WORKING WITH LOOKED AFTER CHILDREN WHO SELF-HARM: UNDERSTANDING COPING, COMMUNICATION AND SUICIDE[1]

Sam Warner and Clare Shaw
s.j.warner@aol.com
Sam at Salford University and Clare Expert by experience and Royal Literary Fellow

Introduction: defining our knowledge-base and focus

Self-harm is a complex issue that affects a great many young people. In the last 20 years there have been significant attempts to capture children's own perspectives on self-harm (Spandler, 1996) and to develop a child-focused knowledge-base (Spandler and Warner, 2007). This chapter is situated within that tradition. We draw on a wide array of sources in order to inform our approach; actively soliciting information from service-users/ experts-by-experience and using this to challenge, theorise, elaborate and reflect on more formal research findings. Specifically, in this chapter Clare draws on her own personal history of self-harm to provide a rich account of what it is like to be a young person struggling to survive with abuse and neglect in an often hostile world. As yet, there is limited research on looked after children as a specific group who self-harm - although this is changing (see Evans et al, forthcoming). However, there is considerable research on the issues children in care often face. Children in care come from backgrounds that are typified by abuse and neglect at home, and/ or exploitation, violence and criminality on the street; such traumatised children are at increased risk of hurting themselves and completing suicide (IRISS, 2013).

In this chapter we identify some of the common self-harm methods available to children in care. We explore the socio-cultural context to self-harm, and identify key experiences and underlying issues that are associated with self-harm for children who may end up being cared for away from their families. We then explicate how self-harm functions to manage emotional distress. We consider the relationship between coping, communication and suicide, and identify key factors associated with increased risk of self-inflicted death. We describe a harm cessation approach designed for working with children who are at high risk of suicide or serious self-injury and consider the negative impacts of over-extending this approach. We then describe core elements of a harm minimisation approach. We discuss the impact on those who work with children in care who self-injure and conclude by identifying principles for practice and policy that are best able to safeguard these children and the people who work with them.

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[1] This chapter is based on a training course on self-harm and suicide developed and delivered by Clare and Sam that was commissioned by Lancashire Care Foundation Trust for their entire mental health work force – that was inclusive of those who work with children in social and mental health care.
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Throughout this chapter, self-harm is used as a generic term to describe any action that by omission or commission causes physical harm to the body (anything from cutting or drug and alcohol use to self-neglect and tattooing). Self-injury is understood as a specific form of self-harm that is distinguished by being directly physically harmful, with a relatively immediate (vis a vis cumulative) impact, and which is heavily stigmatised (e.g. cutting, taking an overdose). Suicide is also a specific form of self-harm and self-injury which is distinguished by the intention to end life.

How children self-harm: Prevalence and underlying issues

Children (and adults) self-harm for many different reasons and use very many different methods. The types of methods utilised by children are indicative of the socio-cultural context of their lives. This means that although individuals utilise methods that have particular *salience* for them, choice of method will be mediated by demographic factors including age, gender, ethnicity, geography, class, ability and institutional/ residential setting. For example, scratching, cutting, hitting the self and head-banging are common methods of self-harm for younger children, children and adults in institutional care, and those with learning difficulties (e.g. Heslop and MacCaulay, 2009). Although diverse in nature, all of these groups have carers who limit *access to* and *opportunity to use* a wider repertoire of self-harm methods (scratching and hitting the self require no tools, and head banging only requires a wall or floor).

Recognising demographic differences is helpful, therefore, because such differences point to key issues (indicated here in italics) that are highly indicative in self-harm. *Identity*, particularly sex/ gender identity, is highly significant. In the UK, men are three times more likely to kill themselves than women (Harker et al, 2013), although women are three times more likely to attempt suicide, with some groups of women being at particular risk – for example, South Asian, Indian and East African women (see Ineichen, 2008). By contrast, in serious case reviews, at least, suicide in the 8-18 age range is fairly evenly spread across boys and girls (see Brandon et all, 2011). Here all children who died had been maltreated (the reason for a SCR) and 2/3 were open to children's social care – with 1/3 being looked after and another 1/3 having been on a CP plan.

Between 2012 and 2014, a 70% increase in 10-14 year olds attending A&E for self-harm related reasons was recorded over the preceding 2 years, with a threefold increase over the last decade in teenagers who self-harm in England (WHO 2014). Indeed, self-harm can be understood to be a particular issue for adolescents – the majority of people who self-harm are aged between 11 and 25 years, with a peak in mid adolescence (see Hagell, 2013). At least 13% of young people may try to hurt themselves on purpose at some point between the ages of 11 and 16, but the actual figure could be much higher (see Self harm UK, 2015 download). Lesbian, gay, bisexual and transgendered people have a higher than average rate of suicide and self-harm, with 1 in 2 LGBT youth reporting self-harm at some point in their lives. The gap is even higher for ethnic minority LGB people and those with disabilities (see Guerra, 2015). It is not insignificant that LGBT children are more at risk

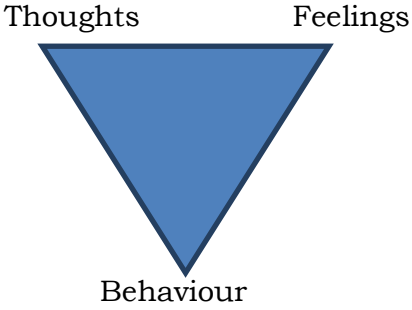
of being bullied than their heterosexual peers (ibid.). Hence, we can assume that issues concerning *helplessness,, and exclusion* are particularly acute for minoritised, ostracised and powerless young people.

Why children self-harm: Underlying issues, core experiences and the management of emotional distress

For most young people, self-harm and suicide is associated with difficult and distressing life experiences that leave them feeling powerless, excluded, invalidated, frustrated, lost, isolated and hopeless. It is little wonder then that looked after children, who suffer disproportionate experiences of abuse, neglect, exploitation and loss resulting in increased mental health and social problems, exhibit higher rates of self-harm and suicide than their peers.

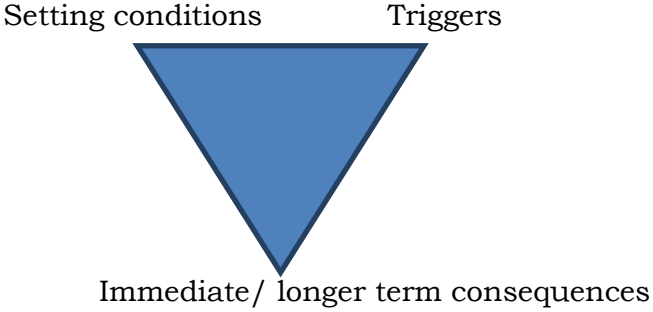
To understand self-harm it is necessary, therefore, to look beyond the behaviour to make sense of the thoughts and feelings that instigate the need to self-harm (see diagram one below). Self-harm is not random, but is an adaptive response to distressing feelings and specific and difficult situations.

Diagram one: Communication[2]



In order to understand how self-harm functions for children in care it helps to consider specific instances of self-harm, - using a functional analysis that identifies core issues in terms of general setting conditions, specific triggers and consequences – both immediate and longer-term (see diagram 2 below).

Diagram two: Self-harm functions



In the box below Clare writes about some of her own experiences of self-harm to illustrate and illuminate this process.

[2] All diagrams taken from Warner (forthcoming) unless otherwise stated.

Clare's story: Feeling alone

1. Setting conditions/ Background

Life had not been easy. I was the youngest of six in a single parent family where money and attention were in short supply. My visits to my father's house were characterised by alcoholic and predatory adults; I was unsafe there but could do nothing about it. At the age of ten, I was raped. I passed through the police and court systems with no support. I began to self-harm as a way of trying to attract the recognition and care I wanted.

But I didn't tell anyone about it. I'd been brought up not to express difficult emotions or to communicate difficult experiences. My sense of shame was huge. By the age of 13, when I started to get crushes on girls, that shame intensified. I had been brought up in the Catholic tradition and on the right wing of British politics and I could tell no-one about how I felt. Self-harm helped me cope with often unbearable feelings of despair, hurt and anger.

2. Triggers and consequences

By fifteen, my distress and my sense of isolation had increased. My hidden sexuality was a huge source of anxiety and shame. I began to harm myself more frequently: starving myself; cutting myself with razors; and taking overdoses. If I was visibly thin, ill, wounded and sleep-starved, surely someone would notice?

It was at this age that I first needed hospital treatment. Everyone was out of the house and I felt profoundly and completely alone. I cut myself on the palm of my hand. I could explain this away as an accident – my Mum had new kitchen knives and had warned me to be careful with them. I preferred to present my injuries as accidental - I didn't want anyone to know that I was hurting myself deliberately.

The immediate consequence : I lost a lot of blood. Watching it flow helped me feel alive, connected to myself at least. It spoke to me about how I felt: wounded, hurt, in pain, but surviving. A secondary consequence was that I needed to go to hospital for stitches, where, as a young person with an 'accidental' injury I received the care, compassion and understanding I desperately needed. Over time, self-harm became the primary means through which I survived my life. It was an effective way of temporarily alleviating my distress; and expressing to myself and the people around me how much I was hurting.

3. Institutionalised care and suicidal thoughts – what didn't help

Eventually I was admitted onto a psychiatric ward. Six years of spending time in and out of psychiatric hospital is hard to summarise: fear, hopelessness, boredom and powerless are just a brief reflection; those feelings, of course, ran alongside the distress and despair that had taken me into the system in the first place. My self-harm escalated to life-threatening proportions.

The more that my distress was dismissed, the more I tried to communicate it through more severe acts of self-harm. I felt – and I was told – that there was no hope; and it was hard to maintain any sense of myself as someone defined by anything other than difficulty and

madness. Ironically, I inflicted all of my most dangerous self-harm in institutions where self-injury was not allowed – in places I felt least understood, most controlled and where I had to use whatever method of self-harm was available before someone could stop me.

Eventually my desire for death outweighed any impulse towards life and I made several attempts to end my life. Ultimately, this time marked a distinct change in my approach. What came before was a struggle with pain; but having survived my suicide attempts, what came afterwards was a struggle towards happiness.

4. Transforming my life - what helped

Suddenly, it seemed, life could improve. I rediscovered small pleasures, like looking at the trees outside the ward. I began to make positive plans. I found myself re-rooted in a physical world, noticing sensations in my own body. I began making choices for myself: including the decision to leave hospital and never go back. I began to take small steps towards the future.

What helped? In the short term, people were there when I reached for them. I was not alone. If I had been, I would not have survived. Friends and staff were there when I needed them; a crisis team worked out crisis plans with me: negotiating with me, step-by-step, the hours ahead. I left enough space in my consciousness for doubt to creep in when I did not die as planned. I allowed that doubt to grow. I reached out. I held on. I was hungry for change and for my life to improve. I noticed what things made me feel better and I tried to do them again. I realised that I was capable of happiness - and I wanted more of it.

Through therapy and reading, I opened myself to the possibility that there were more helpful ways of viewing the world than seeing myself as ill or disordered. I began to move away from the passive "patient" role I'd occupied so unhappily. In times of distress, I attended to the small and necessary details of surviving and thriving. Though I still harmed and starved myself, I dramatically reduced the damage I did to myself.

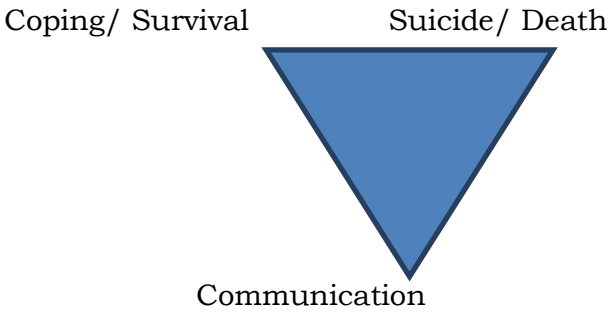
Over the long-term, I have made – and continue to make - large scale, holistic change; addressing the causes of distress in my life at every level. I have a strong sense of connection with the people I have in my life; and I engage with life with a passion and appetite that might only be shared by those of us who have looked death in the face.

Learning from Clare's story

Clare's story is deeply personal, but speaks to important themes that structure the lives of many children in care. Like them, Clare experienced neglect, abuse and sexual violence. She suffered from a profound lack of safety at home and on the streets. Like very many children in care, she was made to feel shame around her identity and was pathologised for her self-harm when she was desperately trying to survive. She was frequently given no permission to voice her hurts and concerns. Like other young people living away from their families, Clare was most hurt within institutions that sought to control her rather than to listen and understand (Shaw and Shaw, 2007).

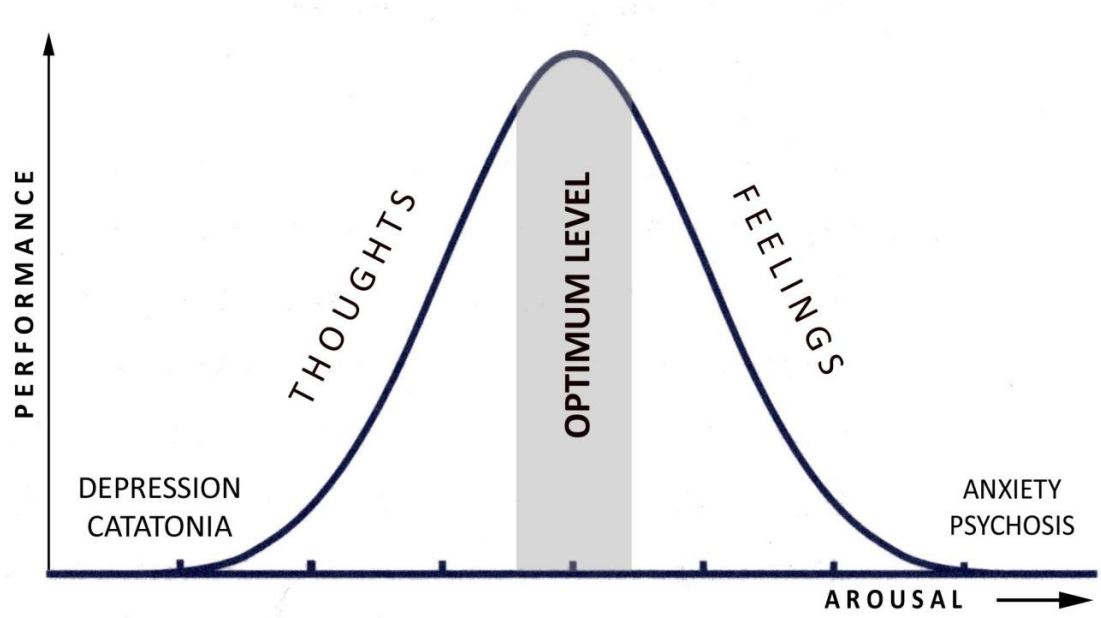
Young people in care use self-harm like Clare for three reasons: mostly to manage their distress, to communicate to themselves and others about their distress, and only sometimes as a means to end life (see diagram three: primary functions of self-harm).

Diagram three: the primary functions of self-harm



Whether self-injury is a survival strategy or a means to end life, something is always being communicated – even when this is not the main function of the injury. It is vital to help children untangle the meaning of self-harm as this helps to identify what is troubling them; and what, specifically, they need. As noted, self-injury helps people manage their emotional world. It does this by helping individuals cope with the emotional pain or numbness that is a result of psychological distress (Lancashire Care Foundation Trust, 2012). In effect, self-harm helps children manage their emotional arousal (see diagram four below).

Diagram four: The relationship between performance and arousal (Warner, forthcoming - adapted from Yerkes-Dodson's Law, 1908)



This model provides a means through which the relationship between arousal and performance can be understood; and through this, illuminates how self-harm works. Simply put, in order to perform people must be aroused/ awake. As arousal increases, so does performance

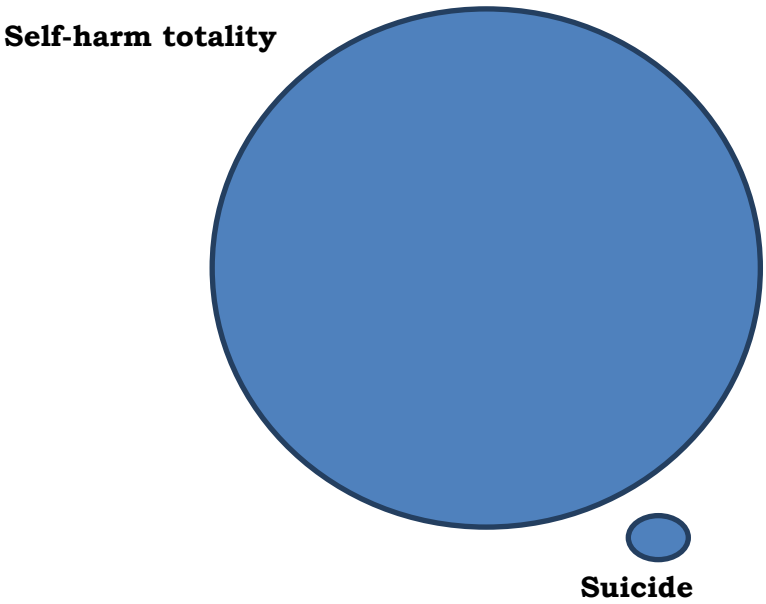
until an optimum level is reached after which the ability to perform well decreases. When people become over-aroused they are overwhelmed by their feelings and if pushed to extreme emotional levels they become highly anxious and eventually may start to see visions, hear voices, have flashbacks. People can retreat from extreme emotionality back to the other side of arousal where thoughts dominate. Too many negative thoughts push people into depressive states where they shut down emotionally - becoming numb, disengaged, dissociated, and in extreme circumstances, catatonic. Self-harm 'works' because it enables people to manage their arousal: if they feel too much it can move them away from their feelings, through distraction or self-punishment for example; or if they feel too numb, self-injury can help people to feel alive and connected - as Clare did when she cut her hand.

Self-injury can only help to manage emotional arousal. It does not solve underlying problems. For some children in care, their emotional pain may be too overwhelming and/ or their disengagement from life too strong; and self-harm simply does not bring enough relief. At this point they may, as Clare did, become actively suicidal. It is crucial, therefore, to understand where coping ends and suicide begins, as coping and suicidal self-harm require very different strategies.

Coping, communication and suicide: Identifying distinctions and understanding how to work with risk

Self-injury has a clear relationship with suicide, but they are not equivalent. Only a small proportion of people who self-harm kill themselves thereafter. For example, Hawton et al (2003a) found that 0.7% of people who were seen in hospital for self-harm die by suicide within a year of that self-harm. This figure increases to 2.4% after ten years. Nevertheless, over half of those who go on to complete suicide will have self-harmed at some point in the past (NICE 2002). Following an act of self-harm the rate of suicide increases to between 50 to 100 times the rate of suicide in the general population (Hawton et al 2003b; Owens et al 2002). See diagram five below.

Diagram five: The relationship between self-harm and suicide



As this diagram illustrates, although the vast majority of people who self-harm do not go onto kill themselves, it is very important to consider the potential for suicidality because a history of self-harm is highly indicative in suicide. The first step, therefore is to assess the risk of suicide. Children and adults with diagnosable mental health problems are at high risk of suicide: the diagnosis, *per se*, indicates very little. Rather, we should be concerned with any change that has occurred in respect of thoughts (e.g. stated intention to die); feelings (e.g. an elevation in mood in the context of nothing changing in circumstance); and/ or behaviour/ circumstance (e.g. negative life event or anniversary of negative life event). In summary, change must occur on at least one of these three dimensions. The child must feel hopeless and believe that things will not get better or will not get better in a time frame they can tolerate. Additionally, the child must have access to lethal methods of self-harm and have the opportunity to use them. In the short term there are a number of psychological and physical measures that can be taken to reduce the risk of suicide.

Stopping suicide and restricting risk: Safe certainty and harm cessation

Risk assessment should lead to a formulation (based on setting conditions, triggers and consequences) that informs the risk management plan. At times of high risk, more restrictive safety plans must be in place. There are two main psychological methods that are designed to stop suicide. These are both designed to build *pause* between the desire to end life and the suicidal act. In the short term psychological barriers are useful. This may simply involve saying, 'can we talk about this first?' to someone who has expressed a desire to die. It is the same principle that underpins the use of safety nets and the provision of the Samaritan's contact details at places where people could kill themselves (high bridges, buildings or cliffs, for example). Psychological barriers cannot physically stop someone trying to kill themselves, but may

provide enough pause for the small voice of survival inside to be heard (as happened with Clare). Longer term services can develop *advance agreements* with young people that can help staff identify when the child is starting to become hopeless; what triggers are around; and what helps and hinders in such circumstances. In this way children are enabled to take their thinking into their most out of control moments. Advance directives can be further developed over time as services get to know the young person and their needs better.

Practical restriction may involve removing a child into care, or moving an already looked after child into a more restricted environment such as a secure unit or hospital. Anything that may be used to cause harm to the body (CDs, knives, tablets, belts etc.) may be removed. Conversely, children may be encouraged or even forced to take increased medication (when detained under the Mental Health Act). Children may be physically restrained, secluded; and/ or placed on 'constant observation' by one or more carers. Such measures may be necessary to keep the child alive, but they have very many negative consequences. The child may feel controlled, hurt, violated, scared, angry. Their relationship with their carers may be undermined. As Clare's story indicates, restricting opportunities to self-harm can paradoxically increase risk (Shaw and Shaw, 2007). As such, any decision to restrict access and opportunity to self-harm should not be taken lightly and a less restrictive approach should be adopted as soon as possible.

Enabling change through positive risk taking: Safe uncertainty and harm minimisation

When children are not engaged in highly risky self-injury and/ or are not actively suicidal, then a less restrictive approach is indicated (c.f. Mason, 1993). This involves positive risk taking in which children are enabled to change, but not overly restricted in their behaviour. This may mean they continue to self-harm. Indeed, from a harm minimisation perspective stopping self-harm ceases to be the primary aim of intervention – rather recovery becomes a more individualised, self-defined process. Pembroke (2007:166) argues that 'harm-minimisation is about accepting the need to self-harm as a valid method of survival until survival is possible by other means'. There are three main aspects to a harm minimisation approach: behavioural, cognitive and emotional.

In behavioural terms, there are a number of measures that can be used to reduce the risks associated with self-injury (see Pembroke, 2000, 2007). These include: using sterilised/ new blades to minimise the risk of infection; having first aid kits; and having someone around to look after the person who is self-harming if needed/ desired etc.

In cognitive terms, children need to know about how their body works and the impact of self-injury on different injury sites; the immediate and longer-term effects of self-poisoning and burns etc; and the impact of infection. They may need to know they are not alone and that self-harm is not indicative of madness: rather, it is something people sometimes do when they are unable to cope in less damaging ways. They may need therapeutic help to make sense of their own relationship with self-harm: the underlying issues that provide the backdrop to their self-injury; the triggers that instigate their self-injury; and the maintaining factors that keep them self-harming. Although children may be aware

that self-harm helps them feel better, they may feel ashamed about what they do (this is unsurprising when it is so highly stigmatised) and they may not fully understand how it works for them.

Finally, in emotional terms, children's desire to self-harm is reduced when they are treated with respect by sympathetic, supportive and warm staff (Arnold 1995); when they have opportunity to talk about their feelings about self-injury and have someone to listen to them (Heslop and Macaulay); when they are treated like whole human beings rather than seen purely through the lens of self-harm (Shaw, 2006); and when they have choice, control, safety and dignity in their lives (Warner, 2009).

In practice, services have differing abilities to engage in the full range of harm minimisation approaches with looked after children. Our duty of care to looked after children is to reduce risk and safeguard their best interests. This may be best achieved by operating a harm minimisation approach - rather than too quickly trying to stop young people's self-harm. This is best achieved by all colleagues adopting a shared understanding of the child, within a context of multi-disciplinary co-operation, utilising our different skill sets. For example, as a clinical psychologist Sam does not have the medical knowledge to offer advice regarding self-harm and the biological body. However, she is well placed to help children make sense of their lives (the abuse, neglect and loss they may have suffered prior to and during their time in care) and how self-harm works for them psychologically (how it helps manage negative thoughts and feelings). All workers have a duty to act with respect, warmth and care whilst being mindful to listen to young people, to treat them with dignity, and to recognise their multiple identities beyond the self-harm.

The impact of self-harm and suicide on professionals and carers: Practice and policy implications

Staff experience secondary trauma when working with young people who self-harm. For example, Arnold and Magill (2005) found that staff who worked with people who self-harm report feeling shock, horror and disgust; incomprehension; fear and anxiety; distress and sadness; anger and frustration; powerlessness and inadequacy: the same feelings that children who self-harm feel. If staff and carers are to use their feelings to help them empathise with their clients, and thereby continue to work compassionately creatively and in a child-centred way they need to robust support from the services they work within. Safe services provide access to training as well as ongoing opportunities to offload and reflect. Staff also benefit from having opportunities to team work and network with other agencies; and having access to peer support groups and effective management and external supervision. Finally, workers (like clients) benefit from acknowledgement and appreciation (ibid.).

Compassionate and safe services are supported by clear and comprehensive policies and guidance that are inclusive of strategies for preventing suicide, as well as identifying strategies for working with children who use self-harm to cope and communicate. There should be shared understanding about self-harm across care providers, whilst recognising and valuing the different roles different professionals and foster carers play in respect of children in care. Service providers should

have developed accessible means for evaluating interventions that provide meaningful information for clients and providers as well as commissioners of services. If behavioural methods are to be used to evaluate intervention, then a more finessed understanding of behaviour should be adopted. Noting whether someone has stopped self-harming is too blunt: rather it is more meaningful to consider the frequency, intensity, number and duration/ FIND of different methods of self-harm (see Warner and Spandler, 2012). There should be clear understanding of how to assess, formulate and work with risk at different levels encompassing a clear appreciation that risk is never static but is mediated by past events and current concerns.

Ultimately, a framework is required for deciding what will work best with each particular child, and identifying when change of method or focus is needed. This involves a functional analysis of changing needs. It is based on a holistic approach that recognises self-harm is best understood in terms of a child's whole life - and that understanding what brings children into care, and facilitating positive relationships thereafter, will reduce children's need to self-harm not just in the present, but also in the future.

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