment patterns from the TAAI.

Procedure

After each participant consented to the study, the first author conducted two Life-mode interviews with a week in between, followed by the MINI, SIDP-IV and LPH, and the fourth author did the TAAI, in a 1-month period. Thereafter, the first author met each participant together with their therapist to give feedback about preliminary findings. All participants received a gift card (worth approximately \$20 USD). After one year (regardless of whether they were still in treatment), the first author met the participants for a follow up qualitative interview and the LPH to get access to information about change. Qualitative interviews and the TAAI were audio-recorded and transcribed. Both the first and third author scored all of the TAAIs. Concerning inter-rater reliability, the two coders rated the same RF-

score on twelve of seventeen interviews. There was a difference of one RF-score on the remaining five interviews, e.g. one of the coders rated RF 2 and the other rated RF 3. Two informants did not complete the TAAI.

Ethics. The Norwegian Regional Committees for Medical and Health Research Ethics approved the study. Participants and their parents (when they were under 16 years old) received written and oral information from their therapist and the first author. All received treatment regardless of study participation. Adults with experience of self-harm read the interview-guide and the manuscript for quality assurance. Importantly, the first author is a trained clinician and familiar with the clinic and was thus able to provide the adolescents with support in times of heightened risk, such as when experiencing thoughts of suicide. Participants read and approved all selected quotes.

Data-Analysis

This multiple case-study (McLeod, 2010) had a qualitative research design allowing for personal explorations of the participants' perspectives. The data analysis was guided by *Interpretative Phenomenological Analysis* (IPA) developed by Smith (2015), which is theoretically rooted in phenomenology, hermeneutics, and ideography. In IPA, there is an explicit aim to explore the participant's perspective, experience and constructions ("hermeneutic") of their world. The researcher aims to suspend and be reflexive of previous assumptions and understanding of the phenomenon to apprehend the participant's descriptions accurately (Smith, 2015). Further, the researcher aims to engage and make sense (interpretation) of how the person understands (interprets) his or her own experience ("double hermeneutic"; Smith, 2015).

Informed by IPA, it was of importance during the interviews that the interviewer (the first author) articulated her understanding (empathically and by questions) of the participants' experiences, and the informants could confirm, correct or explore. At the completion of each

interview, the interviewer, to enhance reflexivity (Levitt, Pomerville, & Surace, 2016), noted non-verbal communication, feelings, and associations. Further, while reading the transcribed interviews during the data analysis, the interviewer and two senior researchers (second and fourth author) were especially attentive, to the descriptions and semantics of the participant's experience and self-understanding. Further, we were attuned to the mental processes (*viz.*, emotional, cognitive, linguistic and physiological) related to the participants' meaning making. Therefore, we studied the convergences, divergences, and patterns in the participants' descriptions and their ways of making meaning of their experiences *and* other participants'. The analysis process can be described as "the hermeneutic circle" – interpretation of data involves looking at the part and the whole and back again (Smith, 2015). During the interviews and data analysis, we had to be reflexive of the preconceptions of the topic from clinical and developmental psychology, based on training in psychodynamic and integrative therapy, and as women in Western culture.

We followed an IPA quality evaluation guide (Smith, 2015) to enhance the quality of data-analysis and presentation of results. The data-analysis consisted of several phases, primarily conducted by the primary author yet discussed and nuanced by the research team. Firstly, the first author read each interview to identify preliminary codes and repeating ideas. Secondly, two senior researchers (second and fourth author) read ten personal interviews and made individual notes before they met the principal investigator to analyze case by case.

The interviewer's interpretation of the participants' experiences and way of making meaning (double hermeneutic) were reflected upon. The researchers checked whether their team members' interpretations of the text were plausible, understandable and overlapping or different from other team members' (research triangulation; Flick, 2002). Research triangulation was of great importance to increase validity and reflexivity in the data-analysis since the interviewer also had the role of the principle investigator. The team members draw

on somewhat different theoretical and methodological perspectives, which helped us to become self-reflective and aware of different ways of reading the data (Lewitt et al., 2016).

Thirdly, reading and discussing the interviews made the team aware of some surprising tendencies. Even though the girls had often been referred to the clinic because of self-harm, none of them experienced self-harm as the problem that motivated them for treatment. Actually, many of them had lived with self-harm as a personal and secret routine for several years as a rescue from a difficult world. The way they described their life and problems varied – some were clearly articulated, while others had difficulty expressing and differentiating thoughts and feelings. Further, the girls' ways out of self-harm were more indirectly than directly related to treatment experiences. In light of these tendencies, we explored similarities and differences in two topics, “beginning self-harm” and “quitting self-harm”. We decided that the next step would be to analyze the selected topics in all interviews.

Fourthly, the first author sorted all qualitative interviews (from the beginning of treatment and follow up after 1 year) in relation to selected topics, organized the content into nodes, sub-themes, themes, and meta-themes, and selected quotes to ensure transparency. For example, most participants described how they managed to end self-harm in the follow up interviews, but some ended self-harm right after starting in treatment, and these descriptions are also included. In several consensus meetings, we continued to discuss multiple interpretations, which ended in agreement (all three agreed) or became integrated into nuances of the material (one or two disagreed), such as renaming, rearranging, adding or merging themes or sub-themes to enhance trustworthiness (researchers and methodological integrity checks; Levitt et al., 2016). The concepts were developed closely with the girls' descriptions (Smith, 2015).

Results

The analysis of two selected topics – beginning and quitting self-harm – resulted in two meta-themes about moving *into* self-harm and three meta-themes about moving *out* of self-harm. Each meta-theme included several themes and sub-themes (see Appendix B). In the following, we present each meta-theme and associated themes with an indication of the frequency of experiences among the participants (Hill et al., 2005): (a) *Most* – result based on data from 15 participants or more; (b) *Many* – based on 10 to 14 participants; (c) *Some* – based on 5 to 9 participants; and (d) *A few* – based on 5 or fewer participants. The sub-themes will not be addressed separately in the text, but both themes and sub-themes are enumerated in Appendix B. This overview outlines common features across a selection of cases as well as variations to the extent that each person will appear as a specific composition.

In the following, we will present three cases – named Anna, Elsa and Sophie – as distinctly different from each other throughout the meta-themes (Appendix C). By selecting and following such a limited number of persons, each participant was given a full portrait and the variations between them captured some divergent points in the data. Further, the excerpts from these cases are rich in details and their affective stance can be interpreted fairly easily. In the end, overall RF scores for Anna, Elsa and Sophie from the TAAI, and examples are presented to show differences in how the participants represent, nuance, and integrate behavior in terms of mental states. However, the RF ratings for these three are not necessarily representative of every participant who described the mentioned themes and sub-themes.

First Selected Topic: Beginning Self-harm

First meta-theme: beginning self-harm as a way to handle difficult feelings and relational problems. Most of the participants highlighted difficult feelings and negative thoughts about themselves as the main reasons for beginning self-harm. In addition, some underlined other mental problems (such as an eating disorder), and most described difficult

relationships with their mother or traumatic family events which made it difficult to ask for help. Many were disappointed with the lack of practical and emotional support from their fathers, and many did not know their fathers at all. Only a few had a close friend, and many related self-harming to interpersonal problems with peers, including peer expectations to be best, pretty, and clever. Some did not know why they began to harm themselves.

“I’m disgusting and worthless”. Anna was 17 years old, had cut herself with razor blades since she was 12 – daily during the first years and twice per month during the last year. Anna began to harm herself during a period when she felt depressed, had negative thoughts about herself, and felt disgusting: “I know how it is to really have a bad time ... to feel totally down. I struggled with depression all through secondary school. I started to self-harm, I experimented, because I felt disgusting”. Her feelings changed suddenly: “I just changed from being very angry to extremely sad, and then very happy, and then sad again”. Anna was dissatisfied with her body: “I didn’t like my body and I wanted to give myself pain because I was how I was”. Although she felt that her mother wanted to help and felt close to her father, it felt unnatural for her to talk to them about problems. She thought they had enough problems after their divorce. Anna also related her self-harm to episodes of being bullied in childhood: “My thoughts about myself were confirmed as true, that I didn’t deserve to live or have a good time... They said I was worthless, and I thought I was worthless”.

“I just did it. I don’t know why”. Elsa, 16 years old, started to harm herself three years ago, mainly by cutting or scratching 1-7 times per week. She experienced the transition to secondary school as difficult. She began to eat less and harmed herself. In the interview, it was difficult for her to say whether she had problems, what kind of problems, or whether self-harm was related to something in her life. Her description of her problems was diffuse: “I don’t know – I don’t really feel very much – in general”. However, sometimes she felt “kind of bad.” Because she had “a nice family and good friends and – nothing traumatic has

happened,” she did not understand “why [she] started in the first place.” Even though there had been “a lot of troubles” in her family, Elsa could not imagine that this was the reason. While describing her relationship with her mother as close, she still could not ask for help – she did not want to be a worry. Elsa did not think her father understood her problems: “We aren’t close. He travels a lot.” Elsa had one friend, but they did not talk about problems.

“It was my exit”. Sophie, 18 years of age, started to cut herself when she was 11, approximately once a month, because of depressive feelings and unstable emotions: “I don’t want to wake up.” Her feelings could change swiftly. She connected her difficulties to her mother’s struggle with depressive periods, psychotic symptoms, and suicide attempts: “... and every time my mother became ... I was stressed and all the time I thought of being careful of what I could say to her or not and how I behaved. And I was so depressed.” Being angry with her mother was impossible: “I was very angry at her as a little girl, but then she got ill – psychotic, she was hospitalized for several periods ... Two years ago, she tried to kill herself.” Despite feeling deeply alone, Sophie pretended to be happy: “I went out, and then I was THE super happy girl, in a way. I was the clown in my class. But when I got home, I went to my room, and just ... yelled and cried.” Losing interest in friends, she got involved with older adolescents or adults, which included risky behavior:

Sophie: It [self-harm] became my exit ... Because I did several f*** things at the time. I went to school, and then I came back home at 1 o’clock at night... Every day I stole – not because I needed anything, but because it was fun. I went to bars and I smoked weed – I had sex with strangers. I was a real slut. That sort of thing... I did EVERYTHING. Drugs, you name it.

Second meta-theme: becoming influenced by peers or media to experiment with self-harm. Some of the participants heard about self-harm from friends, and some read about self-harm in the newspaper, on the internet, or through social media channels. Some discovered self-harm coincidentally, and a few did not know how they got the idea.

“Someone else did it.” Anna heard about self-harming from friends: “I did it because I heard about it from someone, in a way.” In the beginning, it did not feel helpful, just painful, but she decided to continue and hoped it could help her as well.

“I read about it on the internet.” Elsa saw pictures and read about self-harm and mental illness on different blogs on the internet:

Elsa: I saw some pictures on Facebook or – someone talked about it on social media. Then I started to think about it, and then ... I saw someone had done it ... I couldn't understand why anyone could do it ... Then I just did it.

Elsa got the idea of cutting herself while making food. If someone noticed, she thought, she could say she cut herself with the knife. She also heard about self-harm from her friend: “She told me that her mother had discovered her self-harming. Then I got a strong urge to try it out myself. I don't know why. I just had to try it.”

“If it helps others, it may help me”. Sophie heard about self-harm from other girls:

Sophie: I knew for certain – I realized it could help, in a way. I thought ... I was TOTALLY down, in a way, I was – I was SICK at the time. So, I thought, if SO many who are SO depressed do it, then it has to help in one way or another.

Second Selected Topic: Quitting Self-harm

First meta-theme: ambivalence towards help, treatment and ending self-harm.

None of the participants mentioned a wish for help in ending self-harm as a reason for beginning treatment. Some were referred to the clinic because someone else (usually their mother) discovered their self-harm (self-cutting and/or suicidal thoughts or attempts), some were referred for other reasons, and a few decided on their own to seek help. Initially, many thought treatments could not be helpful, and some had earlier negative treatment experiences. While in treatment, many were ambivalent about ending self-harm. However, they decided to end self-harming due to the negative consequences. Some felt obliged to end self-harm.

“I want to be independent.” In the months before Anna started in treatment, she decided on her own to stop self-harming: “I don't think people understand how much energy

you have to use, because you become exhausted – it's an addiction. It's something you have to keep yourself from". Afterwards, she was left without methods for managing stress: "You have to find other actions to fill the empty space every time you want to harm yourself (...) the feeling or the thoughts don't disappear before you do the action." She had excessive suicidal thoughts and attempted to die by suicide:

Anna: Everything was so shit... I did not want to be me, because I'm so tragic and really deserve to die, and then I decided to kill myself because I do not want to live like this. I took an overdose and my mom found me after 6 hours and she took me to the doctor.

The self-cutting and suicide attempt were related to difficult feelings and negative self-thoughts: "It was because of the thoughts of being hopeless and worthless, being a disgusting person – and not having a future". Anna did not think treatment could help her: "I do think I need help but I'm not responsive ... because being independent and managing things by myself is so important to me."

"I don't want to be a burden." Elsa was referred to the clinic because her mother discovered scars on her arms and got worried: "My mother discovered my self-harming, and then she sent me here." However, Elsa herself did not have a wish to end her self-harm: "It's so strange – I wanted to continue, in a way." Although being worried about whether she deserved help, Elsa realized that she enjoyed talking to the therapist. She was ambivalent about ending her self-harm – she did not want to hurt or disappoint her mother, but ending self-harm left her with a feeling of doing something wrong: "So – it's just – it's so strange, but it's like – to manage ... makes me proud, in a way ... Still, I feel I have done something wrong." When Elsa managed to quit self-harming, she began to eat less and/or exercise harder.

"When I have bad times, I don't want to get better." The last year before Sophie was referred to the clinic, her mother was depressed, and one day, she found her mother after a suicide attempt. Sophie was frightened, overwhelmed, and heard voices for the first time: "I

got psychosis. I started to hear voices... We had meetings with child custody, and they referred me to the clinic." Her wish to die increased, and she was admitted to a psychiatric hospital for several weeks. During this hospital stay, she was placed in a care-home. She was happy to finally get help, but she also thought it was a waste of time:

Sophie: To be at the hospital or here at the clinic, it was nice but still – I felt it was a little waste of time and... I'm kind of an agnostic, I don't really believe in it, but I'm open to try, in a way.

She was ambivalent and her wish for help vanished when she was troubled: "When I have bad times, I don't want to get better. Then I just want to die". Sophie knew her problems in childhood had been visible to other adults. Thinking about this today made Sophie disappointed:

Sophie: I remember – when I was 12 years old, I was involved in some problems, and then they began to talk about self-harm. They drove me home and asked me if I thought about suicide. So, I said yes. They said: Do you want to talk to someone about it? And I said yes. I remember they said: Well, then we have to get you help. But it never happened.

Sophie wanted to quit self-harm, mostly because she did not want to have scars:

Sophie: I have a hard time, in a way, but ... I don't always cut myself. Because it's like – I try NOT to do it, in a way ... Because it's – I feel very awkward when people ask, in a way ... Or like NOW for example ... it's like 77 Fahrenheit and I have to wear a hoody ... No, it's horrible.

Further, two earlier suicide attempts made her afraid of the potentially fatal consequences of self-harm. Still, she felt addicted to self-harm: "It's like a drug, in a way – people use it to escape, and you don't think about your problems anymore. You get a kind of drug-feeling."

Second meta-theme: finding one's own way of quitting self-harm. Most of the participants quit self-harm during the project period. Most of them found it helpful to distract themselves from overwhelming thoughts and feelings by doing an activity. Some emphasized the benefits of positive thinking; some tried to remember the negative consequences of self-harm; and a few attended to difficult feelings or thoughts in the moment.

“I delay my self-harming.” For Anna, it was helpful to do something for a while, often by herself in her room: “I can listen to music, very loud, or I look at Facebook just to keep myself busy.” Supporting herself through an inner monologue, she was able to delay the impulse to self-harm: “I know myself ... this is temporary. The urge goes away. I delay the self-harming. So, I think: yes, I will harm myself, but first I have to do my homework.”

“Exhausting exercises.” Elsa also described different helpful activities – to knit, to draw, listen to music or to read a book: “I always have a book with me”. After a year in treatment, many things were changed in Elsa’s life; she had moved and started at a new school. She did not want to harm herself anymore. She did not want to disappoint her mother and emphasized her help: “She helped me in a way, I think. She asked if I was doing okay and such.” Furthermore, Elsa had started to practice kick boxing several times a week and kept herself busy in general: “I have a long day at school, so I’m too exhausted to think about it”. She discovered how much she appreciated being with her family:

Elsa: If I want my mother’s help, or I just want to talk to her about how my day was, I can go to her. I don’t need to talk about the difficulties, but it is nice to know that someone is there.

In addition, it was easier for her to contact her friends while being troubled – to talk or just be together.

“Be with someone.” Initially, Sophie described it as helpful to be with someone, see a movie, play games, or sleep if she had a hard time, but she could not *explicitly* ask someone to be with her. After a year in treatment, Sophie moved to a more permanent home with sufficient support. She also began taking medication, and of most importance in her opinion, she got a cat:

Sophie: It’s a big difference. Because if I’m sad I can cuddle with it and if I’m worried it will come and lay down beside me. There’s so much comfort in it. Earlier, in such situations, I would have been thinking: Should I cut myself? And now it’s more like: No, I cuddle with the cat instead! Every depressed person should have a cat.

Sophie did not decide to quit self-harming: "It just BECAME like that." She recognized she could resist the impulse to harm herself, to drink so much, or have sex with strangers. Additionally, she could call her mother and ask her to come:

Sophie: Now, we do have a nice time together. Earlier I was very angry at my mom, but now – we never argue ... It's more stable. If I'm sad, she may sleep over. I can push her to be up late and watch TV (smiling).

If she had suicidal thoughts, she could even call her doctor:

Sophie: Last week I woke up and just ... fuck life, in a way. It was really bad, and then I called my doctor and asked: What should I do? So, I went to her. She always prioritizes me and gives me the help I need. I have a really good doctor.

Third meta-theme: exploring self-harm together with the therapist. Most of the participants felt treatment was helpful. Some underlined the positive meetings with the therapist, and many described the benefit of talking openly for the first time. Some described the experience of meeting someone who understood their problems, and some emphasized the therapist as a supervisor helping them to cope in difficult situations. Some described how therapy affected their relations in a positive way, and some highlighted how treatment helped them to reduce self-harm. Two participants described treatment as not helpful – not that they had become worse, but they felt that their problems had not changed.

"To get help to remember and find triggers." Anna valued how her therapist listened carefully and tried to understand: "He has a very good memory! So, I feel like, he is like a tape recorder – remembers things, reminds me ... he helps me without me thinking of it – he helps me to help myself if you understand?" Anna also emphasized the therapist's support in exploring thoughts and feelings:

Anna: He is very clever to find the triggers. He said: Yes, but this situation sounds like the same situation you described last summer ... I was thinking: last summer! (laughing). Yes, you reacted in very much the same way, talked in the same way, and you were angry ... And I thought: Wow! What happened? Yes, the same thing – I was dumped by a boy both times!

Furthermore, Anna cherished concrete support in difficult situations and noticed how talking in therapy affected her way of talking to her parents. Although Anna did not experience a direct focus on reducing self-harm, she knew her therapist did not approve of it.

After one year in treatment, Anna thought treatment indirectly helped her to end self-harming by focusing on her tendency to act unsupportively towards herself: "I have always been hard on myself, and I have tried to notice and stop it. If I had continued, I wouldn't get anywhere." Moreover, she motivated herself to end her self-harm by thinking of the therapy, the negative consequences of self-harm (e.g., scars), and the pain of her parents. She still felt that it was difficult to trust her friends. However, Anna described how she – presumably because of therapy – talked supportively to herself in difficult situations to delay self-harm:

Anna: Even if I'm frustrated and sad, and I want to send a message to tell them what I feel and to end the friendship, I say to myself: You will regret this tomorrow, because she (her friend) has been supportive many times. Don't send the message. Think twice. Wait until tomorrow. And the day after I don't feel the same. I delay, and my brain begins to function again (laughing) ... I did not have this possibility earlier. I only had feelings, and now it's in a way: feelings-stop-think-action. It's wonderful!

Anna expressed an optimistic attitude towards the future:

Anna: Compared to EARLIER – I'm more optimistic. I thought I didn't have a future because I was me. But now I think I have opportunities; I just have to find them. I'm not the problem, but my attitude. I'm not STUPID. I can contribute intellectually or in society IF I find something that interests me. I do HAVE a future, but I don't know which one.

"To begin to talk and to get help to understand." Elsa stressed the importance of beginning to talk to someone about her private feelings, thoughts and problems: "In general, to talk to someone ... it has been useful ... talk about it and – discuss it and try to find out ... I have not been talking to anyone about it before." She underlined the support in reaching an understanding of problematic situations:

Elsa: I liked to get an explanation for why I acted in this way, my reasons in a way, and that it was not just ME. It helped ... made it easier and more concrete ... there was so much stress in my family ... everyone was influenced by it, especially my mom. She had so many responsibilities, and you did not want to be another burden.

However, Elsa found it difficult to say whether treatment had helped her: "It's not a big difference, but in general – to speak with someone – maybe – it has been useful ... clearly it made it easier to talk to others." She experienced that her therapist focused explicitly on reducing self-harm by motivating her to test specific coping strategies – for example to breathe in a difficult situation or to use rubber band: "Yes – it's not taboo using a rubber band around my wrist. It's helping." Still, she did not find the exercises so helpful and wished for more dialogue with her therapist. After one year, treatment was completed. She did not remember being motivated to test different coping strategies. Actually, she wished she had received more specific suggestions for activities to do as a distraction: "I found a solution by myself, so it was okay. Still, it was... maybe ... it might have been better if ... we had talked about how I could manage it in a better way if I felt bad." Elsa had a concrete plan for the future: "I had a dream of becoming a doctor since I was a little girl... I love anatomy! ... And if I want something – I want it REALLY bad. It's the way I am."

"To feel welcome and to be respected." Sophie emphasized how she enjoyed being at the clinic – feeling welcome and respected: "It's cozy and nice, actually, to be here". The therapist made her feel safe from the start: "It was strange. I'm not a person who speaks openly to other people ... but this was another kind of relationship than I have with my friends and family. It was not SO bad. It was easier." Still, she felt the therapist wanted her to quit self-harming, and it was difficult for her because of her own ambivalence. She did not think she could manage to reach this goal:

Sophie: To work with... it demands other methods to distract you. I'm not that kind of person: OK, now I go for a walk instead. I'm more like ... When I'm sad, I'm determined to do ONE thing, or else I lose it. I'm in a bubble!

After a year in treatment, Sophie thought treatment had helped, but it was hard for her to say how: "Lately, I have just felt a little better." She had started in group therapy, and appreciated meeting other people with the same problems:

Sophie: I meet other people who can feel the same as me... We talk about things that happen now, or if something difficult has happened the last days. If I tell one of my friends how I feel, they don't understand, because they have not had these kinds of difficulties.

Sophie noticed that she spent more time at home, and she did not drink as much as before. However, it was still hard for her to think about the future: "It's the thoughts about the future ... what I can do or not. I don't know – I'm so tired. I cannot imagine handling a job or going to school or anything".

Reflective Functioning

On average, the participants scored 2.7 on the RF scale (range: 1-5). There was diversity in the participants' capacity of reflective functioning, which will be illustrated here in three selected cases. While Anna showed nearly an ordinary capacity to represent her own and others' behavior in mental states, like thoughts, feelings or fantasies, Elsa's capacity was low and showed an avoidant tendency, and Sophie's capacity was also weak, and she seemed easily overwhelmed.

More specifically, Anna's RF score was 4 (*Ordinary RF*). She has some ability to understand her own and others' behavior in terms of mental states.

Interviewer: "To which parent did you feel the closest as a child?"

Anna: "It was actually my dad ... Because I've always been daddy's girl and I felt more attached to him. Yet ... I think it felt kind of hopeless to be emotionally It was just daddy – I was daddy's girl".

Interviewer: "Why do you think you felt closest to him?"

Anna: "I don't know really. I haven't thought about it. I just remember that I used to shout for daddy and not mummy when I was crying ... Maybe I just felt a bit safer together with daddy. (RF 3)

Throughout the interview, she shows some awareness of the nature of mental states and also recognizes developmental aspects of mental states. At the same time, her reflections vary, and are often general, as shown in the example above. In sum, her model of mind is not coherent enough to warrant a total scoring of RF 5.

Elsa's RF score was 1 (*Lacking in RF*; 1A disavowal). RF is totally absent in this interview. Interviewer: "So how do you think your childhood experiences have affected your personality today?" Elsa: "I don't know... I don't know how things would have been WITHOUT my childhood. It's hard to imagine" (RF 1). Elsa does not mention mental states of herself or others despite the opportunity to do so. However, her understanding of others' minds is not accompanied by hostility.

Sophie's RF score was 2 (*Questionable or low RF*). She has some mental state language without concrete examples. Interviewer: "You have told me about a lot of chaos and your family moving from place to place. How do you think your experiences have affected your personality?" Sophie: "It's a lot of stress. I'm not able to settle down anywhere. Like the place I live now – I don't know – I feel like something's going to happen. I feel like I will – kind of – move away soon anyway" (RF 2). Sophie's understanding of mental states is often vague and general, and she has several examples of absent RF. Moreover, she describes traumatic events in a neutral and distanced language. The diversity in reflective functioning among these three girls will be discussed as a possible contribution to understand the different pathways into and out of self-harm.

Discussion

The present multiple case-study highlights how girls, from their own perspective, began self-harming to handle emotional and relational problems. The results confirm existing knowledge of self-harm by underlining self-harm as a transdiagnostic symptom (Hawton et al., 2012) closely related to difficulty with affect-regulation (Klonsky, 2007) and experienced problems in the interpersonal context (Sinclair & Green, 2005; Wadman et al., 2018). However, the results nuance earlier findings by highlighting girls' struggle to express difficult feelings, and ambivalence towards help and treatment, even if they valued exploring self-harm in therapy. Moreover, most of them were influenced by peers and media to

experiment with self-harm and emphasized discovering their *own* way of quitting self-harm.

In the following, we propose that self-harm in adolescence should be related to developmental psychological challenges: encountering emotional turmoil, changing relationships with parents and peers, identity-formation, and autonomy. Further, we discuss whether differences in *how* they represent and integrate pathways of self-harm indicate diversities in capacity for mentalization and may indicate different resources to cope with developmental challenges and to end self-harm.

Self-harm and Developmental Psychological Challenges during Adolescence

The beginning of self-harm as a way to handle emotional and interpersonal problems. While many of the participants said their parents perceived self-harm as the main problem for which they needed treatment, the girls themselves did not experience self-harm as a problem they wanted to end or as a reason for getting help. Rather, they viewed self-harm as a way of solving emotional and relational problems (McAndrew & Wrane, 2014), confirming self-harm as an important way to regulate difficult affect (Klonsky, 2007; Abrahms & Gordon, 2003). The results indicate that it is important to explore what self-harm is related to in the adolescent's own view. In the earlier mentioned meta-synthesis, self-harm is highlighted as a way to get relief from and control of emotional difficulties, but also as an attempt to *represent* and *share* experiences that are not possible to communicate in another way (Stänicke et al., 2018). What emerges most clearly in our results, are problems in expressing difficult feelings and thoughts in the relationship with their parents, as well as in establishing close friendships with other girls, and having suffered from repeated bullying.

The lack of congruency between the girls' and their parents' perspectives of the problem is also interesting in relation to developmental issues. In adolescence, parents are still important for emotional and practical support, but adolescents also need to find their own way of solving problems and to establish a sense of agency and autonomy. Interestingly,

many girls knew their mother was worried (and for some, their father too) and cared for them, but they felt unable to turn to them for help. Often, they were afraid to make their mother worried or sad and felt their mother was occupied with personal difficulties, and felt their father was distant or out of reach. From this perspective, self-harm may be an attempt to be “self-sufficient.” This “solution,” reflecting a lack of ability to share the challenges of becoming a woman in the relationship with their parents, may unfortunately inhibit and disturb further development of autonomy and relational reciprocity.

As a continuation of Erikson's developmental theory, Blatt (2008) proposes that throughout life all people confront two fundamental psychological challenges: (a) to establish and maintain reciprocal and personally satisfying interpersonal relationships and (b) to establish and maintain a coherent, realistic, differentiated, integrated, essentially positive sense of self. Blatt accentuated how biological predispositions and markedly disruptive experiences can disturb this normal dialectic developmental process, resulting in an overly heavy emphasis on one of these two developmental dimensions at the expense of the other. The girls in our study had few strategies for being with others or maintaining a positive coherent sense of self during bad times. Self-harm may be a way to handle problems by themselves, or a tendency for introjection in an attempt to be independent. Still, they are in need of comfort and support. Thus, they struggle in their developmental quest for autonomy.

The role of friends, peers, social media, and culture. The girls highlighted difficulties with friends, lasting suffering from bullying, and social isolation. Further, they underlined being influenced by friends to begin harming themselves. We know from epidemiological studies that exposure to self-harm among family and friends is associated with self-harm (Liu et al., 2017). Interestingly, even the girls who were bullied searched for a way out of problems by looking at their peers. These results point to the importance of renegotiating relationships to peers during adolescence, representing a source not only for

inspiration in the process of exploring social roles and developing a confidence in their emerging identity as women, but also for non-adaptive problem-solving.

Moreover, the girls were influenced to begin self-harming by Internet blogs and websites. Some studies indicate that repeated online exposure to self-harm may be associated with self-harm among some adolescents (Liu et al., 2017). In adolescence – when peers become the main source of information – social media may become an extension of the sphere of peers. Adolescents search online for information to handle problems, to share and communicate distress, and to find a community (Swannell et al., 2014). However, going online is not, in itself, associated with increased self-harm. In a meta-analysis, Marchant and colleagues (2017) found both negative influences of internet use on self-harm, such as normalization, triggering, competition, and contagion, as well as positive influences, such as crisis support, reduction of isolation, therapy, and outreach. For lonely girls, the internet may become an arena for exploration of identity as well as for coping and reducing isolation. However, the internet can provide access to information, which can lower the threshold to self-harm.

The importance of finding their own way out of self-harm. The participants were ambivalent toward ending their self-harm and obtaining help and treatment. They often viewed self-harm as an effective way of coping with problems, but at the same time, did not want to have scars that others could see and often felt obliged to quit because their caregivers were worried. Thus, we might characterize the adolescents' reasons for ending self-harm as *externally* motivated. Interestingly, the girls did not relate their way out of self-harm to the helpful elements in treatment. Rather, they emphasized how they found their *own* way out of self-harm: Anna delayed self-harm; Elsa did exhausting exercises; and Sophie got a cat. Elsa, in her first interview, described how her therapist explicitly focused on exercises to handle self-harm, but in the second interview she said she wished there had been a direct focus on

coping activities. Perhaps the experience of discovering their own way out of self-harm can be understood as the girls' attempt to separate and to develop a sense of autonomy. They are, so to speak, "inventing the wheel by themselves." This may indicate that self-harm is closely related to the development of self-agency, autonomy, and identity.

Despite their ambivalence, most of the participants found treatment meaningful and helpful. They appreciated the encounters with the therapist – getting help to begin talking openly and having their experiences sorted and validated. Some wanted to share and explore their problems, others wanted advice for handling difficult situations, and many underlined the importance of making sense of their problems. These helpful elements support knowledge from prior therapy research (Binder et al., 2011). The fact that the participants related ending self-harm to their own discovery of distracting activities does not mean that ending self-harm is not related to therapy at all. This is simply the adolescent's description. One possible interpretation of this finding is that the girls found their own way as a result of being supported by a sufficiently positive therapeutic relationship. The therapist may have an important role by giving developmental support in exploring difficult feelings, thoughts and situations, while not being too close or too distant, relational qualities that may have been lacking or insufficient in the girls' primary relationships.

Differences in the Capacity for Mentalization

Despite the similarities among the participants' symptoms of self-harm, there are differences in *how* they represent and integrate their problems, behavior, and affective experiences (Fonagy et al., 1998, 2002). Anna, Elsa, and Sophie were rated as RF 4, 1, and 2, respectively. How do the differences in the capacity for mentalization relate to different ways in and out of self-harm? Even though Anna, Elsa, and Sophie related the beginning of their self-harm to emotional problems, Anna spoke about her problems in a clearly articulated way and experienced her worries as part of herself and could talk about her negative self-image

("I'm worthless"). Anna tended to internalize problems (self-oriented) and had a generally reflective mode. She seemed informed by her actions, thoughts, and feelings. Elsa and Sophie had more difficulties in verbalizing the nuances of their problems. Elsa generally struggled to find words to describe her feelings ("I don't know what I feel"). She had problems representing behavior and mental states (non-elaborating), had a non-reflective mode characterized by disavowal, and was surprised by her own actions. Elsa and Sophie both described their problems in terms of a mental illness ("I got an eating disorder", "I was depressed... I got psychosis"). Sophie tended to externalize problems and described trauma in a neutral voice.

How they related to a basic affect, such as anger, also differed between the three of them. Anna was angry at *herself*; Elsa did *not feel* anything; and Sophie was angry at *everyone*. Furthermore, the three girls related self-harm to interpersonal problems but represented their relational problems differently. In difficult situations, Anna perceived her negative thoughts and feelings about herself as the truth and believed everyone else felt the same way about her. Elsa struggled to represent self-experiences and easily adopted others' descriptions of her. Sophie experienced herself as unpredictable and had problems imagining others' perceptions.

Thus, the girls' different levels of RF and their ability to represent and integrate their mental problems seemed related to different ways into self-harm. Could RF also be related to different ways *out* of self-harm? Although Anna, Elsa, and Sophie tried to find new ways to distract themselves in order to cope with difficult thoughts, feelings, and the urge to self-harm, their *way* of coping seemed different. Anna developed a *self-supportive* monologue, acting as a delay of self-harm, indirectly influenced by the ongoing help from the therapist with sorting out difficult situations. Elsa felt it was best not to think about problems and to just stay busy and occupied but emphasized the benefit of *beginning to talk* about problems

with the therapist. Sophie discovered the possibility of *asking for help*, as well as obtaining medication, care, support, and respect. We can also see differences among the girls' plans and fantasies about the future. After one year in treatment, Anna could look forward towards a future. It seemed like she had started to fight for herself instead of against herself. Elsa had a concrete plan and was quite sure she would fulfill her project. Maybe she had found a way to express energy. In contrast, Sophie was not sure of anything. However, she had started to accept her vulnerability and dependency. Her anger against everyone may have had a protective function. It seems plausible that what the three girls experienced as helpful in therapy was related to their capacities for mentalization, i.e. sorting difficult situations (Anna), sharing experiences and trying coping-strategies (Elsa), and being respected and receiving practical support (Sophie). These three cases may illustrate how different ways of representing, integrating and coping with problems to end self-harm indicate a diversity in capacity for mentalization. The cases also may express important nuances in affect-integration (Bouchard & Lecours, 2008; Solbakken, Hansen, & Monsen, 2011) and organization of self (Fonagy et al, 2002; Clarkin, Yeomans, & Kernberg, 2007). In this way, self-harming girls do not constitute a uniform group.

Clinical implications

From our perspective, self-harm represents an opportunity to express unacknowledged feelings or self-states that are impossible to express verbally, and therefore have to be expressed concretely through actions. Psychotherapy may create a possibility for translating body language into more direct ways of expressing one's needs and feelings. Findings from this study may enhance parents' and clinicians' understanding of adolescents' different ways in and out of self-harm, thus helping them to validate the youths' experience of what self-harm is related to in their life. Treatment interventions should focus on emotional *and* interpersonal problems. Effective treatment requires that clinicians pay attention to

adolescents' way of speaking about self-harm – how they represent and integrate their affective experiences. Validating the youths' own perspective of their difficulties, and especially in expressing and sharing problems with words, could make them feel understood, may build alliance and prevent drop out. The therapist should validate the struggle to find motivation for ending self-harm when the behavior is experienced as an existential rescue. Therapists should offer the patient who exhibits self-harming behavior an opportunity to explore and discover their own way of coping. In sum, the results underline the importance of meeting the young girls' needs for autonomy *and* sufficient support – by not being too close or too distant.

Future Research

Future research is needed to clarify the relationships between helpful elements in treatment of self-harm and capacity for mentalization. Girls were over-represented among our participants, and further explorations of young girls' and boys' experiences of self-harm and self-experience might add nuances to current knowledge. It could be interesting to study sub-groups among adolescents who self-harm by combining personal data with diagnostic categories. Until now, studies on sub-groups have primarily focused on epidemiological methods, mostly adults, and different self-harm methods and diagnoses.

Limitations

This qualitative study enhances knowledge of young girls' experience of self-harm in a clinical context, which may limit the generalization of findings to girls in a community sample, and boys and adults in general. Although the participants represented a range of socio-economic status and ethnic backgrounds in Norway, the findings may not be representative for young persons in other countries and with different cultural backgrounds. However, the concepts and findings from this study may be theoretically generalized and relevant to other samples by further nuancing the pathways of self-harm.

The opportunity to reflect upon their life situation and problems may have had an effect on their treatment process in increasing self-reflections. It should be noted, though, that most of the interviews are from the beginning of treatment. When being asked in the end of the project, the participants appreciated the opportunity to talk to a third person. The principle investigator of this study and the interviewer were the same person, which may have influenced the analysis of the data. We included member checking, reflexive journaling, and feedback to the participants to minimize these potential limitations. Our findings can supply knowledge on self-harm with quantitative methods and thus enhance knowledge on the subjective perspectives of living with self-harm.

Conclusion

This multiple case study supports earlier findings on self-harm and shows how adolescent girls use self-harm as a strategy for handling emotional and relational difficulties. The results from this study highlight how adolescents express ambivalence about ending their self-harm but still appreciate exploring their self-harm together with a therapist. Most importantly, the young girls need to discover their own way to quit self-harming, thus illustrating the developmental significance of establishing autonomy and a separate identity. Further, self-harming girls do not constitute a uniform group. Important variations in capacity for mentalization, ability to represent and integrate problems, difficult feelings and self-experience may lead to different pathways into and out of self-harm as well as inform useful treatment adjustments – exploration, problem-solving, or practical support. Further studies on sub-groups of self-harm are needed to understand these differences more thoroughly.

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Appendix A

Description of participants (n=19)

Sample characteristics	n	Mean	Range
Age (years)	19	15.9	13-18
Age self-harm started (years)	19	13.1	9-15
Reflective function	17	2.7	1-5
Sessions at the clinic			
Youth alone	19	35.4	9-89
Family together		4.0	0-14
One or both parents		3.7	0-16
Treatment period (months)	19	20.2	6-44
Frequency of self-harm when entering therapy	Regular and habitual	Seldom and exceptional	
	4-7 times/ week: 2	1 time/ month: 3	
	1-3 times/ week: 8	2-4 times/ year: 1	
	2-3 times/ month: 4	2-4 times total: 1	
Methods of self-harm	Cutting: 19	Suicide attempts: 9	
	Cutting only: 3	One time: 3	
	Scratching: 6	Two times: 5	
	Alcohol: 5	Four times: 1	
	Hitting: 4		
	Burning: 4		
	Pain killers: 4		
	Piercing the skin: 3		
	Sex: 3		
	Drugs: 2		
Reasons for clinical referral	Self-harm included: 12	Without self-harm: 7	
Depression, unknown suicide thoughts or plan	2	3	
Depression, known suicide thoughts and plan	7	1	
Eating disorder	5	2	
Self-harm	4	0	
Anxiety	3	1	
School dropout	1	1	
ICD-10 diagnosis	Many cases	Few cases	
	Mood disorder: 15	Drug misuse: 2	
	Anxiety disorder: 14	Personality disorder: 3	
	Eating disorders: 6	ADHD: 1	
		Schizophrenia: 1	
Personality disorder (PD)	Several cases	Few cases	
Four had no PD	Avoidant: 7	Obsessive Compulsive: 3	
Three had 1 PD	Borderline: 6	Negativistic: 2	
Seven had 2 PDs	Depressive: 5	Antisocial: 1	
Three had 3 PDs		Dependent: 1	
Two were not assessed		Paranoid: 1	

Appendix B

Different ways into and out of self-harm

FIRST TOPIC: BEGINNING SELF-HARM	
<i>First meta-theme: Beginning self-harm as a way to handle difficult feelings and relational problems</i>	
Themes	Sub-themes
Difficult feelings and negative thoughts about self (n=15)	<i>A feeling of being depressed or sad (n=8)</i> <i>A struggle with anxiety and panic (n=7)</i> <i>Excessive negative thoughts about themselves (n=7)</i> <i>Shifting emotions (n=4)</i> <i>Suicidal thoughts/ideation (n=3)</i> <i>A suicide attempt (n=1)</i>
Other mental or behavioural problems (n= 9)	<i>Eating disorders (n=7)</i> <i>Sleeping problems (n=1)</i> <i>Psychosis (n=3)</i>
Problems in their family (n= 15)	<i>Parents' divorce was very troublesome (n=8)</i> <i>A family member with a mental illness (n=6)</i> <i>A family member with recurrent suicidal ideation (n=4)</i> <i>Parent(s) with alcohol and drug misuse (n=5)</i> <i>Traumatic event (n=5)</i> <i>Violence from a parent (n=2)</i>
Problems with peers (n=11)	<i>Feeling lonely and difficulties building friendships (n=6)</i> <i>Social excluding (n=7)</i> <i>Risk behaviours and carelessness about their own safety (n=3)</i>
Diffuse problem or a problem difficult to describe (n=6)	<i>Difficult to say (n=4)</i> <i>Bored (n=1)</i> <i>Feeling indifferent (n=1)</i> <i>Fatigue (n=3)</i> <i>Somatic pain (n=1)</i>
<i>Second meta-theme: Becoming inspired by peers to experiment with self-harm</i>	
Themes	Sub-themes
Heard about self-harm from friends (n=6)	<i>Heard friends talking about self-harm (n=3)</i> <i>Friend or boyfriend who harmed her/himself (n=3)</i>
Media and/or internet (n=5)	<i>Newspapers (n=1)</i> <i>Internet pages, blogs and social media (n= 5)</i> <i>People they met on the Internet who self-harmed (n=1)</i>
Coincidentally (n=11)	<i>Something was broken, and they got the idea (n=3)</i> <i>Impulsively harming themselves while making food (n=6)</i> <i>Cannot remember (n=3)</i>
SECOND TOPIC: QUITTING SELF-HARM	
<i>First meta-theme: Ambivalence towards help, treatment and ending self-harm</i>	
Themes	Sub-themes
Someone discovered self-harm and suggested treatment (n=6)	<i>Was motivated for treatment, but could not say it (n=3)</i> <i>Thought treatment could destroy their plans (n=4)</i>
Referred to the clinic but not because of self-harm (n=7)	<i>Went by themselves to the doctor (n=3)</i> <i>Told someone about the problems hoping to get help (n=4)</i> <i>Followed advice to get help (n=1)</i>

Ambivalent towards treatment (n=10)	<i>Did not think treatment could help but open to try it (n=4)</i> <i>Wanted help, but not when they are troubled (n=6)</i> <i>Did not feel they deserve the help they got (n=2)</i>
Earlier negative experience (n=8)	<i>Have a negative experience of being in treatment (n=5)</i> <i>People saw their problems and did not react (n=4)</i>
Decided to quit self-harm (n=9)	<i>Do not want to have scares (n=7)</i> <i>Do not want to be one of those who harm themselves (n=1)</i> <i>Afraid of consequences of serious self-harm (n=1)</i>
Ambivalent to quitting self-harm, but managed and experienced new problems (n=11)	<i>Hard to handle the pressure (n=8)</i> <i>Still experiencing problems. Do not know what to do (n=3)</i> <i>Cannot manage to ask for help (n=1)</i> <i>Eat less (n=2)</i> <i>Exercise or run more (n=1)</i> <i>Talk to herself for hours (n=1)</i> <i>Get themselves into risky situations (n=3)</i> <i>Suicidal ideation (n=1)</i>
Would not, but felt obliged to end self-harm (n=8)	<i>Maybe they will feel better if they end self-harming (n=2)</i> <i>Do not want to hurt or disappoint someone (n=3)</i> <i>Afraid to lose positive aspects associated with self-harm (n=4)</i> <i>Do not want to quit (n=2)</i>
<i>Second meta-theme: Discovering one's own way to quitting self-harm</i>	
Themes	Sub-themes
Doing something as a distraction from the urge to self-harm (n=16)	<i>Doing something in their room (knit, read, write/ draw, mobile/ PC, game, film, smoke, change clothes/makeup, eat) (n=9)</i> <i>Music (listen to a melody/text, play or write a song) (n=5)</i> <i>Try to calm down or sleep (n=4)</i> <i>Do something for a while to delay self-harm (n=3)</i> <i>Do something away from home and focus on the activity (n=3)</i> <i>Be with friends (n=5)</i> <i>Drink alcohol (n=1)</i> <i>Do not have any instrument to harm themselves with (n=1)</i> <i>Indirectly harm themselves (n=2)</i>
Attending to something or thinking positively (n=5)	<i>Think about the clinic and their therapist (n=3)</i> <i>Keep a positive attitude towards life (n=2)</i> <i>Think about their wish for a change in life (n=1)</i>
Attending to feelings/ thoughts (n=2)	<i>Tolerating feelings instead of harming themselves (n=1)</i> <i>Talking honestly with someone (n=1)</i>
Remember negative consequences (n=5)	<i>Afraid of increased self-harm lately (n=2)</i> <i>Scars (n=3)</i>
<i>Third meta-theme: Exploring self-harm together with the therapist</i>	
Themes	Sub-themes
A nice meeting with the therapist/clinic (n=7)	<i>Felt safe from the start of treatment (n=1)</i> <i>Enjoyed being at the clinic. Feeling welcome (n=2)</i> <i>Treated with respect, and felt they wanted to help (n=3)</i> <i>Felt comfortable in opposition to earlier experience (n=3)</i>
Talking openly about problems for the first time felt good (n=10)	<i>Speak openly (n=5)</i> <i>Begin talking to someone about feelings and thoughts (n=6)</i> <i>Get help to talk about difficult situations (n=7)</i> <i>Talk to a person about difficult situations and relations (n=2)</i>

Being understood (n=7)	<p><i>A person who listen and tries to understand (n=2)</i></p> <p><i>Mapping feelings, thoughts, and actions in situations (n=3)</i></p> <p><i>Help to understand and attend to a feeling in a situation (n=2)</i></p> <p><i>Get an answer to what their problems are (n=3)</i></p> <p><i>Get other persons' reflections (n=3)</i></p>
Being supervised (n=6)	<p><i>Supervision in difficult situations (n=3)</i></p> <p><i>Help to breathe in difficult situations (n=1)</i></p> <p><i>Exploring specific alternative coping strategies (n=3)</i></p> <p><i>Knowing the therapist had experience (n=1)</i></p>
Reducing their problems and affecting their relations in positive ways (n=12)	<p><i>Feeling better (n=1)</i></p> <p><i>Attending to feelings in stressful situations (n=3)</i></p> <p><i>Irritated or sad when earlier felt stressful (n=3)</i></p> <p><i>Increasing a tolerance for the urge to self-harm (delay) (n=1)</i></p> <p><i>Their parents are paying more attention to them (n=1)</i></p> <p><i>Talking openly with their parents (n=3)</i></p> <p><i>It took some time, but now treatment is feeling useful (n=2)</i></p> <p><i>Treatment is taking time. Important not having time-limit (n=1)</i></p> <p><i>Feeling better, but do not know if it is related to therapy (n=4)</i></p>
Not feeling any better (n=3)	<p><i>Do not feel difference from the beginning of treatment (n=1)</i></p> <p><i>They know it takes some time to become better (n=1)</i></p> <p><i>The recommended exercises were not helpful (n=1)</i></p> <p><i>Difficult to decide on a focus in treatment (n=1)</i></p>
Not wanting to stop self-harming (n=3)	<p><i>Not interested in ending self-harm (n=2)</i></p> <p><i>Focusing on homework and exercises is boring (n=1)</i></p>

Appendix C

Three different ways into and out of self-harm

FIRST TOPIC: BEGINNING SELF-HARM	Anna	Elsa	Sophie
<i>First meta-theme: Beginning self-harm as a way to handle difficult feelings and relational problems</i>	<i>I'm disgusting and worthless</i>	<i>I just did it. I don't know why</i>	<i>It was my exit</i>
<i>Second meta-theme: Becoming influenced by peers and media to experiment with self-harm</i>	<i>Someone else did it</i>	<i>I read about it on the internet</i>	<i>If it helps others, it may help me</i>
SECOND TOPIC: QUITTING SELF-HARM	Anna	Elsa	Sophie
<i>First meta-theme: Ambivalence towards help, treatment and ending self-harm</i>	<i>I want to be independent</i>	<i>I don't want to be a burden</i>	<i>When I have bad times, I don't want to get better</i>
<i>Second meta-theme: Discovering one's own way to quitting self-harm</i>	<i>I delay my self-harming</i>	<i>Exhausting exercises</i>	<i>Be with someone</i>
<i>Third meta-theme: Exploring self-harm together with the therapist</i>	<i>To get help to remember and find triggers</i>	<i>To begin to talk and to get help to understand</i>	<i>To feel welcome and to be respected</i>